



Community Health Plan
OF IMPERIAL VALLEY | ADVANTAGE **PLUS**

Advantage Plus (HMO D-SNP),
a
Medicare & Medi-Cal Plan

PROVIDER MANUAL
2026

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Section 1: Introduction - What You Need To Know

Thank you for being a Community Health Plan of Imperial Valley (CHPIV) provider. We are pleased to have you participate with us in the delivery of high-quality health care for our diverse membership.

CHPIV offers several services to our members including the following:

- Member Services (available 24 hours a day, 7 days a week);
- After-hours Telephone Advice Nurse;
- Care coordination and case management; and
- Electronic eligibility, authorization request submission and status look-up.

The purpose of this Provider Manual is to give you and your office staff the operational “how to” information referred to in our contract. To ensure that we all operate in compliance with changing legislation and regulations. These guidelines are based on CHPIV’s established policies and procedures.

The Provider Manual is not meant to replace personal contact with our expert CHPIV staff. We encourage you to call us using appropriate phone numbers in every section of this document.

Our success depends on the goodwill and satisfaction of participating in health care professionals. We look forward to working with you.

About CHPIV

Community Health Plan of Imperial Valley (CHPIV) is Imperial County’s locally governed health plan, serving as both the Medi-Cal plan and a Dual Eligible Special Needs Plan (D-SNP) that integrates Medi-Cal and Medicare coverage to deliver coordinated, high-quality, and locally driven care for Imperial Valley residents.

Our Mission

High quality, accessible and equitable healthcare for our members through community partnership and innovation.

Our Vision

A community of service, supporting optimal health outcomes, one member at a time.

Principles of Operation

Experience with the diverse needs of our members is a strength of CHPIV. We provide or arrange for our members' health care through:

- Convenient, neighborhood facilities, clinics and health centers,
- Multilingual, multicultural providers and office staff,
- Commitment to the communities we serve, and
- A personalized approach to plan members' health care needs.

Member satisfaction is a top priority at CHPIV. Our experienced Member Services staff is always ready to answer member questions and resolve problems.

Effective cost management is assured through the coordinated delivery of medical services. Utilization management, an integral part of CHPIV, assures the delivery of appropriate health care.

Quality improvement is achieved through a comprehensive Quality Improvement and Health Equity Transformation Program Plan.

Unrestricted communication between physicians and patient regarding appropriate treatment alternatives is encouraged.

Case management and coordination of care between CHPIV case managers and our physicians ensure quality of care, access, and continuity of care for our members. Primary care physicians are responsible for managing their patients' medical care and promoting medical practices that encourage:

- Preventive health services,
- Efficient use of health resources,
- Compliance with quality assessment measures, and
- Member responsibility for good health.

Member Rights and Responsibilities

To access the members' nondiscrimination notice and CHPIV Member Rights and Responsibilities, please visit our website at www.chpiv.org.

Section 2: Key Contact Information

	Phone	Fax	E-mail
Administration			
Information Systems (CHPIV)	(760) 332-6447	(760) 863-5187	lgutierrez@chpiv.org
Information Systems	(619) 498-6445	(619) 476-3818	TInka@chgsd.com
Quality Improvement	(619) 498-6486	(619) 407-4645	CorporateQualityDivision@chgsd.com
Financial Services			
Financial Solvency Capitation Payments	(760) 332-6447	(760) 863-5187	dwilson@chpiv.org
Health Care Services			
Authorization and Referrals	(888) 244-4430	(800) 870-8781	nbaraj@chgsd.com
Behavioral Health Services <i>Imperial County Access and Crisis Line</i>	(800) 404-3332 (800) 817-5292	(877) 862-7603	jmuyot@chgsd.com
California Children Services (CCS)	(619) 240-8920	(619) 407-4659	nbaraj@chgsd.com
Case Management	(760) 332-6447	(760) 863-5187	lgalvin@chpiv.org
Chief Medical Officer (CHPIV)	(760) 332-6447	(760) 863-5187	garakawa@chpiv.org
Chief Medical Officer (CHG)	(619) 498-6423	(619) 407-4648	aconrad@chgsd.com
Medical Director	(619) 498-6458	(619) 407-4648	yfarook@chgsd.com
Health Education	(619) 240-8834	(619) 407-4648	mrami@chgsd.com
Pharmacy Services MedImpact	(619) 498-6476 (877) 606-0727	(619) 407-4653 (858) 790-6060	
Utilization Management	(619) 498-6458		bvargas@chgsd.com
Operations			
Claims	(888) 671-6419	(619) 425-8726	evaldez@chgsd.com
Contracting (CHPIV)	(760) 332-6447	(760) 863-5187	docampo@chpiv.org
Contracting (CHG)	(619)498-6535	(619)476-3836	Sfrench@chgsd.com
Fraud & Abuse Hotline	(800)919-4947	(760) 863-5187	compliance@chpiv.org
HEDIS	(760) 332-6447	(760) 863-5187	garakawa@chpiv.org
Marketing	(760) 332-6447	(760) 863-5187	mramirez@chpiv.org
Member Services (D-SNP)	(888) 330-2117	(619) 426-9437	hi@chpiv.org
Provider Services	(619) 240-8895	(619) 425-8726	rdiaz@chgsd.com
Compliance Officer	(760) 332-6447	(760) 863-5187	etarabola@chpiv.org
Telephone Advice Nurse (TAN)	(888) 671-3332	(877) 862-7603	

Observed Holidays

New Year's Day

Martin Luther King, Jr. Day

Memorial Day

Independence Day (Fourth of July)

Indigenous People's Day

Thanksgiving Day

Friday after Thanksgiving

Christmas Day

When holidays fall on a weekend, the following Monday is designated a holiday.

Section 3: Access to Care

Accessibility requirements, appointment scheduling, & patient recall standards, contact Corporate Quality at (619) 498-6486.

Freedom of Choice and Direct Access to OB/GYN and Family Practice, contact Member Services at (888) 330-2117.

Accessibility of Care

Provider sites will have plan-approved office procedures to ensure members have full access to appropriate healthcare services.

Telephone Triage

- Each site must have procedures for triage or screening services by telephone **24 hours per day, 7 days per week (“24/7”)**.
- All personnel who answer telephones must know the procedures to refer emergency calls to “911.”
- All clinical questions must be directed to a registered nurse, mid-level provider or physician. Patients with serious, acute or urgent problems must be provided with same day services.

Routine/Non-urgent Appointments for Primary Care Visits

- Except in an emergency, all patients will be encouraged to make and keep regular appointments.
- Time-specific appointments for routine non-urgent care must be available within **14 calendar/10 business days** of the request for care.

Hours of Operation

Hours of operation and provision of after-hours services (not 911 or any of CHPIV’s telephone numbers) must be displayed in a clearly visible area, window or door. Primary Care Physician offices must be open and staffed by a physician, physician assistant or nurse practitioner who is available to members for a minimum of 32 hours per week.

Missed Appointments and Patient Recall

Site procedures must specify:

- Staff person responsible for contacting patients for missed appointments or any medical condition that requires urgent follow-up.
- Actions to be taken in the event of any medical condition which requires urgent follow-up such as: positive cultures, Class III to V pap smears, and other crucial laboratory and radiology results.

- Medical record documentation, including procedure for dating clinical results and physician review and signature; and Time frames for contacting patients. After-Hours Service
- The site's after-hours answering service or answering machine must provide specific instructions on how members can reach an on-call provider.
- A physician or licensed registered nurse must be available by telephone to assist in coordinating after-hours weekends, and holidays.

Emergency Access

An emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing in serious jeopardy the health of the member or, in the case of a pregnant woman, the health of the woman or her unborn child; (ii) serious impairment to bodily functions; or (iii) causing serious dysfunction to any bodily organ or part.

Emergency services mean covered inpatient and outpatient services that are (1) furnished by a provider qualified to furnish emergency services and (2) needed to evaluate or stabilize an emergency medical condition.

Normal Working Hours

- The site will instruct patients calling on the telephone with an emergency medical condition to call "911" immediately or proceed to the nearest emergency room. Prior authorization is not required.
- When an emergency medical condition occurs at the site, site staff will call "911" immediately and follow internal procedures for emergency care.
- Each site must have at least one staff member certified in basic cardiopulmonary resuscitation (CPR) present during working hours.
- Each site must maintain an emergency kit/crash cart.

After-Hours Service

The service will instruct patients calling with an emergency medical condition to immediately call "911" or proceed to the nearest emergency room. Prior authorization is not required.

Seniors and Persons with Disabilities

In response to the Seniors and Persons with Disabilities (SPD) beneficiaries transitioning into managed care, the Department of Health Care Services (DHCS) has revised the Facility Site Review tool that assesses the level of physical accessibility of all primary care sites and those specialist and ancillary service providers that provide care to a high volume of Seniors and Persons with Disabilities.

Upon completion of the Facility Site Review, a level of access will be ascertained as to whether the provider has "basic access" or "limited access" and whether the site meets the criteria of

having “medical equipment access”. Each site will be evaluated to determine if the site has or does not have access in the following seven categories: parking, building exterior, building interior, waiting room/reception area, exam room, restroom and medical equipment (height adjustable exam table and patient accessible weight scales).

In order to make it easier for members to select a primary care physician who can accommodate their unique health care needs, Community Health Plan of Imperial Valley has included the standardized accessibility symbols for each primary care site in our Advantage-Plus provider directory. We will continue to update our directory as the information is confirmed from each contracted primary care site. The following is a list of accessibility indicators that will be listed under each primary care physician’s address preceded by ♿ Accessibility:

P = Parking

Parking spaces are accessible with ramps and curb cutouts between the parking lot, office and at drop off locations.

EB = Exterior Building

Handrails are provided on both sides of the ramp. Doorways are accessible, open wide enough to accommodate a wheelchair or scooter and have door handles that are easy to use.

IB = Interior Building

The interior doors open wide enough to accommodate a wheelchair or scooter and door handles are easy to use. Elevators, stairs, and ramps have handrails and are easy to use. The elevator is available for public/patient use at all times the building is occupied. The elevator has enough room for a wheelchair or scooter to maneuver.

W = Waiting/Reception

The reception and waiting areas have enough room for a wheelchair or scooter to maneuver and turn around.

R = Restroom

The restroom is accessible and the doors are wide enough to accommodate a wheelchair or scooter and are easy to open. The restroom has enough room for a wheelchair or scooter to turn around and close the door. There are grab bars that allow easy transfer from wheelchair to toilet. The sink is easy to get to and the faucets, soap, and toilet paper are easy to reach and use.

E = Exam Room

Entrance to the exam room is accessible, with a clear path. The doors open wide enough to accommodate a wheelchair or scooter and are easy to open. The exam room has enough room for a wheelchair or scooter to turn around.

T = Exam Table/Scale

The exam table moves up and down and the scale is accessible with handrails to assist people with wheelchairs and scooters. The weight scale is able to accommodate a wheelchair.

Discrimination Prohibition

CHPIV providers may not discriminate against members on the grounds of race, color, creed, religion, age, sex, national origin, marital status, sexual orientation, genetic characteristics, or physical or mental disability through such actions as:

- Denying any member, a covered service or availability of a facility.
- Providing a plan member with any covered service that is different or is provided in a different manner or at a different time than that provided to other members except where medically indicated.
- Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service.
- Restricting a member in any way in the enjoyment of any advantage or priority enjoyed by others receiving services.
- Treating a member differently from others in determining whether he or she satisfies any admission, enrollment, quota, eligibility, membership, or other requirement or condition that individuals must meet in order to be provided with any covered service.

For information on **requirements for accessibility of care**, contact Corporate Quality at (619) 498-6486.

Accessibility Standards

Advanced Access - Advanced access is the provision of appointments with the primary care provider within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the member prefers not to accept the appointment offered within the same or next business day.

Appointment Wait Time - The applicable waiting time for a particular appointment may be extended if the referring, treating or triaging/screening practitioner determines and notes in the medical record that a longer waiting time will not have a detrimental impact on the health of the member.

Behavioral Health - Appointments for behavioral health services with physician and non-physician mental health care providers must be scheduled as follows; 1) non-life threatening emergency within 6 hours- 2) Urgent care within 48 hours- 3) Routine care within 10 business days.

Call Wait Time - The time a member waits on the telephone to speak to a physician, registered nurse, or other qualified health professional acting within his/her scope of practice and who is trained to screen or triage a member who may need care will not exceed 30 minutes.

Furthermore, the time a member waits for a return call may not exceed 30 minutes.

Child Health and Disability Prevention (CHDP) Periodic Health Screens - Members must be scheduled for CHDP periodic health screening examinations within two weeks of a request for the exam.

Initial Examination and Wellness Check (Preventive Care) - An initial health assessment examination, history and physics, for base line assessment and determination of need for preventive services. This exam must be scheduled within 120 days of the adult member's enrollment with CHPIV and within 60 days of the member under 18 months, unless the member's medical record contains complete and current information to allow for assessments of health status and health risk.

Initial Prenatal Visit - The initial prenatal care visit at obstetric sites must be scheduled within ten business days of request.

In-office Wait Time - The time from the scheduled appointment or the time the member arrives for the appointment, whichever is later, to the time the member receives service from the practitioner, inclusive of wait time in the exam room, will not exceed 30 minutes.

Return Call - A return call from a certified/trained medical assistant relaying information for the physician is acceptable; however, voice mail messages are not acceptable.

Routine/Non-Urgent Appointments for Primary Care Visits - Time-specific appointments for routine non-urgent care must be available within 14 calendar/10 business days of the request for care.



Routine Preventive Physical Examinations - must be scheduled within 30 days of request.

Specialty Care and Ancillary Services - Non-urgent specialty appointments must be scheduled within three weeks/15 business days of identifying the need for specialty care.

Telephone Wait Time - Member calls to the practitioner site must be answered without delay. The site may use a telephone answering machine, voice mail system or answering service whenever the office staff cannot directly answer telephone calls.

Urgent Care - Urgent Care means the services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury. An urgent care condition has the potential to become an emergency in the absence of treatment. Appointments for urgent medical conditions that do not require prior authorization must be scheduled within 48 hours and for conditions that require prior authorization must be scheduled within 96 hours of request.

Timely Access Standards to Obtain an Appointment

Urgent Care	
prior authorization not required by health plan  48 hours	prior authorization required by health plan  96 hours
Non-Urgent Care	
Doctor Appointment	
PRIMARY CARE PHYSICIAN  10 business days	SPECIALTY CARE PHYSICIAN  15 business days
Mental Health Appointment (non-physician)  10 business days	Appointment (ancillary provider ²)  15 business days
Follow-Up Care	
Mental Health / Substance Use Disorder Follow-Up Appointment³ (non-physician)  10 business days from prior appointment (effective July 1, 2022)	

Timely Access to Care Requirements

DISTANCE

A primary care provider / hospital within 10 / 15 miles or 30 minutes from where enrollees live or work

AVAILABILITY

Telephone services to talk to your health plan should be available 24/7

INTERPRETER

Interpreter services must be coordinated and provided with scheduled appointments for health care services

¹ Examples of non-physician mental health providers include counseling professionals, substance abuse professionals and qualified autism service providers.

² Examples of ancillary services include lab work or diagnostic testing, such as mammogram or MRI, or treatment such as physical therapy.

³ Substance use disorder treatment services are a carved-out benefit covered through the county. To learn more about treatment options for substance use disorders, call the San Diego County Access and Crisis Line.

Suggested Guidelines for Length of Appointments

Guidelines for Length of Appointments ¹ _{[YF3][ER4]}	
Routine Visits	10 - 20 minutes
Physical Examination & Wellness Check – Initial Health Assessment	15 - 45 minutes
Physical Examination & Wellness Check – Routine Follow-Up	10 - 20 minutes
Urgent Care Visit	10 - 20 minutes
Initial Prenatal Visit	30 - 60 minutes
Child Health and Disability Prevention (CHDP) Periodic Health Screens	20 - 45 minutes
Specialty Care Visit	15 - 30 minutes
Behavioral Health - Initial Evaluation	60 minutes
Behavioral Health - Visit with a Therapist	60 minutes
Behavioral Health - Medication Management with a Psychiatrist	20 minutes
¹ Allow disabled members an additional 15 minutes to accommodate for their special circumstances	

Direct Access to OB/GYN and Family Practice

All CHPIV members have direct access to OB/GYNs and Family Practitioners for routine obstetrical and gynecological services on an unlimited basis (without referral authorization) within these few restrictions:

- Members assigned to primary care physicians within IPAs and capitated medical groups have unlimited access within the contracted IPA/medical group.
- Members assigned to contracted primary care physicians have unlimited access within CHPIV's specialty network. In this case, the OB/GYNs and Family Practitioners can only provide services for which they are specifically contracted.

We encourage all OB/GYNs and Family Practitioners to call us before providing services. This allows for verification of member eligibility, network status, and primary care physician assignments to ensure proper payment.

Communication with Primary Care Physician

Continuity of care is vital to our members' overall health. We require OB/GYNs and Family Practitioners to communicate with our members' primary care physician regarding condition, treatment, and follow-up care.

Prior Authorization for Procedures or Treatments

OB/GYNs and Family Practitioners must follow prior authorization and utilization review requirements of their respective IPAs/medical groups.

Directly contracted OB/GYNs and Family Practitioners may provide those services listed on pages 21-8 through 21-10 without obtaining prior authorization from CHPIV. Other procedures require prior authorization through CHPIV's Health Care Services Division at (888) 330-2117.

For more information on direct access to OB/GYN and Family Practice physicians, contact Member Services at or (888) 330-2117.

Patient Recall

All primary care sites must have a policy and procedure for following plan members who have failed to keep scheduled appointments or who have a condition necessitating an appointment.

Failed Appointments

The medical records of members who have missed their appointments will be given to their primary care physician at the end of the day. The primary care physician will attach an order to the medical record indicating how soon the patient should be given another appointment (appointment not necessary, 1 day, 2-3 days, one week, etc.).

Designated personnel will call the members in the morning of the next business day. Results of this initial contact will be documented in the medical record.

Two attempts will be made to contact the members by telephone. If telephone contact is not possible, attempts will be made by mail.

If no response is received from either the verbal or written attempts, a letter will be sent to the patient/parent/guardian no later than two weeks after the initial attempt, advising of the medical care needed. If the letter is returned, it will be filed in the medical record with the envelope and “return to sender” stamp.

If the condition is severe and additional documentation is necessary to advise the member of the severity and consequences of non-compliance, the Chief Medical Officer/primary care physician is notified. A letter is sent via certified mail to the last known address, indicating termination of responsibility for the condition for which the patient is non-compliant and indicating all efforts made to provide ongoing care. A copy of this letter is sent to Member Services.

All attempts to contact the patient must be documented in the medical record.

Abnormal Laboratory and Radiology Reports

All laboratory/radiology reports will be dated upon receipt and given to the member’s primary care physician for review.

The primary care physician will attach an order to the medical record indicating if the patient should be given an appointment for follow up (1 day, 2-3 days, one week, etc.).

All laboratory/radiology reports will be initialed by the primary care physician before filing in the patient’s medical record.

For more information on patient recall standards, contact Corporate Quality at (619) 498-6486.

Sample Patient Recall Letter

DATE RECORD / DATE / DATE RECORD / DATE / DATE / DATE / DATE RECORD / DATE /
DATE / DATE / DATE / DOTE / DATE / RECORD / DOTE / DOTE / DOT / DATE // DOTE /
DOT / DOTE / DOTE // DOTE RECORD #

MEMBER NAME
ADDRESS

Dear _____ :

We have attempted to contact you by telephone on at least two occasions but we have been unsuccessful.

- We need to schedule an appointment for you.
- You did not keep a scheduled appointment and we need to reschedule.
- We have received the results of your tests. It is URGENT you return for medical treatment.
- _____

Your physician is very concerned about your needed care. Please call our office as soon as possible to schedule an appointment or to speak with a nurse.

Sincerely,

SIGNED BY SITE CASE MANAGER

Patient Termination

Physicians may discharge members who are uncooperative, do not follow medical advice, do not keep appointments or make violent threats to staff. The decision to end a doctor-patient relationship must be made by a physician and never by office staff. Once a physician begins treatment of a member, care must continue unless:

- The patient's condition is such that care is no longer required.
- The member terminates the doctor-patient relationship.
- The physician gives a member written notice of withdrawal of care and allows sufficient time (up to 30 days) for the patient to be assigned by CHPIV to another doctor.
- The physician agreed to treat only a specific ailment or injury, or agreed to treat at a certain time or place, such as when a doctor is on-call and agrees to see a member on a limited basis for a specific problem.

Contact CHPIV's Provider Services Department when your practice has determined a member dismissal is necessary to arrange reassignment of the member to another doctor. The reason for the dismissal must be documented in the termination letter (see *Sample Termination of Responsibility Letter*).

As appropriate, the treating physician should advise members with chronic conditions if they need ongoing medical attention, stressing any urgency, mentioning medication requirements, and reinforcing earlier health care recommendations.

When the discharge of the member is approved by CHPIV, send the letter by certified mail with return receipt requested, which is evidence the member received the letter.

File a copy of the letter and the return receipt in the member's medical record.

If the member fails to accept the letter, file the returned, unopened letter in the member's medical record and send another letter by regular mail.

Write a note in the members' chart to indicate the date the letter was mailed and by whom.

Tell your appointment schedulers when a member has been sent a dismissal letter, so that an appointment is not offered to the member after the transition period. Scheduling a dismissed member for a new appointment may be construed as the re-establishment of the doctor-patient relationship.

Fax a copy of the termination letter to CHPIV's Provider Services Department at 760-863-5187 | 

Sample Termination of Responsibility Letter

CERTIFIED MAIL

DATE

RECORD #

PATIENT NAME
PATIENT STREET ADDRESS
CITY, STATE, ZIP CODE

RE: NOTICE OF TERMINATION OF PHYSICIAN-PATIENT RELATIONSHIP

Dear [PATIENT NAME]:

This letter is to provide you with formal notice that I will no longer serve as your physician because several attempts have been made by my office to remind you to return for care.

I am still concerned about your condition and hope that you seek medical care as soon as possible. Please be reminded that not doing so could place your health or life at risk. Accordingly, you should immediately seek to establish a physician-patient relationship with another physician. I urge you to contact Community Health Plan of Imperial Valley's Member Services department at 1-888-330-2117 for assistance in obtaining further care without delay.

I will continue to provide your medical care and to prescribe or refill necessary medications for you for a reasonable time, but in no event for more than thirty (30) days after you receive this letter.

This is the last notice you will receive regarding this concern. Continuity of medical care is important for all patients and I urge you to choose and get established with a new physician right away.

Sincerely,

[SIGNED BY SPECIALTY/PRIMARY CARE PHYSICIAN]

[SPECIALTY/PRIMARY CARE PHYSICIAN]

cc: Member Services, Community Health Plan of Imperial Valley

Provider Termination Member Continuity of Care

In the event of a provider termination, an eligible member may request the completion of services by a terminated or non-contracted provider for:

1. An acute or serious chronic condition.
2. Pregnancy in the third trimester and the immediate postpartum period for the duration of the pregnancy.
3. A terminal illness.
4. Care of a newborn child from birth to 36 months of age.
5. Surgery or other CHPIV authorized procedure.
6. A member who presents written documentation of being diagnosed with a maternal mental health condition may request the completion of a course of treatment.
7. A newly enrolled member who become effective with CHPIV and receive services from that provider for one of the above condition recommended and documented by the provider to occur within 180 days of the contract's termination or within 180 days of the effective date of CHPIV enrollment may be eligible for completion of covered services.

All of the above conditions for covered services shall not exceed 12 months from the effective date a member becomes CHPIV eligible, unless expressly authorized by CHPIV.

Authorization of services for non-participating providers are subject to the same terms and conditions imposed on the currently contracted providers providing similar services practicing in the same or similar geographic area as the terminated provider.

Telephone Advice Nurse (TAN)

Our Telephone Advice Nurse (TAN) provides medical advice to members 24 hours a day, 7 days a week, including holidays. The Telephone Advice Nurse at (888) 671-3332 will:

- Triage member calls, according to established protocols
- Direct the member to the appropriate care facility
- Instruct the patient according to appropriate medical protocols, if home treatment advice is appropriate

The advice may include instructions for the member to call his/her primary care physician's (PCP) office for an appointment. It is expected that these patients will be triaged by the PCP's Case Manager and given same day appointments if medically indicated.

For further information regarding the Telephone Advice Nurse program, contact Member Services at (888) 330-2117.

Section 4: Adult Care

Adult Preventive Health Guidelines & Vaccine-Preventable Diseases

Primary care providers ensure that members receive health maintenance services, including health education and counseling, in accordance with CHPIV's Adult Preventive Health Guidelines, which are based on the U.S. Preventive Services Task Force (USPSTF), grade A and B recommendations, *Guide to Clinical Preventive Services*.

Primary care providers are responsible for:

- Providing an initial health appointment for members within 120 days of the member's enrollment with CHPIV.
- Complying with CHPIV's Adult Preventive Health Guidelines for ongoing preventive care
- Referring members to health education services

For more information about adult preventive care guidelines, contact Corporate Quality at (619) 498-6486. For additional information, you may also visit us at our website www.chpiv.org

Adult Preventive Health Guidelines

CHPIV follows the adult preventive services and cancer screening recommendations of the most recent United States Preventive Services Task Force (USPSTF) grade A and B recommendations for adult Members in accordance with the Guide to Clinical Preventive Services published by the USPSTF.

For current guidelines, go to the U.S. Preventive Services Task Force recommendations:

<https://www.uspreventiveservicestaskforce.org/uspstf/>

Vaccine-Preventable Diseases

There are more than 20 life-threatening diseases, which can now be prevented with a vaccination.

Most diseases that can be prevented by vaccination are no longer common in the population. However, if people stop getting the vaccines relevant to them, we may see a reappearance of vaccine-preventable diseases across the world.

Vaccines have helped:

- Eradicate smallpox in the last 60 years.
- Get closer to eradicating polio.

- Decrease deaths related to measles by 73% between 2000 and 2018 worldwide.
- Decrease cases of rubella by 97% between 2000-2018

For the provision and promotion of vaccines, CHPIV follows the most recent adult immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Additionally, CHPIV covers the provision of age and risk-appropriate vaccinations in accordance with the findings of the IHA, or other preventive screenings.

ACIP recommendations may be found at the following website:

<https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html>

Source: U.S. Preventive Services Task Force, Guide to Clinical Services

Section 5: Behavioral Health Services

CHPIV's Behavioral Health Services department coordinates all behavioral health services for our members. Behavioral Health Services staff:

- **Coordinates provider referrals** with network behavioral health professionals.
- Assists **members who self-refer** for behavioral services.
- Acts as **liaison with the County of San Diego's** Mental Health Plan.
- Assists in **coordinating care** between primary care providers and behavioral health specialists.

CHPIV Behavioral Health Services

CHPIV covers outpatient behavioral health services and Substance Use Disorder services (SUDs) for Advantage-Plus members with any mental health condition(s). Services include the following:

- Individual and group mental health evaluation and treatment (psychotherapy).
- Psychological testing when clinically indicated to evaluate a mental health condition.
- Psychiatric consultation for medication management.
- Screening, brief intervention and referral to treatment (SABIRT) 11 and older.
- Acute Medical Detox.
- Outpatient laboratory, supplies and supplements.
- Inpatient Mental Health Services
- Intensive Outpatient Programs
- Partial Hospitalization Programs
- Medication Assisted Treatment (MAT)
- Opioid Treatment

For information, referral and education services during business hours and after hours for urgent calls.

Phone: **(888) 330-2117**

Fax: **(619) 426-9437**

Behavioral Health Information, Referral, and Education Services

CHPIV members may access information, referral, and education services by calling (888) 330-2117. This number may also be used for urgent needs after hours. This is an additional benefit offered to our members and is not intended to be a substitute for a suicide hotline or crisis counseling line which members can access by calling the Imperial County Behavioral Health Services 1- 888-817-5292 and Crisis line at 988.

Information, referral, and education services are available to members regardless of their benefit package. Members may call for services **without referral** from their primary care physician. Behavioral Health Services staff identify care options acceptable to the member, provider, and family.

Community Behavioral Health Resources

Call for current information on community-based organizations throughout Imperial County including:

- Alcoholics Anonymous
- Teen and adult centers
- Crisis houses
- Self-help support groups

Behavioral Health Education Classes

Classes include the following:

- Parenting
- Stress/anger management
- Domestic violence
- Chronic disease
- Substance Misuse

Classes are available at various locations throughout Imperial County. CHPIV covers transportation to all for medical and pharmacy covered services as applicable.

Members or providers may contact Behavioral Health Services at (888) 671-3511 for referral, class reservation information, and community behavioral health resources.

Behavioral Health Warm Line

All Advantage-Plus members seeking behavioral health services have access to our toll free Behavioral Health Warm Line. The "warm line" is a non-emergency, non-crisis support telephone response service that is available Monday through Friday during business hours and staffed by consumer peers, medical or other professionals, consumer advocates and/or volunteers. Warm lines are a cost-effective alternative to crisis lines ("hot lines").

Advantage-Plus' warm line is provided through a contract with the National Alliance on Mental Illness (NAMI) in Imperial County. Advantage-Plus members can call the Warm Line for any reason, including the need to just talk with someone. To access this service, Advantage-Plus members should be referred to our Behavioral Health Services Department at (800) 404-3332.

Coordination of Care for Behavioral Health Services

Primary Care Provider Responsibilities

The Primary Care Physician (PCP) is the primary case manager for members, and as such, makes referrals to specialists, as needed. The PCP is responsible for providing outpatient mental health services within his/her scope of practice. The PCP's responsibilities include:

- Referring to mental health services on the basis of objective and subjective evaluation of the member's medical history, psychosocial history, current state of health and any request for such services from the member or the member's family.
- Informing the mental health provider of any physical health conditions or medications which may influence possible mental health conditions.
- Documenting the mental health condition in the member's medical record.
- Making available to the mental health provider any medical records and documentation relating to the member's mental health condition only if the member signs the Authorization to Release in accordance with CHPIV's policy and applicable laws and regulations.

Coordination of Care between Physical and Behavioral Health Practitioners

The Interdisciplinary Care Team, composed of the Medical Director or Chief Medical Officer, the Behavioral Health Department, the Pharmacy Department, and the Case Manager assigned to the case, along with the member and their caregiver and Primary Care Provider, participate in the creation of a collaborative care plan that approaches the member's needs individually to create a framework of recommendations that will be approved by all the members of this team.

The team matches any services and benefits required so that the most vulnerable and highest-risk members receive timely care proportionate to their needs.

This process ensures that care plan-targeted interventions are designed to educate and empower the member to get to a better state of health, remain independent, and self-manage their conditions.

Maternal Mental Health

- Community Health Plan of Imperial Valley introduces the Maternal Mental Health Program to address the increased demand for mental health services brought to light by COVID-19 pandemic, specifically catering to expectant and new mothers. This program offers accessible, evidence-based interventions, screenings, and collaborative care to support maternal well-being.
- Screening and Assessment <https://www.acog.org/programs/perinatal-mental-health/assessment-and-treatment-of-perinatal-mental-health-conditions>.
- Therapeutic Intervention: If a member screens positive please have member call the Behavioral Health Department at 1-800-404-3332 to assist the member in finding a contracted provider that can see the member timely.

- Collaborative Care: Members needing assistance in coordinating care can call the Behavioral Health Department at 1-800-404-3332. Behavioral Health Services authorized by the Behavioral Health Department are viewable by the Primary Care Physician for care integration purposes.
- Education Resources: please use the following link:
<https://www.acog.org/programs/perinatal-mental-health>

Intermediate Care Facilities for the Developmentally Disabled (ICF-DD)

Community Health Plan of Imperial Valley covers ICF-DD facilities (homes) for members with developmental disabilities effective January 1, 2024. The homes that are eligible are the following:

- Intermediate Care Facility for the Developmentally Disabled (ICF/DD);
- Intermediate Care Facility for the Developmentally Disabled – Habilitative (ICF/DD-H);
- Intermediate Care Facility for the Developmentally Disabled – Nursing (ICF/DD-N);

If you identify a member who may benefit from these services, please refer the member to the San Diego Regional Center (SDRC) by calling (760) 355-8383. The SDRC will evaluate the member and determine if they qualify for ICF-DD services. For further assistance please call Community Health Plan of Imperial Valley's Behavioral Health Department at 1- 800-404-3332.

For more information on this benefit please visit the following link:

<https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-023.pdf>

Section 6: Benefits

Community Health Plan of Imperial Valley is a local, nonprofit health plan offering quality benefits. Our wide network of health care practitioners and hospitals encompass all of Imperial County.

Medicare Advantage Program

CHPIV's Medicare Advantage plan, Advantage-Plus, is a dual eligible special needs plan (D-SNP). Members must be eligible to receive full benefit Medi-Cal and also have Medicare Part A (hospital insurance) and Part B (medical insurance). Community Health Plan of Imperial Valley members must live in Imperial County. Enrollment information can be found on the internet at the Medicare website www.medicare.gov or prospective members may also call Member Services at: (888) 330-2117.

Advantage-Plus

- Offers comprehensive health benefits
- Available to qualified families and individuals
- Offered under contract with the Centers for Medicare and Medicaid Services (CMS)

Our members enjoy the same benefits as those available under the fee-for-service Medicare program. As such, contracted providers are obligated to provide to our Special Needs Plan members those medically-necessary covered services afforded Medicare beneficiaries. In addition to the standard Medicare benefits, Advantage-Plus provides:

- Non-emergency Transportation (*36 one-way trips*)
- Home adaptation services (*\$800 annual maximum*)
- Worldwide Emergency Services \$50,000 annual maximum (*excludes return transportation to the U.S.*)
- Annual eye exam, through a Vision Service Plan (VSP) Provider
- \$500 Annual eye wear or contact benefit, through a VSP or a non-VSP provider.

Additionally, providers are also obligated, in accordance with their agreement with Community Health Plan of Imperial Valley, to meet all requirements and standards for participation for providers of health care services under the Medicare Advantage Program. Providers are also required to comply with all the laws, regulations and rules applicable to the operation of the Medicare Advantage Special Needs Plan, including those prescribed by the Centers for Medicare and Medicaid Services (CMS) pursuant to Sections 1851 through 1859 of the Social Security Act for the operations of a Medicare Advantage Plan, including, without limitation, 42 Code of Federal Regulations (CFR), Part 422, and in the case of pharmacy services, 42 CFR Part 423.

For assistance with case management and referral of members receiving carved-out services, contact Member Services at (888) 330-2117.

Medical Benefit	Coverage		
	Medicare	CHPIV Medi-Cal	FFS Medi-Cal
Inpatient Services			
Inpatient Hospital Care	✓		
Semiprivate room (or a private room if medically necessary); meals (including special diets) and regular nursing services	✓		
Drugs and medications	✓		
Laboratory tests	✓		
X-rays and other radiology services	✓		
Necessary surgical and medical supplies	✓		
Use of appliances, such as wheelchairs	✓		
Operating and recovery room costs	✓		
Physical therapy, occupational therapy, and speech therapy	✓		
<i>Under certain conditions, the following types of transplants are covered: corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral</i>	✓		
Blood – including storage and administration during a covered stay (coverage of whole blood and packed red cells begins only with the fourth pint of blood). All other components of blood are covered beginning with the first pint used.	✓		
Blood – first three pints of whole blood and packed red cells		✓	
Physician services	✓		
Subacute, physician (X9900-X9920)		✓	
Inpatient Mental Health Care (benefit is limited to 190-day lifetime limit for inpatient services in a psychiatric hospital. Lifetime limitation is not applicable to mental health services provided in a psychiatric unit of a general hospital)	✓		
Skilled Nursing Facility Care	✓		
<i>Benefit limitations: 0-100 days (as long as member is receiving skilled care)</i>	✓		
<i>101-161 days or more as needed for appropriate level of care.</i>		✓	
<i>Upon disenrollment from CHPIV</i>			✓
Semiprivate room (or a private room if medically necessary); meals (including special diets) and regular nursing services	✓		
Physical therapy, occupational therapy, and speech therapy; <i>requires skilled level of care</i>	✓		
Drugs	✓		
Blood – including storage and administration during a covered stay (coverage of whole blood and packed red cells begins only with the fourth pint of blood). All other components of blood are covered beginning with the first pint used.	✓		
Blood – first three pints of whole blood and packed red cells		✓	

Medical Benefit	Coverage		
	Medicare	CHPIV Medi-Cal	FFS Medi-Cal
Medical and surgical supplies	✓		
Laboratory tests	✓		
X-rays and other radiology services	✓		
Use of appliances, such as wheelchairs	✓		
Physician services	✓		
<i>Inpatient Services (when the hospital or SNF days are not or are no longer covered)</i>			
Physician services	✓		
Tests (x-ray or labs)	✓		
X-ray, radium, and isotope therapy including technician materials and services	✓		
Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations	✓		
Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices	✓		
Leg, arm, back, and neck braces; trusses; artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss or a change in the patient's physical condition	✓		
Physical therapy, speech therapy, and occupational therapy	✓		
<i>Home Health Care; home health agency care</i>			
Part-time or intermittent skilled nursing and home health aide services	✓		
Physical therapy, occupational therapy, and speech therapy	✓		
Medical social services	✓		
Medical equipment and supplies	✓		
<i>Hospice Care – provided under fee-for-service Medicare when provided in a Medicare-approved hospice</i>			
Hospice room and board (revenue code 658)		✓	
Hospice consultation services (one time only) for a terminally ill individual who has not elected the hospice benefit	✓		

Medical Benefit	Coverage		
	Medicare	CHPIV Medi-Cal	FFS Medi-Cal
Outpatient Services			
Physician services	✓		
Office visits, including medical/surgical care in a physician's office or certified ambulatory surgical center	✓		
Consultation, diagnosis, and treatment by a specialist	✓		
Second opinion by another plan provider prior to surgery	✓		
Outpatient hospital services	✓		
Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor)	✓		
Routine dental care		✓	
<i>Benefit Limitations: Cleanings are covered once every six (6) consecutive months</i>			
<i>Full-mouth x-rays are covered once every twelve (12) consecutive months</i>			
<i>Fluoride Treatments are covered once every six (6) consecutive months. Additional fluoride treatments, up to the eighteenth (18th) birth date, are available at the listed Member copayment amount.</i>			
<i>Sealants are covered only on the first and second permanent molars and up to the fourteenth (14th) birth date</i>			
<i>Crowns, Jackets, Inlays and Onlays are benefits on the same tooth only once every five (5) years, and consistent with professional recognized standards of dental practice</i>			
<i>Replacement of existing Full and Partial Dentures are covered once per arch every five (5) years, except when dentures cannot be made functional through reline or repairs</i>			
<i>Denture Relines are covered twice per year, and only when consistent with professionally recognized standards of dental practice</i>			
<i>Any routine dental services performed by a primary care dentist or specialist in an inpatient/outpatient hospital setting, under certain circumstances, will be considered for coverage</i>			

Medical Benefit	Coverage		
	Medicare	CHPIV Medi-Cal	FFS Medi-Cal
Chiropractic services; <i>limited to manual manipulation of the spine to correct subluxation</i>	✓		
Podiatry services; <i>limited to treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) and routine foot care for members with certain medical conditions affecting the lower limb</i>	✓		
Sterilization; elective surgical procedures		✓	
Comprehensive Perinatal Services Program (CPSP)		✓	
Home and Community Based Services (HCBS) Waiver			✓
Outpatient mental health services (including partial hospitalization services)	✓		
Mental health services provided by a mental health care professional	✓		
Psychology services			✓
Outpatient substance abuse services	✓		
Heroin detoxification (21-day only)			✓
Outpatient surgery	✓		
Ambulance services; emergency	✓		
<i>Ambulance; non-emergency; medical necessity</i>		✓	
<i>Ambulance, air; non-emergency; medical necessity</i>		✓	
<i>Ambulance; medical transportation; medical necessity</i>		✓	
Urgently needed care	✓		
Outpatient rehabilitation services	✓		
Physical therapy, occupational therapy, cardiac rehabilitation, and speech and language therapy; <i>Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris</i>	✓		

Medical Benefit	Coverage		
	Medicare	CHPIV Medi-Cal	FFS Medi-Cal
Durable medical equipment (DME) and related supplies	✓		
DME		✓	
Decubitus care equipment		✓	
Orthotics		✓	
Prosthetic devices and related supplies (other than dental)	✓		
Breast prosthetics; gradient compression stockings		✓	
Orthopedic shoes if they are part of a leg brace and included in the cost of the leg brace	✓		
Diabetes self-monitoring, training and supplies	✓		
Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors	✓		
One pair per calendar year of orthopedic or therapeutic shoes for those individuals with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts	✓		
Supportive devices for the feet; limited to those individuals with diabetic foot disease	✓		
Self-management training; certain conditions apply	✓		
Fasting plasma glucose tests for persons at risk of diabetes	✓		
Medical nutrition therapy for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by physician	✓		
Outpatient diagnostic tests and therapeutic services and supplies	✓		
X-rays	✓		
Radiation therapy	✓		

Medical Benefit	Coverage		
	Medicare	CHPIV Medi-Cal	FFS Medi-Cal
Surgical supplies; such as dressings	✓		
Supplies, such as splints and casts	✓		
Laboratory tests	✓		
If other than suspected heavy metal poisoning; e.g., arsenic, barium, beryllium, bismuth, antimony, mercury)		✓	
Blood (coverage begins with the fourth pint of blood). Coverage of storage and administration begins with the first pint of blood used.	✓		
Blood – first three pints of whole blood and packed red cells		✓	
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)			✓
California Children Services (CCS)	✓		
Operating/recovery room services; <i>if services are part of Medicare non-covered dental treatment. Note: In order to be reimbursable, beneficiary must meet exemption criteria.</i>			✓ (Denti-Cal)
Oxygen delivery systems and supplies; <i>if POS is 31 or 32; if POS is 99, services are included in the per diem rate and are not separately reimbursable by Medicare or Medi-Cal</i>		✓	
Preventive Care and Screening Tests			
Bone mass measurements <i>for qualified individuals, the following services are covered every two years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</i>	✓		
Colorectal screening			
Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months <i>for people 50 and older</i>	✓		
Fecal occult blood test, every 12 months	✓		
Screening colonoscopy (or screening barium enema as an alternative) every 24 months <i>for people at high risk of colorectal cancer</i>	✓		
Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy <i>for people not at high risk of colorectal cancer</i>	✓		
Immunizations			
Pneumonia vaccine	✓		
Flu shots; once a year in the fall or winter	✓		
Hepatitis B vaccine <i>if patient is at high or intermediate risk of getting Hepatitis B</i>	✓		

Medical Benefit	Coverage		
	Medicare	CHPIV Medi-Cal	FFS Medi-Cal
Other vaccines <i>if patient is at risk</i>	✓		
TB, TB tine		✓	
Mammography screening			
One baseline exam between the ages of 35 and 39	✓		
One screening every 12 months for women age 40 and older	✓		
Pap smears, pelvic exams, and clinical breast exam			
For all women, Pap tests, pelvic and clinical breast exams; unlimited	✓		
One Pap test every 12 months <i>if patient is at high risk of cervical cancer or has had abnormal Pap test and is of childbearing age</i>	✓		
Prostate cancer screening exams <i>for men age 50 and older, covered once every 12 months</i>			
Digital rectal exam	✓		
Prostate Specific Antigen (PSA) test; unlimited	✓		
Cardiovascular disease testing			
Blood tests for detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease)	✓		
Physical exams			
Measurement of height, weight and blood pressure; electrocardiogram; education, counseling and referral with respect to covered screening and preventive services; certain conditions apply	✓		
Other Services			
<i>Renal dialysis (Kidney)</i>	✓		
<i>Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area)</i>	✓		
<i>Inpatient dialysis treatments; certain conditions apply</i>	✓		
<i>Self-dialysis training</i>	✓		
<i>Home dialysis equipment and supplies</i>	✓		
Directly Observed Therapy (DOT) for treatment of tuberculosis			✓
Insulin infusion pump supplies		✓	
<i>Speech therapy</i>	✓		
<i>Prescription drugs</i>	✓		
<i>Medications that are not covered under Medicare but are covered under Medi-Cal (i.e., symptomatic relief of cough and colds, nonprescription drugs that are not part of Medicare step therapy, barbiturates and benzodiazepines); to the extent the drugs are covered under CHPIV's Medi-Cal formulary</i>		✓	

Medical Benefit	Coverage		
	Medicare	CHPIV Medi-Cal	FFS Medi-Cal
<i>Hearing services</i>			
<i>Diagnostic hearing exams</i>	✓		
<i>Hearing aid exams</i>		✓	
<i>Hearing aids</i>		✓	
<i>Audiology services (hearing screenings; hearing aid evaluation)</i>	NCB		
<i>Vision care</i>			
<i>Outpatient physician services for eye care provided by an ophthalmologist</i>	✓		
For people who are at high risk of glaucoma: glaucoma screening once per year	✓		
<i>One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.</i>	✓		
<i>Health and wellness education programs</i>	✓		
<i>Acupuncture</i>	NCB		
<i>AIDS waiver</i>			✓
<i>Home adaptation services (\$800 annual maximum); if medically indicated by home assessment</i>	✓		
<i>Worldwide emergency services (excludes return transportation to the U.S.)</i>	✓		

NCB = Not a covered benefit.

Section 7: Case Management

CHPIV maintains a comprehensive, multi-faceted case management approach to ensure the coordination of services across the continuum of care. CHPIV utilizes nationally accepted and evidence-based guidelines to make decisions when coordinating services for its membership.

Case Management Team

The Case Management Team is comprised of primary care physicians (PCP), primary care site case managers, CHPIV's Health Care Services staff, medical specialists, hospital discharge planners, social workers, and ancillary and state/community agency personnel.

Team members are essential to promoting the continuity of all aspects of a member's care through the coordination of preventive services, outpatient services, inpatient services, health education, pharmaceutical services, ancillary services, psychosocial services, and community resources.

The member (or member's representative) and their family are involved (to the extent that they are willing and able) at all stages of the case management process to optimize planning and health outcomes.

CHPIV's Case Management Programs

CHPIV maintains population-specific programs designed to promote an interface between the PCP, the member, and specialty services to ensure timely coordination of medically necessary health services in a cost-effective manner.

CHPIV case management programs identify care options at each level of the continuum, designed to promote optimal health for the members. CHPIV's comprehensive case management program aims to ensure that members have access to and receive optimal, cost-effective healthcare services throughout the continuum of care.

Outpatient Management: home, office, service referral management.

Inpatient and Long-Term Care Management: CHPIV applies chronic disease intervention and a readmission prevention approach.

Elective and emergency admissions are monitored by CHPIV's case managers.

Out-of-Area/Network Management for all services: All out-of-area admissions are screened for permanent residence.

Role of the Primary Care Provider

Each member is assigned to a PCP. They are responsible for ensuring the timely coordination of medically necessary health services in a cost-effective manner and basic case management services for all eligible members. In addition, the case manager's role at the primary site is to facilitate the coordination of services and recommendations requested by CHPIV's Case Management staff.

The PCP must designate a case manager to be the liaison with CHPIV's Case Management staff. In addition, the PCP and site case manager have the following responsibilities for their members that fall within basic case management:

Provide and schedule preventive healthcare such as adult or child periodic examinations and immunizations

- Coordinate/review the initial health exam and health education behavioral assessment
- Provide and report encounters to CHPIV for HEDIS® measures (see Medical Records, pages 14-11)
- Request referrals with appropriate documentation, such as copies of consultations, laboratory, or medical findings
- Request referrals with appropriate codes for service and specialty request

It is the primary care site's responsibility to document procedure codes for all services. When requesting specialty services, consult the specialist's office or the outpatient center for procedure codes.

- Track and maintain records on missed appointments
- Coordinate perinatal care and postpartum follow-up
- Assure appointment for follow-up care after hospital discharge, emergency department visits, specialty consultations, non-network provider services, or Telephone Advice Nurse encounters (within one week or in compliance with the ordering physician)
- Identify home health care needs and obtain authorization for care and durable medical equipment
- Coordinate referrals to special programs (i.e., CCS, Early Start Program, EPSDT, or community-based organizations)
- Refer the member to health education and health promotion services. Contact Community and Preventive Services at (619) 240-8834.
- Educate members well on how to access medical services and on the role of the PCP. Educate members on how to access the nearest contracted urgent care facility. To find the nearest contracted urgent care facility for your members, contact Member Services at (888) 330-2117 or via the CHPIV's website: <https://www.chgsd.com/>
- Utilize member-specific ER utilization reports from CHPIV and identify educational needs for member self-care
- Assist with the arrangement of transportation when needed. Contact Member Services at (888) 330-2117
- Implement plan policies related to primary care services and attend CHPIV's case management/operations meetings as scheduled

Role of CHPIV's Case Managers and Health Care Services Staff

CHPIV Case Managers execute our case management programs. Coordination in any program involves, but is not limited to, participation in the following activities:

Assisting the member in transitions to care, and, if necessary, inform the member and PCP when benefits terminate and ways to obtain continued care through other sources such as community resources.

Communicating medical case management expectations and provide the program and policy updates to providers.

Coordination of care during the member's inpatient stay (hospital, subacute, SNF, etc.) and after discharge.

Coordinating care interventions through:

- Primary care site requests for assistance
- Admissions to the acute care setting or multiple admissions
- Emergency room encounters
- Telephone Advice Nurse (TAN) encounters
- Claims encounters tracking resource utilization
- Pharmacy-specific encounters
- Member and family
- Community/state resources or agencies

Identifying needs by collecting critical data sets from paid claims, authorization, pharmacy, or concurrent clinical data.

Monitoring the member's acceptance of state and community-based service programs.

Providing information and resources to assist the PCP and case managers in all case management efforts.

Reviewing covered benefits and possible alternative community resources.

Case Management Standards

CHPIV's Case Management Program incorporates the principles of the *Standards of Practice for Case Management* of the Case Management Society of America, NCQA Requirements, and Standards for Case Management Services, in addition to other applicable sources.

Imperial County Liaison

Community Health Plan of Imperial Valley has designated liaisons to coordinate care with County Health and Human Services Agency and other organizations:

- AIDS and Community Epidemiology
- California Children Services (CCS)
- Child Health and Disability Prevention (CHDP)
- County Behavioral Health Services
- Hansen's Disease Program

- Immunizations
- Perinatal Care Network
- Polinsky Center for Children
- San Diego Regional Center
- Sexually Transmitted Disease Control
- Tuberculosis Control

For more information on the responsibilities of CHPIV's Imperial County Liaison, please call (760)332-6447

Inpatient Management

Notification of All Admissions to CHPIV

Hospitals must notify CHPIV of all admission types within the first 24 hours of admission. Hospitals are required to fax the face sheets to CHPIV at: for medical (866) 897-6024 and behavioral health (877) 862-7603.

Key Factors for Which Inpatient Review Is Performed

Under the supervision of CHPIV's Chief Medical Officer, CHPIV's case management staff evaluates:

- Admission necessity
- The appropriate level of care
- Appropriateness for continued inpatient stay vs. lower level of care
- Coordination of discharge needs
- Referral for short and long-term case management needs; i.e., care education programs, chronic disease programs and community resources
- Quality of care

CHPIV utilizes MCG (formerly known as Milliman Care Guidelines) and other nationally-recognized resources/guidelines for inpatient utilization management.

For more information on inpatient management, contact Health Care Services at (619) 498-6471.

Admission Types Emergency

Admissions

Emergency admissions are defined as non-planned admissions where members are usually admitted through the emergency room or directly from the primary care physician's office.

Emergency admission cases are generally assigned to a hospitalist or specialty service physician on-call. When the member knows his/her PCP and the PCP has privileges and rounds on his/her members, the PCP may be assigned as the attending physician.

CHPIV's nurse case managers perform daily on-site review for all inpatient admissions. Based on their initial review and the working diagnosis, the nurse case managers:

- assign a goal length of stay (LOS) to each admission;
- monitor the member's clinical condition and treatment plan daily and compare the same to MCG and other nationally-recognized resources/guidelines;
- maintain contact with the attending physician and the inpatient hospital case manager to verify discharge plans and options according to the member's clinical needs and plan benefits;
- facilitate transition of care from inpatient to lower level of care according to the clinical condition of the member;
- refer members, when appropriate, to chronic and preventive disease management programs; and
- assist with and verify that follow-up appointments are in place.

Elective Inpatient Admissions

Elective inpatient admissions are defined as scheduled or planned admissions.

The PCP or specialist physician is responsible for obtaining authorization for the requested pre-scheduled services. The hospital is responsible for verifying with CHPIV authorization for the facility component.

Once the procedure is authorized, the expected LOS will be assigned for elective procedures according to MCG (formerly known as Milliman Care Guidelines) and other nationally-recognized resources/guidelines. CHPIV's nurse case managers perform concurrent review for all inpatient admissions. The nurse case managers:

- Maintain contact with the attending physician and the inpatient hospital case manager to verify discharge plans and options according to the member's clinical needs and plan benefits;
- Facilitate transition of care from inpatient to lower level of care according to the clinical condition of the member;
- Perform post-service reviews for members who are admitted and discharged during non-business hours;
- Refer members, when appropriate, to chronic and preventive disease management programs; and
- Assist with and verify that follow-up appointments are in place.

If the member's PCP is part of a medical group, hospital services must be coordinated between CHPIV and the medical group. Authorization for physician services are generally obtained from the medical group. Authorizations for facility and facility-related charges are obtained from CHPIV.

For assistance with medical group elective inpatient admission authorizations, contact Health Care Services at (619) 498-6423.

Acute Rehabilitation

Acute rehabilitation is defined as short-term, intense rehabilitation including at least three treatment modalities (e.g. speech, physical and occupational therapy). The member must be able to participate in at least three hours of rehabilitation services per day. The member is transferred from a hospital setting to an acute rehabilitation facility.

Extended (Post-inpatient) Care Hospital Admissions

Extended care admissions require authorization prior to the time of admission to the extended care facility.

California Children Services (CCS)

CHPIV case managers pend certification for any inpatient stay meeting criteria for qualification under the CCS program. After a determination is made by CCS, CHPIV will change the status of the certification from "pend" to either "approve" or "deny." Inpatient cases approved by CCS are not covered by CHPIV.

CCS may deny all or part of a hospital stay. When this happens, CHPIV is responsible for the portion not covered by CCS as long as the care being rendered meets criteria for the admission and continued stay.

Requests for services that unequivocally meet CCS criteria are denied by CHPIV. The provider will be asked to complete the CCS application if it has been established that the member does not have an open CCS case.

Denials

Denials for any inpatient days are based on the information provided or reviewed in the chart. CHPIV's nurse case managers, in collaboration with our Chief Medical Officer and outside review specialists, determine the appropriateness of the care that is rendered. Decisions to deny or modify any request for service authorization for reasons of medical necessity are made by a California-licensed physician.

Long Term Care

Long-term care is usually referred to as custodial care and focuses on maintaining the activities of daily functions. Care does not require a skilled service.

Major Organ Transplants

Effective January 1, 2022, CHPIV is responsible for the following Major Organ Transplants: Heart, Bone Marrow, Intestinal, Kidney-Pancreas, Liver and Lung.

Skilled Nursing

Short-term care for conditions which do not require staying in the hospital may be provided in a skilled nursing facility. Members must require treatments or services that can only be provided by a skilled or licensed individual. Examples of such services are physical therapy, occupational therapy, speech therapy, wound care and/or IV antibiotics.

Transitional Care

Transitional care encompasses medical conditions that are stable but require long-term treatment with daily physician oversight and/or visits. The member is transferred from a hospital setting to a transitional care unit.

For more information on case management for hospitalization, or to obtain a copy of CHPIV's authorization criteria, contact Health Care Services at (619) 498-6471.

Section 8: Claims

For all questions regarding claims status, please access CHPIV's web portal at www.chgsd.com
To obtain access to CHPIV's web portal, contact Provider Services at (760) 332-6447.

Submitting Claims

Authorization

Services beyond primary care require prior authorization. Exceptions are emergency services, Freedom of Choice, sensitive services, direct access obstetrics and gynecologic services from OB/GYNs and Family Practitioners, and those services that do not require prior authorization. However, authorization is not a guarantee of payment; payment is based on the member's benefits, eligibility at the time of service, specific contract, and eligible CPT-4 or HCPC codes.

Financial Responsibility

The financial responsibility for services varies according to the provider's and/or IPA's contract. In general, the entity responsible for authorizing services is responsible for payment. For questions regarding payor responsibility, contact our Provider Services at (760) 332-6447.

Member Responsibility

Balance Billing

Providers have agreed to accept payment directly from CHPIV (or a CHPIV-contracted medical group). This payment constitutes payment in full for covered services rendered to members. The provider may not bill members for the difference between the actual charges and the payment negotiated with CHPIV. Community Health Plan of Imperial Valley members do not have any financial responsibility and should not be billed or balance billed for medical covered services.

If a non-covered service is rendered by a provider. Prior to rendering the services, the provider must give the member a written explanation, to be signed by the member, acknowledging that the member is financially responsible for those services and must submit copy of acknowledgement attached to the claim

Retroactive Disenrollment

Payments for members who are retroactively disenrolled from CHPIV will be refunded to CHPIV by offset of future payments or via a provider refund check. CHPIV will give the provider written notice of retroactive disenrollments.

Claims Forms

Primary Care, Specialty, and Ancillary Providers

Claims can be submitted on a **CMS-1500** claim form if an attachment is required such as medical records, sterilization forms, cost of invoice, etc. If none of the mentioned apply, please submit your claim via EDI (please reference page 8-11). If required for payment, based on your contract with CHPIV, medical records and surgical reports must be attached to the claim.

Hospitals and Skilled Nursing Facilities

Claims can be submitted on a **UB-04** claim form if an attachment is required such as medical records, sterilization forms, cost of invoice, etc. If none of the mentioned apply, please submit your claim via EDI (please reference page 8-11).

Billing for Mid-Level Practitioners' Services

If required by Medi-Cal guidelines when billing a mid-level practitioner, include NPI number and name of supervising physician.

National Correct Coding Initiative

Providers are required to follow the coding policies established under the National Correct Coding Initiative (NCCI) adopted by the Centers for Medicare and Medicaid Services (CMS). The NCCI promotes national correct coding methodologies to control improper coding leading to inappropriate payment of claims. The coding policies are based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

CHPIV follows NCCI coding policies during the claims adjudication process. Additionally, we have implemented NCCI edits within our claim processing system as a general reference tool that explains the rationale for NCCI edits. The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations are reported (i.e., billing code pairs that should not be reported together).

Further information on NCCI policies and edits can be found in the NCCI Coding Policy Manual for Medicare Services.

When to Submit Claims

Primary Care, Specialty, and Ancillary Providers

Claims must be submitted within 120 calendar days from the date of service. If CHPIV is a secondary payor, claims must be submitted within 90 days of the receipt or denial of the primary payment with a copy of the primary payor's EOB.

Hospitals and Skilled Nursing Facilities

Claims must be submitted within 120 calendar days following the date of discharge or within 120 calendar days of the date of service unless CHPIV is secondary payor. If CHPIV is secondary payor, claims must be submitted within 90 days of the receipt or denial of the primary payment.

If a hospitalized member incurs an extended length of stay, the hospital should submit interim claims to CHPIV. These claims must be indicated by using the correct bill type

CHPIV does not have an obligation for claims received more than 120 calendar days after the date of service or date discharge. The member may not be billed if the provider fails to bill in a timely manner.

Claims Denied by Primary Payors

Claims denied by any primary payor, must be submitted to CHPIV within **90 calendar days** of the denial of the primary payor's EOB.

How to Submit Claims

Submit all claims, with the exception of those requiring an attachment, via electronic submission. Send claims with attachments to:

Community Health Plan of Imperial Valley
P.O. Box 174
Imperial, CA 92251

Internet-Based Claims Status Access

Practitioners and providers can verify the status of their claims by accessing CHPIV's Internet-based claims status system at www.chgsd.com. A log-in and password are required. Please contact our Provider Service liaison at 760-332-6447 if you do not have access to the portal.

Remittance Advices

A Remittance Advice (RA) is provided with any payment or notice of denial. The RA includes:

- Total fee charged
- Contracted amount
- Total benefit paid to the provider
- Patient account number
- Patient liability (that is coordinated with the member's Medi-Cal benefits)
- Reason code and description

Requests for Additional Documentation

If a claim is denied as "incomplete," the original claim must be resubmitted, including the required documentation, within 90 calendar days from the date indicated on the remittance advice. If the claim and supporting documentation are not received within this timeframe, the claim will be denied. CHPIV reach out to your practice to "develop" the claim if there is information missing prior to issuing a denial for incomplete claim.

Requests for Adjustment

If you feel that a claim has been processed incorrectly, submit a dispute via CHPIV's web portal. Contact our Claims Liaison at 619-240-8933 for access to our portal.

Requests for Refund/Offsets for Overpayment

CHPIV requires network providers to refund an overpayment within 60 calendar days after the date the overpayment was identified. Provider must notify in writing the reason for the overpayment and pertaining claim identification number. If we find that we overpaid a claim or made an incorrect payment, we may either request a refund or offset the overpayment against future payments.

A letter specifying the reason for the refund request will be sent to the provider within 365 days

of the date of payment. If the provider contests the notice of reimbursement of the overpayment of a claim, the provider, within 30 working days of the receipt of the notice of overpayment, must send a dispute to CHPIV stating the basis upon which the provider believes that the claim was

not overpaid. In accordance with applicable law, the 365-day time limit will not apply if the overpayment was caused in whole or in part by fraud, waste, abuse, or misrepresentation on the part of the provider.

If the provider does not contest the notice of reimbursement of the overpayment of a claim, the provider must reimburse CHPIV within 30 working days of the receipt by the provider of the notice of overpayment of a claim. If no response is received within 30 working days, CHPIV will deduct the overpayment from any future payments due the provider.

Audits

CHPIV has the right to review and, at its sole cost and expense, to access, audit and or copy providers' records to confirm the accuracy of claims and services provided. Providers will allow CHPIV access during reasonable business hours to all information and documents reasonably required for the audit.

CHPIV may conduct audits on its own or through an external review agency, either in person or through electronic means, if available, as determined by CHPIV. The costs of any outside auditors or agents engaged by CHPIV for such audits and CHPIV's own internal costs related to such audits will be paid by CHPIV. The provider's costs related to compliance with such audits will be the responsibility of the provider. If any patient authorizations are necessary to allow CHPIV to process claims submitted by the provider, the provider will obtain such authorizations prior to submitting claims to CHPIV.

CHPIV or its agent will notify the provider of its intent to conduct an audit no later than 24 months after the member's date of discharge or date of service. The provider will allow CHPIV or its agent to conduct an audit no later than 12 months from the date of the letter of intent. The letter of intent will state the purpose of the audit and include: i) member's name, ii) date of service/admission and discharge date, and iii) medical record number or the provider's patient account number, if known to CHPIV.

The provider will, upon request by CHPIV or its agent and at no cost to CHPIV or its agent, make available all documents, records, papers, invoices and bills for audit, inspection, and copying by CHPIV or its agent. Any agency selected by CHPIV will have the same access to papers and documents as if CHPIV were to conduct the audit. Upon request of CHPIV or its agent, the provider will provide, either on-site or through electronic means, at the discretion of CHPIV or its agent and at no cost to CHPIV or its agent, complete itemized bills, UB-04, CMS-1500s and support charts.

At the completion of the audit, CHPIV or its agent will provide its findings in writing to the provider. The audit will be considered complete as submitted. CHPIV or its agent will make best efforts to conduct, either in person or telephonically, an exit interview with the provider.

Any amounts due CHPIV from the provider will be paid by the provider within 30 working days. In the event the provider fails to pay CHPIV or to contest CHPIV's notice of reimbursement within thirty 30 working days of receipt of findings, CHPIV may offset such amounts from future payments due the provider.

Helpful Website for Medicare Billing Policies

For information on Medicare billing policies: <https://www.cms.gov/Medicare/Medicare>

Coordination of Claims Payment with Other Insurance Coverage

Overview

The purpose of Coordination of Benefits (COB) is to identify the health benefits available to a CHPIV Medicare member and to coordinate the payment process to prevent mistaken payment of benefits. Some members are covered under more than one health plan or insurance program.

CHPIV coordinates health care coverage in accordance with federal regulations applicable to Medicare Advantage Plans for coordination of benefits, including, but not limited to, 42 Code of Federal Regulations, Section 422.108 and the requirements of the Medicare Secondary Payor (MSP) Procedures set forth in the Medicare Managed Care Manual, including, but not limited to, Sections 70 and 80, applicable to Medicare Advantage Plans and Title 28, Section 1300.67.13 of the California Code of Regulations. To the extent there is a conflict between an insurance plan document or state law and the MSP, the MSP provisions are followed for claims involving Medicare members.

Possibility of Other Primary Coverage

CHPIV requires providers to obtain accurate, up-to-date information about all health insurance or other coverage that members may have in order to determine what payor has the primary responsibility for paying a claim. To facilitate prompt claims processing, this information must be included with the claim submission. Please include a copy of the other payor's Explanation of Benefits (EOB) that indicates payment date and benefits paid, including any denials and the description of the denial.

Provider Obligations

To obtain the benefits of all applicable health plans or insurance programs, providers must comply with the following Coordination of Benefits rules:

- Determine whether any other payor has primary responsibility for the payment of a claim for services that have been rendered to a member. By verifying eligibility information prior to seeing members, providers help make sure that benefit updates and changes are completed thereby avoiding claims processing delays.
- If a Medicare member has primary coverage with another health care carrier, submit a claim for payment to that carrier first. The amount payable by the CHPIV Medicare Advantage Plan depends on the amount paid by the primary plan. All Medicare secondary-payor rules must be followed. Medicare secondary-payor rules are available on the CMS website at <https://www.cms.gov/manuals/downloads/msp105c03.pdf>

- If another payor is primarily responsible for payment of the claim, CHPIV will remit payment only for the difference, if any, between the lesser of the primary payor allowable and CHPIV's negotiated rate with the provider.

Medicare as Secondary Payor (MSP)

For Medicare members, the Centers for Medicare and Medicaid (CMS) does not pay for services to the extent that there is a third party that is required to be the primary payor. Specifically, but not exclusively, a Medicare Advantage (MA) organization (for the purpose of this provider manual, CHPIV is the MA organization) will be considered the secondary payor in accordance with the provisions and situations set forth in the Medicare Managed Care Manual, Sections 70 and 80, including, but not limited to, circumstances when:

- CHPIV has a member who is 65 years of age or older, AND who is covered by a Group Health Plan (GHP) because of either current employment, or current employment of a spouse of any age; and the employer that sponsors or contributes to the GHP employs 20 or more employees.
- CHPIV has a member who is disabled, AND who is covered by a Large Group Health Plan (LGHP) because of either current employment, or a family member's current employment, and the employer that sponsors or contributes to the LGHP employs 100 or more employees.
- The first 30 months of eligibility or entitlement to Medicare for a CHPIV member who is entitled to Medicare solely on the basis of end-stage renal disease and group health plan coverage (including a retirement plan). This provision applies regardless of the number of employees and the member's employment status.
- Secondary payor status can also happen because of settlements. In this case, CHPIV is the secondary payor for a member when:
 - the proceeds from the member's workers' compensation settlement are available; or
 - the proceeds from the member's no-fault or liability settlement are available.

Medicare does not coordinate with health insurance coverage *that is not currently owned*, even when such health insurance is required by state law (i.e., auto liability). In other words, in the absence of a reasonable expectation that another insurer will pay primary to Medicare, CHPIV cannot withhold primary payment.

All Medicare Advantage (MA) organizations have the right under federal law and the Medicare Secondary Payor (MSP) regulations to bill for services for which Medicare is not the primary payor. The MA organization may use this right to bill the proper primary payor, whether it is a plan, another insurer, or an individual. MA organizations also can authorize providers and suppliers to bill the primary payor for services. CHPIV, as an MA organization, may exercise the same rights to recover from a primary plan or individual that the Secretary of Health and Human Services exercises under the Medicare Secondary Payor regulations as they apply to Medicare Advantage plans.

Medicare/Medi-Cal Crossover Claims

Some Medi-Cal recipients are eligible for services under the federal Medicare program. For most services rendered, Medicare requires a deductible and/or coinsurance that, in some instances, is paid by Medi-Cal. A claim billed to Medi-Cal for Medicare deductible and coinsurance is called a crossover claim. This type of claim has been approved or paid by Medicare.

California law limits Medi-Cal's reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum allowed for similar services (Welfare and Institutions Code §14109.5). Medi-Cal may reimburse providers for Medicare non-covered, exhausted or denied services when billed on a straight Medi-Cal claim with the appropriate Medicare denial attached.

CHPIV will automatically generate a crossover claim when billing for Medicare members.

Medi-Cal as Secondary Payor

Medicaid (including Medi-Cal) is secondary to ALL carriers.

Subrogation

In the event that a member receives Plan benefits for an injury or an illness for which a third person, organization or governmental entity is liable to pay damages, CHPIV shall be subrogated to the proceeds of any settlement, judgment or other recovery effected against the third party.

Third Party Liability

When a member receives medical services for which a third party may be liable, for example in the case of a personal injury or workers' compensation, primary care or other network providers must notify CHPIV so that revenues can be appropriately recovered.

Reporting

If a Medicare patient receives covered services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, CHPIV may bill, or authorize a provider to bill, any of the following:

1. The insurance carrier, the employer, or any other entity that is liable for payment for the services
2. The Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

Information Requests

If the **attorney** or **insurance carrier** requests an itemized bill or medical reports, the provider must first obtain written member consent.

Encounter Claims

Primary care providers and medical groups must submit encounter data for all capitated medical services provided to members, including office visits, home visits, radiology procedures, laboratory and pathology procedures, injections and immunizations, and preventive care. If a provider subcontracts for a capitated service (e.g., lab or x-ray), the provider is responsible for submitting a statistical claim for that service.

Format for Encounter Claims

Encounter claims may be submitted to CHPIV by the provider's own report format, CMS-1500 claim.

If encounter claims are submitted on claim forms, they must be identified as such separately from claims that are submitted for fee for service payment.

Encounter claims must include:

- CHPIV subscriber ID #, name, date of birth, gender, date and place of service
- HCPCS/CPT procedure code (including modifiers), quantity, # of days or units
- ICD-10 diagnosis code
- Rendering provider, tax ID #, California license # (*use license # of supervising physician if provider is a mid-level practitioner*)
- Itemization of billed charges
- National Provider Identifier (NPI)

How to Submit Encounter Claims

Submit encounter claims via electronic submission.

Electronic Submission – Electronic Data Interchange

All claims submitted electronically must be in ANSI 837 format as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The 837 standard is referenced in the ANSI 837 Professional V5010 specifications.

Providers desiring to submit claims electronically must complete a trading partner agreement. Please contact Community Health Plan of Imperial Valley's EDI Analyst at (760) 332-6447 to initiate this process.

When to Submit Encounter Claims

Encounter data must be submitted to CHPIV within 45 calendar days from date of service. Providers who fail to submit data in a timely manner are subject to action pursuant to CHPIV's provider sanction policy.

For information and assistance regarding statistical claims, contact the Director of Claims Administration at (888) 330-2117.

For information regarding electronic submission, contact CHPIV's EDI/Applications Manager at (760) 332-6447.

Provider Disputes

Claims Payment Disputes

If you disagree with our claims payment or denial, you have the right to appeal the decision in writing through our provider online portal.

For claims that are the responsibility of a delegated group, your appeal must be made through the delegated group's dispute resolution process.

Time Period for Submission

Your dispute must be received no later than 365 days from the action on the claim that you are disputing.

Required Documentation

Attach the following information to your dispute if applicable:

- Provider's name, identification/license #, if any, and contact information.
- A clear identification of the disputed item, the date of service, clear explanation as well as supporting documentation of your dispute and expected outcome.

Where to Submit Disputes

Send your dispute and any supporting documentation through CHPIV's Provider Portal at: www.chpiv.org. For access to our Provider Portal contact our Provider Services at (619) 240-8895.

Resolution Process

A confirmation receipt will be emailed to the Provider as proof of submission.

If your dispute is incomplete, we will request additional information. You may submit the required information via the provider portal as an attachment in reply to your dispute. The provider may submit an amended dispute within 30 working days of the date of receipt of a returned provider dispute setting forth the missing information.

Once we make a determination of your dispute, we will inform the provider of our final decision via the email provided when disputing the claim.

Beyond the Internal Resolution Process

If you are not satisfied with our determination regarding your dispute, you may seek binding arbitration by submitting a Demand for Arbitration. Providers may pursue arbitration for a claims dispute only after exhausting CHPIV's internal dispute resolution process. A Demand for Arbitration form and additional information about arbitration may be obtained by calling the regional office of the American Arbitration Association at (800) 778-7879.

Demands for Arbitration must be submitted to:

Community Health Plan of Imperial Valley
Chief Corporate Counsel
512 W. Aten RD
Imperial, CA 92251

As a process external to CHPIV, arbitration is beyond the scope of our policies and procedures or internal provider dispute resolution.

Section 9: Compliance

Health Care Fraud, Waste and Abuse Prevention

Community Health Plan of Imperial Valley's compliance program is aimed at fraud, waste and abuse prevention while at the same time advancing the mission of using resources to achieve optimum health care outcomes and providing exemplary service. Our compliance efforts are aimed at prevention, detection, and resolution of possible fraudulent cases. CHPIV's Compliance Plan is consistent with the requirements of all applicable Federal and State standards. For a copy of our plan, visit our website at: www.chpiv.org.

Suspected fraud may be reported to CHPIV by employees, contractors, network providers, members, or any other individuals. Upon initial notification, CHPIV's Regulatory Affairs Manager/Compliance Officer conducts a preliminary investigation. If the investigation appears to substantiate that fraud may have occurred, CHPIV's Antifraud Committee, after consultation with our legal counsel, makes a determination whether to:

- Report the case to appropriate law enforcement authorities
- Take appropriate responsive action, which may include:
 - Termination of coverage (may take the form of plan-initiated disenrollment)
 - Cancellation of provider contract
 - Discipline of CHPIV staff, as appropriate
 - Denial, modification, or suspension of payment of claims (to the extent allowed by law)
 - Assisting authorities in the suspension or revocation of provider license

Seeking restitution

Unless otherwise directed or required by law, reports of suspected Fraud, Waste, or Abuse are treated as confidential, with contents shared with others only on a "need to know" basis. In the event CHPIV is required to share this Confidential Information with a Subcontractor or Network Provider, CHPIV will ensure that Subcontractor and Network Provider acknowledge that such information must be kept confidential by Subcontractor and Network Provider.

Health Care Fraud, Waste and Abuse Prevention Line (Compliance Hotline)

Network providers are required to notify Community Health Plan of Imperial Valley within ten (10) working days of any suspected Fraud, Waste, or Abuse.

Suspected fraud may be reported to the Compliance and Fraud & Abuse Hotline at (800) 651-4459. You can leave a message 24 hours a day, seven days a week.

To ensure caller confidentiality, calls to the Compliance Hotline are not traced. If callers choose to identify themselves, their confidentiality will be protected to the extent permitted by law. No action or retaliation will be taken against anyone for calling the hotline. However, reporting does not protect callers from appropriate disciplinary action regarding their own performance.

Ways to report Fraud, Waste, or Abuse:

Compliance Hotline: (800) 919-4947. You may leave a message 24 hours a day, seven days a week.

Directly to the Compliance Department via email at compliance@chpiv.org.

You may also submit your report anonymously by mailing your report directly to the Compliance Officer at the following address:

Community Health Plan of Imperial Valley

Attention: Compliance Officer

512 W Aten Rd

Imperial, CA 92251

For information on CHPIV's antifraud policies, and for training in the detection of healthcare fraud, contact CHPIV's Compliance Officer at (760) 332-6447.

HIPAA Privacy and Security

DEFINITIONS:

A. **Business Associate:** A person or entity that performs certain functions or activities that involve the use or disclosure of Protected Health Information (PHI) on behalf of, or providing services to, a covered entity (Community Health Plan of Imperial Valley). The types of functions or activities that may make a person or entity a business associate include payment or health care operations activities, as well as other functions or activities regulated by the Administrative Simplification Rules.

B. **First Tier Entity:** Any party that enters into a written arrangement with Community Health Plan of Imperial Valley to provide administrative or health care services for an eligible individual.

C. **Downstream Entity:** Any party that enters into a Provider agreement with a First Tier Entity to provide health care and administrative services.

D. **Contractors:** Includes all contracted Providers and suppliers, first tier entities, downstream entities and any other entities involved in the delivery of payment for or monitoring of benefits.

E. **Health Care Entity:** An individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

F. **Protected Health Information (PHI):** All individually identifiable health information, (including genetic information) whether oral or recorded in any form, that relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member.

1. PHI excludes individually identifiable health information in education records; in employment records held by a Covered Entity in its role as employer; and regarding a person who has been deceased for more than fifty (50) years.
2. PHI generally refers to demographic information, medical history, test and laboratory results, insurance information and other data that is collected by a health care professional to identify an individual and determine appropriate care.

G. **Breach** means the acquisition, access, use, or disclosure of PHI in a manner not permitted under 45 C.F.R. Part 164, Subpart E (“Privacy of Individually Identifiable Health Information”) which compromises the security or privacy of the PHI. An impermissible use or disclosure of PHI is presumed to be a breach unless the covered entity can demonstrate that there is a low probability that the PHI has been compromised.

Breach excludes:

- 1) Any unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under 45 C.F.R. part 164, subpart E.

- 2) Any inadvertent disclosure by a person who is authorized to access PHI at a covered entity or business associate to another person authorized to access PHI at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under 45 C.F.R. part 164, subpart E.
- 3) A disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

H. **Disclosure:** the release, transfer, provision of access to, or divulging PHI in any other manner of information outside the entity holding the information.

Reporting Unauthorized Access or Disclosures:

It is the expectation of Community Health Plan of Imperial Valley that entities involved in breaches affecting Community Health Plan of Imperial Valley members notify Community Health Plan of Imperial Valley within twenty-four (24) hours of discovery if PHI was, or suspected to have been, acquired by an unauthorized person. In the event that an entity provides notices to DHCS, Community Health Plan of Imperial Valley should also be notified.

The Community Health Plan of Imperial Valley member(s) whose PHI has been breached must be notified in writing of the breach in accordance with CMS and DHHS requirements. Community Health Plan of Imperial Valley or Providers are required to also notify the affected member(s) in written form and must be provided without unreasonable delay and in no case later than sixty (60) days following the discovery of a breach. This notification must include, to the extent possible, a brief description of the breach, a description of the types of information that were involved in the breach, the steps affected members should take to protect themselves from potential harm, a brief description of what Community Health Plan of Imperial Valley and/or Providers are doing to investigate the breach, mitigate the harm and prevent further breaches, as well as Community Health Plan of Imperial Valley contact information or the contact information of the entity that caused the breach.

Reporting Breaches to Community Health Plan of Imperial Valley

The Community Health Plan of Imperial Valley Compliance Officer must be notified of any and all unauthorized breaches within the contractual and regulatory timeline requirements stated above. Reports of such breaches may be sent to Community Health Plan of Imperial Valley as follows:

By mail to: Community Health Plan of
Imperial Valley Attention:
Compliance Officer
512 W. Aten Rd
Imperial, CA 92251

By email to: compliance@chpiv.org
By Fax to: (760) 863-5187
By Compliance Hotline to: (800) 919-4947

Section 10: Corporate Quality

Quality Improvement and Health Equity Transformation Program, Access to Care Audit,	Director of Corporate Quality	(619) 498-6476
Provider Credentialing, Use of Non-Physician Medical Practitioners	Credentialing Manager	(619) 498-6438
Site Certification Compliance Surveys	Corporate Quality Nurse	(619) 498-6403 (619) 498-6486
Compliance Surveys	Corporate Quality Nurse	(619) 498-6486
Provider Fair Hearing (CHPIV)	Chief Medical Officer	(760) 332-6447

Quality Improvement and Health Equity Transformation Program

CHPIV's Quality Improvement and Health Equity Transformation Program (QIHETP) is an integrated, comprehensive program that incorporates review and evaluation of all aspects of health care delivery.

The objectives of the QIHETP are to:

- **Monitor, evaluate and improve the quality of care and services provided to** CHPIV members throughout all the settings of the healthcare delivery system. Quality assessment and improvement activities are coordinated through committees of actively practicing physicians and professional staff.
- Improve healthcare delivery by monitoring and implementing corrective action, as necessary, for **access and availability** of provider services to members.
- **Promote cost-effective care** by monitoring and correcting inappropriate under-utilization or over-utilization of health services.
- **Improve health outcomes** for all members by incorporating health promotion programs and preventive medicine services into all primary care delivery sites.
- **Identify and correct problem areas** in the health care delivery system through clinical and management audits or surveys.
- **Support continuity of services** through coordination by primary care physicians in case-management structures.
- Review **quality of care concerns** raised by members for prompt resolution or correction
- **Continuously evaluate** the standards of care and promote the most effective use of medical resources while maintaining mutually acceptable standards. This evaluation includes an annual evaluation of the QIHETP.

Components of the QIHETP include:

- Problem-focused studies
- Risk management
- Practitioner and facility credentialing
- Member satisfaction, complaint and grievance monitoring
- Primary care site monitoring
- Peer review
- Establishing clinical and service standards and indicators that reflect demographic and epidemiological characteristics of the membership, including benchmarks and performance goals for continuous and/or periodic monitoring and evaluation
- Compliance with external regulatory agencies
- Utilization management
- Medical records review
- Ongoing monitoring of key indicators (e.g., mortality review, preventable admissions)
- Health care services evaluation

Quality Improvement and Health Equity Committee

CHPIV's Board of Directors authorizes and designates the Chief Executive Officer (CEO) as the individual responsible for the implementation of the QIHETP. The CEO has delegated oversight of the day-to-day operations of the QIHETP to the Chief Medical Officer (CMO).

The CMO serves as the Chairperson for the Quality Improvement and Health Equity Committee (QIHEC) and is responsible to report to the Board of Directors at least quarterly on the QIHETP including reports, outcomes, opportunities for improvement and corrective actions and communicating feedback from the Board to the committees as applicable. The CMO is responsible for oversight and management of quality improvement and health equity, health care services and peer review activities. The CMO is also responsible for communicating information and updates regarding the QIHETP to CHPIV leadership and staff, senior management team meetings, and other internal meetings.

The QIHEC is responsible for adopting policies, procedures and protocols that promote improvement in the delivery of health care services to plan members. The QIHEC is also responsible for developing, communicating, and implementing clinical practice guidelines based on community medical standards of care.

As a peer review body, the QIHEC determines whether the care provided to members conforms to professionally accepted standards for quality, utilization of resources, timeliness, and appropriateness of treatment setting. Reviews focus on the elements of structure, process, and outcomes of care as determined through review of medical records, member complaints, utilization management review, quality assessment audits, and other relative data sources.

Potential quality of care issues are referred to the Corporate Quality Department for tracking,

monitoring, and further investigation. In addition, the QIHEC may initiate further investigation of a quality issue by a medical expert or an outside peer review organization and make recommendations for specific corrective action(s), if indicated.

For a copy of the complete QIHETP, visit our website at:

Coming Soon

Responsibilities of Network Providers in Quality Improvement

Network providers (primary care physicians, specialists, facilities, and other providers) are contractually required to participate in and cooperate with CHPIV's Quality Improvement and Health Equity Transformation Program (QIHETP).

Primary care physicians and specialty providers participate with CHPIV's QIHETP through:

- Providing all medical care with attention to confidentiality of care and professional standards of human dignity
- Adhering to CHPIV's Facility Site Reviews (FSR) and Medical Record reviews, standards, policies, and procedures as outlined by prevailing Department of Health Care Services (DHCS) requirements.
- Report any serious diseases or conditions to both local and State public health authorities and to implement directives from the public health authorities as required by law, including but not limited to, 17 CCR section 2500 et seq.
- Cooperating with and adhering to CHPIV's quality improvement and health equity transformation program, utilization management plan, and physician credentialing policy
- Identifying a staff physician/Chief Medical Officer who will serve as clinical liaison with CHPIV and who will be authorized to communicate directly with CHPIV's Chief Medical Officer regarding medical services and clinical issues
- Cooperating with CHPIV's staff during facility and medical record reviews and initiating corrective action for areas identified as requiring improvement
- Cooperating with CHPIV's staff during the investigation of potential quality issues, member grievances and appeals by providing requested documentation of medical care and/or discussing the care with CHPIV's Chief Medical Officer to assist with the resolution of such grievances; and to take corrective action (if any) to prevent the recurrence of problem areas (if any are identified).
- Participating on committees and review panels within areas of expertise as requested and as feasible
- Completing a credentialing application and requested documents at the time of initial credentialing and recredentialing

Hospitals, other facilities, and other providers participate with CHPIV's QIHETP through:

- Permitting access to CHPIV's members' medical records for review when quality of care concerns or potential quality issues are identified.
- Investigating identified quality of care issues and reporting resolution to CHPIV's QIHEC.
- Cooperating with CHPIV's staff during the investigation of potential quality issues, member grievances and appeals by providing requested documentation of medical care/services and/or discussing the care/service with CHPIV's Chief Medical Officer to assist with the resolution of such grievances; and to take corrective action (if any) to prevent the recurrence of problem areas (if any are identified)

Provider Credentialing

CHPIV credentials all primary care, specialty physicians, and other independent licensed practitioners (allied health professionals and midlevels) to monitor quality provider care and satisfy health plan requirements. Members are not assigned to primary care physicians or referred to specialists until credentialing is complete.

This manual uses the term "provider" interchangeably with "practitioner" to indicate any health care professional the State of California has licensed or certified to deliver health care services.

Physician, Allied Health, and Mid-Level Credentialing

As applicable, all applicants must complete a Credentialing Profile on CAQH (Council for Affordable Quality Healthcare), including a current curriculum vitae (to include work history), and copies of their California medical license, DEA certificate, medical diploma, board certification, professional liability insurance, and mid-level supervising agreement.

The Credentialing Department is responsible for compiling and verifying the submitted information and forwarding the completed application information to the credentialing sub-committee. Applicants may review information submitted in support of their credentialing application and will be notified of any information that varies substantially from the information personally provided. Applicants will be given the opportunity to correct or have corrected any erroneous information obtained during the verification process.

The Credentialing Department submits clean Level I & II files to the Chief Medical Officer (CMO) for approval daily. The CMO reviews the list and approve information for inclusion in the CHPIV provider network. The Credentialing and Peer Review Committee reviews the verified application information for Level III & IV files and makes recommendations for inclusion or non-inclusion in the CHPIV provider network. If an applicant is denied participation with CHPIV, he/she may request reconsideration one year from the date of the initial application, and/or request an appeal as outlined in the Practitioner Fair Hearing policy and procedure. Board certified specialists are preferred, when compared to non-Board-certified specialists with otherwise similar professional practice backgrounds, when considering applications to join CHPIV's practitioner network.

Re-credentialing

CHPIV reviews the following information for re-credentialing status of primary care and specialty physicians every three years to monitor continuing physician quality:

- Clinical experience
- Current medical licensure (including state continuing education requirements)
- Hospital affiliations
- Inquiry regarding malpractice incidents for the previous three years
- Other information, including member complaints and transfers, medical record reviews and quality assessment studies, utilization activity and practice patterns, and administrative/contract compliance

Plan Notification

CHPIV physicians must notify the Chief Medical Officer immediately following notice of:

- Filing of litigation related to medical practice within 10 days of notification of the filing;
- Any suspension or loss of hospital staff privileges, state licensure, or DEA number;
- Any probationary, revoked or reprimand status regarding state licensure or state-controlled substance certificate; and
- Any physical or emotional impairment affecting his/her ability to practice medicine.

All providers must notify the Credentialing Department (at provider@chpiv.org), immediately and no later than five (5) working days, of any change in the following:

- Practitioner additions or departures.
- Name of provider's practice.
- Practice addresses ((including address, city, zip code) for provider and each participating practitioner.
- Telephone number(s) and other contact information for provider and its participating practitioners (including email address(es) for Provider's office).
- Plan products in which provider and each participating practitioner participates.
- California license number and type of license, Board Certification and specialty, NPI, admitting privileges to identified hospitals for each participating practitioner.
- Provider and participating practitioner language proficiencies.
- Whether provider (*and any other participating practitioners*) are accepting new patients.
- Hours of operation.
- Age restrictions.
- ADA accessibility accommodations.

Failure to promptly notify CHPIV of these changes may delay payment or result in contract termination.

All contracted providers must be fully credentialed prior to rendering services to CHPIV members.

Minimum Practitioner Standards

All practitioners who provide services to CHPIV members must meet the minimum practitioner standards set forth below:

- Valid California license to practice medicine or other applicable profession that is not subject to probation or other limitations;
- Current professional liability (malpractice) insurance coverage in the minimum amounts of \$1 million per occurrence and \$3 million aggregate per year;
- Not currently excluded, suspended, or otherwise ineligible to participate in any federal or state health care programs;
- Never been excluded from participation in federal and/or state health care program based on conduct that supports a mandatory exclusion under the Medicare program set forth in 42 USC § 1396-A7(a) as follows:
 - a conviction of a criminal offense related to the delivery of an item or service under federal and/or state health care programs;
 - a felony conviction related to the neglect or abuse of patients in connection with the delivery of a health care item or service;
 - a felony conviction related to health care fraud; and/or
 - a felony conviction related to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance.

Practitioners must continue to meet all the above Minimum Performance Standards during the time they furnish items and/or services to CHPIV members, including the term of any contract.

The Minimum Performance Standards apply to all practitioners providing services to CHPIV members. Practitioners who fail to meet one or more of the Minimum Practitioner Standards at any time will not be eligible to submit claims nor receive reimbursement from CHPIV. Any amounts paid by CHPIV during the time a practitioner fails to meet one or more of the Minimum Performance Standards will be subject to repayment to and/or recoupment by CHPIV.

Other Provider Organizations/Facilities

Prior to contracting or re-contracting with hospitals, home health agencies, skilled nursing facilities, surgery centers, or similar facilities, CHPIV verifies documentation of competency and compliance with regulatory agencies, including current license to operate in the State of California; proof of compliance with all state and federal regulatory bodies; and proof of approval by a recognized accreditation body, as applicable. Re-credentialing is done every three years.

Delegated Credentialing

CHPIV will accept the credentials of a medical group's practitioners if the group demonstrates that it requires and verifies at a minimum the criteria as outlined in CHPIV's Delegated Credentialing policies and procedures.

Provider Directory Data Accuracy

CHPIV provides a provider directory on its internet web site, which provides information to members and consumers in a consistent manner. All of the current provider directory information is located in the web portal for the providers to review at any time. The directory link is www.chpiv.org. The information available in the online provider directory is the same information that CHPIV's staff accesses when assisting consumers or enrollees inquiring about provider availability.

It is very important to have accurate provider data. Provider data changes often. In general, Providers are required to notify CHPIV within 5 business days of any changes in the provider's directory information.

To help with the provider data accuracy, CHPIV has partnered with Integrated Health Association (IHA) and uses their Symphony/Availity product. Medical groups and facilities are required to attest to the accuracy of their data quarterly. This online interface improves the process of maintaining accurate information.

Provider reviews, updates data online if needed and attest to the accuracy of information. Symphony compares the data they receive with CHPIV provider data. Symphony informs CHPIV when a change is needed.

Process

1. Providers will received a link from Symphony/Avidity each quarter. Adjustments to the data must be updated online, if required. Then the group/facility will attest to the accuracy. Hospitals are exempted from this requirement, but must sent changes in provider directory data to provider@chpiv.org.
2. Providers with more than 50 practitioners may submit their current directory information in an excel file.

State and Federal regulations require accurate provider directories. Attesting to the data accuracy is a requirement. Failure to respond to the notification may result in removal from the provider directory, removal from referrals selection listing, and a delay of payment or reimbursement of a claim, reduction of capitation.

Provider Directory Data Elements

- A. Group Level
 - a. DBA name for the affiliated contract
 - b. DBA website
- B. Site Level
 - a. Site name
 - b. Site address
 - c. Site phone number*
 - d. Site email
 - e. Site accessibility for members with physical limitations (PARS)
 - f. Business hours
 - g. Accessibility by public transportation

- C. Practitioner Level, if applicable
 - a. Practitioner's demographic information
 - i. Name
 - ii. Degree
 - iii. NPI
 - iv. License & license type
 - v. Specialty
 - vi. Board certification status
 - vii. Languages
 - viii. Hospital privileges
 - b. Practitioner's practice location
 - i. Accepting new patients at each location
 - ii. Age restrictions
 - c. Practitioner's Cultural Competency Training

*Office phone number is the general phone number for the facility, clinic or department. Please do not include practitioners or assistant cell numbers.

All changes of the above items and complete terminations from group is to be sent to the Credentialing department (provider@chpiv.org) within five business days. Providers may continue to use the Credentialing Specialist contact. Updates may be sent to provider@chpiv.org if your CHPIV Credentialing contact is not known.

Confidentiality of Credentials Files and Records of Committees

It is the policy of CHPIV to maintain, to the fullest extent possible permitted by law, the confidentiality of all credentials files and all discussions and/or deliberations relating to credentialing, quality improvement, and peer review activities. Disclosure of any such records, information, and/or communications shall be permitted only as described in CHPIV's policy on Confidentiality of Credentials Files and Records of Committees, under the close control of CHPIV's Chief Medical Officer and Credentialing Services Manager.

For more information about CHPIV's **credentialing policies and procedures**, contact CHPIV's Credentialing Services Manager at (760) 332-6447.

Site Certification

Overview

A site certification is conducted for all primary care sites, OB/GYN physicians and high-volume behavioral health practitioners. The purpose of the site certification is to evaluate conformance with CHPIV's standards (i.e., physical accessibility and appearance, adequacy of waiting and examining room space, adequacy of the medical records filing system and recordkeeping, including maintenance of confidentiality, procedures for review of diagnostic test results, and availability of appointments). CHPIV's standards conform with the most current Department of Health Care Services (DHCS) facility and medical record review requirements. This certification becomes effective once the providers have completed the CHPIV credentialing process. Practitioners are required to maintain the standards of site certification.

Primary Care Sites

Each primary care site must complete the site certification process before members are assigned.

OB/GYN Physicians and High-Volume Behavioral Health Practitioners

OB/GYNs and high-volume behavioral health practitioners must complete the site certification process before members will be referred for care.

Certification Process

Our Corporate Quality Department oversees the certification process. A site review is conducted to evaluate the overall operations of the practitioners' offices to assess compliance with CHPIV's processes in the applicable areas of:

- **Administrative Policies and Procedures**
 - Site personnel listing and licensure/certification
 - Access/availability (waiting times, triage protocols)
 - Emergency procedures (patient care, fire, and disaster)
 - Missed appointment and patient recall
 - Referral tracking
 - Infection control/Universal precautions
 - Biohazardous waste management
- **Clinical Protocols**
 - Pediatric Health Services Guidelines
 - Adult Preventive Health Services Guidelines
 - Obstetric Preventive Health Services Guidelines
 - Other treatment protocols, as appropriate
- **Pharmacy, Radiology, and Laboratory Standards**
 - CLIA certification or waiver for laboratory services (if applicable)
 - Current radiology safety report (if applicable)
- **Medical Records**
 - Maintenance and storage
 - Allergy flagging
 - Immunizations
 - Vital signs
 - Full signatures/dates
 - Health education
 - Complete prescription/prescriber consultation
 - Reports (consultation, hospitalization, emergency, ancillary)
 - Initial health assessment examination
 - Sterilization consent forms
 - Other requirements, as indicated
- **Facility Standards**
 - Disabled access
 - Current fire clearance/occupancy certificate

- Equipment and maintenance
- Environmental safety and infection control
- Child Health and Disability Prevention (CHDP) program certification
- Refrigerator/freezer temperature logs (daily)
- Vaccine storage
- Sample drug storage/log
- Other requirements, as indicated

Following completion of the review, a corrective action plan summary is provided to the primary care site, detailing the results of the survey and any required corrective action.

A new site certification is required when a practitioner relocates his/her office.

Ongoing Training and Assistance Following Certification

CHPIV provides follow-up training through personal contact, correspondence, and site visits to assist providers in complying with site certification standards.

- **Orientation Training:** Scheduled shortly after certification. Includes introduction to CHPIV and managed care, eligibility, referrals, member education, preventive health services, mental health, pharmacy, Telephone Advice Nurse, and Member Services.
- **Booster Training:** Includes retraining for areas identified by the site and CHPIV staff to assist the site in making improvements for enhanced member satisfaction or to clarify CHPIV policies and procedures.
- **Health Education and Promotion Curriculum:** Includes cultural and linguistic focused subject matter highlighting specific disease processes, presentation techniques, teaching, and delivery of appropriate health education services.

Compliance Surveys

Compliance surveys are conducted every three years at practitioners' offices to evaluate ongoing compliance with standardized processes. The survey is based on the same standards used during the initial site certification, with an emphasis on medical chart documentation. Interim visits are conducted between each regularly scheduled full scope site review.

The purposes of this monitoring are to:

- Ensure compliance with established protocols and policies
- Assist primary care sites in preparation for regulatory medical audits, and
- Identify operational strengths and opportunities for improvement.

The tools used during the surveys include the Provider Compliance Survey, Adult Health Maintenance Guidelines, Obstetric Health Maintenance Guidelines, and Pediatric Health Maintenance Guidelines.

The compliance survey includes a site facility inspection and a review of a minimum of five medical records per physician per age group (adults/pediatrics) of members treated. The site's contact person is provided with an exit summary and a copy of the completed audit tools. A

summary of scores is presented to the Quality Improvement Committee for review and recommendations.

Provider Corrective Action Plans

The QIHEC establishes compliance goals. A corrective action plan is instituted in the event that these goals are not met. The plan details the area requiring improvement, the proposed corrective action, the person responsible for implementing the corrections, and the approximate date for completion of corrections. Re-surveys are scheduled as necessary.

If the corrective action plan is not effective, the QIHEC has the option of recommending to CHPIV's Board of Directors action which could include additional training, suspension, or termination. The provider is given an opportunity to be heard, orally or in writing, not less than five days before the effective date of suspension or termination.

For information and assistance regarding **site certification, compliance surveys and standards, contact Corporate Quality at (619) 498-6438.**

Corrective Action and Sanction Policy

CHPIV investigates and, when appropriate, takes action regarding any reported instance of practitioner conduct that may be detrimental to patient care or safety, below acceptable professional standards, noncompliant with CHPIV's policies or the contract between the parties, inappropriate or improper, or detrimental to the community's confidence in CHPIV.

CHPIV's Board of Directors has designated the QIHEC as a professional review committee, affording the QIHEC's activities with legal and associated regulatory protections when conducting peer review activities.

CHPIV has established three categories of corrective action: routine, summary/emergency, and automatic.

Routine Corrective Action

The following people may submit to the QIHEC a request for investigation, and possible corrective action, of the activities or professional conduct of a practitioner:

- CHPIV's Chief Medical Officer
- CHPIV's Chief Executive Officer (CEO) (or designee)
- CHPIV's Board or any Board member
- A member of the QIHEC

The request must be written, supported by reference to the specific activities or conduct upon which the request is based. Within seven business days after receipt of the request, the QIHEC notifies the involved physician in writing of the request for investigation and provides a copy of the Request for Investigation/Corrective Action.

The QIHEC completes an investigation, if indicated, within thirty days and, within sixty days of receipt of the request, determines whether corrective action is necessary.

If the QIHEC recommends against corrective action, the chairperson advises the practitioner in writing and notifies the CEO and Board. If the QIHEC recommends corrective action and CHPIV's Provider Fair Hearing policy affords the practitioner procedural rights of review (a "fair hearing") of that recommendation, the fair hearing is completed or waived before the recommendation is forwarded to the Board. If the QIHEC recommends corrective action and policy does not afford a fair hearing, the QIHEC notifies the practitioner, the CEO and the Board of its recommendation. The Board affirms, modifies or denies the QIHEC's recommendation. The QIHEC will notify the practitioner of the determination only after the Board's decision.

CHPIV's Provider Fair Hearing policy affords the practitioner a hearing in those circumstances where the proposed corrective action is based on a medical disciplinary cause or reason (as defined in the California Business & Professions Code).

Summary/Emergency Corrective Action

The Chief Medical Officer for the QIHEC or the CEO for the governing body may impose Summary/Emergency corrective action whenever failure to do so may result in imminent danger to the health or safety of any person. These individuals have the authority to summarily suspend any portion of a practitioner's contracted scope of services.

The individual imposing Summary/Emergency corrective action immediately notifies the practitioner and the CEO of the action. Notification may be verbal, immediately followed by written notice. The Chief Medical Officer provides written notification of this action to the CEO, the governing body, and QIHEC.

Within seven business days of imposing a Summary/Emergency corrective action, the QIHEC investigates the reasons for the action and recommends whether to continue corrective action. If the QIHEC's recommendation is to continue the action and the Provider Fair Hearing policy affords the practitioner procedural rights of review for that recommendation, review is completed or waived before the recommendation is forwarded to the Board. If the policy does not afford the practitioner review/fair hearing, the QIHEC's recommendation is forwarded to the Board. The suspension remains in effect during exercise of the procedural rights of review.

Within twenty-four hours of the Board's decision based on the QIHEC's recommendation, the QIHEC's chairperson sends written notice to the practitioner.

Automatic Corrective Action

CHPIV may impose automatic corrective action, including termination of network membership, if a practitioner is subject to:

- Loss or limitation of his/her professional license
- Loss or limitation of his/her authority to prescribe controlled substances, or
- Loss or limitation of his/her professional liability insurance.

In these circumstances, the practitioner has no right to a "fair hearing."

The Chief Medical Officer notifies the practitioner verbally, followed by immediate written notice, of the imposition of corrective action. The Chief Medical Officer also sends notice to the CEO, the Board, and the QIHEC.

Automatic Suspension or Limitation

Each practitioner is obligated to inform CHPIV's Chief Medical Officer promptly and in writing if he or she fails to meet any of CHPIV's minimum standards for participation at any time including, without limitation, any change (including probationary status) in professional licensure status, eligibility to participate in any federal health care program including Medi-Cal and/or Medicare, compliance with CHPIV requirements for professional liability insurance, or conviction of a felony.

The practitioner's participation may be suspended, limited or restricted, and such action will be final, without any of the Provider Fair Hearing procedural rights. Further, any other action required by CHPIV's policies and contractual requirements with respect to the practitioner's participation in CHPIV's network will be taken as applicable.

- *Licensure*
Whenever a practitioner's license or other legal credential authorizing practice in California is revoked, suspended, lapsed, limited or is made subject to probation, the practitioner's participation will be terminated as of the date such action becomes effective.
- *Controlled Substances*
 - Whenever a practitioner's DEA certificate is revoked, limited or suspended, or expired, the practitioner will be correspondingly divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and at least throughout its term.
 - Whenever a practitioner's DEA certificate is subject to probation, the practitioner's right to prescribe such medication will be subject to the same terms of the probation, as of the date such action becomes effective and at least throughout its term.
- *Medi-Cal/Medicare*
If a practitioner is suspended or excluded from participation or otherwise becomes ineligible to participate in federal and/or state health care programs including, without limitation, the Medicare and/or Medi-Cal program, the practitioner's participation in CHPIV's network will be terminated as of the effective date of the sanction.
- *Conviction of a Felony*
Any practitioner who is convicted of a felony will be immediately terminated from participating in CHPIV's network. Such suspension is effective upon conviction and does not await the conviction becoming final.
- *Professional Liability Insurance Eligibility*
If for any reason a practitioner fails to maintain professional liability insurance as required by CHPIV, the practitioner's participation will be suspended effective the lapsed policy date.
- *CHPIV Minimum Standards*
If for any reason a practitioner fails to meet any of CHPIV's minimum standards (see Provider Credentialing in this section), the practitioner's participation in CHPIV's network will be terminated.

Practitioners whose participation is suspended and/or terminated are not entitled to the procedural rights set forth in Provider Fair Hearing policy unless the suspension is reportable under California Business and Professions Code, Section 805.

In the event CHPIV's Board of Directors or its designee makes a determination, in its sole discretion, that the automatic suspension or termination of a practitioner set forth above would be detrimental to the interest of CHPIV or its members, the Board or its designee may, except for those required by law or regulation, waive the automatic suspension or termination on a temporary or permanent basis. The Board's (or designee's) decision to grant such waiver does not constitute a peer review decision or grounds for a hearing pursuant to the Provider Fair Hearing policy.

For a copy of the Corrective Action and Sanction Policy, contact the Credentialing Services Manager at (619) 498-6438.

Provider Fair Hearing

Community Health Plan of Imperial Valley maintains a Provider Fair Hearing system which affords practitioners the right of review when an adverse recommendation is made by CHPIV's Quality Improvement Committee (QIHEC) or CHPIV's Board of Directors.

The following actions, when taken by the QIHEC or Board, are considered "adverse" and entitle a provider to a fair hearing:

- Termination of a contract based on a medical disciplinary cause or reason
- Denial of credentialing based on a medical disciplinary cause or reason

A medical disciplinary cause or reason is that aspect of a practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

Procedures

Within 10 days of an adverse recommendation, the Chief Medical Officer sends written notice to the provider of his/her right to review by fair hearing and the time limit for the request.

If a timely request for hearing is received, the Chief Medical Officer appoints and chairs a Hearing Committee and schedules a hearing date.

The Chief Medical Officer notifies the provider of the hearing date, time, and location; the names of the Hearing Committee members and a request to notify the Chief Medical Officer of any "preliminary objections to the proposed members" within 10 days; and the names of any witnesses who may appear at the hearing at the request of the QIHEC.

A court reporter attends the hearing. The costs for the reporter are the responsibility of CHPIV. If the provider wants a copy of the transcript, he/she must contact the court reporter directly and is responsible for payment of any costs.

The provider and the Chief Medical Officer may, within five days after the hearing, submit a written statement to be considered by the Hearing Committee. Within 10 days, the Hearing

Committee members recommend affirming, denying, or modifying the adverse recommendation. The recommendation is forwarded to the provider by written notice, with a copy to the CEO.

After review of the Hearing Committee's recommendation, the QIHEC confirms, modifies, or reverses its original recommendation and forwards its final recommendation to the Board for approval. The Chief Medical Officer notifies the provider in writing.

If the final decision restricts the practitioner's ability to practice or results in removal from CHPIV's practitioner network, the Chief Medical Officer will notify the Medical Board of California as required by California's Business & Professions Code section 805(a)(6) and the National Practitioner Data Bank as required by the conditions for participation.

To obtain a copy of the Provider Fair Hearing Policy and Procedure, contact the Credentialing Services Manager at (619) 498-6438.

Use of Non-Physician Medical Practitioners

Non-physician medical practitioners providing care to CHPIV members must be supervised by a California licensed physician who has also been licensed as a supervising physician.

CHPIV's policy provides for the fullest use of non-physician medical practitioners permissible under applicable regulations and statutes consistent with the health and welfare of members.

Non-physician medical practitioners (NPMPs) are defined as one of the following:

- Nurse practitioner licensed by the Board of Registered Nursing,
- Nurse-midwife licensed by the Board of Registered Nursing, or
- Physician assistant (PA) licensed by the Medical Board of California.

State License and Certification Requirement

Each primary care site must ensure that all NPMPs rendering care to members have a current California license and certification on file at their place of employment and available for review upon request by CHPIV or the State Department of Health Care Services.

Supervision of NPMPs

Each NPMP must have a designated physician supervisor. All physician supervisors must maintain a valid California medical license.

Physician Assistants

The supervising physician must, within 30 days, review, countersign, and date a minimum of 10% sample of medical records of patients treated by physician assistants functioning under these protocols. The physician must select for review those cases which by diagnosis, problems, treatment or procedure have, in his/her judgment, the most significant risk to the member.

The medical record of any member for whom a prescription is written must be reviewed,

countersigned, and dated by the supervising physician within seven days.

Ratio of Supervisory Physicians to NPMPs

The maximum number of NPMPs supervised by a physician supervisor will not exceed the following:

- Four (4) nurse practitioners with furnishing numbers, and
- Four (4) physician assistants, or
- Four (4) certified nurse midwife (CNM)/PA in combination where the maximum number of CNMs does not exceed three (3) and the number of PAs does not exceed two (2).

There is no limit to the number of nurse practitioners without furnishing numbers supervised by a physician supervisor.

Exception to Supervision Requirements

The supervising physician need not be present to supervise the NPMP but must be available by electronic communication at all times when the NPMP is rendering treatment to members. The NPMP and the supervising physician must establish written guidelines for adequate supervision. These guidelines must be forwarded to CHPIV's Credentialing Manager.

Physician-Practitioner Interface

The California Code of Regulations requires that each NPMP sign a Physician-Practitioner Interface which specifically establishes the scope and limits of services rendered by the NPMP. Protocols can be developed by the physician or adopted from or referenced to texts or other existing guidelines. Protocols must be signed and dated by the supervising physician and the NPMP. Each Physician-Practitioner Interface must include the following:

- Guidelines as required by Title 16, Section 1470, for registered nurses, and Title 16, Section 1399.541, for physician assistants
- Administration and prescribing of medication by nurse practitioners and physician assistants
- All additional policies agreed upon between the supervising physician and the NPMP
- All written standing orders of the supervising physician
- All written special orders given by the supervising physician

A copy of the written agreement of each NPMP must be retained in the files at the NPMP's place of employment and made available for review upon request of the State Department of Health Care Services and CHPIV. The supervising physician will retain the Physician-Practitioner Interface and provide a copy of this Interface to the NPMP.

For further information on **policies and procedures and sample** and sample **supervision agreements, interfaces, or protocols** regarding non-physician medical practitioners, contact CHPIV's Credentialing Services Manager at (619) 498-6438.

SAMPLE FORMAT

Non-Physician Medical Practitioner Supervision Agreement

PHYSICIAN NAME
FACILITY NAME
STREET ADDRESS
CITY

Dear _____:

This is to confirm that I have agreed to serve as your Supervising Physician and provide services in the area of _____.

The California Code of Regulations, Title 22, stipulates that there be a formal letter of understanding between the supervising physician and the non-physician medical practitioner and that there will be specific procedure protocols based on his/her area of practice (i.e., Pediatrics, OB/GYN, Adult Medicine, as found in Title 22, Sections 51240 and 51241). The following services are to be used as general guidelines:

SERVICES TO BE PERFORMED BY NON-PHYSICIAN MEDICAL PRACTITIONER

1. Obtain a thorough history, perform an appropriate physical examination and make an assessment, and record and present pertinent data in a manner meaningful to the physician.
2. Perform and/or assist in the performance of routine laboratory and screening procedures including but not limited to the following: drawing of venous blood, catheterization of the bladder, naso-gastric intubation, gastric lavage, pelvic examinations, including bi-manual examinations and Papanicolaou smear.
3. Provide health education that is age appropriate and address concerns expressed by the patient. Counseling may include matters pertaining to physical and mental health, such as diet, social habits, family planning, normal growth and development, and the aging process.
4. Recognize and evaluate situations which call for immediate attention of the supervising physician, and institute, when necessary, emergency treatment procedures essential for the life of the patient.
5. Order the following laboratory tests that are considered within the scope of practice in (Pediatrics, OB/GYN, or Adult Medicine):
 - a. Complete CBC
 - b. SMA 20
 - c. Complete urinalysis
 - d. Pregnancy tests (Urine and Serum)
 - e. Venereal disease tests including RPR, GC Culture, and Chlamydia IFT
6. Facilitate supervising physician's referrals to the appropriate health facilities, agencies, and resources in the community.

GENERAL GUIDELINES OF CARE

1. It will be the responsibility of the non-physician medical practitioner to refer patients for further medical evaluation when indicated. Any questions regarding findings on the physical exam must be brought to the supervising physician's attention for recommendations of appropriate referral and follow-up.
2. Non-physician medical practitioners should document in the progress notes when they have consulted with one of the supervising physicians regarding an encounter.
3. Administer medication to a patient, or transmit orally, or in writing on a patient's record, a prescription from his or her supervising physician to a person who may lawfully furnish such medication or medical device. A NPMP may issue written prescription transmittal orders, within the scope of his or her practice, which can be filled by pharmacists.

Applies to Physician Assistants Only: The supervising physician's prescription, transmitted by the physician assistant for any patient cared for by the physician assistant, will be based either on a patient-specific order by the supervising physician or on written protocol which specifies all criteria for the use of a specific drug or device and any contraindications for the selection.

4. In the case where a protocol exists, guiding the non-physician medical practitioner in the use of a specific medication, this non-physician medical practitioner may prescribe these medications as standing orders. This will be outlined for each specific practice area according to general protocols.
5. (*Optional*) Non-physician medical practitioners may transmit an order for the dispensing of medication or the administering of medication with authorization from the supervising physician. Physician assistants and nurse practitioners may administer or issue written prescription transmittal order for controlled substances in schedules two through five inclusive. The specific medications in question are outlined in the policies and procedures protocol #_____.
6. Applies to Physician Assistants Only: Health care services rendered by the physician assistant will be reviewed by examination and co-signature of the medical record as outlined below:
 - a. When protocols are in place: 10% of records within 30 days
 - b. When prescription is written: 100% of records within 7 days

7. Supervising physician agrees to be available directly or by telephone to review the findings of the physical and history examination and the tasks performed by the non-physician medical practitioner. Supervision need not be given prior to treatment and the supervising physician need not be present on the premises if he/she is available by telephone and within reasonable distance. However, this off-site supervision will be discouraged except in emergency cases when the non-physician medical practitioner is the only one available at a primary care site at any one time.

SUPERVISING PHYSICIAN

NON-PHYSICIAN MEDICAL PRACTITIONER

Signed _____

Signed _____

Date _____

Date _____

Sample Addendum to Nurse Practitioner Supervision Agreement

To assist in the guidance of care provided by the undersigned nurse practitioner, _____
_____ (physician's name) has approved the use of: Patient Care Guidelines for Nurse
Practitioner, Hoole, Axalla; Greenberg, Robert; & Pickard, C. Glenn - A Little Brown. (sample
protocol) and (list formulary of drugs from which the nurse practitioner, with furnishing number,
may write a prescription transmittal order without patient-specific order. Note: List cannot
contain any controlled substances.)

An additional resource available as a reference is: Current Pediatric Diagnosis & Treatment - A
Lange Medical Book. (sample reference)

It is mutually agreed that the practice guidelines listed in the texts above will be used as
standardized procedures for _____ (nurse
practitioner's name).

SUPERVISING PHYSICIAN

NURSE PRACTITIONER

MD's Signature

Date

Nurse Practitioner's Signature Date

Section 11: Delegated Services

Utilization Management

CHPIV may delegate any of the following utilization management activities:

- Referral Management (excluding services wherein CHPIV retains financial liability)
- Preauthorization of outpatient services
- Preauthorization of practitioner services
- Post-service authorization of outpatient and practitioner services
- Coordination of post-hospitalization care

Delegation may occur following the provider's demonstration of complying with CHPIV's delegated utilization management policies and satisfactory completion of a pre-delegated on-site review to validate that the delegated entity's UM practices meet CHPIV's standards.

Utilization Management Standards

The delegated entity must have a documented **Utilization Management Program** and a **UM Workplan. UM, semi-annual reports** must be provided to CHPIV using the Industry Collaboration Effort (ICE) format. Annually thereafter, the UM Program must be reviewed, revised as applicable, and submitted to CHPIV.

Preauthorization and concurrent and post-service review must be performed and supervised by currently licensed and qualified medical professionals. For any denial, a licensed physician must conduct a medical appropriateness review and sign the review form. Copies of correspondence relating to health care services that have been denied, delayed, or modified are to be sent to CHPIV at the same time as the correspondence is issued to members. When indicated, the delegated entity must consult physicians from the appropriate specialty areas of medicine and surgery; these physicians must be certified or qualified for certification by one of the American boards of medical specialties, prior to rendering a determination. All technology assessment questions will be referred to CHPIV's Chief Medical Officer.

Decision protocols, consistent with CHPIV's protocols and standards, must be based on current and reasonable medical evidence. Mechanisms that monitor the consistency of the reviewers' application of criteria are required. Annual review of existing criteria, as well as distribution of new or revised criteria to staff and providers, must be documented. Copies of specific review criteria must be available to practitioners, members, and the general public upon request.

Timely decisions must be made on routine, urgent, and emergency referral requests:

- Routine: 14 Calendar days
- Urgent: 72 hours

Notifications of referral denials, deferrals, or modifications must clearly specify the reason and the criteria used, document the disposition, and be provided to the member and the referring provider (please note that contracted providers will have immediate access to notifications of referral denials, deferrals or modifications with the appeal rights on the provider portal).

This notification must also include a description of how to file an appeal, that the physician responsible for the denial, modification, or delay is available to discuss the decision and the phone number of the physician. All appeals are submitted directly to CHPIV.

The delegated entity must submit **utilization management information** to CHPIV's Health Care Services Division, by hard copy or in an electronic format compatible with CHPIV's information system, according to the following schedule.

Annually Utilization Management Work Plan

- Evaluation of Utilization Management Program
- Utilization Management policies and procedures

Semi-annually Revision of Utilization Management Program description

As Issued/Received

- Member appeals
- Copies of denied, deferred, or modified healthcare service correspondence

Any entity that CHPIV has delegated Utilization Management must promptly provide to CHPIV a copy of any and all correspondence regarding a denial, delay, or modification of health care services.

Oversight of Delegated Entities

Delegated entities must submit to CHPIV utilization management meeting minutes as required. Attendance by CHPIV's Chief Medical Officer at delegated entities' utilization management committee meetings shall be deemed compliant with this requirement.

In addition, CHPIV will perform an annual on-site review of delegated entities' utilization management operations to validate the implementation and ongoing use of CHPIV-approved utilization management policies and procedures. Furthermore, CHPIV will review copies of letters and correspondence relating to Utilization Management decisions for appropriateness, timeliness, and compliance with CHPIV standards.

For additional information or assistance with delegated utilization management policies, procedures, or standards, contact Health Care Services at (619) 498-6423.

Delegated Claims Processing

CHPIV may delegate claims payment activities. CHPIV will periodically review the claims payment activities of any capitated provider entity that has been granted the authority to perform the claims payment function on our behalf.

The delegated entity's responsibilities include:

- Completion of a delegated **claims processing agreement**
- Quarterly submission of **claims reports** including the following information:
 - Turnaround time (receipt date vs. check date), by quarter and year to date
 - A total of CHPIV claims received and processed, by quarter and year to date
 - Internal payment accuracy and financial accuracy results for the quarter and year to date
 - Claims payable aging report
 - Listing of denied claims and denial reasons

Claim Payment Oversight

CHPIV conducts annual audits to review claims payment activities. This review includes an analysis of claims payment performance and the following procedures to validate that payment practices meet the standards set forth in the California Health and Safety Code.

Inventory Management/Control

- Mail receipt and document control procedures
- Distribution and control of claims for processing
- Narrative description of claims processing and filing systems and flow charts of document processing

Claim Payment Timeliness

- Reports used to manage turnaround time
- Receipt date vs. paid date

Claim Payment Accuracy

- Procedures vs. applicable claim payment guidelines
- Subcontracts and/or applicable fee schedules for correct allowed amounts
- Data entry for the correct date of service, procedure code, member identification #, patient account #, etc.

Financial Accuracy

Divide underpaid/overpaid dollar amounts (as defined within the review of the above random sample of claims) by the total of billed amounts to determine the financial accuracy percentage.

Claims Processing Software Testing

- Adjudication of benefits function
- Pricing mechanisms
- Eligibility verification function
- Authorization verification/editing function
- Data entry mechanisms (patient, DOS, provider, billed amount entered within 48 hours)
- Claim status workflow (pending, approved, denied status)

Monitoring Capitated Entities for Financial Solvency

Providers who are deemed a Risk-Bearing Organization (RBO) are required to demonstrate financial solvency and viability pursuant to the reporting requirements of Sections 1300.75.4 through 1300.75.4.8 of Title 28 of the California Code of Regulations, as amended. The Department of Managed Health Care has issued regulations adopted pursuant to SB 260, more commonly referred to as the Financial Solvency Regulations. CHPIV is obligated to evaluate and monitor the financial viability of all contracted RBOs and therefore requires each contracted RBO to execute a financial solvency agreement and submit all reports in the time and manner determined by the DMHC to CHPIV.

Obligations and Reporting

As set forth in the Financial Solvency Agreement, each RBO is obligated to:

- Maintain **Cash-to-Claims** ratios as defined by the Department of Managed Health Care (DMHC).
- Submit to DMHC **quarterly financial surveys**, within 45 calendar days following the end of each quarter.
- Submit to DMHC **annual financial surveys**, within 150 calendar days following the close of the RBO fiscal year and an **annual statement of organization survey**.
- Submit an **attestation of the accuracy and correctness** of each report filed with the DMHC.
- Notify DMHC and CHPIV in the event the RBO has experienced any event that materially alters its financial situation or threatens its solvency.
- Permit DMHC to make any examination that it deems reasonable and necessary to implement the regulations pursuant to SB 260.

Corrective Action

In the event an RBO has deficiencies in any of the grading criteria utilized by the DMHC to measure RBOs financial solvency, the RBO must simultaneously submit a self-initiated CAP proposal, in an electronic format developed by the DMHC, to both the DMHC and CHPIV that meets the requirements as set forth in the Financial Solvency Agreement, as amended.

Send CAP reports to CHPIV's Chief Financial Officer, Financial Services, 512 W Aten Rd Imperial, CA 92251.

Delegated Credentialing

CHPIV will accept the credentials of a medical group's practitioners if the group:

- Demonstrates that it **requires** and **verifies** at a minimum the criteria as outlined in CHPIV's Physician Credentialing and Allied Health Professional Credentialing policies and procedures

Medical groups desiring delegated status for credentialing must submit their credentialing policies, procedures, and application for review and approval by CHPIV's Credentialing Sub-Committee.

When delegated credentialing is approved, CHPIV retains the right to:

- Conduct on-site practitioner compliance surveys for individual physicians (primary care, obstetrical, and behavioral health practitioners)
- Conduct on-site audits of the medical group's credentialing files to verify that the medical group meets credentialing requirements
- Approve new physicians for inclusion in the practitioner network
- Terminate or suspend individual physicians, based on quality issues

Responsibilities

The medical group approved for delegated credentialing has the following responsibilities:

- Obtaining a completed and signed application for each physician, including all education, licenses, certifications, and other information required by CHPIV
- Verifying practitioners' professional medical education, internship, residency, and fellowship appropriate for practicing specialty
- Determining any Medi-Cal, Medicare, OIG, and SAM sanctions activity
- Querying the National Practitioner Data Bank (NPDB). The medical group must query the NPDB during the credentialing process, but the information IS NOT to be submitted to CHPIV as part of the credentialing application.
- Verifying hospital privileges with the stated hospital(s)

Delegated Recredentialing

CHPIV monitors files requiring re-credentialing and will notify the delegated group, if applicable, and request required information and documents.

Monitoring Delegated Credentialing Activities

The Credentialing Manager reviews reports and audits of all delegated medical groups' credentialing practices by reviewing files using the NCQA standards on an annual basis. Should the medical group at any time fail to meet established standards, CHPIV will require a corrective action plan and possible delegation agreement termination.

Section 12: Eligibility

Member Eligibility

Member Services Department	(888) 230-2117
Internet-Based Eligibility Access	Contact Plan
Claim Liaison	(619) 240-8933

Member Identification Card

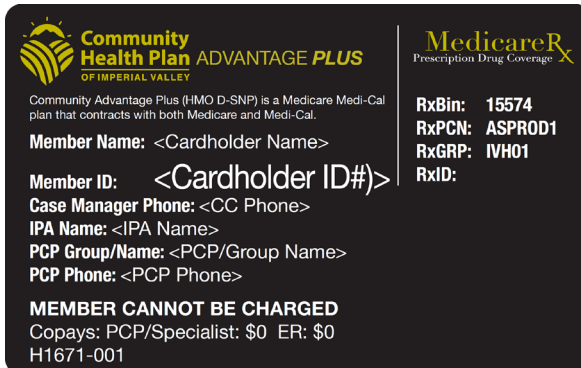
All members receive a CHPIV identification card, issued at the time of enrollment or when they change primary care physicians. This card identifies the member **but does not guarantee continued eligibility**.

We recently changed our member identification cards. Please note, however, that some members may still present an older version of a valid card. Samples of the new ID cards are shown below:

Members may also use their Medicare Identification Card to identify themselves.

Sample CHPIV's Identification Card

Advantage-Plus Card



Community Health Plan ADVANTAGE PLUS
OF IMPERIAL VALLEY

Community Advantage Plus (HMO D-SNP) is a Medicare Medi-Cal plan that contracts with both Medicare and Medi-Cal.

Member Name: <Cardholder Name>

Member ID: <Cardholder ID#>

Case Manager Phone: <CC Phone>

IPA Name: <IPA Name>

PCP Group/Name: <PCP/Group Name>

PCP Phone: <PCP Phone>

MEMBER CANNOT BE CHARGED
Copays: PCP/Specialist: \$0 ER: \$0
H1671-001

MedicareRx
Prescription Drug Coverage X

RxBin: 15574
RxPCN: ASPROD1
RxGRP: IVH01
RxID:



In an emergency, call 911 or go to the nearest hospital emergency room, or you may call your primary care provider (shown on the front of this ID card).

Member Services: 1-888-484-1412
Member Services TTY: 1-888-671-3263
Behavioral Health: 1-888-671-3511
Pharmacy Help Desk: 1-877-606-0727
24-Hour Nurse Advice: 1-888-671-3332

Website: www.chpiv.org

Send claims to: Community Advantage Plus (HMO D-SNP)
P.O. Box 174
Imperial, CA 92251

Claim Inquiry: 1-888-671-6419

Verifying Eligibility

A Plan membership card is not a guarantee of current eligibility. Each time a member presents for services, eligibility must be verified.

Internet-Based Eligibility Access

Primary care physicians can verify member eligibility by accessing CHPIV's Internet-based eligibility system. This allows you to:

- Verify member eligibility
- Retrieve and print your own current eligibility lists

To download the eligibility list you may access the provider portal. You can then either view your individual member's eligibility or print your entire monthly membership roster.

Medicare Verification Systems

Providers may also verify member eligibility through Medicare's automated eligibility system at (866) 502-9054.

CHPIV eligibility must be verified with **each appointment** to ensure the patient is covered by CHPIV at the time of service.

For assistance with installing Internet Based Eligibility Access, contact the Claims Liaison at (619) 240-8933

CHPIV-Initiated Disenrollment or Reassignment

CHPIV-initiated disenrollment or reassignment of a member must be based on documentation validating that there has been a breakdown of the CHPIV/member or physician/patient relationship. Provider requests for a member's disenrollment are directed to the CHPIV Member Services Manager.

Reasons for disenrollment may include:

- The member is verbally or physically abusive to CHPIV providers, ancillary or administrative staff or to other CHPIV members.
- The member is otherwise repeatedly disruptive to CHPIV or provider operations.
- The member falsifies health status or eligibility information to CHPIV providers.

Whenever possible, efforts must be made to counsel the member or modify the member's behavior, and must be documented.

Documentation of the reasons for the disenrollment request and all efforts made to resolve the problems and/or modify the member's behavior may include:

- Pertinent progress record notes indicating the dates of the patient's visits and no shows
- Records of the date, time, and subject of any counseling the patient has received in an effort to prevent or eliminate a breakdown in provider/patient relationship
- Correspondence sent to the patient in an effort to improve the patient's knowledge and understanding of CHPIV procedures
- Copies of any police reports, legal writs or filings and statements from witnesses or otherwise involved persons
- Documentation of any physical or abusive behavior, including incidents that warrant immediate disenrollment.

For Medicare members, CHPIV-initiated disenrollment must be approved by the Centers for Medicare and Medicaid Services. CHPIV has the authority to reassign members to a different primary care physician.

For information on disenrollment, contact the Member Services Manager at (888) 330-2117.

Section 13: Emergency Care

For information on coordinating urgent and emergency care call:

Health Care Services Department
(619) 498-6471
(888) 330-2117

Provider Site Emergency Standards

Providers must have trained staff and appropriate equipment to handle in-office medical emergencies.

Telephone Triage

All personnel who answer telephones (including office and after-hours telephone staff) must be trained to **immediately contact** a physician for **triage** of problems and, if necessary, to instruct patients to call “911” in an emergency.

Office Emergencies

- Each site must have procedures for emergencies that occur at the site, including immediately calling “911” and summoning a physician to determine the need for basic life support or emergency medical services.
- There must be at least one staff person certified in CPR on-site at all times when the site is open for patient services.

Emergency Supplies and Equipment

Each provider site must maintain an emergency supply of medication and equipment that is appropriate for the patient population served, any applicable licensing requirements, and the site’s location (i.e., proximity to a hospital-based emergency room).

Required emergency medications and equipment:

• Drugs	Strength	Unit
*Epinephrine amp.	1:1000	1 ml
*Diphenhydramine (Injectable Benadryl®) amp.	50 mg/ml	1 ml
or		
*Diphenhydramine (Oral Benadryl®) 25 mg	25/bottle	
Nitroglycerin sublingual	1/150 gr	25/bottle
Naloxone (Narcan®) amp.	0.4 mg/ml	1 ml

- **Equipment**
 - *Oral Airways (adult, pediatric, infant)
 - *Ambu Bags (adult, pediatric)
 - IV Fluids
- *Per California State regulations.

Coordinating Urgent and Emergency Care

Urgent/Non-Emergent Care

Members must obtain **urgent care** services at their primary care site unless directed to go elsewhere.

Members are instructed to contact their primary care physician or the CHPIV Telephone Advice Nurse (TAN) at (800) 671-3332 before accessing urgent care centers for urgent and non-emergency medical treatment. If the Telephone Advice Nurse determines that medical treatment should be rendered during the hours that the primary care physician's office is closed, the member will be directed to the most appropriate urgent care or emergency facility. TAN forwards to CHPIV assessment summaries of a potential emergency room or urgent care dispositions.

Emergency Care

If a member reasonably believes he or she has an **emergency medical condition**, they should call "911" or proceed to the nearest hospital emergency room. Prior authorization is not required.

If the emergency department's medical screening evaluation indicates that the member's condition does not constitute an emergency, ER staff redirects the member to his/her primary care site for non-emergency care. We are striving to significantly reduce inappropriate utilization of the emergency room by diligently working with both our primary care providers and members to make certain members access the appropriate care site.

Hospitals are required to notify CHPIV within 24 hours regarding all members being admitted to the hospital and/or presenting to the emergency room. Emergency rooms are directed to fax the ER face sheets within 24 hours of the ER episode to CHPIV at (866) 897-6024. In turn, CHPIV notifies the member's PCP of the emergency room encounter/admission. Our PCPs will take necessary clinical measures to promote appropriate emergency room utilization.

Follow-up to Emergency Care

Follow-up care for an emergency episode is provided through the primary care site. Emergency room personnel instruct the member to return to his/her PCP for follow-up care. If the member's condition requires a specialty referral, the PCP's office will request authorization and arrange the appointment.

Out-of-Area Care

Members experiencing out-of-area medical emergencies are instructed to go to a nearby hospital emergency room or an appropriate urgent care center. The CHPIV identification card directs providers to call CHPIV for authorization of services beyond treatment for the emergency episode. When CHPIV is notified of an out-of-area admission, a CHPIV case manager coordinates the transfer to a contracted facility when the member is medically stable for transfer.

Scope of the Telephone Advice Nurse (TAN)

Within its scope of services, TAN:

- Triage member calls
- Provide members with medical advice
- Provide written notification to CHPIV of member emergency and urgent care encounters

Section 14: Health Education

Health Education Programs and Materials (619) 240-8831

Health Education Sessions

CHPIV provides group and individual health education sessions to members at locations in Imperial County. Many of these classes are available in languages other than English.

We encourage providers to refer members to any of these health education and promotion services. Members can attend any program based on their interest in improving lifestyle behaviors. No prior authorization is required. Transportation is available at no cost for eligible members.

Topics include:

- AIDS
- Alzheimer's
- Anger Management
- Arthritis
- Asthma
- Cancer Awareness and Prevention
- Cholesterol Awareness
- Chronic Disease Management
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Renal Disease/Failure
- Congestive Heart Failure
- Coronary Artery Disease
- Dental Health
- Depression
- Diabetes
- Elder Abuse/Domestic Violence
- Emphysema
- Energy Conservation
- Exercise/Adult Fitness
- Gastroesophageal Reflux
- Hospital/ER Prevention
- Hypertension
- Immunization
- Incentive Spirometer
- Infection Prevention
- Liver Disease
- Managed Care 101-PCP Access
- Medication Compliance and Safety
- Menopause
- Microalbuminuria
- Nutrition/General and Special Diets
- Osteoporosis
- Pain Management
- Parkinson's Disease
- Pursed Lip Breathing (COPD)
- Safety/Injury Prevention
- Senior Health Issues/Resources
- Smoking Cessation
- Stress Management
- Stroke Prevention
- Support Groups
- Weight Control

Our staff can arrange individual or group consultation for members with special health education needs.

Health Education Information to Members Health Education Materials

Community Health Plan of Imperial Valley maintains a library of health education materials for providers' use. Many are available in English, Spanish, Vietnamese, Arabic, Tagalog, Farsi, Chinese and other languages. Materials cover a wide variety of specific topics. Please call 619-240-8831 for more information.

Section 15: Marketing

CHPIV's Marketing Department vigorously promotes the Advantage-Plus program. Our bilingual Marketing representatives regularly visit primary care sites to keep providers and staff up-to-date with changes in the program that may impact their practice. Our representatives also actively work with your office staff to increase member enrollment—through many avenues such as the enrollment card process and ensuring that CHPIV Provider Services literature is readily available for your patients.

In addition, CHPIV staff help market our Advantage-Plus program by participating in community-sponsored events such as health and resource fairs. Often our representatives set up a booth and present the benefits of enrolling in our Advantage-Plus program to eligible individuals and families. As part of our provider network, you are the best tool we have in promoting the benefits of enrollment through CHPIV.

Call our Provider Service Line for general CHPIV operational issues, including;

- Site Certification,
- Training and Education Scheduling,
- Contracts,
- Provider Changes,
- Capitation,
- Enrollment, and
- Access to Online Services.

Training and Education Programs

CHPIV is committed to providing comprehensive training opportunities for our providers and their staffs. Listed below are general training topics available to our providers.

Access to Behavioral Health and Other Community Services: Target group: providers and staff.

Booster Training: Retraining for areas identified by the primary care site or CHPIV staff, or for specific topics such as appointment access, after hour coverage, and walk in appointments. Target group: providers and staff.

CHPIV Web-Based Services: Internet member eligibility, referral authorization status lookup, member and provider resource information. Target group: providers and staff.

CPSP Provider Training: CPSP trainings are scheduled prior to program implementation. Target group: providers and staff.

- Health Education and Promotion Classes: Rotating schedule of topics such as asthma, diabetes, nutrition, hypertension, parenting, smoking cessation, and stress management. Target group: providers and members.
- Member Service: eligibility issues, and electronic data access. Target group: front line staff at the primary care site.
- Primary Care Orientation: Introduction to CHPIV and managed care, marketing activities, eligibility reports, Customer Service, referrals, claims, Telephone Advice Nurse service, preventive health education, pharmacy and case management information. Target group: providers and staff.
- Quality Improvement/Site Certification: Educating and training primary care site staff to meet all standards for certification. Target group: providers and staff.
- Referral Training: Referral process, network providers, carved-out services, behavioral health services, services that do not require authorization, shared risks arrangements, and changes/updates. Target group: providers and staff.

Section 16: Medical Records

For information on medical records requirements or sample of medical records forms contact:

Corporate Quality
(619) 498-6486

Medical Records Administration

Community Health Plan of Imperial Valley requires each provider site to maintain an effective medical records system for collecting, processing, maintaining, storing, retrieving, and distributing medical records of members. The site must keep a medical record for each member accessing care.

Each provider site must establish policies and procedures conforming to the laws, rules, and regulations of the State of California governing:

- **Retention** of active records
- **Retirement** of inactive records. Inactive medical records must remain accessible for a period meeting state and federal requirements (seven years, or two years past the age of majority)
- **Data entry** procedures, and
- **Release** of medical information according to federal laws, state laws, and regulatory agencies.

The person designated in charge of clinical records is responsible for:

- Maintaining adequate **storage** to ensure confidentiality and physical safety
- Developing an **identification system** for record filing
- Assuring **timely** location and **retrieval** of records when requested
- Supervising the medical record system to ensure **compliance** with laws, rules, and regulations of the State of California, and
- Maintaining medical records to ensure appropriate and **uniform organization**.

Records Review

CHPIV expects providers to maintain their medical records at an 80% minimum compliance with the established requirements. Providers who receive notification of noncompliance are required to develop, implement, and submit a written corrective action plan to the Quality Improvement and Health Equity Committee.

Medical Records Contents

To ensure adequate capture of identifying information and uniformity of historical and clinical information, the records must include the following forms:

- Data face sheet, consisting of a registration application and patient information profile
- Health history form
- Annual physical form
- Problem list
- Medication list

In addition, the medical record must contain:

- **Personal/biographical data** that includes age, sex, address, telephone number, marital status, and emergency contact name, ID number, race and ethnicity and language.
- **Medical history**, including serious accidents, operations, and illnesses. For children, past medical history related to prenatal care and birth information should be recorded.
- Documentation of **each visit** including physical findings and diagnosis
- A completed **immunization record** and records of immunizations given at locations other than the primary care site (for members under 21)
- **Drug allergies** or adverse drug reactions, noted in a designated uniform location in the record
- **Idiosyncratic** medical problems
- **Smoking/alcohol/substance abuse** notations for members 12 years and older
- **Consultations, referrals, and specialist reports/notes**, with the ordering provider's initials or other documentation signifying they have been reviewed. Consultation and abnormal lab and/or imaging results must have an explicit notation in the record of follow-up plans.
- **Telephone advice** prescribed to a patient
- All **emergency care** and follow-up, including copies of emergency room records
- **Hospital discharge summaries** for all hospital admissions that occur while the patient is enrolled in a CHPIV plan and prior admissions, as necessary
- Documentation of whether or not the individual has executed an **advance directive** (for adults)
- Requests for **language and translation** services and how provided
- Referrals for **behavioral health services** including documentation of **patient-approved exchange of information** between PCP and behavioral health practitioners/providers

- For **patients 21 years and older**, there is appropriate **notation concerning the use of cigarettes, alcohol and substances**
- Possible **risk factors** relevant to the **particular treatment**
- **Working diagnoses** that are consistent with findings
- **Treatment plans** that are consistent with diagnoses
- Any **other reports** necessary to evidence continuity of care
- Evidence of **preventive screening** and services offered in accordance with CHPIV's practice guidelines

Patient **noncompliance** with scheduled appointments, follow-up care (i.e., abnormal laboratory, cytology), scheduled tests, or instructions about medication or diet, with a three-step process to assure adequate measures for continuity of care. For sample adult, pediatrics, or obstetric medical records forms or other information regarding medical records, contact Corporate Quality at (619) 498-6486.

Documenting Care

The medical record must provide appropriate and adequate clinical documentation of all care received to facilitate continuity of care for all medical problems addressed in the medical record.

Consultation reports, hospital reports, laboratory data, and any other patient clinical information must be dated upon receipt. Providers must review, initial, and incorporate the report into the medical record within 30 days of care/services.

Providers must make their entries to the medical record at the time of services, using acceptable abbreviations. If a late entry is necessary, the date and time of the entry should be noted as a "late entry" for a specific date.

Entries for patient visits must document the following:

- **Patient identification** (name and/or patient identification number on each page)
- **Date, provider name** and title
- **Subjective** information (chief complaints, history of present illness [HPI])
- **Objective** information (vital signs, clinical and physical findings)
- **Assessment** (diagnostic impression)
- **Plans** (therapeutic treatments or diagnostic studies; also patient education, if indicated)
- Patient **instructions** regarding medication use and any additional special care information
- The full **signature** of the provider (first initial, last name, professional title, e.g., MD, RN, MA), plus a countersignature of a physician when required. If the signature is not legible, a name stamp (not a signature stamp) may be used below the name

- When **medication** is prescribed, the name of the drug, strength, quantity, directions for use, and refill information, when applicable
- **Follow-up notes** concerning follow-up care, call, or visit. The record will reflect a specific time to return in days, weeks, months, or PRN (as necessary).
- **Unresolved problems** from previous visits to be addressed in subsequent visits.

SOAP (Subjective Objective Assessment Plan) format problem-oriented charting is encouraged.

Confidentiality of Patient Information

Protected Health Information (PHI)

CHPIV providers must comply with all applicable state and federal laws and regulations regarding confidentiality of patient records. All personal and medical information must be secured and handled to ensure confidentiality in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Where California law is more stringent in any requirement than the Privacy Rule, California law governing the use and disclosure of patient health information as set forth in the California Confidentiality of Medical Information Act of 1981 supersedes the related federal Privacy Rule requirement.

Unless otherwise provided by federal and state law, a written authorization for the use and disclosure of PHI is necessary where such information is used for purposes other than medical evaluation and treatment, payment of health-related services, or health care operations.

Results of quality assessment studies, chart audit summaries, research studies, other summary data or case presentations (for educational purposes) must be presented without any personal identification.

Medical Records

All information contained in the medical record must be treated as confidential and must not be released without the written consent of the member or his or her authorized personal representative, except as noted in the following section on “Release of Medical Information.” Providers must be committed to protecting the confidentiality and security of PHI and maintaining physical, electronic and process safeguards that restrict unauthorized access to such information.

Providers are encouraged to adopt security measures that include locked files where such PHI is contained, separately staffed storage areas for both live and archived medical records, shredding of information when it is lawfully purged, and information security mechanisms such as user passwords, data encryption and encoding, and firewall technology.

Certain medical information is subject to additional confidentiality protection, including genetic predispositions, mental health records, substance abuse records, and HIV test results and HIV-related medical information.

The same conditions apply when using or disclosing PHI for any other reason where specific written authorization has been obtained from the individual for whom the PHI relates.

Staff Training

Providers are responsible for instructing their staff on current regulations regarding confidentiality of patient information and must safeguard members' personal medical information and, to every reasonable extent, protect their privacy rights in accordance with current state and federal laws. Access by staff to the medical, financial, and demographic information related to CHPIV's members must be limited to only those with the "need to know" and "minimum necessary" basis in order to perform functions related to treatment, payment for medical services, and health care operations, or where required by state or federal law.

Where there are state and/or federal laws that prohibit the sharing of a member's PHI without the individual's written permission, providers must comply with those requirements.

When is an Authorization Not Required?

In addition to use/disclosure for the purpose of treatment, payment of claims, and health care operations, PHI can be used/disclosed without written patient authorization, but with patient agreement as evidenced by an acknowledgement of a Notice of Privacy Practices, for the following activities:

- to maintain a provider or facility directory
- to inform family members or other identified persons involved in the patient's care, or notify them about patient location, condition, or death
- to inform appropriate relief agencies during disaster operations
- to provide public health agencies with information related to disease prevention or control
- to report victims of abuse, neglect, or domestic violence
- for health oversight activities, such as audits, legal investigations, license, or for certain law enforcement purposes
- to avert a serious threat to public health and safety.

Core Elements of a Patient Authorization

There are two **required** core elements when obtaining patient authorization to use/disclose PHI:

- In order to be a valid authorization, the authorization form must contain
 - a description of the PHI to be used/disclosed, in clear language
 - who will use/disclose PHI and for what purpose

- whether or not use or disclosure will result in financial gain for the covered entity
 - a statement that the authorization may be revoked at any time, and will govern any PHI not already used/disclosed based on the submitted authorization
 - the signature of the patient or his/her authorized representative, and the date of signing
 - the time frame when the authorization expires, such as 90 days from the date of signature
- The written authorization is only valid for the specific PHI described. A new authorization must be obtained if any further PHI is to be used/disclosed.

The Patient Self-Determination Act & Advance Directives

The Patient Self-Determination Act (PSDA) of 1990 and the California Health Care Decisions Law (AB 891) require health care providers to inform patients of their rights to make health care decisions and execute advance directives. The primary responsibility for opening this discussion with a patient rests with the primary care physician.

Patient Self-Determination Act

CHPIV does not prohibit or otherwise restrict a health care practitioner, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient about

- the patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options;
- the risks, benefits, and consequences of treatment or non-treatment; or
- the opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

All patients who are at least 18 years of age, of sound mind, and acting upon their own free will also have the right to

- participate in and direct their own health care decisions, and
- accept or refuse medical or surgical treatment.

Additionally, the Patient Self-Determination Act requires that:

- each patient record indicate whether the patient has elected to execute an advance directive.
- physicians or their office staff inform each patient, 18 years or older, of their rights and responsibilities under the PSDA, and ensure that each medical record identifies whether or not a patient has elected to execute an advance directive.
- any information relating to discussion of PSDA is clearly documented in the patient's medical record. If a patient states that he/she is not interested in any discussion of this subject, it is important that this information be entered into the medical record as offered and declined.
- an advance directive be signed and witnessed by two persons, at least one of whom is not mentioned in the patient's will and is not a potential claimant to his/her estate.
- no provider involved in the patient's medical care may sign nor witness the signing of such directive in the course of his/her duties.
- no patient may be forced to execute an advance directive, and any advance directive can be revoked by the patient at any time.
- practitioners not condition the provision of medical care or otherwise discriminate against a patient based on whether or not the patient has executed an advance directive.
- an advance directive goes into effect when the patient is either terminally ill or in an irreversible coma or vegetative state and cannot make his or her own health care decisions.
- changes in California law regarding advance directives must be reflected in the information that practitioners provide their patients as soon as possible, but no later than 90 days after the effective date of the law of the court order.

Advance Directives

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

All patients who are at least 18 years of age, of sound mind, and acting upon their own free will may choose:

- to complete an advance health care directive,
- to **refuse to complete an advance directive**, or
- to **submit** to the provider a **valid advance directive** from another state.

Information on Advance Directives is available at the California Medical Association website at: <https://oag.ca.gov/sites/all/files/agweb/pdfs/consumers/ProbateCodeAdvancedHealthCareDirectiveForm-fillable.pdf>. A simplified Advance Directive form is available and can be downloaded from our website. The document is available in English and Spanish and the link can be found through the "Provider" section of our website.

Release of Medical Information

Medical information is subject to both state and federal confidentiality protections. Generally, medical information may not be disclosed without the written consent of the patient or his/her authorized representative. Exceptions that provide for limited disclosures are those pursuant to court order, subpoena, some reporting requirements, and some situations in which disclosure is allowed at the discretion of the physician. If in doubt, obtain written authorization from the patient. A valid authorization must be written, signed and dated by the patient or his/her legal representative, and must include the use and limitations on the types of medical information to be disclosed, the name of the provider authorized to disclose, who may receive the information and a date after which the authorization is no longer valid.

There are some situations in which the physician may disclose medical information without the patient's written consent, including:

- to other health care providers for diagnosis or treatment
- to third party payors, only to the extent necessary to allow responsibility for payment to be determined or to secure payment
- for peer review and to organizations/individuals insuring a provider's professional liability; and
- certain other exceptions

There are also situations in which additional confidentiality protections apply and special consent must be obtained, depending on the type of information being requested: information about genetic predispositions, AIDS, STDs and HIV testing. Information regarding substance abuse and mental health treatment is also subject to additional confidentiality protections.

The privacy standards and release of medical information apply equally to electronic records.

Adult patients are entitled to access their medical information upon request. They also have the right to request a change to their medical record when discrepancies are noted and the right to provide a written addendum to the records if they believe that the records are incomplete or inaccurate.

While Section 164.524 of the Privacy Rule provides patients with the right to access, inspect, copy or amend their PHI in their designated record set, the following is not included in this right:

- psychotherapy notes;
- information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceed; and
- PHI for which the provision of access to the individual is prohibited by law, specifically, the Clinical Laboratory Improvement (CLIA) Amendments of 1988.

HEDIS® Documentation Requirements

Community Health Plan of Imperial Valley uses Healthcare Effectiveness Data and Information Set (HEDIS®) and the Adult and Child Health Care Quality Measures to assess its performance in meeting quality care for our members.

Developed by National Committee for Quality Assurance (NCQA), HEDIS® measures the care and service provided by health plans, evaluates the effectiveness of health plans' care, access to healthcare, use of services and members' satisfaction.

In addition, Centers of Medicare & Medicaid Services (CMS), an operating division of the Department of Health and Human Services (HHS), creates sets of core measures showing the quality of care and health outcomes for adults participating in Medi-Cal.

The majority of HEDIS® and core set information is from claims; however, medical record review results are also incorporated into our data.

As physicians you can help facilitate that the care provided in your offices is acknowledged in the HEDIS® assessment by:

- Providing the appropriate care within the designated timeframes
- Accurately coding all claims and encounters
- Documenting all care in the patient's medical record

Here are the measures with tips that will help meet HEDIS® and core set documentation requirements:

Pediatric and Adolescent Measures

- **Appropriate Testing for Children with Pharyngitis** – The percentage of children 3 – 18 years of age who were diagnosed with pharyngitis, prescribed an antibiotic and received a group A streptococcus (strep) test for the episode.
- **Appropriate Treatment for Children with Upper Respiratory Infection** – This measure assesses the percentage of children 3 months – 18 years who were given a diagnosis of upper respiratory infection (URI) and *were not dispensed* an antibiotic prescription on or within three days after the diagnosis.
- **Asthma Medication Ratio – AMR** – The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ration of controller medications to total asthma medications of 0.50 or greater during the measurement year.
- **Childhood Immunization** – The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. If the

child has a history of having the chicken pox, please document the date on the immunization record.

- **Children and Adolescents Well-Care Visits** – The percentage of members 3 – 21 years of age who had a well exam visit with a primary care practitioner (PCP) during the measurement year.
- **Chlamydia Screening in Women** – The percentage of women 16 – 24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.
- **Depression Screening and Follow-up for Adolescents and Adults**- Members 12 years and older need to be screened for clinical depression and, if screened positive, a follow-up plan is documented on the date of the positive screen.
- **Developmental Screening in the First Three Years of Life**- Children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, and third birthday.
- **Follow-up After Hospitalization for Mental Illness** – The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.
 - The percentage of members who received follow-up within 30 days of discharge
 - The percentage of members who received follow-up within 7 days of discharge
- **Follow-up for Children Prescribed ADHD Medication** – The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.
 - *Initiation Phase.* The percentage of members 6 – 12 years of age as of the IPSP with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
 - *Continuation and Maintenance (C&M Phase).* The percentage of members 6 – 12 years of age as of the IPSP with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

- **Immunizations for Adolescents** – The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td), and two HPV vaccine by their 13th birthday.
- **Lead Screening in Children** – The percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.
- **Prenatal and Postpartum Care**
 - *Prenatal Care.* Percentage of women who delivered and received a prenatal care visit in the first trimester or within 42 days of enrollment.
 - *Postpartum Care.* Percentage of women who had a postpartum visit on or between 7 days and 84 days after delivery.
- **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents** – The percentage of members 3 – 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of:
 - *BMI Percentile Documentation.* Annually document BMI percentile or BMI percentile plotted on an age-growth chart meets criteria. A BMI value is not acceptable for this age range.
 - *Counseling for Nutrition.* Documentation must include a note indicating the date and at least one of the following:
 - Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors);
 - Checklist indicating nutrition was addressed;
 - Counseling or referral for nutrition education;
 - Member received educational materials on nutrition;
 - Anticipatory guidance for nutrition, and
 - *Counseling for Physical Activity.* Documentation must include a note indicating the date and at least one of the following:
 - Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation);
 - Checklist indicating physical activity was addressed;
 - Counseling or referral for physical activity;
 - Member received educational materials on physical activity, or
 - Anticipatory guidance for physical activity.

- **Well-Child Visits in the first 30 months of life** – The percentage of members who had the following number of well-child visits with a PCP during the last 15 months.
 - **Well-Child visit for the first 15 months- Six or more well-child visits.**
 - **Well-Child visit for Age 15 months – 30 months- Two or more well-child visits.**

Adult Measures

- **Antidepressant Medication Management** – The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.
 - *Effective Acute Phase Treatment.* The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).
 - *Effective Continuation Phase Treatment.* The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).
- **Asthma Medication Ratio – AMR** - The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ration of controller medications to total asthma medications of 0.50 or greater during the measurement year.
- **Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis** – The percentage of adults 18 – 64 years of age with a diagnosis of acute bronchitis who *were not dispensed* an antibiotic prescription.
- **Breast Cancer Screening** – The percentage of women 50 – 74 years of age who received a mammogram during the measurement year or the year prior to the measurement year.
- **Cervical Cancer Screening** – The percent of women 21– 64 years of age who received a Pap smear screening during the measurement and two years prior to the measurement year. Women 30-64 years of age who had a pap smear and cervical high-risk human papillomavirus (hrHPV) contesting within the last five years.
- **Chlamydia Screening in Women** – The percentage of women 16 – 24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.
- **Comprehensive Diabetes Care** – The percentage of members with diabetes 18 – 75 years of age who had each of the following:
 - Hemoglobin A1c (HbA1c) testing
 - HbA1c poor control (>9.0%)
 - HbA1c control (<8.0%)
 - Eye exam (retinal) performed
 - Medical attention for nephropathy
 - BP control (<140/90 mm Hg)

- **Controlling High Blood Pressure** – The percentage of members 18 – 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90) during the measurement year based on the following criteria:
- **Depression Screening and Follow-up for Adolescents and Adults**- Members 12 years and older need to be screened for clinical depression and, if screened positive, a follow-up plan is documented on the date of the positive screen.
- **Diabetes Screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications**- The percentage of members 18-64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication need to have a glucose or an HbA1c test annually.
- **Follow-up After Hospitalization for Mental Illness** – The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.
 - The percentage of members who received follow-up within 30 days of discharge
 - The percentage of members who received follow-up within 7 days of discharge
- **Osteoporosis Management in Women Who Had a Fracture** – The percentage of women 67 -85 years of age and older who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.
- **Prenatal and Postpartum Care**
 - *Prenatal Care.* Percentage of women who delivered and received a prenatal care visit in the first trimester or within 42 days of enrollment.
 - *Postpartum Care.* Percentage of women who had a postpartum visit on or between 7 days and 84 days after delivery.
- **Use of Imaging Studies for Low Back Pain** – The percentage of members with a primary diagnosis of low back pain who *did not have* an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.
- **Use of Spirometry Testing in the Assessment and Diagnosis of COPD** – The percentage of members 40 years of age and older with a new diagnosis or newly active chronic obstructive pulmonary disease (COPD) who received appropriate spirometry testing to confirm the diagnosis.

HEDIS: <https://www.ncqa.org/hedis/>

Adult and Child Core Set: <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>

Section 18: Member Services

We want our members to be satisfied with the care and services they receive. Our Member Services staff is available to assist members and providers with the following services:

- Verification of **covered services**
- Assistance with **access** to services
- Processing voluntary and emergency **disenrollments**
- Processing member **complaints and grievances**
- Working with **non-compliant** or disruptive members
- Arranging for primary care **site changes**

Interpreter Services

Our staff can speak to your patients in English, Spanish, Arabic, Vietnamese, and Tagalog. In addition, we offer Telephone Interpreter Services in more than 140 languages, and interpreting and TDD services for the hearing impaired.

Member Services Department hours of operations 24 hours a day, 7 days a week.

Contact us at (888) 330-2117.

Language Assistance Program

CHPIV's Language Assistance Program (LAP) is dedicated to meeting the language needs of our members. Language assistance services, both clinical and non-clinical, are provided in a culturally competent manner and accessible to all members, including those with limited English proficiency or reading skills, hearing or visual impairment, and diverse cultural and ethnic backgrounds.

Although a majority of CHPIV staff is bilingual and adequately proficient to provide translation and interpretation services, we also contract with designated agencies to provide limited English proficient members with language assistance services not available through CHPIV staff. The purpose of the LAP is to:

- provide clear communication with members,
- ensure effective interpretation and translation services are easily accessible and available to members in threshold languages, and,
- support appropriate and timely provision of care.

Interpretation services, whether medical or non-medical in nature, are available to all members at all points of contact. Please note, the LAP is accessible at no cost to either the member or the provider.

Member Assessment and Education

CHPIV conducts an annual assessment to review member language needs and demographic information. Member language preferences and ethnic diversity are evaluated to determine

significant changes in threshold languages. This information is entered into CHPIV's information system which is available to all staff and providers who interact with CHPIV members.

CHPIV also educates members on accessing language assistance services. CHPIV conveys the availability of these services via our Evidence of Coverage (EOC), new member welcome calls, contacts with Member Services to request interpreter assistance, or when care is accessed and interpreter services are not readily available through the provider's office.

Requests for interpreter and translation services are coordinated through Member Services. Members with limited English proficiency are encouraged to use LAP services and discouraged from bringing family, including their minor children, or friends to medical appointments for the sole purpose of providing translation assistance.

Provider Training and Education

Training on the availability of interpreter services is mandatory for all primary care providers and their staff. During the primary care site orientation, CHPIV provides an overview of operational procedures. A key component of this overview includes addressing the language needs of prospective members and the process of accessing interpreter services through Member Services.

Requests for Language Assistance Services are coordinated through Member Services. Staff is available 24 hours a day, seven days a week. When there is a need for interpreter service for languages other than those readily available from CHPIV staff, interpreter services are provided through the use of the Language Line, face-to-face interpretation or TDD line. Both Member Services staff and other interpretation services are available 24 hours per day, seven days a week.

When members report their preferred language, CHPIV captures this information and makes it available to all CHPIV providers through the CHPIV on-line eligibility system.

CHPIV providers are required to document any member refusal for interpreter or translation services in the member's medical record. Additionally, providers are reminded to inform members of the availability of language assistance services for all points of contact and at no cost to either the member or provider.

Members with limited English proficiency should not be encouraged to bring family members, including minor children, or friends to medical appointments for the sole purpose of providing translation assistance.

Access to Telephone Interpreter Services

Language assistance is provided by an appropriate interpreter in a conference call setting. A CHPIV Member Services representative remains on the call to provide additional service and/or answer any questions which are translated by the interpreter for the member.

Make language requests with Member Services staff. If staff are unable to provide translation, they will contact a Language Line representative for assistance.

Face-to-Face Interpreter Services

CHPIV may arrange face-to-face interpreter services. Call Member Services 48 hours prior to the appointment with information regarding the language requested, the date and time of the member's appointment, and the address of the location where interpretation services are needed.

Communication with Hearing-Impaired Members

CHPIV provides hearing-impaired members access to services through:

- Network Interpreting Service, which can arrange an interpreter to accompany a member to a health care appointment
- California Relay Service's Telecommunications Device for the Deaf (TDD) or Teletypewriter (TTY) (855) 266-4584.

The California Relay Service (CRS) operates 24 hours a day, seven days a week. Users can make as many calls as desired and talk as long as needed. All CRS calls are confidential and available for members and providers at no charge. The CRS is coordinated through CHPIV Member Services.

If providers do not have their own arrangements for interpretation and TDD services, they may contact Member Services at (888) 330-2117, 24 hours a day, seven days a week. Depending on the type of assistance required, an interpreter is scheduled or a message is typed to the member via TDD and the member's response is verbally relayed.

To ensure knowledge of language assistance services for hearing-impaired members, training on the availability and proper use of interpreter resources and TDD equipment is mandatory for all primary care providers and their staff.

Communication for Visually-Impaired Members

CHPIV makes available printed material upon request for members who are visually-impaired. Requests for enlarged print or audio recordings, including those related to grievance procedures and forms or CHPIV's response, are coordinated through the Braille Institute Universal Media Services at:

The Braille Institute
741 North Vermont Avenue
Los Angeles, CA 90029
Contact: Carol Jimenez, Transcribing Coordinator

Health Education Materials

CHPIV makes available, at no cost to either members or providers, health education materials in several languages and at appropriate reading levels.

For further information or assistance with language interpreter services or services for hearing or visually-impaired members, contact Member Services at (888) 330-2117. For training on the use of interpreter services and TDD equipment, contact Provider Services at (760) 332-6447.

Transportation

Non-Emergency Medical Transportation (NEMT) & Non-Medical Transportation (NMT) is provided to eligible members for medically necessary services. When arranging NEMT, the Plan reviews the Physician Certification Statement (PCS) form submitted by the provider to determine

the need for door-to-door assistance for members who cannot reasonably ambulate or are unable to stand or walk without assistance. In the case of NMT, a PCS form is not required; however, if the need to provide door-to-door assistance is identified, the Plan authorizes this service.

If authorized by CHPIV, transportation providers will ensure their staff are providing door-to-door assistance for members who cannot reasonably ambulate or are unable to stand or walk without assistance.

Transportation via the Bus/Trolley System or Taxi

Transportation via the public transit system is coordinated through the provider requesting the authorization or Member Services. Except for public transit transportation, all other transportation requests require an authorization.

Member Complaint and Grievance System

Members have the right to voice grievances, either verbally or in writing, about CHPIV or the care that the member received. Members also have the right to ask for an appeal of decisions to deny, defer, or limit services or benefits. The purpose of the Complaint and Grievance System is two-fold: 1) to resolve CHPIV member concerns promptly and 2) to ensure that members have recourse if they feel their care or service or access was less than satisfactory.

Providers who know that a CHPIV member has become dissatisfied can refer the member to Member Services or simply notify Member Services of the situation. Grievances are reviewed with members by the Grievance and Appeals Team and coordinated with the Director of Corporate Quality, as appropriate.

Definitions

“**Grievance**” means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, a request for reconsideration, or appeal made by an enrollee or the enrollee’s representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

“**Complaint**” is the same as “grievance.”

“**Complainant**” is the same as “grievant,” and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.

“**Resolved**” means that the grievance has reached a final conclusion with respect to the enrollee’s submitted grievance, and there are no pending enrollee appeals within the plan’s grievance system, including entities with delegated authority.

“**Exempt Grievances**” are those grievances received by telephone, facsimile, email or online through CHPIV’s website, and are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day. These grievances are exempt from the requirement to send a written acknowledgement letter and response.

“**Parties to an appeal or State Hearing**” include the parties to an appeal or State hearing include the Contractor as well as the Member and his or her representative or the representative of a deceased Member’s estate.

“Expedited (Urgent) Grievance” is a grievance involving an imminent and serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb or major bodily function. Expedited Grievances must be resolved within 72 hours.

“Standard Grievance” is any grievance that is not an exempt or expedited grievance. A standard grievance is an expression of dissatisfaction that cannot be resolved by the next business day, or involves coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment. Standard grievances require both an acknowledgement letter (within five calendar days of receipt of the grievance) and a resolution letter (with 30 calendar days of receipt of the grievance).

“Appeal” means a request for review of one of the following actions:

- A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- A reduction, suspension, or termination of a previously authorized service;
- A denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner;
- Failure to act within the timeframes provided in 42 CFR 438.408(b);
- For a resident of a rural area with only one MCO, the denial of an enrollee’s request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; or
- A denial of an enrollee’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Information to Plan Members about Complaint and Grievance Procedures

Members are notified of complaint and grievance procedures through the CHPIV Member Guide and/or the Evidence of Coverage mailed to all new members and annually thereafter.

Processing a Complaint or Grievance

CHPIV is responsible for resolving member grievances; we do not delegate grievance resolution.

Members may address their complaints and grievances by phone or in written form to the Grievance and Appeals Supervisor, who acknowledges all complaints in writing within five days, unless otherwise permitted by regulation. You may also obtain the grievance form at www.chpiv.org. Members may file a grievance at any time; there is no time limit to file a complaint.

Upon resolution of grievances, the member is notified in writing of the action taken within 30 days of the receipt of the date the grievance was received in non-urgent and within 72 hours in urgent situation.

Standard appeals may be pre-service or post service. Standard appeals must be initiated by submitting the request with additional information for review by telephone, writing, CHPIV’s website or by fax.

For Medi-Cal members, the timeframe for a provider to file an appeal on behalf of the member is 60 days from receiving notice of denial, delay or modification of a request for services, or of any

decision made by CHPIV or a CHPIV contractor for which appeal rights apply. Determinations are made within 30 calendar days of receipt of required documentation for review. Urgent matters involving a serious health concern are resolved within 72 hours. Medi-Cal members have a right to access and to get a copy of their medical records, and request that records be amended or corrected. With written permission from the member, an authorized representative may access medical records and file an appeal on the member's behalf.

For services that the member is currently receiving, the member can continue to receive the services while the appeal is being considered. This is called Aid Paid Pending. To receive Aid Paid Pending, the member must request an appeal within 10 days from the date of the Notice of Action (denial or modification letter) or before the date that authorization for the service ends, whichever is later.

If the member is dissatisfied with the determination of the Grievance Committee, he/she may further appeal, as follows:

Medi-Cal members may request a fair hearing from the State of California. The member may request a fair hearing without first going through the appeal process, or may request a fair hearing concurrently with the appeal process.

For more information or a complete copy of CHPIV's Member Complaint and Grievance Policy and/or Independent Medical Review process, contact Member Services at (888) 330-2117 or (TTY) (855) 266-4584.

Independent Medical Review

Members have the right to an **Independent Medical Review (IMR)**. The IMR provides a mechanism administered by the California Department of Managed Health Care to review, upon request, member grievances involving CHPIV's or a CHPIV contractor's decision to deny, delay, or modify a health care service in whole or in part due to a finding the proposed service is not medically necessary.

If a member believes that health care services have been improperly denied, modified, or delayed by CHPIV, or a CHPIV contractor, he or she may have the right to request an IMR from the State of California. IMR involves a review of a grievance by a State-contracted independent review organization (IRO) whose decisions are binding.

Independent Medical Review Eligibility

Member grievances involving a disputed health care service, or a coverage decision *and* a disputed health care service, are eligible for IMR, provided that ALL of the following eligibility conditions are met:

- The member's provider recommended a service as medically necessary or the member received urgent care or emergency services that a provider deemed medically necessary OR the member, in the absence of a provider recommendation or receipt of urgent care or emergency services, was seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the member seeks IMR;*
- The disputed service was denied, modified, or delayed by CHPIV or one of its contractors based on a decision that the service was not medically necessary;

- The member filed a grievance with CHPIV and the disputed decision was upheld or it remained unresolved for 30 days;
 - At any time after an event occurred.
 - In cases in which a member is seeking an IMR in response to a denial of a request for an experimental/investigational service, the member is not required to submit a grievance to CHPIV before seeking an IMR.
- * *CHPIV will expedite access to an in-plan provider upon member request. The in-plan provider need not recommend the disputed service as a condition for the member's eligibility to request an independent review.*

Given these eligibility conditions, members may request IMR after participating in CHPIV's grievance process for 30 days. An exception occurs in the case of a member with an urgent grievance, involving an imminent and serious threat to the health of the member. In such a case, the member is not required to participate in CHPIV's grievance process for more than three days.

Member Rights

- Members have the right to request an IMR should they believe that health care services have been improperly denied, modified, or delayed by the plan or one of its contracted providers.
- Members need not bear the costs of the independent review organization, including any application or processing fees.
- Members or their legal representatives may appoint a representative to act on their behalf.

CHPIV Responsibilities

- CHPIV is responsible for receipt and resolution of all member grievances, including those relating to utilization management decisions made by entities to whom CHPIV has delegated this authority. Therefore, CHPIV is responsible for informing members of their rights regarding IMR, including information on how to access IMR.
- CHPIV is responsible for providing the member with an IMR application form, and providing any relevant information required by the DMHC.
- Upon notice that a member has applied for IMR, CHPIV or its contracting provider(s), as applicable, shall supply to the independent review organization copies of the following documents within three (3) business days (as always, the confidentiality of all medical record information is maintained in accord with state and federal laws):
 - The member's medical records relevant to (i) the member's medical condition, (ii) the health care services being provided for that condition, and (iii) the disputed health care services requested by the member for the condition.
 - Any newly developed or discovered relevant medical records. CHPIV will also forward copies to the member or the member's provider unless the offer is declined or prohibited by law.

- Any information provided to the member concerning plan and provider decisions relevant to the member's condition and care, as well as any materials provided to the plan or its providers in support of the member's request for disputed health services. This documentation shall include the written response to the member's grievance.
- Any other relevant documents or information used by the plan or its contracting provider(s) in determining whether disputed health services should have been provided. These will also be furnished to the member and his or her practitioner.
- Correspondence informing members and practitioners, as applicable, of the upholding of a denial in whole or in part to a medical necessity determination shall include notice of IMR rights and processes, contact information, and of the member's exemption from related costs.
- The required information shall be provided to the IMR organization within 24 hours of the approval of the request for review if there is imminent and serious threat to the health of the member including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or of the member's immediate and serious deterioration of health.

Overturned Decisions

If the IRO determines that a CHPIV or a contractor's decision concerning a disputed health care service should be overturned, the DMHC is notified. Once the DMHC has informed us of its determination, we will convey the time and procedure for claim payment or approval of service to the member in writing.

Informing Members about IMR

Members are informed of their right to IMR through information contained in their Evidence of Coverage and in correspondence to members concerning grievances. IMR is available to Medi-Cal members who meet all eligibility criteria.

If you require additional information regarding our Grievance and Appeal and/or IMR policies, contact CHPIV's Grievance and Appeals Supervisor at (888) 330-2117.

Transfer of Primary Care Site

Our members have the right to choose or change their primary care doctors and sites. Members or primary care sites can initiate transfer requests by calling Member Services at (888) 330-2117. Non-emergency transfers are effective on the first day of the following month.

Primary Care Physician Emergency Transfer Request

One of the following criteria must be met to initiate an emergency transfer:

- A member was assigned to an inappropriate provider. For example, a pediatric member was assigned to an internal medicine physician.
- A member has a history of service with a provider other than the assigned provider.
- A member has moved and needs to access care immediately.
- A member is dissatisfied with the current primary care site/provider and transferring sites is a condition for continuing CHPIV membership.

When we receive an emergency transfer request, capitation for the month of the transfer will be paid to the provider on file as of the last day of the month. Any capitation payments made to

previous providers will be deducted in the subsequent month. This is to prevent duplicative payments.

We realize there is potential for financial risk when emergency transfers occur. Therefore, we do consider exceptions to our policy. If either physician renders services during the month of the emergency transfer, capitation reimbursement will be considered for both providers when appropriate documentation, such as encounter forms or chart notes, is submitted to the Capitation Administration Department.

Coordination and Continuity of Care

Primary care physicians are responsible for ensuring coordination and continuity of the member's care. CHPIV's Health Care Services case managers are available to assist with the transition.

Section 18: New Provider Orientation Training

Any new provider (contracted) will receive orientation training on how to navigate the CHPIV portal within 10 business days. If provider would like to request a refresher or additional training for any new staff, please contact our provider service line at 760-332-6447. All the orientation presentation information is available within our CHPIV provider portal and on our main website www.chgsd.com.

Every year, upon logging into to your CHPIV provider portal account, you will be prompted to download the orientation slides and attesting that you have done so.

In addition, CHPIV provides Provider Newsletters which is a communication method used by Community Health Plan of Imperial Valley to share topic specific updates and changes. Provider Newsletters are sent on a quarterly basis and focus on areas, which can improve quality of care. The newsletters are mailed or emailed to providers. Provider newsletters are also posted on the CHPIV main website.

Provider Newsletters are to be shared within your organization with the appropriate parties to ensure that changes are communicated throughout the impacted units.

If you have any questions on a specific Provider Newsletter or need access to the CHPIV provider portal, please contract our Provider Services Line at 760-332-6447.

You may view CHPIV's previously issued Provider Newsletters at the following link: www.chpiv.org

Section 19: Pharmacy Services

CHPIV's Advantage-Plus pharmacy benefits program is administered through MedImpact Healthcare Systems, Inc., located in San Diego. In most cases, MedImpact can answer a provider's or pharmacist's specific questions regarding formulary, member coverage, limitations, exceptions, and prior authorization. MedImpact can be reached at (877) 606-0727, 24 hours a day, seven days a week.

In addition, CHPIV's Pharmacy Services staff is available to assist you in serving our members.

Claims, Electronic Transmission, Payment, Prior Authorization, Provider Verification	
MedImpact Healthcare Systems, Inc. 10181 Scripps Gateway Ct. San Diego, CA 92131	
<i>Customer Service</i> (888) 648-6758	<i>Prior Authorization Fax</i> (858) 790-7100
Member Eligibility Verification	
<i>Member Services</i> (888) 330-2117	
Durable Medical Equipment (DME) Authorization	
<i>Health Care Services</i> (800) 330-2117 Fax: (619) 426-9437	
General Program Information	
<i>Pharmacy Services Department</i> (619) 498-6507 Fax: (619) 382-1217 Email: CHGPharmacyGroup@chgsd.com	<i>Pharmacy Manager</i> (619) 240-8888 Fax: (619) 382-1217 Email: ttran@chgsd.com

Pharmacy and Therapeutics Committee

Community Health Plan of Imperial Valley uses a Centers for Medicare and Medicaid (CMS) approved formulary for our Medicare Medicaid Plan (MMP) that is maintained by our pharmacy benefits manager (PBM). Our PBM's Pharmacy and Therapeutics (P&T) Committee is an advisory group of medical professionals and practicing health care providers, including at least one practicing physician and one practicing pharmacist who are experts in the care of the elderly or disabled persons, that develops and reviews the formulary. The P&T Committee ensures that the formulary is appropriately revised to adapt to both the number and types of drugs on the market.

Our PBM's P&T Committee first looks at medications that are clinically effective. When two or more drugs have the same therapeutic advantages in terms of safety and efficacy, the Committee may review economic factors that achieve appropriate, safe, and cost-effective drug therapy. The P&T Committee uses appropriate scientific and economic considerations to consider utilization management activities that affect access to drugs, such as access to non-formulary drugs, prior authorization, step therapy, generic substitution, and therapeutic interchange protocols. The Committee will recommend protocols and procedures for the timely use of and access to both formulary and non-formulary drug products.

The P&T Committee will make a reasonable effort to review within 90 days, and will make a decision on each new chemical entity and new FDA clinical indicators within 180 days of its release onto the market. The Committee will approve inclusion or exclusion of the therapeutic classes in the formulary on an annual basis.

Who May Prescribe for CHPIV Members

All prescriptions for drugs, medical supplies, and durable medical equipment must generally be prescribed by a CHPIV contracted, credentialed practitioner. Exceptions may be authorized for prescriptions written by non-plan physicians on a one-time, case-by-case basis (for example, for newly enrolled members to allow them time to establish a relationship with a primary care physician)

Part D Medicare Prescription Rules

The Centers for Medicare & Medicaid Services (CMS) requires physicians and, when applicable, other eligible professionals who write prescriptions for Part D drugs to be enrolled in Medicare in an approved status or to have a valid opt-out affidavit on file for their prescriptions to be covered under Part D. Prescribers must submit their Medicare enrollment applications <https://pecos.cms.hhs.gov/pecos/login.do> or opt-out affidavits to the Medicare Administrative Contractor, Palmetto GBA at <http://www.palmettogba.com/nsc> by January 1, 2019 to avoid denial of member drug claims by CHPIV's Pharmacy Benefit Manager.

Frequently Asked Questions regarding prescribers of Part D drugs can be found at: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/CMS-4159_FAQs.pdf

Pharmacy Benefits and Limitations Summary

Prescriptions must be prescribed by a CHPIV contracted provider and dispensed by a network pharmacy.

Prescriber Information

Pharmacy Network	Prescriptions must be filled at CHPIV network pharmacies. Contact MedImpact at (877) 606-0727 for verification of contracted pharmacies.	
Formulary	MedImpact Advantage Formulary	
Prior Authorization Process	Call MedImpact at (877) 606-0727 or fax Medication Request Form (MRF) to (858) 790-7100. Customer Service is available 24 hours a day, 7 days a week.	
Copayments	<p>\$0 per generic prescriptions \$0 per brand prescriptions*</p> <p>*members must be eligible for Low-Income Subsidy (LIS) and not be in a share of cost agreement with the Medi-Cal portion of their benefit</p>	
Frequency of Billing Limitations (specific medications)	Applicable	
Preferred Branded Interchange	Certain multisource branded drug products may be excluded from coverage. For example, the Zestril® brand of lisinopril may be covered while the Prinivil® brand is not. For a complete list of these drug products, contact MedImpact at (877) 606-0727.	
Generic Policy	As listed on formulary	
Days Supply	<p>31 or 93</p> <p>Members should be encouraged to fill their prescriptions at a Choice 90 pharmacy to receive 90 day supplies. (Choice 90 is available at most chain retail pharmacies within our network)</p>	
Mail Order	Available – 93-day supply Members with a low income subsidy will pay one co-payment for a 3-month supply. For brand and generic drugs, this could mean \$0 co-pay. Members may call CHPIV’s Member Services Department for mail order information and forms at (888) 330-2117. Prescriptions must be written for a 93-day supply.	
Retail Extended Supply	Available at some network pharmacies. For brand and generic drugs, this could mean \$0 co-pay. Members may call CHPIV’s Member Services Department at (888) 330-2117 for details and listings of pharmacies in their area that provide this service.	

Benefits and Limitations

By law, certain types of drugs or categories of drugs are not covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs.” These drugs include:

Non-prescription drugs	Drugs when used for anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or hair growth
Drugs when used for the symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	Drugs for erectile dysfunction

To the extent that the exclusions listed above are Medi-Cal benefits, the member will be able to receive these medications under his/her Medi-Cal coverage. In addition, a drug that would be covered under Medicare Part A or Part B will not be covered under the Part D portion of coverage. If a member has coverage provided by Community Health Plan of Imperial Valley for both Medicare and Medi-Cal (vs FFS), the coordination of benefits process will be seamless to the member.

This table below provides a quick and easy reference guide for the most frequent B/D coverage determination scenarios. It does not address all potential situations. For more extensive discussion, please refer to Appendix C of Chapter 6 of the Medicare Prescription Drug Benefit Manual. This document can be found at: <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/Chapter6.pdf>.

Part B Coverage Categories	Part B Coverage Description	Retail and Home Infusion Pharmacy Setting B/D Coverage	LTC Pharmacy Setting B/D Coverage	Comments
Durable Medical Equipment (DME) Supply Drugs NOTE: Only available for beneficiaries residing in their “home”¹	Drugs that require administration via covered DME (e.g., inhalation drugs, IV drugs “requiring” ² a pump for infusion, insulin via infusion pump) ³	Part B	Part D Because most LTC facilities are not considered a beneficiary’s “home” ⁴	Blood Glucose Testing Strips and Lancets covered under Part B DME benefit are never available under Part D because they are not Part D drugs
Drugs furnished “incident to” a physician service	Injectable/ Intravenous drugs 1) administered “incident to” a physician service <u>and</u> 2) considered by Part B carrier as “not usually self-administered”	Part D By definition, a pharmacy cannot provide a drug “incident to” a physician’s service (only a physician office would bill Part B for “incident to” drugs)	Part D By definition, a pharmacy cannot provide a drug “incident to” a physician’s service (only a physician office would bill Part B for “incident to” drugs)	Part D plans should not implement pharmacy edits to determine B vs. D coverage for injectable/IV drugs only covered under Part B when furnished “incident to” a physician service

Erythropoietin (EPO)	Treatment of anemia for persons with chronic renal failure who are undergoing dialysis	<u>B or D:</u> Part B for treatment of anemia for beneficiaries undergoing dialysis Part D all other situations	<u>B or D:</u> Part B for treatment of anemia for beneficiaries undergoing dialysis Part D all other situations	EPO may be covered under Part B “incident to” physician’s service for other indications but a pharmacy would not be billing for “incident to” drugs
Prophylactic Vaccines	Influenza, Pneumococcal and Hepatitis B (for intermediate to high risk beneficiaries)	<u>B or D:</u> Part B for Influenza, Pneumococcal, and Hepatitis B (for intermediate to high risk) Part D for all others	<u>B or D:</u> Part B for Influenza, Pneumococcal, and Hepatitis B (for intermediate to high risk) Part D for all others	Vaccines given directly related to the treatment of an injury or direct exposure to a disease or condition are always covered under Part B
Parenteral Nutrition	Prosthetic benefit for individuals with “permanent” dysfunction of the digestive tract. If medical record, including the judgment of the attending physician, indicates that the impairment will be long and of indefinite duration, the test of permanence is met.	<u>B or D:</u> Part B if “permanent” dysfunction of digestive tract Part D for all other situations	<u>B or D:</u> Part B if “permanent” dysfunction of digestive tract Part D for all other situations	Part D does not pay for the equipment/ supplies and professional services associated with the provision of parenteral nutrition or other Part D covered infusion therapy

¹ In addition to a hospital, a SNF or a distinct part SNF, the following LTC facilities cannot be considered a home for purposes of receiving the Medicare Part B DME benefit:

- A nursing home that is dually-certified as both a Medicare SNF and a Medicaid nursing facility (NF);
- A Medicaid-only NF that primarily furnishes skilled care;
- A non-participating nursing home (i.e., neither Medicare nor Medicaid) that provides primarily skilled care; and
- An institution which has a distinct part SNF and which also primarily furnishes skilled care.

² The DMERCs determine whether or not an IV drug requires a pump for infusion.

³ The DMERCs do a medical necessity determination with regard to whether a nebulizer or infusion pump is medically necessary for a specific drug/condition.

⁴ If a facility does not meet the criteria in footnote 1, it would be considered a home, and Part B could cover the drugs.

CHPIV Pharmacy Network

We maintain a **nation-wide network** of pharmacies providing pharmaceutical services. The network includes both independent and major chain pharmacies, including several 24-hour and extended-hour stores.

In addition to the pharmacy network, many primary care **community clinics** are able to provide pharmacy services on-site for their assigned members.

Generally, we only cover drugs filled at an out-of-network pharmacy in limited, non-routine circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Members are encouraged to call Member Services to see if there is a network pharmacy prior to filling a prescription in these circumstances. Members who fill prescriptions at an out-of-network pharmacy for the reasons listed below may have to pay the full cost (rather than paying just the co-payment).

We will cover prescriptions that are filled at an out-of-network pharmacy under the following conditions:

- if the prescriptions are related to care for a medical emergency or urgent care;
- if a member is unable to obtain a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provides 24-hour service;
- if a member's prescription is not regularly stocked at an accessible network retail pharmacy (including high cost and unique drugs), or
- if a member is receiving a vaccine that is medically necessary but not covered by Medicare Part B or some covered drugs that are administered in his/her doctor's office.

Advantage-Plus Plan Formulary

The Advantage-Plus Plan Formulary is developed in consultation with a team of health care providers and represents the prescription therapies believed to be a necessary part of a quality treatment program. CommuniCare Plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Advantage-Plus Plan network pharmacy, and other plan rules are followed. For more information on how to fill prescriptions, members should refer to their Evidence of Coverage.

Generally, if a member is taking a drug on our formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during that coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year.

If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The current Advantage-Plus Formulary is included on our web site at: www.chgsd.com. The drugs in this formulary are arranged by therapeutic categories. Drugs may also be looked up alphabetically. The Index provides an alphabetical list of all of the drugs included in the formulary. Both brand-name drugs and generic drugs are listed in the Index. The first column of the chart within the Formulary lists the drug name. Brand-name drugs are capitalized (e.g., PULMICORT) and generic drugs are listed in lower-case italics (e.g., *hydrocortisone*). The information in the Requirements/Limits column states whether Advantage-Plus Plan has any special requirements for coverage.

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Advantage-Plus Plan requires prior authorization for certain drugs. If approval is not obtained, Advantage-Plus Plan may not cover the drug.
- **Quantity Limits:** For certain drugs, Advantage-Plus Plan limits the amount of the drug that Advantage-Plus Plan will cover. For example, Advantage-Plus Plan provides 30 units per 30-day period per prescription for Zyprexa®. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, Advantage-Plus Plan requires a trial of certain drugs to treat the member's medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, Advantage-Plus Plan may not cover Drug B unless Drug A is tried first. If it is established that Drug A does not work, then Advantage-Plus Plan will cover Drug B.

Members may request that Advantage-Plus Plan make an exception to these restrictions or limits following the established exception process.

If a member's drug is not included in the Advantage-Plus Plan formulary, members have two options:

- Members are encouraged to contact Advantage-Plus Plan's Member Services Department for a list of similar drugs that are covered by Advantage-Plus Plan. Members are asked to show the list to their doctor and ask him or her to prescribe a similar drug that is covered by Advantage-Plus Plan.
- Members may also ask Advantage-Plus Plan to make an exception to cover the drug. See below for information about how to request an exception.

NOTE: Due to a change in Medicare, most Medicare Drug Plans no longer cover drugs when used to treat erectile dysfunction (ED), Drugs used to treat ED, such as Viagra, Cialis, Levitra, and Caverject, may be covered when used for conditions other than ED

Members and their physicians may ask Advantage-Plus Plan to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on a drug. For example, for certain drugs, Advantage-Plus Plan limits the amount of the drug that we will cover. If a drug has a quantity limit, you can ask us to waive the limit and cover more for a specific member.

Generally, Advantage-Plus Plan will only approve a request for an exception if the alternative drug included on the plan's formulary, or additional utilization restrictions, would not be as effective in treating a specific member's condition and/or would cause a specific member to have adverse medical effects.

When requesting a formulary or utilization restriction exception, the requesting physician should submit a statement supporting the request. Generally, we must make our decision within 72 hours of receiving a request with a physician's supporting statement. An expedited (fast) exception may be requested if the member or his/her doctor believes that the member's health could be seriously harmed by waiting up to 72 hours for a decision. If the request to expedite is granted, we must render a decision no later than 24 hours after we receive the prescribing physician's supporting statement.

Transition Policy

New or continuing members in our plan may be taking drugs that are not on our formulary or that have limitations placed on them; e.g., prior authorization may be required from us before we cover a certain prescription. Members are encouraged to talk with their doctors to decide if the prescription should be switched to an appropriate drug that we cover or request a formulary exception so that we will cover the drug that the member is taking. Advantage-Plus will provide a 31-day supply of the medication(s) (unless the prescription is written for fewer days) that requires an exception or prior authorization within the first 90 days of enrollment when the member goes to a network pharmacy. This allows the member time to speak with their doctors to determine the right course of action. After the first 31-day supply, we will not pay for these drugs, even if the member has been on the plan for less than 90 days.

If the member is a resident of a long-term care facility, we will cover a temporary 31-day transition supply (unless the prescription is written for fewer days). We will cover more than one refill of these drugs for the first 90 days the member is on our plan. If a member needs a drug that is not on our formulary or is limited, but is past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless the prescription is written for fewer days) while a formulary exception is pursued.

For level-of-care transitions, for example, when a member is discharged from the hospital to a long-term care facility or home, Advantage-Plus will make coverage determinations and re-determinations as soon as the member's health condition requires. Members involved in

unplanned transitions will be provided with an emergency supply of non-formulary drugs, including Part D formulary drugs that are subject to certain restrictions, such as prior authorization or step therapy.

Please note that our transition policy applies only to those drugs that are “Part D drugs” purchased at a network pharmacy. The benefit under this policy does not cover purchase of a non-Part D drug or a drug out-of-network unless the individual qualifies for out-of-network access.

Medication Request for Non-Formulary Drugs

A member, his or her authorized representative, or the member’s physician may request prior authorization for Part D covered drugs. If you determine that the member needs a drug that requires prior authorization, has a quantity limit, step therapy restriction, generic substitution, or other utilization management requirements for medical necessity reasons, you may **request an exception** on behalf of your patient. Prior authorization requests may be made by faxing a completed Medication Request Form (MRF) to MedImpact Healthcare Systems at (858) 790-7100. Requests may also be processed over the telephone by calling a MedImpact Customer Service representative at (877) 606-0727. A copy of the MRF is available on our web site at: <http://www.chgsd.com/formulary/formulary/MedRequestForm.pdf>.

The following general criteria are used to evaluate requests for non-formulary drugs:

- The use of formulary drug(s) is contraindicated
- The patient has failed an appropriate trial of formulary drugs or related agents
- The choices available on the drug formulary are not suited for the present patient care need and/or the requested drug is required for patient safety
- The use of a formulary drug may exacerbate an underlying condition that would be detrimental to patient care
- The patient has been maintained on the requested drug by CHPIV or previous insurance immediately prior to enrollment date (documentation required; Medi-Cal members only).

MRFs must be filled out completely and legibly. This helps expedite the review process. All requests will be processed within 24 hours or one business day but no later than 72 hours after the date and time that CHPIV receives the request for a routine request (standard coverage determination) and as expeditiously as the member’s health condition requires.

If you feel that waiting for a decision under the standard time frame may place the member’s life, health, or ability to regain maximum function in serious jeopardy, you may request that CHPIV expedite the coverage determination. A claim for payment for prescription drugs that the member has already received will not be expedited. The request for expedited coverage determination may be submitted either orally or in writing. You may provide oral or written support for the expedited determination. Call or fax your request to the numbers listed above.

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION
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This form may be sent to us by mail or fax:

Address: CHPIV Advantage-Plus Plan c/o MedImpact Healthcare 10181 Scripps Gateway Ct. San Diego, CA 92131	Fax Number: (858) 790-7100
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You may also ask us for a coverage determination by phone at (888) 648-6758 or through our website at www.chgsd.com.

Who May Make a Request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name		Date of Birth
Enrollee's Address		
City	State	Zip Code
Phone	Enrollee's Member ID #	

Complete the following section ONLY if the person making this request is not the enrollee or prescriber:

Requestor's Name		
Requestor's Relationship to Enrollee		
Address		
City	State	Zip Code
Phone		

Representation documentation for requests made by someone other than enrollee or the enrollee's prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare.

Name of prescription drug you are requesting (if known, include strength and quantity requested per month):

Type of Coverage Determination Request

- I need a drug that is not on the plan’s list of covered drugs (formulary exception).*
- I have been using a drug that was previously included on the plan’s list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*
- I request prior authorization for the drug my prescriber has prescribed.*
- I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*
- I request an exception to the plan’s limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my prescriber prescribed (formulary exception).*
- My drug plan charges a higher copayment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*
- I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*
- My drug plan charged me a higher copayment for a drug than it should have.
- I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

***NOTE: If you are asking for a formulary or tiering exception, your prescriber MUST provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Your prescriber may use the attached “Supporting Information for an Exception Request or Prior Authorization” to support your request.**

Additional information we should consider (*attach any supporting documents*):

Important Note: Expedited Decisions

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.

CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS (if you have a supporting statement from your prescriber, attach it to this request).

Signature:	Date:
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Supporting Information for an Exception Request or Prior Authorization

FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber’s supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72-hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function.

Prescriber’s Information			
Name			
Address			
City	State	Zip Code	
Office Phone		Fax	
Prescriber’s Signature			Date

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:	Quantity:
Height/Weight:	Drug Allergies:	Diagnosis:

Rationale for Request

- Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure** [Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s)]
- Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** [Specify below: Anticipated significant adverse clinical outcome]
- Medical need for different dosage form and/or higher dosage** [Specify below]:
(1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason]
- Request for formulary tier exception** [Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome]
- Other** (explain below)

Required Explanation

Medication Therapy Management Program (MTMP)

Members with multiple medical conditions who are taking multiple medications and are likely to incur annual costs for covered part D drugs that exceed \$ 5,330 will be invited to participate in Advantage-Plus Plan's medication therapy management program (MTMP). Participation is free and voluntary. The MTMP promotes optimum therapeutic outcomes for targeted beneficiaries through improved medication use and/or a reduction of adverse events. The MTMP has been developed in cooperation with California-licensed and practicing pharmacists and physicians and may be furnished by pharmacists or other qualified providers. The MTMP is coordinated with Advantage-Plus Plan's disease and case management programs. Targeted members will be identified from the pharmacy claims database. Members' primary care physicians will be notified when members are identified for participation, when they elect to participate ("opt in"), and when they receive any MTMP services. Advantage-Plus Plan physicians are encouraged to reinforce the information provided by the MTMP.

For more information on our **Medication Therapy Management Program**, contact Pharmacy Services at **(619) 498-6507**.

Opioid Edits at the point of sale

Opioid drugs commonly referred to as narcotics have serious risks such as potential addiction, overdose, and death. Community Health Plan of Imperial Valley has implemented a strategy to combat this public health emergency in accordance with state and federal requirements.

1. Opioid Naïve Edit (*no opioid claims in the past 60 days*)

Members who have not had a recent (in 60 days) prescription for opioids will be limited to no more than a 7-day supply for their first opioid prescription for the treatment of acute pain.

Is the patient truly opioid naïve or just new to CHPIV?

1. If *yes*, inform member that another prescription is required for the remaining amount of that fill as the patient can only receive a 7-day supply.
2. If *no*, an override can be entered at the pharmacy

2. Opioid Cumulative Dosing (*The patient's opioid prescriptions are above a safe dosage limit.*)

Opioid prescriptions will be monitored for safe dosage levels. If one or more opioid prescription is above a safe dosage limit, the prescription will be stopped at the pharmacy for review by the provider to make sure that the prescription is medically necessary and appropriate.

3. Opioid-Benzodiazepine Combination

Opioid prescriptions that are taken together with benzodiazepine prescriptions will be stopped at the pharmacy for review by the provider to make sure that the prescriptions are medically necessary and appropriate.

4. Duplicative Long Acting Opioids (*Look for medications that end in ER or LA*)

Prescriptions for Long-Acting Opioids that are taken at the same time will be stopped at the pharmacy for review by the provider to make sure that the prescriptions are medically necessary and appropriate.

5. Opioid-Buprenorphine Concurrent Use

Opioid prescriptions taken along with Buprenorphine for Medication Assisted Treatment (MAT) will be stopped at the pharmacy for review by the pharmacist to make sure that the prescription is medically necessary and appropriate.

Please call pharmacy department at (619) 498-6507 if you have any questions

Section 20: Primary Care

Provider Services/Claims Liaison

760-332-6447

Dental Screening and Provider Information

(619) 498-6471

Communicable Disease Reporting

Imperial County Health Department

935 Broadway St

El Centro, CA 92243

(442) 265-1444

Primary Care Responsibilities

The most important aspect of health care delivery is the availability of and access to primary care services. Primary care is the first and most comprehensive level of care provided to all CHPIV members. Every member is asked to select a primary care physician (family practice, general practice, or internal medicine).

The PCP is responsible for coordinating all aspects of care for his/her patients including specialty referral coordination.

Services Provided Directly by the Primary Care Physician

- Office visits for examinations, treatment, and preventive services
- Injections and immunizations
- Basic diagnostic radiology services including pre-operative studies
- Diagnostic laboratory services including pre-operative studies
- Minor surgical procedures
- Newborn care (newborn coverage should be verified with CHPIV's Member Services Department)
- Well-baby and well-child care, and services covered by the Child Health and Disability Prevention Program
- Initial health assessment examination (This exam must be scheduled within **120 days** of the member's enrollment with CHPIV)
- Family planning services
- Post hospital discharge follow up
- Post emergency room follow up
- Post specialty consultation follow up
- Health education services
- Case management services

Services Arranged and Coordinated by the Primary Care Physician

- Specialty physician consultations and services
- Hospital admissions
- Surgical procedures
- Non-routine outpatient diagnostic and treatment procedures (e.g., MRI, CT, endoscopy)
- Urgent care
- Emergency care follow-up
- Community-based and preventive and health education services
- All other covered services, or non-covered services deemed medically necessary

Notification of Operational Changes

Primary care sites must notify CHPIV in writing at least 45 days in advance of any operational changes that pertain to:

- Delivery of care
 - Address, telephone number, hours of operation
 - Physician and non-physician medical practitioner roster updates
 - Physician profiles
 - Languages spoken by providers
 - Contractual status, including closing of panel to new plan members
 - Changes in hospital privileges
 - Opening additional sites
- Please fax all changes to Credentialing Department at (619) 382-1211

Initial Health Appointment Examinations

CHPIV primary care physicians must provide each new member an initial health appointment (complete history and physical examination) within 120 days of initial enrollment in a way that is culturally and linguistically appropriate for the member. Adult examinations must conform to the recommendations of the U.S. Preventive Services Task Force. Examinations of members under the age of 21 must bring the member's periodic health assessment requirements up to date and comply with the American Academy of Pediatrics guidelines. For Members under the age of 18 months, the primary care subcontract is meant to ensure the provision of an IHA within 60 calendar days following the date of enrollment.

Members are advised of the availability and value of scheduling an initial health assessment examination appointment through the Member Guide, member newsletters, and new member welcome call.

CHPIV's eligibility reports contain members' addresses, telephone numbers, and language. Eligibility reports are available in real-time and can be historically viewed for up to one year.

Primary care providers are responsible to complete the IHA and document in the member's medical record. Primary care providers must make at least three documented attempts that demonstrate the unsuccessful efforts to contact a member and schedule an IHA. Contact methods must include at least one telephone and one mail notification. The components of the IHA may be performed over the course of several office visits; all attempts to perform all components must be documented until all of the components of the IHA are completed.

The initial health appointment includes:

- A comprehensive medical and mental health history and a physical examination that is age and gender-specific, including weight/height data, blood pressure, and dental screening;
- Preventive health screens/tests consistent with CHPIV's protocols, American Academy of Pediatrics (AAP), American College of Obstetrics and Gynecology (ACOG), and U.S. Preventive Services Task Force (USPSTF);
- Discussion of appropriate preventive measures;
- identification of members whose health needs require coordination with appropriate community resources and services;
- Arrangements for future follow-up appointments as indicated.

Upon a member's **initial medical visit for any reason**, the PCP must assess the adequacy/currency of the member's medical records that are on file at the physician's office. If a member's health status does not require that records be obtained urgently, and the member provides written consent that allows the PCP to obtain complete medical records from previous physicians, the PCP will send for previous records. Further action is contingent upon the adequacy/currency of those records.

If the member's health status does not indicate urgency and previous medical records are not available, and if conducting the assessment as part of the medical visit is not feasible, the PCP must contact the member for an initial health appointment.

If a member misses a scheduled appointment for an initial health appointment, the primary care site staff must follow CHPIV's Patient Recall policy to follow up and reschedule the appointment. All attempts (including refusals) to schedule an initial health assessment must be documented in the member's medical record.

The primary care provider coordinate follow-up services which are necessary given the findings or risk factors identified in the initial health appointment, or during visits for routine, urgent, or emergent health care situations. Primary care providers should initiate these services as soon as possible but no later than 60 calendar days following discovery of a problem requiring follow up.

On a monthly basis, a Members Encounter by PCP (report is generated to identify the members who have and have not had an initial encounter with their PCP. On a quarterly basis a Member Encounters by PCP – IHA Definition (First 120 Days of Eligibility) report is generated to

determine the individual PCP and overall Plan IHA compliance rate. This report, as well as a listing of members needing an IHA (gap report) is posted to CHPIV's provider portal.

For more information regarding initial health assessment examinations, contact the IHA department 619-653-1944.

The Medicare Special Needs Plan (SNP) Model of Care and PCP Responsibilities

Medicare SNP members also receive an initial and annual Health Risk Assessment (HRA). The content and methods used to conduct the HRA directly affect the development of the individualized care plan (ICP) and ongoing coordination of the interdisciplinary care team (ICT) activities. The health risk assessment tool (HRAT) assesses the member's medical, functional, cognitive, psychosocial, and mental health needs to create meaningful interventions tailored to each member's needs.

CHPIV's case management staff reach out to members to complete the initial and annual HRAT. Based on the HRAT, the ICP is drafted or modified to address the needs of the member and/or any change(s) in the member's condition. The drafted or revised ICP is reviewed and finalized by the ICT. PCPs are invited to attend and encouraged to participate in the ICT meetings. Once finalized the ICPs are sent to the Primary Care Provider (PCP) through CHG's provider portal. The PCP should modify the care plan based on the course of treatment and covered services the PCP and member elect to pursue. PCPs also make the determination of any needs and arranges the care that members may need. PCPs should perform an annual wellness evaluation and provide any vital information to CHPIV and the member's ICT.

PCPs can communicate any changes needed to the ICP to CHPIV's Case Management Department at (760) 332-6447.

Reporting Communicable Diseases

Primary care sites are required to report communicable diseases to the County of San Diego Health and Human Services Agency.

When a health care worker becomes aware of a member with a communicable disease, the worker will notify the attending provider that the disease is a reportable disease.

Imperial County Public Health Department
935 Broadway St
El Centro, CA 92243
442-265-1444
1-800-478-4650

Diseases which Require *Immediate* Notification by Telephone

(County of Imperial, Public Health Department, Clinical and Health Services.)

- Anthrax, human or animal
- Botulism (infant, foodborne, wound, other)
- Brucellosis, animal (except infections due to *Brucella canis*)
- Cholera
- Ciguatera Fish Poisoning
- Coronavirus Disease 2019 (COVID-19)
- Dengue
- Diarrhea of the newborn (outbreaks)
- Diphtheria
- Domoic Acid Poisoning (Amnesia Shellfish Poisoning)
- *Escherichia coli* infection
- Flavivirus infection of undetermined species
- Hantavirus infections
- Hemolytic Uremic Syndrome
- Human Immunodeficiency Virus (HIV) infection, any stage
- Influenza due to novel strains (human)
- Measles (Rubeola)
- Meningococcal infections
- Middle East Respiratory Syndrome (MERS)
- Novel Coronavirus Infection
- Novel Virus Infection with Pandemic Potential
- Paralytic Shellfish Poisoning
- Plague (human or animal)
- Poliovirus Infection
- Rabies (human or animal)
- Scombroid Fish Poisoning
- Shiga toxin (detected in feces)
- Smallpox (Variola)
- Tularemia, human
- Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa and Marburg viruses)
- Yellow Fever
- Outbreak of Any Disease
- Occurrence of ANY unusual disease

- Diseases which Require Notification by *Mail, Telephone or Electronic Transmission* within One Working Day of Identification
- Amebiasis
- Anisakiasis
- Babesiosis
- Campylobacteriosis
- Chickenpox (Varicella) (outbreaks, hospitalizations and deaths)
- Chikungunya Virus Infection
- Colorado Tick Fever
- Cryptosporidiosis
- Conjunctivitis Cryptosporidiosis
- Dengue Virus Infection
- Encephalitis (specify etiology: viral, bacterial, fungal, parasitic)
- Foodborne disease
- Hemophilus influenza (invasive disease), all serotypes (report an incident less than five years of age)
- Hantavirus Infections
- Hepatitis A, acute infection
- Listeriosis
- Lymphocytic Choriomeningitis
- Malaria
- Measles (rubeola)
- Meningitis (specify etiology: viral, bacterial, fungal, parasitic)
- Paratyphoid fever
- Pertussis (whooping cough)
- Poliomyelitis (paralytic)
- Psittacosis
- Q Fever
- Relapsing Fever
- Salmonellosis (other than Typhoid Fever)
- Shigellosis
- Streptococcal infection (outbreaks of any type and individual)
- Swimmer's Itch (Schistosoma Dermatitis)
- Syphilis
- Trichinosis
- Tuberculosis
- Typhoid Fever (cases and carriers)
- Vibrio infection
- West Nile Virus (WNV) Infection
- Water-associated Disease
- Yellow fever
- Yersiniosis
- Zika Virus Infection

- Diseases which Require Notification by *Mail, Telephone, Fax, or Electronic Transmission* within Seven Calendar Days
- Anaplasmosis
- Brucellosis
- Chancroid
- Chlamydial infection
- Coccidioidomycosis
- Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
- Cyclosporiasis
- Cysticercosis
- Echinococcosis (Hydatid Disease)
- Ehrlichiosis
- Giardiasis
- Gonococcal infection
- Hepatitis, Viral
- Hepatitis B (specify acute case or chronic)
- Hepatitis C (specify acute case or chronic)
- Hepatitis Delta (D)
- Hepatitis E, acute infection
- Hepatitis (other, acute)
- Human Immunodeficiency Virus (HIV) infection, any stage
- Human Immunodeficiency Virus (HIV) infection, progression to stage 3 (AIDS)
- Kawasaki Syndrome (mucocutaneous lymph node syndrome)
- Legionellosis
- Leprosy (Hansen's Disease)
- Leptospirosis
- Lyme Disease
- Mumps
- Non-Gonococcal Urethritis (excluding laboratory confirmed Chlamydial infections)
- Pelvic Inflammatory Disease (PID)
- Respiratory Syncytial Virus-associated deaths in laboratory-confirmed cases less than five years of age
- Reyes Syndrome
- Rheumatic Fever (acute)
- Rickettsial Disease (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like illnesses
- Rocky Mountain Spotted Fever
- Rubella (German Measles)
- Rubella Syndrome (congenital)
- Tetanus
- Toxic Shock Syndrome
- Toxoplasmosis
- Tularemia
- Typhus Fever
- Occurrence of Any Unusual Disease

Notification

The State of California Confidential Morbidity Report form/card will be completed when submitting written notification of diseases to the County of Imperial Health Department.

<https://www.icphd.org/clinical-and-health-services/outbreak-reporting>

Please note that California regulation states that any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed above must report this information to the local Health Officer of Imperial County.

Primary care physicians/sites must report to the County Health Officer:

- Where the plan member resides as required by the California Department of Health Care Services
- Name of the disease or condition being reported; the date of onset; the date of diagnosis; the name, address, telephone number, occupation; race/ethnic group; Social Security number; sex; age; and date of birth for the case or suspected case, the date of death if death has occurred; and the name, address and telephone number of the person making the report.

For information on communicable disease reporting, contact Imperial County Public Health Department at (442) 265-1444.

Dental-Related Services

Screening

To prevent dental disease and promote timely, appropriate dental treatment, adult and child health assessments incorporate dental screening and referral.

Referral

If dental services are indicated, the PCP should refer the member to the member's own dentist and offer assistance in scheduling a dental appointment. If the member does not have a dentist, the primary care site staff or member may contact the member's dental plan's toll-free phone number for a referral to a dentist.

Members are eligible for dental services from dentists participating in the Medi-Cal program

Medical Services Related to Dental Conditions

Certain medical services for dental conditions may be the responsibility of CHPIV and its network providers. These services include:

- Hospital and professional services required for a dental procedure (e.g., to restore teeth and oral structures following accidental injury)

- Prescription drugs
- Laboratory services
- Pre-admission physical examinations required for admission to a facility
- Anesthesia services
- Outpatient surgical center services

For information regarding responsibility for medical services for dental conditions, contact Member Services at (888) 330-2117.

Section 21: Provider Alerts

A “Provider Alert” is a communication method used by CHPIV to share topic specific updates and changes. Provider Alerts are sent to notify you of operational changes CHPIV is implementing.

Provider Alerts are sent via a fax blast to the appropriate parties impacted by the message in the Alert and published on our website.

Provider Alerts are to be shared within your organization with the appropriate parties to ensure that changes are communicated throughout the impacted units. Additionally, Provider Alerts fulfill Provider Services Agreement notice requirements with regard to Provider Manual revisions, and they also communicate non-substantive contract language changes which are effective 45 working days after the distribution date.

If you have any questions on a specific Provider Alert, please call the Claims Liaison Line at (888) 671-6419. You may view CHPIV’s previously issued Provider Alerts at the following link: www.chpiv.org

Section 22: Provider Newsletters

A “Provider Newsletter” is a communication method used by CHPIV to share topic specific updates and changes. Provider Newsletters are typically sent on a semiannual basis and focus on areas which can improve quality of care. Newsletters are mailed or emailed to providers. Provider newsletters are also posted on the CHPIV website.

Provider Newsletters are to be shared within your organization with the appropriate parties to ensure that changes are communicated throughout the impacted units.

If you have any questions on a specific Provider Newsletter or need access to the CHPIV provider portal please contact our Provider Services Line at 760-332-6447. You may view CHPIV’s previously issued Provider Newsletters at the following link: www.chpiv.org

Section 23: Provider Services

CHPIV's Provider Services Department vigorously promotes the Advantage-Plus Plan. Our bilingual Provider Services representatives regularly visit primary care sites to keep providers and staff up-to-date with changes in the program that may impact their practice. Our representatives also actively work with your office staff to increase member enrollment—through many avenues such as the enrollment card process and ensuring that CHPIV Provider Services literature is readily available for your patients.

In addition, CHPIV staff help market our Medi-Cal program by participating in community-sponsored events such as health and resource fairs. Often our representatives set up a booth and present the benefits of enrolling in our Advantage-Plus to eligible individuals and families. As part of our provider network, you are the best tool we have in promoting the benefits of enrollment through CHPIV.

Call our Provider Service Line for general CHPIV operational issues, including; Site certification, training and education scheduling, contracts, provider changes, relocations, capitation, enrollment and access to online services.

Provider Services
Tel. (760) 332-6447
Fax. (760) 863-5187

Training and Education Programs

Community Health Plan of Imperial Valley is committed to providing comprehensive training opportunities for our providers and their staffs. Listed below are general training topics available to our providers.

- **Access to Behavioral Health and Other Community Services:** Target group: providers and staff.
- **Booster Training:** Retraining for areas identified by the primary care site or CHPIV staff, or for specific topics such as appointment access, after hours coverage, and walk in appointments. Target group: providers and staff.
- **CHPIV Web-Based Services:** Internet member eligibility, referral authorization status lookup, member and provider resource information. Target group: providers and staff.
- **CPSP Provider Training:** CPSP trainings are scheduled prior to program implementation. Target group: providers and staff.
- **Emergency Preparedness and Response Training:** Community Health Plan of Imperial Valley provides emergency preparedness and response training to providers to operate in a safe manner during an emergency or disaster. **Health Education and Promotion Classes:** Rotating schedule of topics such as asthma, diabetes, nutrition, hypertension, parenting, smoking cessation, and stress management. Target group: providers and members.
- **Member Service:** , Member Services, eligibility issues, and electronic data access. Target group: front line staff at the primary care site.
- **Primary Care Orientation:** Introduction to CHPIV and managed care, marketing activities, eligibility reports, Customer Service, referrals, claims, Telephone Advice Nurse service, preventive health education, pharmacy and case management information. Target group: providers and staff.
- **Quality Improvement/Site Certification:** Educating and training primary care site staff to meet all standards for certification. Target group: providers and staff.
- **Referral Training:** Referral process, network providers, carved-out services, behavioral health services, services that do not require authorization, shared risks arrangements, and changes/updates. Target group: providers and staff.

Section 24: Referral and Authorization

For referrals, authorizations , assistance with locating specialty services , or other authorization-related questions:	
<p><i>Health Care Services</i> (619) 498-6471- Inpatient (888) 330-2117 - Outpatient</p> <p>Hours: 8:00 a.m. to 5:00 p.m. Monday through Friday</p>	
<p><i>Authorizations</i> Fax: (760) 863-5187</p>	<p><i>Emergency and Inpatient Notification</i> Fax: (866) 897-6024</p>
<p><i>Behavioral Health</i></p>	
<p><i>CHPIV Behavioral Health Services</i></p> <p>Phone: (800) 404-3332 Fax: (619) 476-3849</p>	<p><i>Imperial County Access and Crisis Line (for Medi-Cal members)</i></p> <p>(800) 817-5292 (members) (800) 798-2254 (providers)</p>
<p>Internet-Based Authorization Status Access</p>	
<p><i>Provider Services/Claims Liaison</i> (760) 332-6447</p>	

Requesting Authorization

Pre-Certification of Non-Urgent Requests

Either a primary care physician (PCP) or specialty physician may initiate the referral process. Requests for authorization of routine, non-urgent services are to be submitted electronically and appropriate supporting medical information, e.g., physician progress notes, lab and x-ray results, and prior specialty consultation reports must be uploaded to the portal. For providers who do not have access to the portal, the referral request must be submitted via fax. Providers are requested to include a fax cover sheet identifying the requestor's name, telephone number, and the number of pages transmitted.

Use only CHPIV contracted providers. If you need assistance confirming CHPIV specialty providers in your service area, please call the Health Care Services department for assistance. Out-of-network (non-contracted) provider referrals may be authorized by the Chief Medical Officer.

Pre-Certification of Hospital Admission and Outpatient or Ambulatory Services

Providers must request authorization from CHPIV Health Care Services at least 10 business days before the proposed scheduled admission or prior to the services being rendered. The requesting physician or designee (e.g., medical group) must provide the following information:

- Member's name, CHPIV subscriber ID #, age, sex, and date of birth
- Diagnosis, current exam findings
- Reason for admission or service
- Planned procedure or surgery, including diagnosis and CPT codes
- The proposed scheduled day of admission and/or date of planned procedure or surgery
- Proposed hospital to which the member will be admitted
- Name and telephone number of admitting physician, if applicable
- Diagnostic lab/radiology reports related to current diagnosis, pertinent specialist reports, and PCP progress notes, including pre-operative work-ups

Prior authorization is required for the services of an assistant surgeon for elective surgical procedures.

Once CHPIV has received all the necessary documentation, a decision will be rendered within five working days, and the provider will be notified within 24 hours of making the decision.

If the member's PCP is part of a medical group, hospital services must be coordinated between CHPIV and the medical group. Authorization for physician services is generally obtained from the medical group. Authorization for facility and facility-related charges is obtained from CHPIV.

Pre-Certification of Urgent Requests

Urgent means the services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury; has the potential to become an emergency in the absence of treatment; when the member's condition is such that the member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb or other

major bodily function. An urgent request is also any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on the prudent layperson's judgment **or**
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Requests for urgent services, **when no automatic approval is received**, are to be submitted electronically and appropriate supporting medical information, e.g., physician progress notes, lab and x-ray results, and prior specialty consultation reports must be uploaded to the portal. For providers who do not have access to the portal, the referral request must be submitted via fax and must be noted as "Urgent" on faxed requests. All urgent requests are processed within 72 hours of receipt.

Emergency Episodes

Prior authorization is not required for emergency medical conditions. However, emergency rooms must notify CHPIV within 24 hours regarding all members accessing the emergency room.

If the member is found to have a non-emergency condition, emergency room staff coordinates with CHPIV to redirect the member to his/her primary care site for non-emergency care.

Follow-up to Emergency Care

Follow-up care for an emergency episode is provided through the primary care site. Emergency room personnel instruct the member to return to his/her PCP for follow-up care. If the member's condition requires a specialty referral, the PCP's office will request authorization, or send a direct referral and arrange the appointment.

Emergency Admissions

Hospitals are required to fax face sheets to CHPIV at (866) 897-6024 within 24 hours of admission or notify via the electronic equivalent of the face sheet. Emergency admissions are reviewed by CHPIV's Health Care Services staff for auto-authorization. All hospital stays are monitored either telephonically or on-site to determine the medical necessity for continued acute hospitalization.

Post-Service (Retrospective) Review

Post-service review is an assessment of the medical necessity and appropriateness of services after services have been rendered. Post-service review occurs following late notification of a member's admission or the hospital's failure to provide pertinent medical information. Post-service review is conducted on a case-by-case basis when case record information is received by CHPIV's Health Care Services Division.

Long Term Care

Members to be transitioned to long-term care facilities must have a written order from the member's primary care or attending physician indicating the level of care, estimated length of stay, treatment plan, and discharge plan. The member's records are reviewed by the CHPIV case manager prior to the member's transfer to ensure that the member meets the criteria and that all member needs have been anticipated.

The member's stay is reviewed at least once a week and authorization for continued stay is issued when appropriate. No authorization will be given for more than two weeks at a time without a review for skilled nursing care. Longer authorization periods may be appropriate for custodial (long-term care). This benefit does not include assisted living and housing.

Intermediate Care Facility for the Developmentally Disabled (ICF-DD)

Community Health Plan of Imperial Valley covers ICF-DD facilities (homes) for members with developmental disabilities effective January 1, 2024. The homes that are eligible are the following:

- Intermediate Care Facility for the Developmentally Disabled (ICF/DD);
- Intermediate Care Facility for the Developmentally Disabled – Habilitative (ICF/DD-H);
- Intermediate Care Facility for the Developmentally Disabled – Nursing (ICF/DD-N);

If you identify a member who may benefit from these services, please refer the member to the San Diego Regional Center (SDRC) by calling (760) 355-8383. The SDRC will evaluate the member and determine if they qualify for ICF-DD services. For further assistance please call Community Health Plan's Behavioral Health Department at 1-800-817-5292.

For more information on this benefit please visit the following link:

<https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-023.pdf>

Referral Tracking and Follow-up

CHPIV requires that primary care sites maintain a system for tracking and following up on referrals and consultant reports. Specialty physicians must submit consult reports to the member's PCP within 10 working days following the specialty visit. The PCP reviews and initials the report before filing it in the member's medical record.

Internet-Based Electronic Referral Access

Practitioners and providers can submit authorizations electronically by accessing CHPIV's Internet-based referral system at www.chpiv.org. A login and password are required. Please contact CHPIV provider liaison staff for assistance.

CHPIV's "Online Referral Submittal Instructions" are available on our website at www.chpiv.org; click on "Provider Services" and then go to "Health Care Resources."

Internet-Based Authorization Status Access

Practitioners and providers can verify the status of authorization by accessing CHPIV's Internet-based authorization status system at www.chpiv.org. A login and password are required. Please contact CHPIV provider liaison staff for assistance.

Denials and Appeals

Only a physician may deny an authorization request based on medical necessity. If an authorization request is denied, deferred, or modified, the PCP or member may appeal the determination. A physician reviewer is available to discuss medical necessity denials, delays, or modifications of health care services.

California Children Services (CCS) Referrals CCS

Program Overview

CCS is a statewide tax-supported program that pays for specialty healthcare services for eligible children and young adults with serious and/or chronic medical conditions. The CCS program is open to anyone under the age of 21 who meets the CCS program eligibility requirements. CHPIV has a formal Memorandum of Agreement (MOA) with the local CCS program. This MOA addresses the relationship between CHPIV and CCS staff in co-managing members with CCS-eligible conditions. The CCS program is statewide, however, the coordination of services is managed by local CCS staff.

CCS Carve-Out

CCS services are "carved out" from CHPIV's responsibilities when a child is enrolled in Medi-Cal. "Carved out" means that the services to treat a child's CCS-eligible condition are excluded from CHPIV's financial responsibility. CCS services are authorized and paid for by the CCS program, once CCS eligibility is determined. The member remains enrolled in CHPIV and the primary care physician (PCP) and CHPIV continue to be responsible for providing primary care, preventive services, and specialty and ancillary services not related to the CCS-eligible medical condition.

- If CCS refuses payment due to late provider application submission, CCS may deny payment for all related services, including those delivered by paneled providers. CHPIV assumes no financial responsibility for such CCS-denied services.
- If CCS declines authorization or payment because the attending/rendering provider is not CCS paneled, CCS may deny payment for all related services, including those delivered by paneled providers. CHPIV assumes no financial responsibility for such CCS-denied services.
- The CHPIV-issued tracking number is intended to facilitate care coordination but must not be construed to equate to authorization for services not the financial responsibility of CHPIV.

CCS Program Eligibility

The local CCS program staff determines medical eligibility for the CCS program. Once CCS eligibility is determined, the CCS program assumes case management responsibilities, including prior authorization and payment for services related to the CCS-eligible condition.

Referrals for treatment of CCS-eligible conditions **must be pre-authorized by CCS** and must be provided by a CCS-paneled provider.

CCS-eligible conditions are very specific to pre-determined criteria. You may access the latest CCS-eligible criteria at: <http://www.dhcs.ca.gov/services/ccs/Pages/qualify.aspx>.

Requesting Pre-Authorization from CCS

Prior authorization is required for all CCS services. Services must be authorized starting from the date of referral, with specific criteria for urgent and emergency referrals. CCS services must be rendered by CCS-paneled providers, CCS-approved facilities, and special care centers. Providers must submit the referral to CCS first, using a CCS Service Authorization Referral (SAR) form. All providers, including practitioners, hospitals, and ancillary providers, must indicate that the patient is a CHPIV member in the insurance information section of the SAR (insert “CHPIV” in the Insurance Plan field) and fax a copy of the referral to CCS at 858-514-6514 and CHPIV at (760) 332-6447.

Failure to timely submit a SAR to CCS will result in non-payment of claims by CHPIV.

CHPIV will accept the completed CCS SAR in lieu of the CHPIV Referral Authorization form for a potential CCS case.

All future referrals for specialty services related to the CCS condition must be prior approved by CCS. CHPIV’s case managers are available to assist with the tracking of the CCS application, referral to CCS-paneled specialty providers, and coordination of care.

If coverage is denied by CCS, CHPIV may review the medical necessity or appeal the denial to CCS.

Process for CCS Case Identification, Referrals, and Request for Services

The CCS program accepts referrals for an eligibility determination from any source. Any providers of care, hospitals, parents/legal guardians, school nurses, and other community agencies such as the San Diego Regional Center may refer children to CCS.

Coordinating CCS-Eligible Services

Please follow the steps below when coordinating care for members with CCS-eligible conditions.

Step 1. Early identification is key - Please identify the child’s suspected diagnosis or condition. If the diagnosis is CCS-eligible, identify the requested service and to which provider you are referring this child for care. Remember, all providers and facilities rendering care to CCS-eligible children must be CCS paneled.

Step 2. Timeliness of referrals - All referrals must be made to CCS within 24 hours of diagnosis of a CCS-eligible condition. Anyone can refer a child to CCS. All CCS-eligible services require prior authorization except for urgent, emergency, and services rendered after CCS office hours. For these services, CCS referrals must be made within the next business day. All referrals must be sent to CCS by completing a SAR. Providers must fill out the SAR form completely. For CHPIV members, providers must indicate “CHPIV” in the insurance section of the SAR. This allows CHPIV staff to access this record. All referrals must be made to paneled

providers. To access a listing of paneled providers, please log on to <http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx>. SARs must include relevant medical reports that legibly document the CCS-eligible findings. Medical reports are necessary for the CCS program to determine medical eligibility.

Step 3. What to do if the child already has an open CCS case - If the child has an open case, providers must assess whether the requested service is to treat the CCS condition or is related to the CCS-eligible medical condition. If so, providers must contact the CCS program to request prior authorization. For help with case management of children with open CCS cases, providers may call CHPIV's CCS staff at (619) 498-6421 for assistance.

Step 4. Determining provider paneling - The CCS program requires that all providers be part of the CCS panel to be authorized to provide services for a CCS-eligible child. CCS also requires that hospitals be CCS-approved. You may access a CCS provider directory at <http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx>.

Step 5. How does the family member know a CCS referral was made? - CCS will send the family a CCS application. Please see the application at: <https://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/dhcs4480.pdf>.

The family must complete this application and return it to CCS. A signed application gives the parent/guardian the legal right to appeal a decision made by the CCS program. If the child loses Medi-Cal eligibility, he/she may continue to receive CCS services for the eligible condition. For questions regarding this application, parents may call CHPIV's Member Services at (888) 330-2117 and request assistance.

Step 6. CCS authorization process - Authorizations are written approvals for the services requested to treat a child with a CCS-eligible condition. Every authorization includes the service provider, scope of services, effective date, and expiration date. Every child is assigned a permanent CCS case number. The CCS program conducts an annual eligibility review. Authorization for medical services cannot be issued until CCS program staff makes a CCS eligibility determination.

Step 7. CCS care coordination process - Care coordination is a proactive process that involves teamwork with both families and providers. Since children require services from multiple providers in separate care delivery systems, coordination between CCS and CHPIV providers offers the following opportunities for co-management:

- Effective communication with CCS, other providers, and the child's family enhances care coordination
- Reduction of duplication and fragmentation of care
- Promotion of continuity of care while maximizing resources
- Improved access to quality care and improved outcomes
- Increased family satisfaction
- Coordination of care and referrals to other agencies such as the San Diego Regional Center
- Shifting of responsibilities to CCS for the following services:

- determining medical eligibility and identification of paneled providers,
- reviewing and authorizing services for CCS-eligible conditions, and
- providing medical care management for the CCS-eligible condition.

Medical Reporting Requirements

Relevant medical reports should be regularly submitted to the CCS program for children receiving ongoing medical care for their CCS-eligible conditions. The following are examples of the reports that should be submitted to CCS for various services:

- **New referrals:** submit sufficient medical documentation specific to the CCS-eligible condition for CCS to determine CCS medical eligibility.
- **Diagnostic reports:** documentation should illustrate whether or not the child has a CCS-eligible condition that requires treatment.
- **Treatment services:** submit special care center and provider reports that illustrate the child's treatment plan and continuing need for medical treatment.
- **Hospital admissions:** submit copies of the admitting history and physical exam, interim progress reports for the duration of the hospital stay and the discharge summary.

CCS Denials

CHPIV must receive a copy of your CCS denial notification before we will consider paying for any claims for services denied by CCS. Only denials not meeting CCS-eligible medical criteria will be considered for payment. It is very important that you submit a completed SAR to CCS prior to the service being rendered. Without this submission, CHPIV is not obligated to pay your claim if CCS denies the service. CHPIV will not pay claims arising from CCS denials that are based upon late notification to CCS, failure to notify CCS, or services not being rendered by a CCS-paneled provider.

Services Requiring Prior Authorization

You will not need to request authorization for specialty services rendered in the office by CHPIV contracted providers.

1. Services Requiring Prior Authorization

Requests for prior authorization must be made **before** services are rendered. The following services **always** require prior authorization please visit the following link: www.chpiv.org

Additional Services Not Requiring Prior Authorization

Emergency Services

Emergency services do not require prior authorization. Services beyond post-stabilization care and non-emergency treatments in the emergency room are subject to prior authorization or post-service review.

Sensitive Services and Freedom of Choice Services for Medi-Cal Members

For Medi-Cal members, services designated as “sensitive services” by the Department of Health Care Services are not subject to prior authorization. Sensitive services are defined as any test or service rendered in relation to the following:

- Family planning
- Mental or Behavioral Health
- Sexual and Reproductive Health
- Substance Use Disorder
- Gender Affirming Care
- Intimate Partner Violence
- Diagnosis and treatment of sexually transmitted diseases (STDs)
- Sexual Assault and Abortion
- Human immunodeficiency virus (HIV)/AIDS testing and counseling

Sensitive services are also defined by certain implementation requirements that require services to be rendered in a timely manner, available without pre-authorization, and administered in strict confidentiality.

Family planning, initial visit for an STD disease episode, and HIV testing are also federal “Freedom of Choice” services, meaning that members may self-refer to any provider for these services. Follow-up care for STD treatment is provided by the member’s primary care provider or contracted OB/GYN or Family Practice physicians.

Abortion is a Freedom of Choice service. CHPIV does not require prior authorization for abortion services; members may go to any provider of their choice for abortion services, at any time, for any reason, regardless of network affiliation.

Sensitive services do not require a protected individual to obtain the primary subscriber or other enrollee’s authorization to receive sensitive services. In addition, all communications regarding a protected individual’s receipt of sensitive services utilize the protected individual's preferred mailing address, email address, or telephone number for confidentiality. Requests for confidential communications of sensitive services must be documented and implemented within 7 calendar days.

Minor Consent

Services covered under California’s minor consent laws do not require prior authorization. However, eligibility should be confirmed before providing services to ensure proper payment. Please see Section 16 for a summary of medical services for which a minor, or others on his/her behalf, may consent to medical services.

Preventive Health Services

Preventive health services such as initial health assessments, screening tests, developmental testing, well-baby, and well-child exams, immunizations, and health risk assessments are provided by the member’s primary care physician. Preventive health services do not require prior authorization.

OB/GYN and Family Practice Direct Access

All CHPIV members have direct access to OB/GYNs and Family Practitioners for routine obstetrical and gynecological services on an unlimited basis (without referral authorization) within these few restrictions:

- Members assigned to primary care physicians within capitated medical groups have unlimited access to the contracted medical group
- Members assigned to directly contracted primary care physicians have unlimited access **to CHPIV’s specialty network**. In this case, the OB/GYNs and Family Practitioners can only provide services for which they are specifically contracted.

We encourage all OB/GYNs and Family Practitioners to confirm eligibility before providing services. This allows for verification of primary care physician assignment to ensure proper payment.

Prior Authorization for Procedures or Treatments

OB/GYNs and Family Practitioners must follow the prior authorization and utilization review requirements of their respective medical groups.

Directly contracted OB/GYNs and Family Practitioners may provide those services listed on pages 21-14 through 21-16 without obtaining prior authorization from CHPIV. Other procedures require prior authorization through CHPIV’s Health Care Services Division at (888) 330-2117.

Communication with Primary Care Physician

Continuity of care is vital to our members’ overall health. We require OB/GYNs and Family Practitioners to communicate with our members’ primary care physicians regarding condition, treatment, and follow-up care.

Please visit the link below for updated list of services which don’t require prior authorization:
www.chpiv.org

Imperial County

Preferred Providers for Radiological Diagnostic Services at Free-Standing Facilities

The following facilities are available for diagnostic services in Imperial County.

Area of County	Available Provider	Address and Phone Number	Services Provided
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Imperial County	Imperial Radiology	Address: 2407 Marshall Ave suite a, Imperial, CA 92251 Phone: (760) 545-0340	MRI, CT, Ultrasound, X-Ray, DEXA
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Coordination of Specialty Care

Referrals for specialty and ancillary care are initiated and coordinated through the primary care physician. Authorizations only cover those services specified on the referral form. Referrals must be prior authorized by CHPIV, as applicable, unless the services have been specifically exempted. CCS-eligible services are “carved out” from CHPIV’s responsibilities. “Carved out” means that the services to treat a child with a CCS-eligible condition are excluded from CHPIV’s financial responsibilities. Please refer to the CCS section of this manual for additional information regarding CCS care coordination.

Role of the Primary Care Site

Primary care site referral coordinators or case management staff:

- Schedule specialty or ancillary appointments or services
- Facilitate members’ follow-through with their authorized services
- Confirm that the appointment was kept
- Obtain a copy of the specialty or ancillary report for primary care physician review, to be signed and dated by the primary care physician and included in the permanent medical record

Role of the Primary Care Provider

The primary care physician maintains responsibility for case management and follow-up care.

Role of Specialty or Ancillary Provider

Specialty or ancillary providers must

- Send copies of all consultation, diagnostic, and treatment reports directly to the primary care physician within 10 working days of the specialty or ancillary visit
- Call the primary care physician’s office directly to obtain authorization for:
 - Evaluations by additional specialists
 - Follow-up visits for continuing care
 - Additional diagnostic tests or treatments
 - Elective hospital admissions
 - Outpatient surgical procedures

Standing Referrals

Members who require continuing care from a specialist or have a condition or disease that requires specialized care over a prolonged period of time and is life-threatening, degenerative, or disabling may receive a standing referral to a specialist or a specialty care center that has expertise in treating the condition or disease.

Standing Referral

A standing referral is a referral by a primary care physician to a specialist for more than one visit to the specialist, as indicated in the treatment plan, without the primary care physician having to provide a specific referral for each visit.

Specialty Care Center

A specialty care center is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening, degenerative, or disabling disease or condition for which it is accredited or designated.

Qualifying Chronic Disease Conditions

Chronic disease conditions that are eligible for standing referrals include:

- HIV infection/AIDS
- Chronic Hepatitis B/C infection
- Uncontrolled diabetes
- Uncontrolled hypertension
- Rheumatoid arthritis
- Parkinson's disease
- Multiple sclerosis
- Other degenerative neurologic diseases
- Chronic obstructive pulmonary disease
- Asthma
- Congestive heart failure
- Chronic pain syndrome
- Chronic renal failure
- Cancer

This list is updated periodically. Other chronic conditions will be considered on a case-by-case basis.

Treatment Plan

Once the member's primary care physician identifies and documents the need for a standing referral, the PCP must submit the member's treatment plan to CHPIV for approval. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized or require the specialist to provide the PCP with regular reports on the health care provided as well as the member's progress.

We will review the treatment plan, in consultation with the PCP, the specialist, and the member, when necessary, prior to issuing an authorization for the standing referral. Upon approval, the PCP will not be required to provide a specific referral for subsequent visits.

If the PCP has determined that the member has a chronic disease condition that requires ongoing care, standing referrals may be authorized for up to one year.

Authorization Process

Requests for standing referrals are processed within CHPIV's established timeliness standards.

Second Opinion

Under certain conditions, members have the right to a second medical opinion, from appropriately qualified healthcare professionals, regarding a medical condition, their care, or a proposed surgical procedure. The request for a second opinion can be made by either the member, a participating health professional who is treating the member, or CHPIV's Chief Medical Officer.

An appropriately qualified healthcare professional is defined as a primary care physician or specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition, or conditions associated with the request for a second opinion.

Reasons for approving a second opinion may include, but are not limited to, the following:

- the member questions the reasonableness or necessity of recommended surgical procedures;
- the member questions a diagnosis or plan of care for a condition that threatens the loss of life, limb, or bodily function, or substantial impairment including, but not limited to, a serious chronic condition;
- the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the member requests an additional diagnosis;
- the treatment plan in progress is not improving the medical condition of the member within an appropriate period of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment, or
- the member has attempted to follow the plan of care or consult with the initial provider concerning serious concerns about the diagnosis or plan of care.

Requests for a second opinion will be processed in accordance with CHPIV's utilization management guidelines. The second opinion must be authorized or denied in a timely fashion. If the member's condition involves an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or major bodily function, or if lack of timeliness would be detrimental to the member's ability to regain maximum function, the utilization management decision concerning the second opinion will be made in a timely fashion appropriate to the member's condition, not to exceed 72 hours after receipt of the information needed to make the decision.

If the member is seeking a second opinion about care from his or her primary care physician, the second opinion will be provided by an appropriately qualified healthcare professional of the member's choice within the same physician organization.

If the member is requesting a second opinion about care from a specialist, the second opinion will be provided by any provider of the member's choice from any medical group within CHPIV's network, who is appropriately qualified and of the same or equivalent specialty. Any associated copayments will apply.

If there is no appropriately qualified healthcare professional within CHPIV's network, CHPIV will authorize a second opinion by an appropriately qualified practitioner outside of CHPIV's network, taking into account the member's ability to travel to the provider. If an out-of-plan provider provides a second opinion, the associated copayments must be equivalent to those of an in-plan provider of the same expertise.

Healthcare professionals who render second opinions are required to provide the member, the initial health professional, and CHG's Chief Medical Officer with a consultation report of the second opinion. The consultation report must include recommended procedures or tests that the second opinion professional believes to be appropriate.

If the request for a second opinion is denied, the member will be notified in writing of the reasons for the denial and of the right to file a grievance with CHPIV. In accordance with CHPIV's policies and procedures related to delegated utilization management, any entity to whom CHPIV has delegated utilization management decision-making authority shall provide a copy of all notices to members communicating decisions to deny, delay, or modify any request for a second opinion.

For more information or a complete copy of CHPIV's Second Opinion Policy, please contact Health Care Services at (888) 330-2117.

Notification of Utilization Management Decisions

Community Health Plan of Imperial Valley notifies members and practitioners when we approve, modify, delay, or deny requests for health care services. Our authorization management (UM) decisions are in accordance with standards and time frames based on applicable laws and external accreditation agency standards.

CHPIV adheres to the standards defined in the following table. These standards are in effect from the time we obtain all information necessary to render a decision.

	Urgent Pre-service	Non-urgent Pre-service	Urgent Concurrent	Post Service
Decision Time Standard	Within 72 hours of the receipt of the request and appropriate with the nature of the member's condition.	Within 5 business days from the receipt of the request and appropriate with the nature of the member's condition.	Within 24 hours of the receipt of the request.	Within 30 calendar days of the receipt of the request.
Notification Standard*	Provider: Within 24 hours of decision (all). Member: Within 2 business days for adverse decisions, not to exceed 72 hours of the receipt of the request.	Provider: Within 24 hours of decision (all). Member: Within 2 business days for adverse decisions.	Provider: Within 24 hours of decision (all). Member: Within 24 hours of the request for adverse decisions.	For all decisions, to the provider and member, within 30 calendar days of the request.
Extension Needed**	Extension notice provided within 24 hours of the receipt of the request and 48 hours are provided for the submission of the request. Decision is made within 48 hours of receipt of the information or within 48 hours of the end of the timeframe specified in the notification, whichever is earlier. For Medi-Cal, may extend 14 calendar days.	Timely fashion appropriate for the nature of the enrollee's condition, not to exceed 5 business days from the receipt of information reasonably necessary and requested to make a determination and no later than 28 days from the date of the initial request (23 days from the date of the "5-day" letter).		Notify member and provider within 30 calendar days of the receipt of the request of the need for an extension and the date by which a decision is expected. 45 calendar days must be given to provide the information. Once the information is received, decision must be made within 15 calendar days of receipt of the requested information. If requested information not received, the decision must be made at end of 45-day period.

	Urgent Pre-service	Non-urgent Pre-service	Urgent Concurrent	Post Service
Notification with Extension	<p><u>Extension Notice:</u> Member and practitioner notified with 24 hours of receipt of request. Notice states that decision cannot be made, specific information necessary to make the decision, and time period given to provide information (48 hrs).</p> <p><u>Decision Notice:</u> Provider: Within 24 hours of decision. Member: Within 2 business days for adverse decisions, not to exceed 72 hours of the receipt of the request.</p>	<p><u>Extension Notice:</u> If a decision cannot be made within 5 business days, or as soon as it is determined that a decision cannot be made in 5 business days whichever occurs first, provider and member are notified in writing. Notice states that a decision cannot be made, specifies the information requested, and the anticipated date on which a decision may be rendered.</p> <p><u>Decision Notice:</u> Provider: Within 24 hours of decision. Member: Within 2 business days for adverse decisions.</p>		Upon expiration of 30 calendar days from the receipt of the request or as soon as it is apparent that a decision cannot be made, the provider and member will be notified in writing that a decision cannot be made, the reason specified, and the anticipated date on which a decision may be rendered.

* CHPIV’s initial notification and electronic confirmation occur at the same time.

** An extension of the decision time period is possible where the member or member’s provider requests an extension or CHPIV can justify a need for additional information and that the extension is in the member’s best interest.

Notification of Review Determination

CHPIV notifies the member, the requesting practitioner, if applicable when an authorization request is approved. CHPIV notifies the member by letter; the practitioner is notified electronically. The notifications describe the approved healthcare service.

The following information is provided, in writing, to members and practitioners when requested services are denied, delayed, or modified:

- Reason for the denial, modification, or delay, including an easily understandable summary of the UM criteria or criteria of specific regulations, and the clinical reasons for the decisions regarding medical necessity

- Member's right to appeal the decision and an explanation of the appeal process
- Instructions on how to initiate an expedited appeal for urgently required services and authorizations denied as a result of concurrent review
- Name and phone number of the physician responsible for the review determination **(limited to practitioner notification)**
- Disclosure on the use of utilization criteria and availability to review and receive a copy of the specific criteria used in the review determination
- Benefit coverage if the reason for the denial, modification, or delay is based on a finding that the proposed service is not a covered benefit. The decision will clearly specify the provisions in the contract that exclude that coverage.
- Member's right to seek an independent medical review (IMR), as applicable, through the Department of Managed Health Care's IMR process

All members are informed of their right to contact the Department of Managed Health Care (DMHC), including DMHC's toll-free number, California Relay Service's toll-free number (TTY), and DMHC's internet website.

In addition, **Medi-Cal** members are informed of:

- The right to and the method for obtaining a fair hearing to contest the denial, deferral, or modification action, and information that he or she may file a grievance concerning CHPIV's action, prior to or concurrent with the initiation of the fair hearing process.
- Availability of assistance in filing an Appeal, Grievance, or State Fair Hearing
- The right to represent him- or herself at the fair hearing or to be represented by legal counsel, friend, or other spokespeople.
- Member's right to request continuation of benefits during an Appeal or State Fair Hearing
- The State's toll-free telephone number for obtaining information on legal service organizations for representation, and the name, address, and phone number of CHPIV, plus a statement that CHPIV's Member Services department may be contacted if the member does not understand the information.
- The opportunity to access the Independent Medical Review (IMR) system for life-threatening or seriously debilitating conditions if the denied services are experimental or investigational in nature.

Coordination for Hospital-Based Services

All providers are required to notify Health Care Services of all requests for outpatient surgery and inpatient services.

To coordinate these services as follows:

- **Hospital-Based Outpatient Services (day surgery):** Members must be referred to a CHPIV-participating hospital/facility. Hospital services must be coordinated between CHPIV and the medical group **prior to** any service being rendered for which CHPIV is financially responsible for payment.

- **Elective Admissions:** The medical group or referring provider must refer members to a CHPIV-participating facility. Prior to any elective hospital admission, they must submit the prior authorization request via the portal. CHPIV will confirm the medical necessity of the admission, issue a case number, assign an initial length of stay (LOS), and conduct a concurrent review.
- **Urgent/Emergent Admissions:** The medical group or referring provider may direct members to a CHPIV-participating hospital, but must notify CHPIV of any urgent/emergent admission (in or out of the area) within 24 hours or the next business day. When CHPIV is notified directly by the hospital of any urgent/emergent inpatient admission, CHPIV will notify the Primary Care Provider within 24 hours or no later than the next working day. CHPIV will review the case, and conduct a concurrent review on all continuing stays.
- **Emergency Services:** In the event of an **emergency medical condition**, the member may go to the nearest emergency facility without prior authorization. If the member is subsequently admitted, that admission requires notification and authorization as specified in Urgent/Emergent Admissions (above).
- **Discharge Planning:** The CHPIV Health Care Services staff acts as a liaison between the medical group or referring provider, case manager, the attending physician, and the member in assisting hospital staff to make arrangements for the member's discharge. Health Care Services will contact the Primary Care Provider to ensure the timely provision of medical services following hospital discharge. CHPIV case managers interface with the hospital's discharge coordinators and social services staff, and the PCP if placement in an extended care facility is anticipated or home health services are required.
- **CCS Care Coordination:** Please refer to the CCS section of this manual for specific instructions on care coordination for CCS-eligible members.



If the member's PCP is part of a medical group, hospital services must be coordinated between **CHPIV** and the medical group. Authorization for **physician services** is generally obtained from the medical group. Authorization for **facility and facility-related charges** is obtained from **CHPIV**.

Hospital Notice Obligations

Authorization is based upon the member's benefit package and eligibility in effect at the time services were rendered. Therefore, authorization by CHPIV's Health Care Services is not a guarantee of payment.

Hospitals are required to notify CHPIV's Health Care Services when rendering services to members as follows:

- **Scheduled Admissions:** Notify CHPIV at the time the member presents to the hospital for admission. Hospitals are required to fax face sheets to CHPIV at (866) 897-6024 within 24 hours.
- **Emergency Admissions:** Notify CHPIV within 24 hours of any emergency admission. Hospitals are required to fax face sheets to CHPIV at (866) 897-6024 within 24 hours.
- **CCS Emergency Admissions:** Hospitals must fax a completed SAR for all CCS-eligible emergency admissions to the CCS program within 24 hours of admission. Emergency treatment provided after CCS office hours, on holidays, or on weekends may be authorized for the date of service if CCS is notified on the next business day. If the facility is not CCS approved and/or the provider is not CCS-paneled, hospital staff must communicate with CCS and CHPIV to coordinate the transfer of the CCS-eligible child to a CCS-approved facility.
- **CCS Elective Admissions:** Hospitals must submit a completed SAR to CCS prior to the date of admission. Hospitals must include the following on the SAR: child's complete demographic information, attending CCS-paneled provider, name of CCS-approved facility, admitting diagnosis and diagnostic ICD-10 codes, operative or diagnostic procedure with appropriate CPT code, estimated length of stay, and specific reference to "CHPIV" in the insurance section of the SAR. A request to extend a previously authorized hospital admission requires ongoing timely notification and medical reports justifying continued acute care. Hospitals must submit progress reports to CCS during the duration of the hospital stay along with the discharge summary.

CCS does not pay for services rendered prior to the date of referral, even though the child may have a CCS-eligible condition. Exceptions may only be made for Medi-Cal members. For retroactive payment, the services must have been provided by a CCS-paneled provider in a CCS-approved facility.

- **Outpatient Services (physical, speech, and occupational therapy, diagnostics):** When the member presents to the hospital's outpatient department for referred services, the hospital must verify that the services to be provided are within the scope of the referral authorization.
- **Emergency Room Episodes:** Emergency medical conditions do not require prior authorization. Follow-up care must be provided by the member's primary care provider unless otherwise authorized.
- CCS may cover certain emergency-related services for CCS-eligible conditions. CHPIV staff will coordinate with CCS accordingly.
- **Day Surgery:** The hospital is responsible for obtaining authorization from CHPIV and/or the member's Primary Care Provider prior to the member presenting to the hospital's outpatient department.

Section 25: Site Safety

For information on site safety and exposure control, or for sample policies and procedures, contact Corporate Quality Nurse at (619) 498-6486.

Fire and Disaster Plans

Each provider site must maintain a fire and disaster plan that provides for effective evacuation of the premises and notification of the appropriate authorities.

The fire and disaster plan must designate:

- A pre-arranged assembly area
- Appropriate exit routes
- Responsibility for notifying the appropriate authorities (i.e., calling “911”), site staff, and patients
- Responsibility for evacuating all staff and patients in the provider site through designated exit routes, and
- Responsibility for verifying evacuation of the provider site.

For more information on or assistance with **Fire and disaster Plans**, contact Corporate Quality at (619) 498-6486.

Isolation Precautions

Patients with a suspected communicable disease must be isolated upon entry into the site to prevent infection transmission among physicians, patients, and staff.

- Patients with a suspected communicable disease must enter and exit the site through a separate entrance, if possible.
- The patient must be taken immediately to an exam room, and the door must be closed.
- All staff caring for the patient with a possible communicable disease must follow universal precautions for infection control.
- Prior to use by another patient, the exam room used for the patient with a possible communicable disease must be cleaned according to OSHA Exposure Response, Prevention, and Control Cleaning and Decontamination Guidelines.
- If the patient had a possible airborne communicable disease, the exam room cannot be used for at least two hours.

For more information on **isolation precautions**, contact Corporate Quality at (619) 498-6486.

Exposure Control Plan

Providers are required to implement an Exposure Control Plan as defined by the Occupational Safety and Health Act (OSHA) and adapted to the individual site.

Exposure Control Plan Elements

The Exposure Control Plan must be in accordance with CHPIV's compliance guidelines which are contained in the following sections:

- Availability of Guidelines to Employees
- Exposure Determination
- Job Classifications with Occupational Exposure
- Methods of Compliance
 - Universal Precautions
 - Personal Protective Equipment
 - Engineering and Work Practice Controls
 - Regulated Waste
 - Warning Labels
 - Laundry
- Medical Surveillance and Post-Exposure Evaluation
- Recordkeeping
- Training

For detailed **Exposure Control Plan** information, **sample policies**, or other assistance, contact Corporate Quality at (619) 498-6486.

Availability of Guidelines to Employees

The guidelines must be made available in a place easily accessible to the employees in all work areas where employees are subject to occupation exposure to blood or other infectious materials.

Exposure Determination

All employees whose duties include routine or reasonably anticipated tasks or procedures where there is potential exposure to blood or other potentially infectious materials are included in the plan.

Job Classifications with Occupational Exposure

- Physicians
- Physician assistants
- RNs and LVNs (direct patient care)
- Nurse assistants/medical assistants
- Medical technicians
- Laboratory technicians/laboratory assistants
- Phlebotomists
- Central processing and distribution (autoclaving and sterilization) staff
- Respiratory therapists
- Housekeeping staff
- Laundry (soiled linens) staff
- Radiology technologists/technicians (performing invasive procedures)
- Biomedical technicians

Additional job classifications may be subject to exposure at the individual provider site.

Section 26: Utilization Management Program

For information regarding Utilization Management Program:

Utilization Management Director
(619) 498-6486

Health Care Services
(800) 244-7766

2024 Utilization Management Program Description

Philosophy

The Utilization Management (UM) Program applies to all healthcare management activities, including behavioral health care, performed by Community Health Plan of Imperial Valley, under the direction of the Chief Medical Officer (CMO). Community Health Plan of Imperial Valley is committed to managing resources effectively and efficiently while ensuring quality healthcare delivery. Community Health Plan of Imperial Valley works in partnership with members and practitioners to promote seamless delivery of health care services. Community Health Plan of Imperial Valley's managed care programs balance a combination of benefit design, reimbursement structure, information analysis and feedback, consumer education, and active interventions to control cost and improve quality.

Purpose

Utilization Management is the process of influencing the continuum of care by evaluating the necessity and efficiency of health care services and affecting patient care decisions through assessments of the medical appropriateness of care. The purpose of the Utilization Management Program is to implement a comprehensive integrated process that actively coordinates, directs, and monitors the quality and cost-effectiveness of health care resource utilization at all levels within Community Health Plan of Imperial Valley. The UM Program assists in ensuring that services are available promptly, provided in appropriate settings, and are planned, individualized, and evaluated for effectiveness. The UM Program also serves to promote safe, accessible, and timely delivery of care.

The UM Program promotes the continuum of care principles that integrate a range of services appropriate to meet individual member needs while maintaining flexibility in adapting services as needs change.

Scope and Structure

The UM Program, using the principles of continuous quality improvement, monitors the delivery of health care services provided to all members. It applies to all utilization management activities performed by Community Health Plan of Imperial Valley. These activities include all types of care (primary, specialty, including behavioral health, ancillary); all sites and levels of care (e.g., ambulatory, inpatient, home health, skilled nursing, hospice); and all aspects of care (e.g., preventive, diagnostic, treatment, palliative).

The UM program addresses

- UM staff members' assigned activities
- UM staff who have the authority to deny coverage
- Involvement of a designated physician and a designated behavioral health care practitioner
- The process for evaluating, approving, and revising the UM program and the staff responsible at each step
- The role of the UM program in the Plans' Quality Improvement Program, including how the organization collects UM information and uses it for QI activities.
- The Plan's process for handling appeals and making appeal determinations
- Specifies the triage and referral process for behavioral health (BH) care services and how the Plan evaluates service sites at the various levels of BH care
- Specifies senior-level physician, who is the Chief Medical Officer or a Medical Director, Associate Medical Director, or equivalent, is involved in UM activities, including implementation, supervision, oversight, and evaluation of the UM Program.
- Specifies how the designated behavioral healthcare physician is involved in implementing and evaluating the behavioral healthcare aspects of the UM Program.
- Specifies the plan's processes that are utilized to make determinations

Community Health Plan of Imperial Valley is accountable for all the utilization management activities conducted for its members. Although parts of utilization management may be delegated to other entities, Community Health Plan of Imperial Valley retains accountability for the decisions made by these entities.

Community Health Valley of Imperial Valley is responsible for assuring that members receive equitable access to care and service across its network.

The scope of the UM Program is to:

- Review of authorizations and care
 - Prior authorization
 - Concurrent authorization
 - Retrospective authorization
- Promote sound processes so that health care services provided are medically necessary;
- Manage benefit resources effectively and efficiently while ensuring quality care is provided;
- Make utilization decisions based on sound, objective clinical evidence, taking individual circumstances and the local delivery system into account;
- Identify and resolve inefficiencies in resource utilization;
- Assess the effect of cost containment activities on the quality of care delivered; and
- Identify and coordinate with Quality Improvement in the management of quality of care issues or trends.

Goals

The goals of the Utilization Management Program are as follows:

- Make certain the provision of medically necessary and appropriate services to members
- Promote the delivery of quality medical and behavioral health services at the appropriate level of care in a timely, cost-effective and efficient manner
- Continually monitor, evaluate and optimize the use of health care resources; identify

events and patterns of care in which outcomes may be improved through efficiencies in utilization management, and institute actions to improve performance

- Develop, adopt, review, evaluate and update criteria for the authorization of health care services to members
- Educate members, practitioners, hospitals, and other ancillary providers about Community Health Plan of Imperial Valley's goals for providing high quality, cost-effective managed health care
- Maintain an overall perspective of members' health needs to explore creative alternatives for delivery of care that support the most appropriate and cost-effective treatment methodologies
- Promote coordination of activities between quality improvement and utilization management
- Identify and assess the need for case management through early identification of high or low utilization of services, high cost, chronic or long-term diseases
- Promote health care in accordance with local, state, and national standards and regulations
- Monitor for timely responses to appeals and grievances

Objectives

The objectives of the UM Program include:

- Review and evaluate health care services for quality, medical necessity, the appropriate level of care, and discharge planning needs;
 - Support communication and flow of information between the Chief Medical Officer, the UM & New Technology Committee, the Clinical Quality Improvement Committee, and the Quality Improvement Committee;
 - Support confidentiality of member and practitioner information;
 - Review utilization data identifying over-and under-utilization practices, and to identify and implement programmatic improvements that enhance appropriate utilization;
 - Monitor consistent application of UM functions across all product lines; and
 - Evaluate member and practitioner satisfaction at least annually.

Goals

The goals of the UM Program are to optimize members' health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. The UM Program aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting, and meet professionally recognized standards of care.

Functions

Components of the UM Program include:

- **Prior Authorization.** Authorize and arrange for medical, facility, and ancillary services using criteria to determine medical necessity and following established timeliness standards. (Policy 7251a (Medi-Cal) and 7251b (D-SNP) - "Referral and Prior Authorization System", Policy 7251.7a and 7251.7b – "Organization Determinations-

Timeliness of Medi-Cal and Medicare Determinations and Notification”, Policy 7251.8a and 7251.8b – “Review of Requests for Health Care Services”, Policy 7251.9a and 7251.9b, “Clinical Criteria for Utilization Management Decisions”)

- ***Urgent Care Triage.*** Provide screening of member calls to the telephone advice nurse of an urgent nature and to coordinate care with the Primary Care Practitioner (PCP) or his/her designee.
- ***Emergency Services.*** Provide, arrange for, or otherwise facilitate all needed emergency services, including appropriate coverage of costs, 24 hours a day, and seven days a week.
- ***Medical Necessity and In-patient Case Monitoring.*** Coordinate and conduct data collection for medical necessity, quality of care, appropriateness of hospital admission, coordination with other member benefit plans, level of care, and continued inpatient stay as required. This review is performed cooperatively with the hospital's utilization review personnel through on-site or telephonic review and substantiates the medical necessity and level of care for members in an inpatient status.
- ***Discharge Planning.*** Identify discharge planning and case management needs for hospitalized members in conjunction with discharge planning and/or case management personnel at participating hospitals and coordinating with the member’s PCP, IPA, CHG CCM department, and/or Enhanced Care Management providers (ECM) when applicable.
- ***Case Management.*** Assist the PCP and site case managers with the development of a case management plan to meet the needs of Community Health Plan of Imperial Valley members. Serve as an on-going resource to the PCP and site case managers regarding case management of individual members. Assist with a member’s transition to other care, if necessary when benefits end. Community Health Plan of Imperial Valley’s *Chronic Care Case Managers* address the needs of members who have been hospitalized at least once for recurring or chronic conditions. The objective of these case managers is to prevent hospitalization by maximizing outpatient modalities, such as prompt referral to specialists, quick access to primary care, medication management, health education, and home health. These case managers maintain regular contact with targeted members to assist members with their care plans and to provide necessary follow-up.
- ***Behavioral Health Care.*** Authorize, coordinate, and arrange for in and out-patient care; facilitate the coordination of physical and behavioral health services; and evaluates sites of service and levels of care.
- ***Quality Monitoring.*** Perform quality reviews on hospitalized members and screen ambulatory referrals for quality of care indicators.
- ***Eligibility and Benefits Verification.*** Verify member eligibility, benefits coverage, and physician/hospital contract status at the time of authorization.
- ***Appropriateness of Service Monitoring.*** Review member and practitioner utilization data to evaluate the appropriateness of care provided and detect potential over and under-utilization.

- **Post-service Review.** Review selected cases retrospectively for medical appropriateness and level of care.
- **Network Education.** Provide ongoing education to network practitioners and ancillary providers on medical criteria, clinical practice guidelines, disease management protocols, preventive services guidelines, pharmaceutical advances, and technology assessment.
- **Notification of Medical Necessity Determinations.** The Chief Medical Officer or designee, who is also a California-licensed physician, determines the recommendation and notifies the attending physician in writing of the decisions and the right to appeal. The letter includes the reason for the denial, modification, or delay; criteria used; phone number of the physician who rendered the decision; and clearly outlines the appeal process and member's right to independent medical review. Expedited appeals language is included in all denial letters. Failure to meet authorization criteria at the time of authorization review may result in denial, modification, or deferral of a service requests. (Policy 7251.7a and 7251b – "Organization Determinations-Timeliness of Medi-Cal and Medicare Determinations and Notification")
- **Technology Assessment.** Reviews and assesses treatment, tests, medical and behavioral health procedures, devices, equipment, and drugs to determine their clinical- and cost-effectiveness; seek input from relevant specialists and professionals who have expertise in the technology evaluated; communicates these findings to clinicians to assist them in making evidence-based decisions; assists in the education of members in understanding the impact of technology on their health and quality of life; supports that members have equitable access to safe and effective medical care. UM & New Technology Committee
- **Disease Management.** The Utilization Management Program incorporates Community Health Plan of Imperial Valley's disease management programs and clinical practice guidelines. Activities and medical review criteria are consistent with the established program and initiatives.

Accountability and Organizational Structure

- **Board of Directors (Board).** The Board of Community Health Plan of Imperial Valley has ultimate responsibility for the quality and cost-effectiveness of the health care delivered to Community Health Plan of Imperial Valley's members whether services are arranged for or directly provided by a contracted entity. The Board delegates this responsibility to the Chief Medical Officer. The Board receives, at a minimum, a quarterly summary of all Utilization and Quality Improvement activities, including findings and actions taken by the UM & New Technology Committee. The Board provides feedback to the UM & New Technology Committee via the Chief Medical Officer.
- **Chief Medical Officer.** Community Health Plan of Imperial Valley's Chief Medical Officer, who holds an unrestricted license to practice medicine in the state of California, is matrixed with Chief Operating Officer to oversee responsibility for the overall direction of the Health Care Services Division including monitoring supervising, and evaluating the implementation of the Utilization Management and Quality Improvement processes and ensuring that corrective actions are taken when appropriate. The Chief Medical Officer or Medical Director reviews all clinical services not meeting review criteria. Decisions that initiate a

modification or denial of service(s) are made exclusively at the physician level.

- **Medical Director.** The Medical Director, who holds an unrestricted license to practice medicine in the state of California, is responsible for reviewing requests for services that do not meet clinical review criteria and may initiate the modification or denial of services. The Medical Director provides clinical direction to second and first level reviewers.
- **Senior Director of Healthcare Services.** *The Senior Director of Healthcare Services provides operational oversight to Healthcare Services Department.* The Utilization Management (UM) Program applies to all healthcare management activities, including behavioral health care, performed by Community Health of Imperial Valley, under the direction of the Chief Medical Officer (CMO).
- **Behavioral Health Practitioner.** The designated Behavioral Health Practitioner is a licensed psychologist or psychiatrist and is responsible for the overall clinical direction of all behavioral health services covered by the appropriate line of business. The Behavioral Health Practitioner is actively involved in implementing the behavioral health aspects of the UM program including setting policies, participating in credentialing, reviewing potential denials, and participating on the UM & New Technology Committee. The Behavioral Health Practitioner is also actively involved in assuring continuity and coordination of care between medical and behavioral health practitioners and assists in developing programs focused on the coordination of care.
- **Chief of Operations.** The Chief of Operations, in conjunction with the Community Health Plan of Imperial Valley Chief Medical Officer, provides oversight of utilization, disease, and case management, medical quality management, and behavioral health management activities. The Chief of Operations is responsible for the coordination of the operational components of the Utilization Management Program. The Chief of Operations is responsible for coordinating the oversight of delegated UM activities and compliance with applicable delegated agreements.
- **Director of Pharmacy Services.** The Director of Pharmacy Services, under the supervision of the Chief Medical Officer and Chief of Operations, oversees the areas of behavioral health, disease management, community and preventive services, and pharmacy services. The Director of Pharmacy Services serves as the co-chair of Community Health Plan of Imperial Valley's Pharmacy & Therapeutics Committees and is actively involved in ensuring the integration of drug therapy with all aspects of medical and behavioral health.
- **Director of Utilization Management Services.** The Director of Utilization Management Services provides support to the CMO who is responsible for the supervision of staff performing utilization review (pre-service, concurrent, and retrospective) and case management. The Director of Utilization Management Services manages in conjunction with the CMO all aspects of the UM program and serves as the co-chair of Community Health Plan of Imperial Valley's UM & New Technology Committee. The Director of Utilization Management Services in conjunction with the CMO also manages staff performing out-patient review and the supportive functions to the UM Department, including but not limited to the UM call center and help desk, intake, and document management, UM notification, and correspondence, and data entry.

- ***Director of Case Management.*** The Director of Case Management Services is responsible for the supervision of staff performing case management and care coordination services. The Director of Case Management manages all aspects of the Case Management program and serves as a member of Community Health Plan of Imperial Valley's UM & New Technology Committee. The Director of Case Management also manages staff performing case management and care coordination activities and other support functions to the UM Department.
- ***Behavioral Health Services Program Manager.*** The Behavioral Health Services Program Manager manages the operational aspects of the provision of behavioral health services as covered by lines of business and coordination with physical care. The Behavioral Health Services Program Manager works closely with the Contracting Department to maintain a network of practitioners to meet the needs of CHPIV's members.
- ***Primary Care Practitioners (PCPs).*** The primary care physician, along with designated site case managers, is the primary case manager of each member. The Primary Care Practitioner is responsible for the coordination of medically necessary health care services, assuring the provision of preventive services in accordance with established standards and periodicity schedules, and ensuring continuity of care for members. This includes a health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.
- ***Community Health Plan of Imperial Valley Case Managers.*** Community Health Plan of Imperial Valley Case Managers authorize and administer health care benefits based on eligibility and benefit coverage; direct members to the appropriate contracted hospitals and providers; evaluate medical necessity, proposed place of treatment and treatment plans for members referred for non- Primary Care Practitioner services; monitors that all specialty referral services are provided under the direction or concurrent agreement of a designated Primary Care Practitioner, coordinate requests for care outside of the referral network with the Primary Care Practitioners; review inpatient services to support that medically appropriate care is provided in a quality manner to members; provide oversight and assist practitioners with case management activities; and manage high-risk and members with chronic diseases.
- ***Intake Specialists.*** Intake specialists verify eligibility and benefit coverage and perform first-level review by approving services following specific protocols and provide administrative support to Community Health Plan of Imperial Valley Case Managers.
- ***Data Analyst/Statistician.*** The Data Analyst/Statistician abstracts data and creates reports that assist in the identification of utilization patterns and trends (e.g., under or over-utilization of services, the appropriate level of care of services); supports disease management programs and initiatives, and confirms the statistical validity of reports and analysis.
- ***Behavioral Health Services Unit.*** The Behavioral Health Services Unit coordinates behavioral health care as covered by lines of business and provides information, referral, and case management services along with advocacy for members in need of mental health and substance abuse services. Behavioral health services are available to members

24 hours a day via a toll-free number. A designated behavioral health practitioner advises Community Health Plan of Imperial Valley in the implementation of the behavioral health care aspects of the UM program. Behavioral health care practitioners also participate in committees, as necessary. A psychiatrist or psychologist reviews any behavioral health denial of care based on medical necessity.

- **Telephone Advice Nurse (TAN).** A registered nurse (RN) is available to Community Health Plan of Imperial Valley members through a dedicated toll-free number 24-hours a day to provide medical triage, advice, and education per standardized criteria. TAN encounters are documented and sent via facsimile to Primary Care Practitioners within 24 hours. (Policy 7261a and 7261b - “PCP Instruction for Emergency Room Department and TAN Program”)
- **Information Systems Staff.** Information systems staff is responsible for overseeing the data warehouse, maintaining and supporting the case management/utilization management and quality improvement software, and providing regular and ad hoc reports to monitor under and over-utilization.
- **Contracting Department.** The Contracting Department assures language in contracts and delegated agreements supports the Utilization Management Program and responds to requests for the new practitioner and ancillary contracts.
- **Compliance Officer.** The compliance officer assures that Community Health Plan of Imperial Valley is aware of and is in compliance with all regulatory requirements.
- **Hospitals.** Participating hospitals are responsible for verifying authorization for elective admissions and outpatient services; communicating with Community Health Plan of Imperial Valley’s Case Managers regarding the current intensity and level of services provided; notifying CHPIV within 24 hours or one business day of emergency services and/or admissions of members, and coordinating discharge planning with Community Health Plan of Imperial Valley Case Managers.
- **Delegated Entities.** Contracted network entities that qualify for delegation of utilization management functions and responsibilities are evaluated as part of the pre-contractual assessment process and reviewed and approved by the UM & New Technology Committee. Delegation of this responsibility is contingent upon these plans effectively meeting the requirements contained in Community Health Plan of Imperial Valley’s Utilization Management Program. Delegated Utilization Management entities are regularly reviewed to monitor compliance with these requirements.

Utilization Management & New Technology Committee

The Utilization Management (UM) & New Technology Committee is a group of actively practicing practitioners that serves to facilitate the implementation of the Utilization Management Program. Input is additionally solicited from the members of the Plan’s healthcare delivery system. The Committee is a sub-committee of the Quality Improvement Committee. It serves as a review body for problem identification, action, resolution, and confirmation of corrective measures. Refer to UM & New Technology Committee Charter.

The UM & New Technology Committee promotes the optimum utilization of health care services while protecting and acknowledging member rights and responsibilities, including their

right to appeal denials of service. The UM & New Technology Committee is multidisciplinary and provides a comprehensive approach to support the Utilization Management Program in the management of resource allocation through systematic monitoring of medical necessity and quality while maximizing the cost-effectiveness of the care and services provided to members.

The UM & New Technology Committee monitors the utilization of health care services by CHPIV and its delegated entities to identify areas of under or over-utilization that may adversely impact member care. The UMC oversees Inter-rater Reliability testing to support consistency of application in criteria for making determinations, as well as the development of Evidence-Based Clinical Practice Guidelines and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based and comply with regulatory and other agency standards. The UM & New Technology Committee meets quarterly and reports to the QIC.

Details of the UM & New Technology Committee membership, quorum, meetings, goals, and objectives is addressed in the UM & New Technology Committee Charter.

Utilization Management Staffing, Qualifications, Training

Staffing. Utilization management activities are coordinated and conducted under the direction of the Chief Medical Officer. Managers and supervisors oversee the daily functions of the UM Program. The utilization management staff works as a team to cover all geographic areas, facilities, and product lines. The staff includes:

- Medical Director – Third Level Reviewer as described below; with Chief Medical Officer or Medical Director, reviews all denials, modifications, and deferrals
- Registered nurses (or qualified licensed professional) – Second Level Reviewers as described below
- Intake specialists – First Level Reviewers (non-clinical) as described below
- Administrative support – staff call center, document management, UM correspondence, data entry
- Pharmacist – with Medical Director, reviews pharmacy modifications and denials
- Pharmacy technical support – First Level pharmacy review
- Behavioral health specialists – psychologists and psychiatrists; review all behavioral health service denials, modifications, and deferrals
- Behavioral health administrative staff – oversee operational (non-clinical) aspects of behavioral health services

Staff Qualifications. Community Health Plan of Imperial Valley employs qualified individuals with licensure and experience specific to the job requirements. Appropriately licensed health professionals conduct all review decisions. Those with the qualifications listed below perform decisions requiring clinical judgments.

First Level – Non-clinical Reviewer. First level reviewers may approve services following specific protocols developed by Community Health Plan of Imperial Valley’s clinical staff. Services specified for approval by non-clinical reviewers include services that are generally approved given specific diagnoses or situations and do not require the reviewer to exercise clinical judgment. Initial behavioral health consultations are included in services authorized by first-level review.

Services authorized by non-clinical reviewers are monitored through reports. Qualifications include:

- Training and testing (90% minimum score) on ICD-10, CPT, and medical definitions;
- Training and testing (90% minimum score) on the application of Community Health Plan of Imperial Valley's benefit and provider grids; and
- Clinically supported by a licensed clinical reviewer.

Second Level – Clinical Reviewer. Second level reviewers conduct the initial clinical review of health care services requests against medical appropriateness criteria. The second-level review is generally conducted by registered nurses or other qualified health professionals. Qualifications include:

- Current state licensure and/or qualified clinical reviewer;
- Adequate training to utilize medical appropriateness criteria and applicable review of standards or medical policy; and
- Clinically supported by a licensed physician or clinical peer.

Third Level – Peer Reviewer. The Chief Medical Officer or Medical Director conducts a clinical review of services that do not meet initial clinical review appropriateness criteria. In addition, services that have a specific requirement for authorization, as noted by medical policy, are reviewed at this level. Qualifications include:

- Current non-restricted license to practice medicine in California;
- Education, training, or professional experience in medical or clinical practice;
- Adequate training to utilize medical appropriateness criteria and other applicable review standards or medical policy;
- Ability to review cases for which a clinical decision cannot be made by the second level reviewer; and
- Reasonable availability, within one business day, to discuss clinical determinations with the attending or ordering physician.

Fourth Level - Peer Clinical Reviewer. Consultations and appeal reviews are conducted by fourth level or clinical peer reviewers. Qualifications include:

- Current non-restricted license to practice medicine or related health profession in California;
- Board certification in the same or similar specialty as usually manages the medical condition, procedure, or treatment under review; and
- Oriented to the principles and procedures of the UM Program and the medical appropriateness criteria and other standards or medical policy.

Staff Training. A formal program of orientation and training applies to clinical reviewers at all levels. Staff is trained in the concepts, components, and processes of Utilization and Case Management.

Inter-Rater Reliability. Monitoring and peer review are being performed at a minimum annually at all professional staff levels, including physicians, to monitor consistency among reviewers. The UM & New Technology Committee actively assists in monitoring tool development and evaluation.

All professional staff receives annual performance evaluations and periodic progress reviews.

Decisions Made Without Regard to Financial Incentives. Community Health Plan of Imperial Valley

distributes to all its members, practitioners, providers, and employees who make UM decisions a statement describing its policy on financial incentives and requires practitioners, providers, and staff who make utilization-related decisions and those who supervise them to sign a document acknowledging that they have received the statement. This statement affirms that:

- UM, decision making is based only on appropriateness of care and service and existence of coverage;
- Community Health Plan of Imperial Valley does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care, i.e., compensation is not related to review decisions; and
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

Confidentiality

Community Health Plan of Imperial Valley is committed to preserving the confidentiality of its members and practitioners. All employees, participating practitioners, providers, and consultants will maintain a standard of ethics and confidentiality regarding both patient information and proprietary information. Written policies and procedures are in place to ensure the confidentiality of patient information and records. Patient information gathered to facilitate utilization reviews and claims administration is available only for review and is maintained confidentially. Records requested from practitioners are those that will provide relevant information to complete reviews or facilitate adjudication of claims. Training includes appropriate storage and disposal of confidential information. Documents of a sensitive or confidential nature are shredded prior to disposal.

Employees receive and sign a confidentiality agreement at the time of their initial company orientation. Employees are also required to use approved passwords for member information access. Breach of confidentiality is considered a serious offense and will result in disciplinary action up to and including termination.

The confidentiality process is extended to practitioners by verification, during compliance surveys, that policies and procedures exist to prevent unauthorized or inadvertent disclosure of confidential information.

All committee minutes, reports, medical records, audits, studies, worksheets, documentation of utilization management activities, and other data are maintained in a manner ensuring strict confidentiality. They are made available, upon request, for review by the Committee, appropriate Community Health Plan of Imperial Valley management staff and regulatory bodies (as required). All Committee members and guests to the UM & New Technology Committee sign a confidentiality statement that is kept on file.

Integration and Linkage with Other Activities

The utilization management staff and the Chief Medical Officer plan, coordinate, and direct the operation of the UM Program. Representatives from the Utilization and Quality Improvement (QI) departments participate in the UM & New Technology Committee and the Clinical Quality Improvement Committee. UM, staff report identified quality issues and trends to the QI staff. Data collected and reported through the committee process is reported back to QI for the development of practice standards and quality improvement plans to improve outcomes. Utilization management issues that are revealed during the QI process are reported to UM via the

committee structure.

Integration with other departments includes, but is not limited to the Preventive Services Department Provider Relations, Member Services, and the Credentialing Department.

Case management and behavioral health staff work with the member, the member's PCP, and Member Services to coordinate care when a new member is receiving covered services from a non-participating provider when a contract is discontinued between Community Health Plan of Imperial Valley and a provider, and when member's benefits end.

Communication Services

Community Health Plan of Imperial Valley provides access to staff for members and practitioners seeking information about the UM process and the authorization of care. The following communication services are provided to practitioners and members:

- Availability of staff at least eight hours a day during normal business days for inbound calls regarding UM issues;
- The ability of staff to receive inbound communication after normal business hours regarding UM issues;
- Outbound communication from staff regarding inquires about UM during normal business hours, unless otherwise agreed upon;
- Staff identifies themselves by name, and title and indicates that they are calling from Community Health Plan of Imperial Valley when initiating or returning calls regarding UM issues;
- A toll-free number regarding UM issues (Member Services Department);
- Access to staff for callers with questions about the UM process;
- TDD/TTY services for deaf, hard of hearing, or speech-impaired members; and
- Language assistance for members to discuss UM issues.

The Member Services Department has an established documented process that addresses when a Member Services Representative should transfer callers to the UM staff.

Medical Review Criteria

Community Health Plan of Imperial Valley utilizes standardized review criteria that are evidence-based and supported by documented references and internally developed medical criteria for making decisions concerning medical necessity and appropriateness of services. The definition of "medical necessity" will be based on program regulation. In cases where there is an overlap between the coverage of benefits (e.g., the coverage of durable medical equipment services by Medicare and Medi-Cal), the definition of medical necessity that is the more generous of the applicable standards will be applied. Criteria are available and practitioners are informed of the use of criteria and how to obtain them through the Provider Update, Provider Alert, newsletters, and through Community Health Plan of Imperial Valley's web site. In addition, as stated in the Provider Manual, practitioners may request copies of criteria from the health care services division. The review process is designed to make certain that medically necessary services are provided in a uniform and timely manner to members.

The primary review criteria utilized by Community Health Plan of Imperial Valley in the authorization/review process are MCG. These evidence-based, nationally recognized and

accepted guidelines are the

primary criteria that Community Health Plan of Imperial Valley staff apply when determining the appropriateness of an admission or inpatient length of stay or the medical necessity of requested service. MCG is the primary criteria for reviewing the appropriateness of behavioral health services.

During the review process, Utilization Review Process staff may additionally consult and apply a variety of peer-reviewed criteria, guidelines, and reference tools to assist in the medical appropriateness determination. Case managers apply criteria to individuals on a case-by-case basis and consider the individual's age, co-morbidities, complications, the progress of treatment, psychosocial situation, home environment, and any other individual needs when applicable; as well as the capabilities of the local health care delivery system.

Additional internally developed authorization/review criteria may be developed from various references to supplement the primary MCG in the case where a procedure/service is not addressed in the primary criteria. These reference tools include, but are not limited to:

- Peer-reviewed medical appropriateness criteria
- Standard quality indicators (National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS));
- American Medical Association (AMA) specialty guidelines and state or county medical association guidelines;
- Length of Stay (LOS) by Diagnosis and Operation, United States (developed by HCIA, Inc.);
- Governmental agencies such as Centers for Disease Control, Food and Drug Administration, Agency for Health Care Policy and Research, National Institutes of Health;
- Local/regional agencies (State and County health departments);
- Non-profit health care organizations (e.g., American Heart Association, American Diabetes Association, American Lung Association);
- Peer-reviewed periodicals and journals;
- Consultation with actively practicing physicians who are appointed to teaching faculties, research foundations, and/or members of recognized specialty societies; and
- *Standards of Practice for Case Management* of the Case Management Society of America (CMSA).

Development Process. The process for developing or adopting authorization/review criteria is as follows:

- In the formation of the internal authorization/review criteria, Community Health Plan of Imperial Valley references the above-mentioned tools.
- Based on the research of the reference materials identified above, a draft of the medical review criteria is formulated or adopted by the Director of Utilization Management Services with input from the Chief Medical Officer and appropriate, actively practicing health care providers and practitioners.
- The draft criteria may be distributed to all or a subset of practitioners for additional review and input.
- The Director of Utilization Management Services is responsible for presenting the draft criteria to the UM & New Technology Committee for review, recommendation, adoption, and/or approval. A summary of the newly-developed review criteria activity is reported to the Board of Directors through the Chief Medical Officer's (QIC) report.

Additionally, finalized review criteria are available at Community Health Plan of Imperial Valley for individual practitioner review with the Director of Utilization Management Services and/or Chief Medical Officer.

Ongoing Review. As the outside reference materials described above are modified, the changes/updates are presented, as appropriate, to the UM & New Technology Committee to review and approve medical necessity criteria that are updated as needed to incorporate current developments in clinical practice.

The UM & New Technology Committee reviews the new or revised guidelines and determines whether or not to adopt the changes. If adopted, the existing criteria will be modified to incorporate the recommendations of the Committee. The Director of Utilization Management Services then follows the same procedure as for newly-developed criteria.

Annual Review. Periodically, but at least annually, the UM & New Technology Committee reviews the Authorization/Review Criteria. The Committee makes appropriate change recommendations to the Quality Improvement Committee. Changes are communicated to contracted practitioners through Community Health Plan of Imperial Valley's quarterly Provider Update newsletter, Community Health Plan of Imperial Valley's Provider Alerts, and individual mailers to each contracted Primary Care Physician and/or contracted applicable specialties as required.

Urgent/Emergent Review. For criteria requiring immediate or urgent review, the Chief Medical Officer may call an ad hoc meeting of the UM & New Technology Committee. The process for developing or modifying the Authorization/Review Criteria remains the same as mentioned above.

Distribution of Criteria. Medical review criteria are available upon request to practitioners. Practitioners may receive a copy of individual criteria, review the entire set of criteria on-site at Community Health Plan of Imperial Valley, or may have sections read or faxed upon request. Practitioners are informed in the Provider Manual, provider newsletters, and on Community Health Plan of Imperial Valley's web site of the existence of criteria and how to request or review criteria. When a request for services is denied, both the member and practitioner are informed of the availability of the criteria used to make a determination and of how to obtain a copy.

The development, review, update, and distribution of clinical review criteria are described in Policy 7251.9 – “Clinical Criteria for Utilization Management Decisions.” Procedures for applying criteria are described in Policy 7251.8 – “Review of Requests for Health Care Services.” The process for assessing the consistency in applying criteria is described in Policy 7273 – “Utilization Management Program Evaluation and Process Monitoring.”

Review of Requests for Health Care Services

Community Health Plan of Imperial Valley will receive all referral requests through the online provider portal. Providers will not require prior authorization for services performed within the office along with referrals to specialists. Community Health Plan of Imperial Valley does require that all contracted providers use the provider portal on daily basis to submit referrals request for items on the exclusion list.

Providers are required to monitor the referral status through the online notification center. All notifications to the provider of the referral status approved, denied, or pending will be provided through the provider portal notification center. Providers can track referrals and see all related

documentations like denial letter along with the appeal right through the provider portal.

Community Health Plan of Imperial Valley obtains relevant clinical information and consults with the treating physician when making a determination of coverage based on medical necessity. All information relevant to a member's care is considered when making a UM decision.

Requests for services are reviewed to determine whether adequate supportive medical documentation has been submitted by the requesting practitioner to make a decision. Information required will be limited to that which is reasonably necessary to make a determination. The following member-based information is considered in making a utilization management decision:

- diagnosis
- severity
- treatment tried, failed, or contraindicated
- age
- comorbidities
- complications
- progress of treatment
- psychosocial situation
- home environment, when applicable
- urgency
- benefit structure

When it is necessary to conduct an on-site review at facilities to obtain relevant clinical information, Community Health Plan of Imperial Valley Case Managers follow established procedures. Community Health Plan of Imperial Valley's policy requires that Case Managers abide by the check-in policy for a third-party reviewer at each hospital, wear a CHPIV identification badge (picture ID) that is issued upon employment, observe the Joint Commission on Accreditation of Healthcare Organizations requirements that govern each hospital's policy, and observe the individual hospital's policies regarding member records. Upon employment, each CHPIV case manager receives training and orientation. The training and orientation schedule includes reviewing applicable facility contract language, facility contacts, and policies and procedures related to onsite reviews. When possible, a "veteran" CHPIV case manager will accompany a newly employed case manager to a facility for the first time.

Denial Process

The process of review, using established criteria, encompasses first, second, third, and fourth level reviews as described previously. A physician with a current California license to practice without restriction with education, training, or professional experience in medical or clinical practice, reviews services that are deferred, modified, or denied.

All denial decisions are followed with written notification to the requesting practitioner and member, as described in Policy 7254a and 7254b – "Notification of Utilization Management Decisions." Denial decisions include, in easily understandable language, the rationale for the denial, reference to the benefit provision, guideline, protocol or another similar criterion on which a denial decision was based treatment alternatives, phone number and availability of the practitioner who rendered the decision, notification that the member can, upon request, obtain a copy of the actual benefit provision, guideline, protocol, or another similar criterion on which the denial decision was based, and information, in writing, about the appeals process, including the

member's right to submit written comments, documents or other information relevant to the appeal, member representation and time frames, and independent medical review. Members are also notified about the expedited appeal process and that expedited external review can occur concurrently with the internal appeals process for urgent care and ongoing treatment. Decisions are made in the timeframes specified in Policy 7251.7a and 7251.7b – "Timeliness of UM Decisions".

Appeals

The purpose of an appeal is to provide a formal reconsideration or second look at denial. The member, practitioner, facility, or authorized representative of the member may submit an appeal on behalf of the patient. Two mechanisms for appeals of utilization management exist:

Expedited appeal. An expedited appeal may be requested to change an adverse determination for urgent care or as a result of the concurrent review. Expedited appeal requests may be initiated by telephone, fax, Community Health Plan of Imperial Valley's website, or in writing. Additional information for review must be submitted, and determinations are made as expeditiously as the medical condition requires, but no later than three calendar days (72 hours) after the request is made.

Standard appeal. Standard appeals may be pre-service or post-service. Standard appeals must be initiated by submitting the request with additional information for review by telephone, writing, Community Health Plan of Imperial Valley's website, or by fax within 180 days after notification of the denial. Determinations are made within 30 calendar days of receipt of required documentation for review.

Appeals are reviewed by the interdisciplinary Grievance and Appeals Committee, which includes a physician not associated with the original review and who is not the subordinate of any person involved in the initial determination. The Committee may reverse a denial of services on appeal. However, when there is not a reversal of the decision and the denial is upheld, the appeal may be reviewed by a specialty-matched, licensed, board-certified physician or clinical peer at the reviewing physician's discretion. Additionally, in cases of denials based in whole or in part on medical necessity, members have a right to an independent medical review (IMR) by requesting that service through the state's Department of Managed Health Care.

The member handbook provides educational information regarding the appeals process. In addition, the Provider Manual provides appeal information to practitioners and other providers. All denial correspondence and explanation of benefit (EOB) statements include information regarding the appeals process. The appeals process is further described in Policy 5510.4a and 5510.4b – "Medicare Complaints, Grievances, and Reconsiderations."

Delegated Utilization Management

Contingent upon an entity effectively meeting the condition for delegation, Community Health Plan of Imperial Valley may delegate some of its Utilization Management functions to practitioner groups with the exception of the appeals process and technology assessment. The Delegation Oversight Committee oversees the compliance of delegated activities by means of the signed and mutually agreed upon, Delegation Agreement for Utilization Management Services Agreement. Through the Delegation Program, Community Health Plan of Imperial Valley retains responsibility for assuring compliance with performance standards while giving a contractor the authority to perform

designated functions on its behalf.

Medical groups with delegated utilization management maintain responsibility for conducting the referral and authorization processes set by the benefit plan, contractual agreement(s) (including a delegation agreement signed by both parties), and Community Health Plan of Imperial Valley's utilization management standards, as set forth in the Utilization Management Program and delegation policy.

Community Health Plan of Imperial Valley's Chief Medical Officer, who holds an unrestricted license to practice medicine in the state of California, is responsible for Delegation Oversight. Community Health Plan of Imperial Valley performs an initial assessment of the delegated entity's capacity to perform the activities and ongoing oversight, implementation, evaluation of delegated utilization management functions. The goal in conducting oversight is to review all processes of the delegated medical group to have a process that will support the appropriate utilization and quality of services.

Oversight functions include a review of:

- Annual review and approval of the delegate's Utilization Management Program;
- Utilization Management summary of activities and semi-annual/annual reports;
- Appeal log with the outcome of appeals (to monitor that delegated entity is not performing this function on Community Health Plan of Imperial Valley's behalf);
- Denials made by the delegated medical groups which being assessed by file review;
- Member and practitioner satisfaction surveys; and
- Annual evaluation (on-site review) of the delegate's performance.

Delegation of utilization management responsibility by Community Health Plan of Imperial Valley is contingent upon the delegated entity effectively meeting the requirements contained in the mutually-signed Delegated Agreement for Utilization Management. The delegated agreement includes the responsibilities of Community Health Plan of Imperial Valley and the delegated entity in terms specific to this relationship.

The document clearly states the process for evaluating the delegate's performance. There is also an explicit statement regarding the consequences if the delegate fails to meet the terms of the agreement. Consequences may range from the development of corrective action plans to additional audits of compliance by Community Health Plan of Imperial Valley, to revocation of the agreement. (See attachment E, Delegated Services Agreement template, and delegation grid.)

The delegation agreement also describes the requirement for privacy and confidentiality protections if the delegation arrangement is not with a covered entity as defined in the HIPAA regulations.

Delegation and oversight of utilization management activities are outlined in Policy 7271 – “Delegated Utilization Management.”

Utilization Management Program Evaluation and Process Monitoring

Community Health Plan of Imperial Valley evaluates its Utilization Management Program to assess the fairness, consistency, and appropriateness, and timeliness of its utilization management decisions. The monitoring and evaluation process assures that the Utilization Management Program does not create a barrier to care and cause unnecessary problems for members and providers. This process is described in Policy 7273a and 7273b – “Utilization Management Program Evaluation and Process Monitoring” and Policy 7273.1a and 7273.1b – “Review of Utilization Management Non-Certification Notices.”

Interrater-Reliability. Community Health Plan of Imperial Valley reviews the consistency of decisions made across all reviewers at least annually. Community Health plan of Imperial Valley acts on identified opportunities for improvement if identified.

Satisfaction with Utilization Management Process. Information is gathered through annual surveys from both members and practitioners regarding their level of satisfaction with Community Health Plan of Imperial Valley's Utilization Management process. The UM & New Technology Committee members are regularly surveyed regarding their experience with the utilization management process. Where opportunities for improvement are identified, Community Health Plan of Imperial Valley takes action to change its processes to meet its goals and to meet members' and practitioners' expectations.

UM Timelines and Denials Review. Community Health Plan of Imperial Valley monitors and evaluates its utilization management process to its established policies and procedures. The evaluation process reviews timeline standards, notification timeframes, and compliance with health plan utilization management policies. Community Health Plan of Imperial Valley takes action to change its processes to meet established guidelines when necessary.

Administrative Day Authorization Requirement. Providers who are contracted for and bill Administrative Days will require prior authorization from CHPIV's Inpatient Case Manager. CHPIV will pay for Administrative Day beginning when CHPIV authorizes administrative day payment.

Annual Review of the UM Program. The UM Program is evaluated and the program description is updated annually based on regulatory and accreditation requirements as well as input from members and practitioners. It is approved by the UM & New Technology Committee, and ultimately, the Board of Directors.

Section 27: Women's Care

Obstetrics Care

Obstetrical care must be provided in accordance with The American Congress of Obstetricians and Gynecologists (ACOG) standards for the content and frequency of visits. Please visit The American Congress of Obstetricians and Gynecologists website at: <https://www.acog.org/> for current obstetrical care guidelines. CHPIV members are encouraged to seek early access to antepartum care, periodic evaluation of health status with special attention to risk factors, and postpartum care.

Members may access perinatal care from network providers without authorization. Primary care providers are responsible for coordinating perinatal care and for ensuring that members receive appropriate postpartum care.

In addition to services meeting ACOG standards, Medi-Cal members receive services according to the Comprehensive Perinatal Services Program (CPSP) standards.

Comprehensive Assessments

Members are assessed for medical, genetic, and psychosocial risk and for nutrition, health education, and other needs that affect a healthy outcome. Additional assessments must be conducted if the provider feels the patient is a danger to herself or if she is a danger to another person. If risks are present, the patient must be counseled and appropriately referred to contracted consultant staff. Providers must comply with applicable reporting laws.

Health Education Materials

CHPIV provides primary care site case managers with health education materials covering topics such as:

- AAP guidelines
- AIDS
- Alpha Fetal Protein (AFP)
- Breastfeeding vs. bottle feeding
- Child abuse
- Depression
- Diet and exercise
- Family planning (following delivery)
- High risk
- Lamaze
- Parenting tips
- Signs of an emergency
- Smoking
- Stages of pregnancy
- Substance abuse
- Tuberculosis

For more information on obstetrics care, contact Corporate Quality at (619) 498-6486

Comprehensive Perinatal Services Program (CPSP) (Medi-Cal Members)

Medi-Cal members are encouraged to receive prenatal assessment and health education services in accordance with the requirements of California's Comprehensive Perinatal Services Program. These requirements supplement those of the American Congress of Obstetricians and Gynecologists (ACOG).

CPSP Requirements

In addition to the ACOG standards, CPSP requires:

- At the **initial visit**:
 - Genetic assessment
 - Domestic abuse screening
- At the **initial visit**, once during **the second and third trimesters** and at the **postpartum** visit:
 - Medical/obstetrical risk assessment
 - Psychosocial risk assessment, including suicidal and homicidal ideation
 - Nutrition assessment
 - Health education assessment
- During **any of the trimesters** and at the **postpartum** visit, education and counseling regarding:
 - Parenting
 - Breastfeeding
 - Alcohol, drugs, smoking
 - Car seats and lap and shoulder belts
 - Diet and nutrition
 - HIV

Assessment Tool

The CPSP Combined Assessment Tool defines CPSP requirements for multidisciplinary assessments.

All identified risk conditions must be followed up by appropriate multidisciplinary interventions.

CPSP Provider Certification

To provide CPSP services, providers must be certified by the State CPSP program.

A CPSP provider's support staff must include, at a minimum, an RN or LVN or a Certified Perinatal Health Worker. The provider must have operational and referral resources to provide the required assessment, health education and treatment.

Case Management

The PCP is responsible for ensuring that the member receives appropriate perinatal care and referrals to specialists, as appropriate. The member may choose her own provider for obstetrical services. However, if the obstetrician is not CPSP certified, the member will be referred for CPSP services.

PCPs who refer members for perinatal services notify the CHPIV case manager of the referral. No prior authorization is required. However, the referral is entered to document requested services and to expedite claims processing.

The CHPIV case manager maintains ongoing contacts with the perinatal services staff, the PCP, the primary care site case manager and the member to ensure that health care services are provided in a coordinated and timely manner.

Documentation

All CPSP assessments and interventions must be documented using CPSP-specific procedure codes on the CMS-1500 form or submitted as statistical claims (depending on contract).

Assessment tools must be approved by CPSP or, at a minimum, contain CPSP-required content. Compliance with CPSP requirements is determined through review of chart and encounter data.

Health Education Resources

The CPSP program has created a health education resource guide, “Steps to Take”. If you would like copies of this guide, contact the CPSP program at **1-800-675-2229**.

Section 28: Member Emergency Preparedness Plan

Emergency Preparedness and Response

Member Emergency Preparedness plan (MPP) is part of CHPIV's Emergency Preparedness and response.

The MPP provides CHPIV Members with information on how to prepare for and what to do during an emergency and how to continue accessing CHPIV's services to obtain critical access to care. This MPP is posted on the CHPIV website and can be accessed for Member use. Additional emergency resources are available for members on the CHPIV website.

During an emergency, CHPIV Members, Network Providers, and Subcontractors may contact CHPIV's Member Services Department for questions available 24/7/365. CHPIV will provide dedicated staff and resources toward the emergency process, and how CHPIV will address the continual and timely resolution of claims. CHPIV maintains emergency contact information and other contact information for staff, Network Providers, Subcontractors, and other essential persons and entities. CHPIV updates this contact information as changes occur, but no less than every six months.

CHPIV has a 24/7/365 Member Services Department who are bilingual in languages including English, Spanish, Vietnamese, Arabic and Chinese (Mandarin and Cantonese). In an emergency, staff are provided with appropriate information and resources to address the emergency at hand and assist the members in obtaining the services they need. Member services staff will assist members by linking them to resources such as 2-1-1, 24/7/365 Telephone Advice Nurse, Find Help, Medi-Cal Rx and to CHPIV on-call staff who are available 24/7/365.

CHPIV also posts emergency related information to the CHPIV website to provide the most current information possible to members, providers, and staff. Information will be posted to the CHPIV website, provider portal, and member portal. In addition, Provider Alerts are sent to CHPIV providers by email and fax and are posted on the CHPIV website and Provider Portal to provide information on emergency actions/decisions to ensure our members receive their needed health care.

To access all Prover Alerts, please visit www.chgsd.com/providers/alerts and www.chgsd.com/providers/provider-emergency-factsheet