Gold Coast Health Plan℠
A Public Entity

To Improve the Health of Our Members Through Provision of the Best Possible Quality Care and Services

2013 PROVIDER MANUAL

1-888-301-1228
www.goldcoasthealthplan.org

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Forms posted at our website: www.goldcoasthealthplan.org

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SECTION 1: INTRODUCTION

Gold Coast Health Plan Mission Statement

"To improve the health of our Members through the provision of the best possible quality health care and services."

Welcome to Gold Coast Health Plan

Gold Coast Health Plan (GCHP) is a County Organized Health System (COHS) that administers the Medi-Cal program to the beneficiaries in Ventura County. The COHS is governed by the Ventura County Medi-Cal Managed Care Commission (also referred to as "the Commission") which is comprised of 11 members representing providers, clinics, hospitals, service agencies, elected officials and the public. There are two collaborative groups that report to the Commission: Providers Advisory Committee (PAC) and the Consumer Advisory Committee (CAC). The Commission meets monthly to review local concerns about healthcare issues, receive advisory input, and revise policy for GCHP as appropriate. GCHP's policies are responsive to local input due to our local governance and operations.

Organization of the Provider Manual

This Provider Manual describes operational policies and procedures of Gold Coast Health Plan, which is referred to throughout the manual as GCHP. Topics covered are included in the Table of Contents at the beginning and Index of Topics at the rear of the Provider Manual. You also may access this Provider Manual on-line by visiting our website at **www.goldcoasthealthplan.org**. For your convenience, a list of forms you may require can be found in Section 17 and are also available in printable format at the GCHP website. The Manual will be updated and revised periodically as needed to reflect the Provider Operations Bulletin. Revisions and updates will be automatically incorporated into the online version of the Manual.

Provider Web Portal

Registered providers may access the GCHP Provider Web Portal to verify eligibility of GCHP Members, check status of a claim and query and submit Prior Authorizations. Providers must register using their GCHP Provider Identification Number to access the Provider Web Portal. To access and utilize these services, go to the Providers section at our website, go to "Provider Web Portal" and complete the registration process. For any problems or assistance please contact our Customer Service Department at **1-888-301-1228**.

Other Resources on the GCHP Website

Visit the GCHP's website at **www.goldcoasthealthplan.org** to find a wealth of other helpful information, references, resources and tools, such as:

- **Provider Directories:** The Primary Care Provider Directory and the Specialist Physicians and other Non-Primary Care Physician Directory are available in PDF format to download and print at your convenience.
- **Drug Formulary:** Plus other Pharmacy Information
- **Forms and Documents:** GCHP's various forms are posted for a whole host of uses.

If you have ideas or suggestions for ways we can improve our service to providers or Members please let us know by emailing us at **ProviderRelations@goldchp.org**.

SECTION 2: GLOSSARY OF TERMS

Administrative Day: Any day in an acute care facility for which inpatient care is not required due to Medical Necessity or the physical condition of the Member but as such is approved by GCHP.

Administrative Members: An Administrative Member is an eligible Medi-Cal Beneficiary who is eligible by an aid code that only provides limited coverage, limited duration or a specific set of services and such Member would not be required to select a Primary Care Physician. Examples include: Dual Eligibles under Medicare and Medi-Cal where Medicare is primary; some Breast, Cervical Cancer and Treatment Program eligibles; Share of Cost eligibles; Medi-Cal beneficiaries confined to a Long Term Care facility; etc. Administrative Members will be identified as such on their Gold Coast Health Plan identification card (I.D. card) or those residing outside of Ventura County while regular Members will have their Primary Care Provider listed on their I.D. cards.

Appeal: A formal request to an organization by a practitioner or Member for reconsideration of a decision (e.g., utilization review recommendation, benefit payment, administrative action, quality-of-care or service issue) with the goal of finding a mutually acceptable solution.

Assigned Members: Medi-Cal Members who have been assigned to or who have chosen a Primary Care Physician for their medical care. (Also referred to as *Linked* or *Case Managed Members*).

Attending Physician: a) any Physician who is acting in the provision of Emergency Services to meet the medical needs of the Medi-Cal Member, b) any physician who is, through referral from the Member's Primary Care Physician, actively engaged in the treatment or evaluation of a Medi-Cal Member's condition, and c) any physician designated by the Medical Director, or designee, to provide services for Plan Members.

Auto Assignment: This is the process utilized by the Plan for assigning Members automatically by a pre-determined process to a particular Primary Care Provider (Physician or Clinic). It only occurs when the Member has neglected to complete the selection process within the thirty days allowed upon initial enrollment. The auto assignment is based on the residence of the Member, past history with a specific Primary Care Provider, available capacity in the Provider's practice to accept new Plan Members, preferred language, and other factors. If the Member is not satisfied with the auto assignment he/she can contact the Plan and select a new Primary Care Provider. If the Member completes the Primary Care Provider selection in a timely manner there will be no auto assignment.

California Children's Services (CCS): A public health program that ensures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions, as defined in Title 22, California Code of Regulations (CCR), Section 41800.

Capitation Payment: The prepaid monthly amount that Plan pays to Primary Care Physician (or group of Primary Care Physicians) based on assigned membership and treatment of capitated primary care services (Attachment B) for the scope of services as defined in Attachment C as incorporated into the Primary Care Physician Medical Services Agreement.

CAQH: The Council for Affordable Quality Healthcare (CAQH). A nationally recognized central repository for provider credentialing information storage and retrieval. If providers are affiliated with CAQH and their information is current and complete they do not have to file a new credentialing application with GCHP.

Care Manager: GCHP Care Managers are licensed registered nurse professionals and licensed clinical social workers with specialty certifications specific to their role.

Case Management: Describes the responsibility of the PCP to provide and/or arrange for the provision of coordinated, continuous medical services for the patients under his/her care.

Case Manager: The health care professional (usually the PCP) who is responsible for the case management of a patient. GCHP Utilization Management Team may also assist in case management of difficult cases.

Case Rate: An all-inclusive payment paid by the Plan to a Participating Provider for a defined set of covered services that are delivered to a Member for medical or surgical management of the case in question. (e.g., hearts transplant case).

Community Based Adult Services (CBAS): An outpatient, facility based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals, and transportation to eligible Medi-Cal beneficiaries.

Chief Medical Officer (CMO): The Medical Director of Plan or his/her designee, a physician licensed to practice medicine in the State of California, who is employed by the Plan to monitor Quality Improvement and implement Quality Improvement Activities of Plan.

Child Health and Disability Prevention Services (CHDP): California's version of the Federal EPSDT program, which provides for health care preventive services and immunizations for beneficiaries under 21 years of age provided in accordance with the provisions of Health and Safety Code Section 124025, et. seq., and Title 17, CCR, Sections 6842 through 6852.

Complaint or Grievance: If a Plan Provider is not satisfied with any aspect of the Provider's dealings with the Plan then a complaint or grievance may be filed in accordance with the provisions in the Provider's Contract. The issues might cover a range of possibilities from service issues, denial of request for prior authorizations, incorrect claims payment, Member abuse of the provider's office staff or any other events that may require remedial attention. The Plan will acknowledge each complaint or grievance and try to resolve them in a fair and expeditious manner. If the matter cannot be resolved quickly then the Plan will notify the Provider of the status and expected date for resolution.

Comprehensive Perinatal Services Program (CPSP): A Program that provides a wide range of services to pregnant women, from conception through 60 days post-partum. In addition to standard obstetrical services, women receive enhanced services in the areas of nutrition, psychosocial and health education. This approach has shown to reduce both low birth weight rates and health care costs in women and infants. The program is funded by Title V (Maternal and Child Health) and Title XIX (Medicaid) and other state and Federal funds.

Contract Year: The 12-month period following the effective date of the Service Agreement between each specific Participating Provider and Plan and each subsequent 12 month period.

Contracting Providers: This is a medical group, independent practice association, or other entity that delivers, furnishes, or otherwise arranges for or provides healthcare services for GCHP enrollees under a contracted arrangement, but does not include an individual or a plan.

County Organized Health System (COHS): A health care plan serving Medi-Cal members in a designated county. The COHS known as Gold Coast Health Plan only serves Ventura County.

Covered Services: All Medically Necessary services to which Members are entitled from Plan as set forth in the Member Handbook, including Primary Care Services, referral specialist, medical, hospital, preventive, ancillary, emergency and health education services.

Department of Health Care Services (DHCS): California State regulatory organization that finances and administers a number of individual health care service delivery programs, including the California Medical Assistance Program (Medi-Cal). Their mission is to protect and promote the health status of Californians through the financing and delivery of individual health care services.

Eligible Beneficiary: Any Medi-Cal beneficiary who receives Medi-Cal benefits under the terms of one of the specific aid codes set forth in the Medi-Cal Agreement. The Member must be certified as eligible for Medi-Cal by the county agency responsible for determining the initial and continuing eligibility of persons for the Plan's Medi-Cal Managed Care Program's Service Area.

Emergency Medical Condition: A medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

Emergency Services: Those health services needed to evaluate or stabilize an emergency medical or psychiatric condition.

Encounter Form: The UB-04 claim form used by Participating Hospitals and other providers to report to Plan the provision of Covered Services to Medi-Cal Members or the CMS-1500 claim form primarily used by Participating Physicians to report to the Plan the provision of Covered Services to Medi-Cal Members. May also include other forms as deemed appropriate such as the PM-160 information only form to report CHDP services or the 25-1C form for Long Term Care facilities.

Enrollment: The process by which the Ventura County Human Services Agency (HSA) determines Medi-Cal benefits eligibility of an individual which then communicates eligibility to GCHP.

Excluded Services: Those services that are non-covered or carved-out for which the Plan is not responsible and for which it does not receive a capitation payment from DHCS

Early Periodic Screening, Diagnosis and Treatment: The EPSDT Screening Program provides routine physicals or well-child checkups for Medicaid eligible children at certain specified ages. It is considered preventive care. Children are checked for medical problems early. Specific tests and treatments are recommended as children grow older.

Fee-For-Service Payment (FFS): The lowest allowable Fee-For-Service Medi-Cal payment that is permitted by DHCS. This rate is the lower of the following rates applicable at the time the services were rendered by the provider: a) the usual charge made to the general public by the provider; b) the maximum Fee-For-Service rate determined by DHCS for the service under the Medi-Cal Program; or c) the rate agreed to by the provider. All Covered Services that are authorized by and compensated by Plan pursuant to its written Service Agreement will be compensated by Plan at the lowest allowable Fee-For-Service rate unless otherwise identified in a special Attachment to the signed Agreement.

Fiscal Year of Plan: The 12 calendar months for which the Plan prepares and submits its financial reports. The Fiscal Year starts July 1 and ends June 30 of each year.

Formulary: The list of pharmaceutical items that has been approved for prescribing by Plan Providers and prescribed use by enrolled Members. Any prescriptions for drugs or other items that are not on the formulary will require prior authorization by the Plan in accordance with the procedures outlined in this Provider Manual.

Gemini Diversified Services (GDS): This is the Credentials Verification Organization (CVO) that has contracted with GCHP as its agent to verify primary source documentation of credentials for all provider applicants wishing to join GCHP's network to serve Medi-Cal beneficiaries in Ventura County.

Governmental Agencies: The State of California Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Centers for Medicare & Medicaid Services (CMS), United States Department of Justice (DOJ), and California Attorney General and/or any other agency which has jurisdiction over Plan or Medi-Cal (Medicaid)

Health Insurance Portability and Accountability Act (HIPAA): Enacted in 1996 by US congress to protect the health insurance coverage for workers and their families under certain conditions related to employment. This law also covers issues of privacy over the collection, use, handling and disclosure of confidential patient records called "Private Health Information" or "PHI".

Hospital: Any acute general care facility

Hospital Day: Any period up to twenty-four (24) hours commencing at 12:00 a.m. during which a Physician has ordered the stay and the Member's condition is such that acute services are required and rendered and the care meets professionally recognized standards.

Identification Card (ID Card): The card that is prepared and issued by the Plan which bears the name and logo of Plan and contains: a) Member name and identification number, b) Member's Primary Care Physician or Clinic (if Assigned/Regular Member) and c) other identifying data. NOTE: The card is not proof of Member eligibility with Plan or proof of Medi-Cal eligibility.

Limited Service Hospital: Any hospital which is under contract to the Plan, but not as a Primary Hospital since it is located outside of Ventura County. [Please see: Primary Hospital definition].

Long-Term Care (LTC): Refers to the care for patients in long term care, who are in need of nursing care and assistance with activities of daily living.

Medically Necessary: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. These services will be in accordance with professionally recognized standards of medical practice and not primarily for the convenience of the Member or the Participating Provider. When determining the Medical Necessity of Covered Services for a Medi-Cal Beneficiary under the age of 21, "Medically Necessity" is expanded to include the services that are necessary to correct or meliorate defects and physical and mental illnesses and conditions discovered by EPSDT screening services.

Medi-Cal Managed Care Program: The program that Plan operates under its Medi-Cal Agreement with the DHCS for the Service Area.

Medi-Cal Provider Manual: The Medical Services Provider Manual of DHCS, issued by the DHCS Fiscal Intermediary for the state of California.

Medical Transportation: Transportation of the sick, injured, invalid, convalescent, infirm or otherwise incapacitated persons by ambulances, specially-equipped vans or wheelchair vans licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances or regulations. Medical transportation services do not include transportation of beneficiaries by passenger car, buses, trains or other forms of public or private conveyances.

Member (Regular): An Eligible Medi-Cal Beneficiary who is enrolled in the Plan and is required to select a Primary Care Provider. Also referred to as "Linked Members" or "Case Managed Members." Enrolled Members will have the name of their Primary Care Provider listed on their Plan ID cards. [Please see Administrative Members defined above.]

Member Handbook: The Plan Medi-Cal Combined Evidence of Coverage and Disclosure Form that sets forth the benefits to which a Medi-Cal Member is entitled under the Medi-Cal Managed Care Program operated by Plan, the limitations and exclusions to which the Medi-Cal Member is subject and terms of the relationship and agreement between Plan and the Medi-Cal Member.

Non-Emergency Medical Transportation: Transportation services required to access medical appointments and to obtain other Medically Necessary Covered Services by Members who do not have a medical condition necessitating the use of medical transportation as defined in Title 22, CCR, Section 51323.

Non Physician Medical Practitioner: A physician assistant, nurse practitioner, registered nurse or certified midwife authorized to provide primary care services under physician supervision.

Observation Day: A period of a minimum of 8 hours (not to exceed 24 hours) in duration during which services furnished by a Participating Hospital on the Hospital's premises, including use of a bed and at least periodic monitoring by a Hospital's nursing staff, which are reasonable and Medically Necessary and appropriate to evaluate a Member's outpatient condition or determine the need for a possible admission to the Hospital as an inpatient.

Out-of-Area: The geographic area outside Ventura County.

Out-of-Plan: Non-contracted providers located inside or outside of Ventura County. Also referred to as "non par providers" indicating they are not Participating Providers in the network of Plan Contracted Providers.

Outpatient Services: Medical procedures or tests that can be done in a medical facility without requiring an overnight stay. Outpatient services include:

- **Wellness and prevention**, such as counseling and weight loss programs.
- **Diagnosis**, such as lab tests and MRI scans.
- **Treatment**, such as some surgeries and chemotherapy.
- **Rehabilitation**, such as physical therapy.

Participating Hospital: A facility licensed by the State of California as an acute care Hospital or other licensed facility that provides Covered Services, or for any out-of-area/out-of-plan services as authorized by Plan, to Medi-Cal Members through a written agreement between Participating Hospital and Plan.

Participating Provider: A health professional, facility or vendor typically licensed by the State of California and credentialed to provide Covered Services to Members which has executed an agreement with Plan to participate in the Plan's network of contracted providers.

Per Diem Payment: The all-inclusive fixed amount of payment for a Hospital Day unless exceptions ("carve-outs") are listed. The applicable Per Diem Payment is described in Attachment B of each written Hospital Service Agreement.

Physician: A person who holds a degree of Doctor of Medicine ([MD) or Osteopathy (DO) from an accredited university program.

Plan: The Medi-Cal Managed Care Program governed by the Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan serving Ventura County Medi-Cal Eligible Beneficiaries.

Plan Partners: This is a health care service plan, subject to regulation by the Department of Managed Health Care, which contracts directly with GCHP and:

- Is responsible for providing health care service for GCHP enrollees.
- Receives compensation for those services on any capitated or fixed periodic payment basis.
- Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of the Plan Partner that are covered under the capitation or fixed periodic payment made by GCHP to the Plan Partner.

Placement Day: A day that shall be approved by Plan, when a Member is clinically stable for discharge from the Participating Hospital but the Member cannot be discharged for reasons outside of Hospital's control. Hospital staff shall contact Plan's UM staff twenty-four (24) hours after the planned discharge date for authorization of Placement Days if Hospital is unable to discharge the Member after sufficient discharge planning efforts.

If the discharge is planned for the weekend or a holiday, Hospital staff shall contact Plan staff the following business day. If sufficient discharge planning efforts occurred, Placement Days shall be authorized to include any weekend or holiday.

Primary Care Case Management: The responsibility for primary and preventive care, and for the referral, consultation, ordering of therapy, admission to hospitals, provision of Medi-Cal covered health education and preventive services, follow-up care, coordinated hospital discharge planning that includes necessary post-discharge care, and maintenance of a medical record with documentation of referred and follow-up services.

Primary Care Provider (PCP): A clinic, physician(s) or mid-level licensed professional practicing under physician supervision who has executed an Agreement with Plan to provide Primary Care Services. The individual must be licensed by the appropriate professional Board of California and enrolled in the State Medi-Cal Program. The Primary Care Provider is responsible for supervising, coordinating, and providing Primary Care Services to Members; initiating referrals; and for maintaining the continuity of care for the Members who select or are assigned to the Primary Care Provider. Primary Care Providers include general and family practitioners, internists, pediatricians, and other mid-level professionals such as nurse practitioners, physician assistants, etc…

Primary Care Provider (PCP) Directory: The listing of all Primary Care Providers and Clinics that is periodically updated and published by the Plan. It is provided to Members to aid in their selection of a Primary Care Provider for each Member of their family. Members of the family do not have to select the same Primary Care Physician from the Directory and Members are able to change their selection if they so desire. (See also: ***Auto Assignment***).

Primary Care Services: Those services defined in Attachment C to the Primary Care Physician Service Agreement and are provided to Members by a Primary Care Physician. These services constitute a basic level of healthcare usually rendered in ambulatory settings and focus on general health needs (Please see ***Capitation Payment***.)

Primary Hospital: Any Hospital affiliated with Participating Primary Care Physician(s) that has entered into a written Agreement with the Plan for providing Covered Services to Members.

Provider Advisory Committee: A committee composed of 10 voting members; each seat represents a constituency served by the plan, and serves as a platform to exchange ideas and present peer/community interests to the Plan, regarding health care matters at the national, regional, state and local levels.

These issues may include, but are not limited to:

- Improvement of health care and clinical quality
- Improvement of communications, relations and cooperation between physicians and the Plan
- Matters of a clinical or administrative nature that affects the interaction between physicians and the Plan

Provider Manual: The manual of operational policies and procedures for the Plan's Medi-Cal Managed Care Plan.

Quality Improvement Program (QIP): Systematic activities to monitor and evaluate the clinical and non-clinical services provided to Members according to the standards set forth in statute, regulations, and Plan's Agreement with the DHCS. The QIP consists of processes, which measure the effectiveness of care, identifies problems, and implements improvement on a continuing basis towards an identified target outcome measurement. The Plan's Quality Improvement Program is overseen by the Quality Improvement Committee.

Referral Physician: Any qualified physician, duly licensed in California who meets the general credentialing requirements of the Plan and has signed an Agreement with the Plan. The Provider has an executed Agreement with the Plan, to whom a Primary Care Physician may refer any Member for consultation or treatment. Also referred to as Participating Provider.

Referral Services: Covered services, which are not Primary Care Services, provided by Specialist Physicians on referral from the Primary Care Physician.

Service Agreement: Agreement entered into between a licensed Physician, Hospital, Allied Health Care Professional (non-physician, non-hospital), or other such healthcare providers and the Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan.

Service Area: GCHP's service area in Ventura County and the zip codes located therein.

Urgent Care Services: Medical services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury.

Vision Care: Pursuant to the policies and limitations of the Medi-Cal schedule of covered vision benefits, the eye examination, eyeglasses prescription and basic low-cost frames will be provided by the VSP Contracted Optometrists. Lenses must be provided by the Prison Industries Authority (PIA) under contract to the DHCS.

Section 3: Provider Application, Credentialing and Contracting

Initial Application Process and Recredentialing

To participate in the GCHP network all providers must have their credentials approved by the Credentials Committee of GCHP and sign a Service Agreement with the Plan. Providers are re-credentialed within 36 months after the initial credentialing date or last re-credentialing approval date.

Pursuant to the Provider Services Agreement, all new Providers and those eligible for re- credentialing must return a signed credentialing application form to GCHP, along with all required attachments, including but not limited to copies of the following documents:

- Current California Medical License or Business License
- Current DEA License
- Documentation for National Provider Identifier (NPI) and Taxonomy Code
- Professional Liability Insurance (malpractice) face sheet (Required limits are $1,000,000 per occurrence/$3,000,000 annual aggregate)
- Signed Taxpayer Identification Form (W-9)
- Current signed Attestation as to accuracy of all information submitted

Additional Requirements for CHDP, CPSP, HIV/AIDS

For some physician specialties there are additional credentialing pre-requisite requirements. For example, pediatricians and family practice specialists who care for children should also be paneled by Children Health Disability Prevention Program (CHDP) to participate in the GCHP network. Neonatologists should be certified by CCS. Obstetricians should be paneled by CPSP. HIV/AIDS specialists must document that they meet certain additional education and training requirements. For more information on these particular requirements please contact our Provider Relations Department at **ProviderRelations@goldchp.org**.

CAQH and Gemini Diversified Services

The Council for Affordable Quality Healthcare (CAQH) is a centralized nationally recognized repository or warehouse for Provider credentialing information. If the physician applicant is a participant with the CAQH and has all active credentialing information on file and up-to-date then the Provider does not need to complete and submit a completed credentialing application to GCHP. The Provider merely has to authorize access for GCHP to obtain primary source documentation from the CAQH repository and confirm that all information is accurate and up to date. If this is not the case then the Provider will either have to file with CAQH or complete the credentials application provided by Gemini Diversified Services (GDS). GDS is a Credentialing Verification Organization (CVO) that has contracted with GCHP to verify primary source documentation for all GCHP Providers. Neither CAQH nor GDS make any recommendations as to approval or denial of admission to the GCHP network. All initial credentialing and recredentialing decisions are the sole responsibility of the Credentials Committee on behalf of Gold Coast Health Plan.

Facility Site Review (FSR) for Primary Care Office Locations

Before the credentialing verification process is finalized, a nurse from GCHP will visit each PCP practice location to conduct a Facility Site Review (FSR). After the site review and complete processing of the information provided, such as; license status, wheelchair access, fire extinguishers, etc., Providers' initial credentialing and re-credentialing files are submitted to the Credentials Committee for review and approval. If a provider's credentials are approved, the Chairperson of the Committee or his designate will formally authorize the provider Services Agreement.

Notification of Adverse Actions Taken Against You or Your Staff

Federal and State laws require that you notify us immediately by phone (with a follow up in writing) if any of the following actions are taken towards you or any practitioner on your staff:

- Revocation, suspension, restriction, non-renewal of license, certification, or clinical privileges.
- A peer review action, inquiry or formal corrective action proceeding or investigation. A malpractice action or government action, inquiry or formal allegation concerning qualifications or ability to perform services.
- Formal report to the State licensing board or similar organization or the National Practitioner Data Bank (NPDB) of adverse credentialing or peer review action. Any material change in any of the credentialing information.
- Sanctions under the Medicare or Medicaid programs.
- Any incident that may affect any license or certification, or that may materially affect performance of the obligations under the Service Agreement with GCHP.

Appealing Adverse Decisions by the Credentials Committee

If the Credential Committee should make a decision that alters the condition of a provider's participation with GCHP based on issues of quality of care or service, the provider may appeal the adverse decision. For more information on the GCHP credentialing policy, please see the forms section of the website for Fair Hearings and Filing of Appeals. The appropriate forms may also be requested by contacting **ProviderRelations@goldchp.org**.

If a provider fails to meet the credentialing standards or if his/her license, certification or privileges are revoked, suspended, expired or not renewed, GCHP must ensure that said provider does not render any services to our Members. Additionally, any conduct that could adversely affect the health or welfare of a Member will result in written notification instructing the provider not to render services to our Members until the matter is resolved to GCHP's satisfaction.

Debarment, Suspension, Ineligibility or Voluntary Exclusion

In accordance with 45 CFR (Code of Federal Regulations) Part 76, GCHP receives indirect Federal funding through the California Medi-Cal Program and, therefore, must certify that it has not been debarred or otherwise excluded from receiving these funds. Under this rule, because GCHP receives this indirect Federal funding, GCHP is considered a "lower tier participant."

As subcontractors, our providers—who essentially receive Federal funding by nature of their Agreement with GCHP — are also considered "lower tier participants" and thus must also attest to the fact that, by signing the Provider Service Agreement, they have not been debarred or otherwise excluded by the Federal government from receiving Federal funding. Pursuant to this certification and your agreement with GCHP, should you or any provider with whom you hold a subcontract become suspended or ineligible to receive Federal funds, you are required to notify GCHP immediately.

Fraud, Waste and Abuse Reporting Program

As a Provider, you are required to report to Gold Coast Health Plan any incident of fraud, waste and/or abuse that may have occurred by members, providers, or employees, within 10 (TEN) DAYS from the date when you first became aware of or were put on notice of such activity.

Report fraud, waste and abuse by calling Gold Coast Health Plan's Compliance and Fraud Hotline at **1-866-672-2615** or send an email to **https://gchp.alertline.com**. All calls and emails can be made anonymously.

Provider Contract Termination

To ensure that Medically Necessary, in-progress, covered medical services are not interrupted due to the termination of a provider's contract, we assure continuity of care for our Members, as well as for those newly enrolled individuals who have been receiving Covered Services from a non-participating provider.

Additionally, GCHP shall make a good faith effort to notify Members who received their primary care from or were seen on a regular basis, by the terminated contracted provider within fifteen (15) business days of receipt of issuance of the termination notice from the Provider and at least thirty (30) calendar days prior to the effective date of the termination.

In the case of unforeseen circumstances, and GCHP receives less than thirty (30) calendar days' notice of a change in the Provider contract, GCHP shall notify members of the change within fourteen (14) calendar days prior to the effective date of the change.

If GCHP terminates a contracted Provider's contract without prior notice as a result of his or her endangering the health and safety of member's, committing criminal or fraudulent acts, or engaging in grossly unprofessional conduct, GCHP shall provide written notification to affected members within thirty (30) days after the date of the contract termination. If GCHP determines that it is in the best interest of the member, GCHP may modify the notification period to the members.

In the event of a natural disaster or emergency, GCHP shall notify members of any significant changes in the availability or location of covered services, as soon as possible, and within fourteen (14) calendar days of the change.

Continuity of Care

When a practitioner's contract is terminated or discontinued for reasons other than a *medical disciplinary cause, fraud, or other unethical activity*, a Member may be able to receive continued care with the practitioner after the contract ends. Continuity of care is permitted for the following conditions:

- A chronic condition.
- A serious chronic condition and/or a terminal illness.
- A pregnancy and care of a newborn child from birth to 36 months (not to exceed 12 months from the contract termination).
- Surgery or other procedure that has been authorized and documented by the provider to occur within 180 days of the contract termination.
- Any other Covered Service dictated by good professional practice.
- The practitioner must continue to treat the Member and must accept the payment and/or other terms of the GCHP Service Agreement.
- For an acute or terminal condition, the services shall be covered for the duration of the illness or episode of care.

Section 4: Medi-Cal Programs

Coordination of Care

Gold Coast Health Plan will continue to provide normally covered medical services for Members receiving services from California Children's Services (CCS), and will coordinate with the PCP and the designated center to assist with the development of a care plan, or in complying with the care plan that has been developed.

As PCP you are part of the interdisciplinary team supporting the Member's medical as well as psychosocial and environmental needs. Screening along with preventive, Medically Necessary and therapeutic services that are covered benefits will continue to be covered by GCHP.

GCHP maintains a Memorandum of Understanding (MOU) with the Ventura County Health Care Agency as well as other local and regional public agencies such as Tri-Counties Regional Center (Developmentally Disabled or Delayed patients), Public Health (TB and STD services and counseling), WIC (Women, Infant and Children Nutritional Supplement Programs), Behavioral Health, etc. The MOU is an agreement between GCHP and the agency that delineates how the two or more entities will coordinate the provision of Covered Services and/or public health services, as appropriate. The MOU also delineates the roles and responsibilities of each agency related to specific public health services.

California Children's Services (CCS)

CCS is a statewide program managed by the Department of Health Care Services (DHCS), and administered by the Ventura County's Health Care Agency CCS Office. CCS provides medical case management and financial assistance to GCHP Members under the age of 21 who are eligible to receive CCS services.

Conditions that qualify for CCS coverage are those that limit or interfere with physical function but can be cured, improved or stabilized.

Only providers who have been approved by CCS are eligible for reimbursement under the CCS program. CCS reimbursement is separate from any reimbursement under GCHP and is billed directly through the CCS program. GCHP will not cover CCS eligible services denied by CCS because the rendering provider is not paneled by CCS.

CCS qualifying conditions include birth defects, handicaps present at birth or later developed, and injuries from accidents or violence, such as congenital heart disease, endocrine disorders (including diabetes), organ transplant, prematurity, AIDS, major trauma, craniofacial anomalies, inherited metabolic disorders, chronic renal disease and hemophilia. These are conditions that tend to be relatively uncommon, chronic rather than acute, and are costly. They generally require the care of more than one healthcare specialist.

If you determine that a Member may have a CCS qualifying condition, you must refer the Member to CCS for case certification, case management and treatment of the particular condition.

Please notify the GCHP Health Services Department at **1-888-301-1228** immediately about any potential CCS qualifying condition.

Members under the care of CCS will continue to remain enrolled in GCHP for primary-care services and referrals unrelated to the CCS conditions. The PCP relationship remains intact for all healthcare interventions unrelated to CCS condition.

GCHP's Health Services Department will help identify CCS eligible conditions through review of referrals, claims and encounters for diagnosis categories, as well as during hospital concurrent review. In addition, we will work with Providers, admitting Physicians, hospital discharge planners, perinatologists, neonatologists, or hospital pediatricians, as appropriate; to ensure that potential candidates are referred to CCS.

For information on how to become a CCS provider, please contact the local CCS office at **805-981-5281**.

Child Health and Disability Prevention (CHDP)

The Child Health and Disability Prevention (CHDP) is a preventive program to ensure periodic health assessments and services for low-income children and youth in California. CHDP is funded by both State and Federal governments to ensure the provision of a pre- specified maximum number of preventive-care visits for children under 21 years of age who are enrolled in Medi-Cal.

Health assessments are provided by CHDP approved providers, local health agency departments, community clinics, managed care plans, and some local school districts. As noted previously, GCHP pediatricians and family practice specialists who treat children should be prior certified by CHDP to join the GCHP network. Providers interested in becoming an approved CHDP provider should contact the local CHDP office at **805-981-5291**.

Some of the services covered by CHDP include, but are not limited to:

- Dental screening
- Developmental assessment
- Health and development history
- Immunizations
- Laboratory tests and procedures (including tests for serum levels of lead)
- Nutritional assessment
- Periodic health examination
- Psychosocial screening
- Speech screening
- Vision screening

For members under 21, the Initial Health Assessment IHA and the American Academy of Pediatrics AAP scheduled health appointments are to include age specific assessments and services required by the CHDP program. Complete guidelines for CHDP preventive health services are available at the State website, **www.dhcs.ca.gov/services/chdp**. Frequently Asked Questions (FAQs) about CHDP are contained in Section 18. Appendix 5 of this Manual. Information about billing GCHP for CHDP services can be found in Section 10 Claims and Billing.

Comprehensive Perinatal Services Program (CPSP)

The CPSP program provides a wide range of services to pregnant women from conception to 60 days post-partum. Women receive enhanced services in addition to standard obstetric services including nutrition, psychosocial support and health education because this comprehensive approach has proven to reduce problems and medical complications caused by low birth weight infants and thus reducing costs of care and adverse outcomes. For more information, please refer to the CPSP website home page at: **http://www.cdph.ca.gov/programs/CPSP**.

Members with Developmental Disabilities or Developmental Delay

The Initial Health Assessment (IHA) is performed when enrolling new children into your practice. During the IHA you will identify those who have, or are at risk of acquiring, developmental delays or disabilities,

including signs and symptoms of mental retardation, cerebral palsy, epilepsy or autism. Additionally, developmental screening is a required part of each well-baby and well-child visit; children at risk for developmental delay may also be identified during prenatal examinations when developmental histories as well as physical and neurological examinations are conducted.

A *developmental disability* is a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or other conditions similar to mental retardation that originates before the age of 18 years, is likely to continue indefinitely, and constitutes a significant handicap for the individual. A *developmental delay* is an impairment in the performance of tasks or the meeting of milestones that a child should achieve by a specific chronological age.

GCHP covers all Medically Necessary and appropriate developmental screenings, primary preventive care, diagnostic and treatment for Members who have been identified or are suspected of having developmental disabilities, and for Members who are at high risk of parenting a child with a developmental disability. GCHP assures that Members identified with developmental disabilities receive all Medically Necessary screening, preventive, and therapeutic services as early as possible.

As noted earlier, GCHP has entered into Memorandum of Understanding with various agencies to coordinate our activities in serving Members with special needs. For example, some Members are referred to the appropriately funded agency, such as the Local Education Agencies (LEA). Other agencies in Ventura County are part of a statewide system of locally based regional centers that offer supportive services programs for California residents with developmental disabilities. Regional centers provide intake and assessment services to determine client eligibility and needs and work with other agencies to provide the full range of early intervention services. Local regional centers can provide specific information on the services available in the Member's service area. Services include respite day programs, supervised living, psychosocial and developmental services, and specialized training.

Members with developmental disabilities are linked to a PCP, who provides them with all appropriate preventive services and care, including necessary Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services. Preventive care is provided per the current guidelines of American Academy of Pediatrics and the United States Preventive Services Task Force for Adults.

As a PCP, you are required to provide or arrange for Medically Necessary care to correct or ameliorate developmental disabilities and provide/arrange for all Medically Necessary therapies and items of durable medical equipment within the scope of your practice. For those necessary services that are beyond the scope of your practice, you should make the necessary referrals and coordinate with the appropriate funding agency.

Early Start Program for Developmentally Disabled Infants and Toddlers

The Early Start Program is California's response to Federal legislation ensuring that early intervention and Medically Necessary diagnostic and therapeutic services are provided to infants and children up to 3 years of age with disabilities — and that such services are provided in a coordinated, family-centered network.

GCHP Members eligible for early intervention services are infants and toddlers from birth to 36 months for whom documented evaluation and assessment confirms that they meet any ***one*** of the following criteria:

- Child has a developmental delay in either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing.
- Child has an established risk condition(s) of known etiology, with a high probability of resulting in delayed development.

- Child is at high risk of having a substantial developmental disability due to a combination of risk factors.

California State legislation requires that you refer children between 0-36 months to the Early Start Program for evaluation if they exhibit a significant developmental delay, have multiple risk factors, or have an established risk factor; this referral must take place within 48 hours of your assessment.

GCHP has entered into a Memorandum of Understanding with the local Early Start Program in order to coordinate our services to Members.

Community-Based Adult Services (CBAS)

Effective October 1, 2012 GCHP is managing the Community Based Adult Services (CBAS) benefit for Ventura County Medi-Cal members. The State eliminated the Adult Day Health Care (ADHC) benefit and replaced it with the new Medi-Cal benefit called Community-Based Adult Services (CBAS).

CBAS provides services and support to eligible Medi-Cal or GCHP eligible members to keep them healthy and help them live safely at home. Providers should identify potential members to determine if they qualify for CBAS. If you as a provider identify a potential member who would benefit from the services provided through the CBAS program, as a provider you should refer the member to Gold Coast Health Plan for an evaluation.

The qualification criteria are as follows:

- 18 years old or older
- Diagnosed with physical, behavioral or memory problem
- At risk for institutionalization in a long-term care facility

In order to participate you must be a CBAS provider.

Please adhere to the following Claims Pre-Submission Check List:

- Eligibility must be verified prior to billing
- Provider NPI must be actively registered with Gold Coast Health Plan
- Prior Authorization required for initiation of all CBAS services
- Claims Submission, no claims will be accepted prior to the 10/01/2012 effective date
- Claims must be billed on a UB-04 claim form
- Claims must be submitted within 6 months from the date of service
- All required fields must be completed or your claim will be rejected back to you
- Providers and clearinghouses are required to enroll as a Trading Partner to submit claims electronically

For more information about CBAS benefits, eligibility for CBAS benefits, and referral to CBAS providers see the “CBAS FAQs” under provider resources at www.goldcoasthealthplan.org.

Health Insurance Premium Payment Program (HIPP)

GCHP may pay private health insurance premiums for certain qualified Medi-Cal beneficiaries. For example a Member may qualify for HIPP if s/he has a high-cost medical condition, private health insurance, and/or high-cost monthly premiums. If you believe a Member qualifies for this benefit, please have them contact our Member Services Department at **1-888-301-1228** in order to obtain the necessary forms and instructions on how Members may apply for HIPP.

Objectives of HIPP

The Health Insurance Premium Payment (HIPP) program was established by the enactment of Assembly Bill (AB 3328, Margolin 1989) and it is codified in the Welfare and Intuitions Code (W& I, Section 14124 91) and the California Code of Regulations (CCR, Title 22, Section 50778). These statutes authorize GCHP to pay private health coverage premiums for our Members, whenever it is cost-effective to do so, thus ensuring that GCHP is the payer of last resort. Medi-Cal/GCHP is billed first only for beneficiaries with health coverage provided through the Indian Health Act (1905B), the Ryan White Act (Title SS V12617 b 3F), Title V Programs (1902) (i.e., California Children's Services (CCS), or Special Education Programs (1903.c). The chart below summarizes the eligibility requirements as well as documents needed for a Member to participate in HIPP.

Eligibility and Documentation Requirements for HIPP

Eligibility Requirements	Documentation Requirements
The applicant is CURRENTLY on full-scope Medi-Cal	A completed & signed Health Insurance Questionnaire (HIQ/DHS 6155)
The applicant is a resident of Ventura County	A completed and signed HIPP Application (DHS 6172)
The applicant's Share of Cost (SOC) is $500 or less per month	A copy of current insurance card & policy booklet
The applicant has a high cost medical condition	A signed and dated Provider's statement of diagnosis, prognosis & treatment plan
The average monthly savings to GCHP is at least twice the monthly premiums	A copy of the latest insurance premium payment notice or signed COBRA election form
The applicant's health coverage policy is not issued through the Calif. Major Risk Medical Insurance Board	Copies of the Explanation of Benefits (EOB) required from the insurance company detailing the medical costs of the last six months
The applicant's health coverage policy covers the high medical condition	A list of current medications including dosage and cost

Despite a Member's participation in HIPP, s/he will continue to receive medical benefits from GCHP. GCHP implements the HIPP by purchasing the health coverage for its Members only when the expected savings are at least double the amount of the premium cost. In addition, for GCHP to continue to pay the premiums, we must re-evaluate each case annually to determine if it remains cost effective; annual re-evaluation will also be performed for patients who have organ transplants or AIDS.

The chart below summarizes our responsibilities vs. those of the specific county of residence when a GCHP Member participates in HIPP.

HIPP Responsibilities – GCHP vs. Ventura County

GCHP RESPONSIBILITIES	COUNTY RESPONSIBILITIES
Review and process the GIQ/DHS 6155 and DHS 6172 forms Notify the beneficiary of GCHP's decision to approve or deny HIPP participation	Identify Medi-Cal applicants/beneficiaries potentially eligible for the HIPP program Issue a HIQ/DHS 6155 to all beneficiaries
Establish a beneficiary case and tickler file for re-evaluation to be conducted annually	Complete the HIQ/DHS 6155 accurately and legibly, including: beneficiary's name/address, social security number, beneficiary's phone number and diagnosis
Initiate premium payments to the insurance carrier, employer, or beneficiary	Notify HIPP of any changes to the beneficiary's OHC Provide and assist applicant/beneficiary with HIPP application

Vision Services

GCHP contracts with local community Optometrists to provide limited vision services to Medi-Cal Members.

On July 1, 2009 the State excluded optometry services from coverage for adults under the Medi-Cal program. Effective July 26, 2010, California reinstated optometry services as a Medi-Cal covered benefit for Members 21 years of age or older. This benefit is limited for adults in that it only includes routine eye examinations, office visits, and certain diagnostic, ancillary and supplemental procedures used for the evaluation of the visual system. Services relating to the supply, replacement or repair of eyeglasses and other eye appliances will remain non-covered benefits for adult Members.

Medi-Cal will only pay for eyeglasses, contact lenses or other things to help people see better for only the following people:

- Pregnant women; and only if the doctor says that not having eyeglasses will be harmful to the baby or pregnancy; or
- Children or people less than 21 years old who have full scope Medi-Cal; or
- People who live in a nursing home

Services of new eyeglasses or to fix old glasses every two years will continue to be available for Members under 21years of age.

The eye examination, eyeglasses prescription and basic low-cost frames will be provided by the GCHP Contracted Optometrist but lenses must be provided by the Prison Industries Authority (PIA) under contract to the DHCS. For more information about this benefit contact the State at **1-916-552-9539** or go to the website at **http://www.dhcs.ca.gov** or **http://www.medi-cal.ca.gov**. Or you may call our Customer Service Department at **1-888-301-1228**.

Routine vision care services for GCHP Members are managed by VSP. Please call VSP for information on Participating Optometrists, benefits and details of coverage. The VSP Customer Service Number is **1-800-877-7195**.

For information on becoming a Participating Provider with VSP for Gold Coast Health Plan, please call the VSP Provider Network Department at **1-800-852-7600 extension 5339**.

Carved-Out Services Not Administered by GCHP

Certain medical or allied-health services are covered benefits but are not administered by GCHP. GCHP is not responsible for authorizing or providing those services; rather, they are covered directly by the State Medi-Cal program. These are referred to as "Carved-Out Benefits." Following is a list of these benefits which are administered by and billed directly to the State Medi-Cal program:

- Dental services: Please call Denti-Cal at **1-800- 322-6384** for assistance in locating a Medi-Cal dentist or to obtain prior authorization for service.
- Mental Health: Short-Doyle/Medi-Cal mental-health services (inpatient or outpatient).
- Providers are required to provide assistance to Medi-Cal Members needing specialty mental-health services by referring them to the appropriate local Medi-Cal mental-health plan. Additionally, Providers should coordinate services with the Medi-Cal Member's mental-health provider, as appropriate. Please contact the Ventura County Behavioral Health Department, STAR Program and/or Crisis Team at **1-866-998-2243** for referral information.
- Alcohol and drug treatment program services (including outpatient heroin detoxification).
- Laboratory services provided under the State serum alpha-fetoprotein testing program administered by the Genetic Disease Branch of the Department of Health Care Services.
- Targeted Case Management Services as specified in Title 22 CCR Section 51351.
- Services rendered in a State or Federal hospital.
- Home and community-based waivered services (e.g., In Home Operations, HIV/AIDS Home and Community Based Services Waiver, Multipurpose Senior Services, Community Based Adult Services). California Children's Services (CCS). Providers must identify and refer Members with CCS- eligible medical conditions to the local CCS Program for authorization of such services. The GCHP-CCS Liaison Case Manager will guide you through the CCS referral process. Please call GCHP's CCS Liaison Care Manager at **1-888-301-1228**. The number for CCS in Ventura County is **805-981-5281**.
- Early Start Program for early intervention and Medically Necessary diagnostic and therapeutic services provided to infants and children aged 0-36 months that have disabilities.
- Members with developmental disabilities who shall be referred to the appropriate agency, such as the Local Education Agencies (LEA).

For details about any of the above mentioned programs you may call our Customer Service Department at **1-888-301-1228** to obtain current referral or contact information.

Audiology

Audiology evaluations (hearing tests) are a limited benefit. This service is covered only for the following members:

- Pregnant women (only if part of pregnancy-related care)
- Members residing in a licensed nursing home such as a Skilled Nursing Facility (SNF), intermediate developmentally disabled (ICF-DD), or Sub Acute Facility
- Children/young adults 20 years old and younger receiving full scope Medi-Cal (Children/young adults 20 years old and younger with suspected hearing loss of 30 db or greater should be referred to CCS)

Hearing aids are a covered benefit

To obtain this benefit, the following steps need to be completed. Members who qualify for audiology coverage under Medi-Cal:

- Referral by PCP to an Otolaryngologist
- Referral for hearing aid evaluation from Otolaryngologist
- Evaluation by an audiologist with results forwarded back to the Otolaryngologist
- Hearing Aid dispenser obtains prior authorization from GCHP for hearing aid by documenting Otolaryngology prescription and qualifying audiology exam

Members who do not qualify for audiology services under Medi-Cal:

- Referral by the PCP to an Otolaryngologist
- Referral for audiology evaluation from Otolaryngologist
- Evaluation by an audiologist (at member's expense) with results forwarded back to the Otolaryngologist
- Hearing Aid dispenser obtains prior authorization from GCHP for hearing aid by documenting Otolaryngology prescription and qualifying audiology exam.

Audiology results must include:

- Pure tone air conduction threshold and bone conduction test of each ear
- Speech tests (aided and unaided)
- Speech Reception Threshold (SRT)

Section 5: Medi-Cal Eligibility

Categories of Medi-Cal Eligibility: Aid Codes

GCHP does not make the determination of eligibility. The responsibility for determination of Medi-Cal eligibility resides with the State of California and the Ventura County Human Services Agency. There are more than 160 categories of Medi-Cal eligibility, also known as aid codes. These aid codes are assigned by eligibility staff at Ventura County Human Services Agency, based on the Federal and State guidelines for eligibility.

The Medi-Cal aid code is the two-digit number or combination of alpha and numeric characters that indicates the specific Medi-Cal program category under which the individual qualifies. The Aid Code can be found at the Medi-Cal eligibility website. The aid codes for GCHP Members can be found when checking eligibility at the GCHP Provider Web Portal. The GCHP ID card does not provide the Member aid code.

Any requests related to eligibility aid codes not covered by GCHP should be directed to the Medi-Cal field office at **1-888-472-4463** or the Ventura County Human Services Agency at **1-866-904-9362**.

Types of Medi-Cal: Levels of Benefits

Medi-Cal is California's version of the Federal Medicaid program. With a combination of Federal and State funding, Medi-Cal provides healthcare coverage to low-income families/children, and elderly and disabled individuals who meet certain income and asset thresholds. Medi-Cal offers three basic levels of benefits — *full scope, limited scope, special programs* — and one additional type of eligibility called *share of cost (SOC)*.

Full-Scope Medi-Cal

The majority of GCHP Medi-Cal beneficiaries are eligible for full scope Medi-Cal, which provides coverage for the full range of Medi-Cal covered services. A person may be eligible for full scope Medi-Cal with or without a share of cost. There are a few full-scope aid-codes that are also under fee-for-service Medi-Cal, such as the Child Health and Disability Prevention (CHDP) aid-codes.

Limited-Scope or Restricted Medi-Cal

Limited-scope or restricted Medi-Cal provides coverage only for emergency, pregnancy and long-term care services. An individual may be eligible for limited-scope Medi-Cal with or without a share of cost. GCHP currently covers only a few limited-scope aid-codes. Most other limited-scope aid-codes are under fee-for-service Medi-Cal administered directly by the state.

Special Programs

Medi-Cal also has aid-codes that provide a limited scope of coverage. These special-program aid-codes include Tuberculosis (TB) services, pregnancy-only services, and minor-consent services.

Share of Cost

A share of cost (SOC) is the amount that the individual or family is required to pay out of pocket for medical expenses before becoming eligible for Medi-Cal benefits during that month. It is comparable to a commercial health insurance plan payment referred to as a "deductible." For example, if a person has an SOC of $150, s/he must pay that amount out of pocket on medical expenses before you may bill Medi-Cal for any services rendered that month that are in excess of the Member's SOC. An SOC is a monthly obligation — it must be met each month in order for the individual to be covered by Medi-Cal that month. SOC Medi-Cal recipients do not become GCHP Members until they have met their SOC for that month.

Once they meet their SOC, they become Administrative Members of GCHP and may receive care from any willing Medi-Cal provider in GCHP's service area.

Providers can post monies paid for services toward a Member's SOC via the Medi-Cal Point of Service (POS) system SOC amounts should be posted on the date the Member paid for the service). Call the POS/ Internet Help Desk toll-free at **1-800-541-5555** for assistance with installing the equipment and executing the connectivity test transaction. Please do not contact GCHP for assistance with posting a Member's SOC.

Administrative vs. Regular Member

A "Regular" Member or "full scope" Member of GCHP is an individual who has selected or is assigned to a PCP. An "Administrative Member" is a Member who is not assigned to a specific Provider or clinic and, therefore, may see any willing Medi-Cal provider. Administrative Members will have "Administrative Member" listed on their GCHP ID cards in the PCP section, rather than the name of a doctor or clinic. An unknown portion of GCHP Medi-Cal Members will be Administrative Members and they are subject to change based on eligibility for services in specific aid categories. Categories of Administrative Members include:

- Some Breast and Cervical Cancer Treatment Programs (BCCTP) eligibles. Note: The following aid codes provide the member with BCCTP coverage and full scope Medi-Cal coverage OW, ON, OP, and OM. The GCHP membership Id card will designate them as Administrative Members; however they do have FULL coverage under Medi-Cal for all services not related to their breast or cervical cancer diagnosis. Share of Cost — Some Medi-Cal Members must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This dollar amount is called Share of Cost (SOC). The SOC is similar to a private insurance plan's out-of-pocket deductible.
- Long-Term Care — A Member who is residing in a skilled or intermediate-care nursing facility (LTC or Long-Term Care facility) for more than 30 days after the month of admission.
- Out of Area — A Member who resides out of GCHP's service area but whose Medi-Cal case remains in Ventura County. These may include out-of-area foster care or adoption assistance placements and Long-Term Care placements.
- Newly Eligible — A Member in the first month of eligibility as a GCHP Member who may see any willing Medi-Cal provider within GCHP's service area until they have chosen or been assigned to a PCP.
- Other Health Coverage (OHC) — A Member who has other health insurance that is primary to their Medi-Cal; this includes Members with both Medi-Cal and Medicare Part B (also called "Dual Eligibles"), as well as Members with both Medi-Cal and commercial insurance. GCHP Members with other health coverage (Administrative Members) must access care through their primary insurance and are not required to select a GCHP Primary Care Provider. Please remember that Medi-Cal is the payer of last resort and only pays after all other avenues have been attempted. Coordination of benefits will be calculated using the Medi-Cal fee schedule as the provider's maximum reimbursement.

The change of a Member's status from Regular to Administrative or vice-versa is not automatic. If the Member's eligibility status should be changed, contact the Member's eligibility worker to discuss the circumstances. The Member's eligibility worker is responsible for coordinating the process of changing the Member's eligibility not GCHP.

Claims for services rendered to Administrative Members are sent to GCHP unless the Member is also in the California Children's Services (CCS) program and the claim is for CCS-related care, in which case the claim should first be forwarded to the CCS office. If the Member has other health coverage, then the claim should be sent to the primary payer. All Covered Services that GCHP is responsible for that are provided to eligible Administrative Members are reimbursed by GCHP on a fee-for-service basis based on the state fee schedule as of the effective dates of service.

Eligibility, Enrollment and Member ID Cards

Individuals and families apply for Medi-Cal through the Ventura County Human Services Agency. Elderly and disabled individuals who receive Supplemental Security Income (SSI) automatically receive Medi-Cal along with their SSI benefit.

Eligibility for Medi-Cal is month to month. Most Medi-Cal recipients must re-certify their eligibility every 12 months. It is not uncommon for individuals or families to lose Medi-Cal eligibility and then regain it at a later date. Eligibility for Medi-Cal can also be effective retroactively in some cases. Please note that a Member's eligibility must be verified before delivery of services — and that the GCHP identification card alone is not a guarantee of eligibility.

Selection of a Primary Care Provider

The following outlines the major elements of the selection process for Members who are eligible as Full-scope or Managed Care Members:

- Selection of a PCP upon enrollment
- New Members receive an enrollment package containing a Primary Care Provider Directory
- Members must complete the PCP Selection Form indicating their choice of PCP, and return it to GCHP
- If GCHP receives a Member's PCP Selection Form prior to the first calendar day of the month, the Member will be enrolled with their PCP on the first calendar day of the immediate next month
- If a Member does not choose a PCP, GCHP will auto-assign the Member to a PCP based on a predetermined algorithm
- A Member may change his/her PCP for any reason but not more frequent than every 30 days. The change will be effective the first day of the following month after receipt of the change request
- Members may request to change their PCP by contacting GCHP
- Members may choose any of the doctors or clinics listed in the GCHP Primary Provider Directory as their PCP. If the PCP is not open to new Members, GCHP will ask the Member to choose another PCP

How to Verify Eligibility

To check Member eligibility on-line, you will be required to register at the Provider Web Portal. When you visit the Provider Portal at our web site, you will find the Web Portal link and will be guided through the registration process by using the Web Portal User Guide. A link to the State Medi-Cal web site is also accessible on our web site in case you need to verify fee- for-service Medi-Cal status.

The online and automated eligibility systems will provide you with the following information:

- Member PCP
- Member is an Administrative or Regular Member.
- Member's eligibility for CCS eligibility (if applicable)

Other ways to verify eligibility are:

- Call the GCHP Customer Services Department at **1-888-301-1228** (Mon-Fri, 8 am to 6 pm). Eligibility can be verified for a maximum of 3 Members at a time

When you telephone please provide all of the following:

- The Member's full name
- The Member's GCHP Member ID number
- If you do not have either of these, provide the Member's date of birth
- Date(s) of service for which you want to check eligibility

Please remember that **not all Medi-Cal beneficiaries will be GCHP Members**. If you cannot verify eligibility for a Medi-Cal Member through GCHP, swipe the BIC card or check the State Medi-Cal web site; results should tell you if your patient is eligible for State Medi-Cal. The state website is **https://www.medi-cal.ca.gov/Eligibility/Login.asp**.

Member Identification Card

The State of California issues a plastic Medi-Cal ID card known as the Benefits Identification Card, or "BIC". The BIC shows the Member's name, date of birth, 14-digit identification number, and the card issue date. Use this information to verify eligibility with the State. The Ventura County Human Services Agency may issue a temporary, emergency "paper card" when the Member cannot wait for the State-issued BIC.

The GCHP ID card is a blue and white card that identifies Medi-Cal recipients as GCHP Members and shows the Member's GCHP identification number which is comprised of the first 9-digits of the BIC; however, this ID card is *not a guarantee of eligibility or payment for services*. It is the responsibility of the Providers to verify eligibility before providing services. Examples of these ID cards are shown under Member Resources at **www.goldcoasthealthplan.org**.

Out of Area Medi-Cal Beneficiaries

Medi-Cal beneficiaries who become eligible for Medi-Cal benefits in a county other than Ventura, are not the responsibility of GCHP. Medi-Cal Providers who render services to these beneficiaries should submit claims to the State Medi-Cal Program or the appropriate Medi-Cal Managed Healthcare Plan.

When a Member moves out of the area, s/he must notify his/her Medi-Cal eligibility worker or, for those receiving Social Security Insurance (SSI), the Social Security Administration.

If you become aware of GCHP Members who have moved, or are planning a permanent move out of our service area, please contact our Member Services Department at **1-888-301-1228** and provide the out-of-area address so we may confirm that the Member has reported the move to his/her eligibility worker. The majority of GCHP Members who leave the service area will eventually become the financial responsibility of the new county of residence and cease to be GCHP Members. The timeframe in which to effect this change depends on several factors and can take from 1-2 months.

Circumstances in which residence or relocation out of our service areas will not result in a change of responsible county include placement of foster/adoptive children out of our service area; or other out-of-area placement of children or residents of Long Term Care facilities when there is a local conservator or guardian involved.

Benefits

For a complete summary of benefits for GCHP Medi-Cal Members, please refer to the Member Handbook at our website, **www.goldcoasthealthplan.org**. If assistance or clarification is required, please call the Customer Service Department at **1-888-301-1228**.

Section 6: Responsibilities of the Primary Care Provider

The Primary Care Provider (PCP) plays the central role in structuring care for GCHP Members. The PCP is the main provider of health care services, and is responsible for the delivery of health care to their assigned Members. The PCP is contractually obligated to provide GCHP with their office hours, staffing and any on-call or after hours coverage arrangements. Office hours and an emergency 24-hour number must be clearly displayed in the GCHP contracted Provider's office. The PCP is responsible for supervising, coordinating, and providing Primary Care Services to Members and for maintaining the continuity of care for the Members who select or are assigned to the Primary Care Provider. Primary Care Providers include general and family practitioners, internists, and pediatricians.

Access to Care

PCP responsibilities include but are not limited to, the following:

- Providing the full scope of quality primary care health services to GCHP Members who have chosen them as their PCP, including preventive, acute and chronic health care.
- PCP should ensure access to care twenty-four (24) hours per day, seven (7) days per week. The PCP office should have an adequate telephone system to handle the Member volume.
- PCP should ensure or facilitate patient access to the healthcare system and appropriate treatment interventions.
- PCP is responsible for arranging consultation with referral specialists. Including Initiating and coordinating referrals to Specialists or other GCHP participating providers as needed.
- PCP is responsible for follow up and monitoring of appropriate services and resources required to meet the needs of the assigned Member. Including identifying any clinical problems unique to your particular patient population.
- PCP is to assure that no unnecessary or duplicate medical services are being provided.
- PCP is to ensure that each GCHP patient chart includes member information needed to facilitate both appointment scheduling and patient recall. The information should include the member's Medi-Cal number, alternate numbers, language needs, and any special access needs.
- PCP is responsible for establishing a good medical-records system for tracking regularly scheduled routine appointments, failed scheduled appointments and for procedures needing completion prior to the patients next scheduled visit.
- PCP office should also develop a method for patient notification for preventive care.
- PCP office should give consideration to severity of medical condition when rescheduling of appointments for unforeseen circumstances, if possible patients should be "worked in".
- General office flow including accessibility to care at the site should be monitored by the staff. PCP office should also recognize any patient complaints or comments and take them into consideration when making changes to the access and availability of care.
- PCP will be responsible for ensuring backup coverage during the PCP's absence, including while the PCP is currently handling an emergency call at the hospital.
- PCP is to ensure that Members in your practice are not discriminated against in the delivery of services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.
- PCP shall consider special needs of GCHP members when scheduling appointments.
- PCP office should have recorded After-Hours directions for GCHP member's calling after hours, the members should be advised by a recorded outgoing message that if the situation is a true Medical Emergency then they should hang up and call 911 or go to the nearest Hospital. This message should be recorded in at least English and Spanish and possibly other languages if the provider has GCHP members that speak languages other than English and Spanish.

- PCP office with After-Hours answering service should contact the PCP or designated covering physician within 30 minutes for urgent questions. The PCP or designee is required to call the member back within 60 minutes for probable urgent problems and within 4 hours for probable non-urgent matters.
- The PCP is responsible for coordinating and directing appropriate, Medically Necessary services; risk assessment, treatment planning, including:

Routine Appointments

Primary non-emergent appointments should be available within 10 business days of request for an appointment. These visits are described as care appropriate at a primary care level for evaluation and treatment of non-acute problems for new or established patients.

Physical Examinations

Appointments for routine physical examinations should be available within six (6) weeks of request. If possible, special consideration should be given to GCHP members who require a physical examination as part of their employment.

Initial Health Assessment (IHA) and Individual Health Education Behavioral Assessment (IHEBA)

Medi-Cal requires that each PCP complete a comprehensive Initial Health Assessment (IHA) for all assigned Members **within 120 days** after the Member's enrollment, unless the PCP has determined that the Member's medical record is sufficiently current to enable an assessment of the individual's health status. At a minimum, an IHA consist of a comprehensive history and physical examination and the Individual Health Education Behavioral Assessment (IHEBA). Providers shall document that IHA was completed.

The IHA is to be included in the Member's Medical Record and available during subsequent health visits. Providers shall make repeated attempts to contact member and schedule an IHA. At least three documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member to schedule an IHA and IHEBA. Contact methods must include at least one telephone and one mail notification

Additionally, screening using the age-specific IHEBA - "Staying Healthy" Assessment (SHA) must be included in the IHA — this tool and related instructions can be found at **www.dhcs.ca.gov**.

- If the Staying Healthy Assessment is completed by the member, providers are shall explain the SHA's purpose and how it will be used by the PCP to the member.
- Provider shall offer SHA translation, interpretation, and accommodations for any disability if needed.
- Providers are to assure members that the SHA responses will be kept confidential in the member's medical record, and that the member has the right to skip any questions.
- If the member refuses to complete the SHA, provider shall document the refusal on the SHA and refer to the SHA instruction sheet for the Provider Office on documenting in the medical records. The SHA Provider Instructions may be fund on the Gold Coast Health Plan website.
- A parent/guardian must complete the SHA for children under 12.

Specialty Care

Specialty care will be provided by GCHP contracted providers within the Plan's service area whenever possible. If a medically necessary specialty service is unavailable with the plans service area, please contact GCHP staff to coordinate specialty care outside of the plan service area.

First Prenatal Visit

The first prenatal visit must be scheduled within two weeks of Member's request.

Preventive Care

As a PCP you are required to provide preventive healthcare according to nationally recognized criteria. If you need assistance with Preventive Care Guidelines for either children or adult patients, the GCHP prevention guidelines are based on the Center for Disease Control and Prevention recommendations and the US Preventive Services Task Force (USPSTF). To view the recommended immunization schedule for children, please go to (**http://www.cdc.gov/vaccines/recs/acip**, the American Academy of Pediatrics (**http://www.aap.org**), and the American Academy of Family Physicians (**http://www.aafp.org**). The recommended immunization timeline for adults can be found at: **http://www.cdc.gov/vaccines/recs/acip**.

24/7 Availability

GCHP will ensure that a Plan healthcare professional or a Contracting Physician will be available 24 hours per day, seven (7) days per week to coordinate the transfer of care of a Member whose emergency condition is stabilized, to authorize Medically Necessary post- stabilization services, and for general communication with hospital emergency room personnel.

Timely Member access to health care, delivered in an appropriate, cost effective setting, will be ensured through a monitoring process using acceptable performance standards. What follows is a brief description of the access standards for GHCP Medi-Cal Members:

Type of Care	Wait Time
Emergency Services	Immediately
Urgent Care	Within forty-eight (48) hours (No Preauthorization required)
Primary care	Within ten (10) business days of request for appointment
Specialty care	Within fifteen (15) business days of request for appointment
Telephone wait time	Within three to five (3-5) minutes whenever possible
Ancillary services for diagnosis or treatment	Within fifteen (15) business days of request for appointment
Initial Health Assessments (IHA) and Individual Health Education Behavioral Assessments (IHEBA)	Within one-hundred-twenty (120) calendar days after enrollment
Waiting time in office	Not to exceed forty-five (45) minutes after time of appointment
Sensitive services	Ensure confidentiality and ready access to sensitive services in a timely manner and without barriers – NO AUTHORIZATION REQUIRED

Medical Records

Each primary care office is responsible for maintaining adequate medical records of patient care. Records should be maintained in accordance with applicable State and Federal privacy laws. GCHP has the right to review your records for claims and service authorization. All medical records should be maintained in a manner consistent with professional practices and prevailing community standards. You are required to maintain records for seven years after termination of your Agreement with GCHP and for the period of time required by State and Federal law and Membership Contracts, including the period required by the Knox-Keene Health Care Service Plan Act and Regulations and Medicare and Medi-Cal programs.

Access to and Copies of Records

Our Health Services staff Quality or Compliance Departments may request records from your office for one of our covered Members for several reasons, including:

- Quality Improvement studies mandated by the State of California such as Healthcare Effectiveness Data and Information Set (HEDIS®) or Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Preauthorization requests
- Claims payments issues
- Assistance with case coordination
- Possible CCS referrals for CCS-eligible conditions
- Follow-up to a Member complaint

For complete details on provider responsibilities relative to medical records, please refer to your signed Service Agreement with Gold Coast Health Plan.

Reporting Encounter Data

Encounter Data are detailed data about individual services rendered by a provider contracted with a managed care entity. The level of detail about each service reported is similar to that of a standard claim form. (Encounter data for capitated providers where no claims payment is expected since services are prepaid are also sometimes referred to as “shadow claims” or “dummy claims.”)

Capitated providers are required by GCHP to submit claims for all of their services, even though they are “pre-paid” by capitation. Claims that have been pre-paid via capitation are considered “encounter data” in that the claim describes the details of patient encounters with the PCP. We require that you submit encounter data at least once a month, as it is critical for disease management programs and HEDIS studies. Most important, this data is used by the State to set future GCHP revenue which has a direct impact on our payments to Plan Providers.

PCPs may transmit encounter data via paper or electronically using the HIPAA compliant, Ansi 837 format, the detailed guidelines for which are made available at **www.wpc-edi.com/hipaa/HIPAA_40.asp**. If you would like to send this information electronically, please contact our Customer Call Center at **1-888-301-1228** for assistance and possible referral to our IT (information technology) vendor, ACS.

Confidentiality of Information

Providers are responsible for ensuring and maintaining the confidentiality of information about Members and their medical records, in accordance with applicable Federal and State laws. The names of any Member receiving public social services must be kept confidential and protected from unauthorized disclosure. This includes all information, records and data collected and maintained for the operation of the Agreement. Providers may not use any such information for any purpose other than carrying out the

terms of their Agreement. In compliance with the HIPAA regulations and the privacy rules for Protected Health Information (PHI), Members are entitled to an accounting of any disclosure of their confidential information.

PCP Request for Member Reassignment

Requesting Member reassignment should be the last resort for an untenable Patient/Provider relationship and it is a measure not taken lightly. Policies and procedures governing a PCP Request for Member Change of PCP:

a. A Provider's request to transfer the Member to another PCP requires the Plan's approval.
b. Such requests for transferring a Member to another PCP will be granted for the following reasons:
    1. Significant lack of cooperation, understanding and/or communication between doctor and patient. In such cases, the PCP and Plan will use their best efforts to provide the Member with the opportunity to be served by a PCP with whom a satisfactory Provider/patient relationship can be developed. If the Plan is unable to make such arrangements and the Member is in active care, the PCP will continue to serve the Member according to the PCP's best professional judgment until the Plan is able to change the Member's PCP, a period not to exceed two months.
    2. Requests to transfer a Member to another PCP due to the patient's medical condition resulting in high cost or frequent visits will not be granted.
    3. The PCP must notify our Member Services and Provider Relations Department in writing regarding the PCP's desire to disenroll a Member from their practice. Complete documentation regarding the nature of the problem must be included with the request. Requests to disenroll a Member will be considered based on criteria outlined in this Provider Manual.
    4. Requests will be reviewed and the PCP will be notified of the Plan's decision. Once the PCP has been notified of the disenrollment, it is expected that the PCP will notify the Member in writing regarding the PCP's decision to terminate the Member from their practice and that the PCP will no longer be responsible for the Member's medical care effective the date of the disenrollment. GCHP's Member Services Department will contact the patient to facilitate enrollment with a new PCP.
    5. Exceptions to this policy will be considered on a case by case basis.
    6. A Provider can cease providing care for a non-assigned Member when the Provider/patient relationship becomes unsatisfactory. In these cases, the Provider must notify the Member in writing that they will no longer provide care for the Member. The Provider should assist the Member in choosing another Provider and transfer appropriate office medical records to that Provider.
    7. A Specialist Provider can cease providing care for any Member when the Provider/patient relationship becomes unsatisfactory. In these cases, the Specialist Provider must notify both the PCP and the patient that they will no longer provide care to the patient. The PCP will refer the Member to another participating Specialist for care and treatment if specialist care is still Medically Necessary.

Member Requests for change of PCP will be reviewed by the Plan's Member Services Department.

Change of PCP requests from Members during active treatment requires special review by the Plan's Chief Medical Officer. Normally, such Member requests will not be granted until the treatment plan is completed. However, if the new PCP is willing to accept the transfer of the Member in active care, the request will generally be granted.

Non-Emergency Medical Transportation from PCP Office to Hospital

On occasion Members require admission to acute-care facilities directly from the PCP's office; in such cases we reimburse the costs of this transportation to the hospital; however we do not reimburse for transportation to other care sites, e.g., pharmacies, outpatient therapy, etc.

When a PCP determines that a Member requires immediate hospitalization from his or her office, the PCP may determine at his/her own medical discretion which is the most appropriate and safe mode of transportation.

Non-Emergency Medical Transportation (NEMT)

GCHP covers NEMT as specified in the California Code of Regulations, Title 22, Section 51323. Such transportation is approved when the Member has a medical condition that prevents him or her from traveling by another form of conveyance without jeopardizing the Member's health.

GCHP has contracted with Ventura Transit System (VTS) for NEMT services. NEMT will be authorized for the transfer of a Member from a hospital to another hospital or facility provided that the transport is Medically Necessary, and has been authorized in advance by VTS. VTS requires advance notice of 48 hours for routine NEMT requests. Urgent requests are considered on a case by case basis. Specifically, the following types of transport will be allowed:

The Member is being moved either to a higher or lower level of care (with the exception of mental-health patients moving from a higher to a lower level of mental healthcare).

The Member requires transportation from his/her home to a Medically Necessary medical appointment for services covered by GCHP.

VTS can be reached by calling: **1-855-628-RIDE (7433)**

Member Procedures/Rights for Emergency Care

- In the event of a true emergency, all providers should have a telephone prompt that says, "if this is an emergency please hang up and call 911."

In any emergency, in accordance with our Member Handbook, Members have a right to access care at any hospital or facility during and emergency medical condition. Once Member is post-stabilized, they will be moved to a contracted facility if Medically Necessary.

Section 7: Quality Improvement

Gold Coast Health Plan's mission is to improve the health and well-being of the people of Ventura County by providing access to high quality medical services. In line with that goal, Gold Coast Health Plan's Quality Improvement Program will strive to continuously improve the care and quality of service for its members in partnership with its contracted provider network. GCHP's quality program is centralized at the Plan under the Chief Medical Officer and is not delegated to any other entities.

The *scope* of the QI process encompasses the following:

1. Quality and safety of clinical care services including, but not limited to:
    - Preventive services
    - Chronic disease management
    - Prenatal care
    - Family planning services
    - Behavioral health care services
    - Medication Management
    - Coordination and Continuity of care
2. Quality of nonclinical services including, but not limited to:
    - Accessibility
    - Availability
    - Member satisfaction surveys
    - Grievance process
    - Cultural and Linguistic appropriateness
    - Availability
3. Patient safety initiatives including, but not limited to:
    - Facility site reviews
    - Credentialing of practitioners
    - Peer review
    - Sentinel event monitoring
    - Health Education
4. A QI focus which represents
    - All care settings
    - All types of services
    - All demographic groups

The *goal* of the QIP is to ensure the objective and systematic monitoring, evaluation and pursuit of opportunities to improve, and resolve identified problems.

GCHP's Quality Improvement Committee oversees the monitors established by GCHP's committees. Performance indicators are tracked to maintain a continuous focus on the Plan's operational and clinical priorities for improvement.

Quality Improvement Committee (QIC)

The QIC is responsible for the monitoring and enhancement of organization-wide quality improvement processes to ensure the delivery of quality customer service and access to high quality medical services. It is accountable to the Ventura County Medi-Cal Managed Care Commission.

QIC Objectives:

- Ensure quality committees have acc mess to timely information to ensure prompt implementation of quality improvement initiatives.
- Ensure QIC members can have a candid discussion about barriers to achieve quality goals and objectives, and to facilitate the removal of such barriers.

QIC Responsibilities:

- Recommend policy changes or implementation of new policies to GCHP's Administration and Commission.
- Ensure indicators established for monitoring Access, Care and Service and Quality Improvement Projects are appropriate and will lead to improvement
- Review quarterly committee reports regarding monitoring of health plan functions and activities. Suggest interventions or corrective actions to ensure follow-up when indicated.
- Oversee the development and annual review of the QIP, quality improvement activities (QIAs) and projects, Quality improvement Work Plan, and Work Plan Evaluation.
- Oversee the annual analysis and evaluation of the effectiveness of quality improvement activities, and achievement of Work Plan goals.

External Accountability Set (EAS) Performance Measures

The Department of Health Care Services (DHCS) selects a set of performance measures annually, referred to as the EAS, to evaluate the quality of care delivered by the Plan to their members. DHCS selects most EAS measures from the Healthcare Effectiveness Data Information Set (HEDIS®), which provides DHCS with a standardized method to objectively evaluate the Plan's delivery of services. Plans must annually collect and report rates for EAS measures. Providers will receive a request for medical records, electronically or hard copy, each year for this requirement.

Each Plan must calculate its rates for the required performance measures, and these rates will be confirmed by the External Quality Review Organization (EQRO) or its subcontractor and reported to DHCS. Each Plan must report to the EQRO the results for each of the performance measures required of that Plan while adhering to HEDIS® or other specifications for the reporting year. Plans must follow NCQA's timeline for collecting, calculating, and reporting rates. Plans must calculate and report HEDIS® rates at the county level, unless otherwise approved by DHCS.

DHCS will publicly report the audited results of HEDIS® or other performance measurements for each Plan, along with the Medi-Cal managed care program average and comparisons to national data for each DHCS-required performance measure. Plans must meet or exceed the DHCS-established "Minimum Performance Level" (MPL) for each required HEDIS® measure (excluding the utilization/"use of services" measures). DHCS establishes a "High Performance Level" (HPL) for each required performance measure and publicly acknowledges Plans that meet or exceed the HPLs.

GCHP must submit an improvement plan (IP) for each measure that does not meet the DHCS-established MPL or is given an audit result of "Not Reportable" (NR). The IP must include an analysis of barriers, targeted interventions, and relevant data to support its analysis. IPs must include new targeted interventions, justify including interventions from the prior year, include prioritization of barriers and interventions, and include a mechanism for evaluating interventions.

IPs must contain the signature of the MCP's Medical Director who approved the IP prior to submission to DHCS. GCHP must submit the required IPs within 60 days of being notified by DHCS of each measure for which an IP is required.

Quality Improvement Projects (QIP)

GCHP is required to conduct and/or participate in a minimum of two Quality Improvement Projects (QIP). One of the projects must be participation in the DHCS-led statewide collaborative (SWC) QIP and conduct an internal QIP. The Quality Improvement Committee reports on the status of the QIP's, usually quarterly. Plans must also report rates for the statewide collaborative.

For more information about our Quality Improvement System, please call our Quality Improvement Department at **1-888-301-1228** for referral to the appropriate resource.

Section 8: Care Management Program

CARE MANAGEMENT PROGRAM

The Gold Coast Health Plan Care Management Program is a collaborative process that includes the member, health care provider, family, and care manager.

Our mission is to empower high risk and potentially high risk members to gain control of their health care needs by coordinating quality health care services through an appropriate, cost- effective, and timely care management plan. The value of care management will be evidenced by best practices and quality outcomes that contribute to the optimal health, function, safety, and satisfaction of our members.

The Care Management (CM) Program function is ultimately under the direction of the Medical Director of Health Services who provides guidance for and is responsible for all clinical aspects of the CM program. Our Care Managers are licensed registered nurse professionals and licensed clinical social workers with specialty certifications specific to their role.

Care Management Process

The care management process is carried out telephonically. Every effort is made to reach the member to facilitate positive outcomes. This is done by following our guiding principles:

- Promoting adherence with physician-prescribed treatment plan.
- Building a trusting partnership with members through evidence-based intervention.
- Utilizing a comprehensive, holistic approach.
- Promoting member empowerment by providing education through evidence-based intervention, informed choice, and linkage to community resources.
- Promoting self-care management of chronic conditions through evidence-based care models.
- Integrating behavioral change science.

Types of Care Management

Non-complex Care Management is for members who require short term coordination of services and support. Interventions are goal-driven and time limited. Services are provided to members who require assistance and support due to an event or change in care that has caused disruption in an otherwise 'stable' situation; as opposed to having persistent, long- term, ongoing needs.

A few examples may include:

- Discharge from hospital to lower (or higher) level of care requiring support during the transition.
- New diagnosis/es that effect physical, emotional and mental health adjustment
- Significant health change that requires support, resource procurement and coordination of care during the adjustment.
- Coordination of primary and specialty care to improve adherence and/or access to necessary services
- Cultural or language barriers that prevent understanding and access to needed services

Complex Care Management can include members with multiple chronic illnesses, high utilization, medical conditions and complex social situations which can affect medical management or those that may require extensive use of resources.

A few examples may include:

- Medically fragile
- One or more severe conditions with co-morbidities not well managed
- Significant likelihood of exacerbations and ER visits/re-hospitalizations
- Pre and post-transplant
- Seniors and Persons with Disabilities (SPD)
- High Risk OB under 35 weeks
- Palliative care needs

Care Management Program Goals

- Consistently perform the activities of assessment, planning, facilitation, and advocacy for members throughout the continuum of care, consistent with accreditation standards and standards of practice.
- Collaborate and communicate with the physician, member/family, and other health care providers in the development and implementation of a care plan that is driven by the member's goals for health improvement.
- Accomplish the goals in the individual member's care plan.
- Provide members and their families with information and education that promotes self-care management.
- Educate and involve the member and family in the coordination of services.
- Assist members in optimizing use of available benefits.
- Improve member and provider satisfaction.
- Assure timely interventions that increase effectiveness and efficiency of care/services provided to the member.
- Promote effective utilization and monitoring of health care resources while ensuring that services arranged or coordinated are appropriate for the member.
- Promote the health, independence, and optimal functioning of members in the most proactive and effective way.

Referrals to GCHP Care Management

Care Management referral forms are available on the Gold Coast Health Plan website at **http://goldcoasthealthplan.org/media/12824/20130325_care_mngmt_referral_form.pdf**

Providers are encouraged to print the document, complete the information and fax the referral to **855-883-1552**.

Providers will be notified by a Care Manager within five (5) working days if the member meets program criteria for Care Management intervention

Section 9: Services Requiring Prior Authorization

Prior Authorization requests are reviewed by a Prior Authorization nurse according to predetermined criteria, protocols, and the medical information from the Physician or other Provider. In some cases, the nurse may need to contact the Provider directly to request additional information. Only licensed medical professionals employed by GCHP are able to make decisions about Preauthorization Requests. Only the Chief Medical Officer, Medical Director for Health Services or other physician reviewer have the authority to deny service authorization requests. Authorization decisions are based upon evidence-based GCHP policies as well as nationally recognized standards including:

- Milliman Care Guidelines
- United States Preventive Services Task Force (USPSTF)
- State of California Department of Health Care Services (DHCS)

Nationally recognized standards of practice from organizations, such as:

- American Academy of Family Physicians (AAFP)
- American College of Obstetricians and Gynecologists (ACOG)
- American College of Physicians (ACP)
- American College of Radiology (ACR)
- American College of Surgeons (ACS)
- American Diabetes Association (ADA)
- American Gastrointestinal Association (AGA)
- American Medical Association (AMA)
- American Urological Association (AUA)
- Centers for Disease Control (CDC)
- National Cancer Institute (NCI)

Members must obtain a referral from their PCP before scheduling an appointment with any other provider, except for the self-referral services described below under "Self-Referral." Pre- authorization requests must be submitted prior to provision of a service unless it is medically urgent or will result in an unnecessary extension of a hospital stay.

If, under exceptional circumstances, a request must be submitted after a service has been provided or initiated to a GCHP Member, it must be received by GCHP within 60 calendar days of initiation of the services or the request will be denied for non-timely submission. If the request is submitted for a Member who has obtained retroactive eligibility, it must be received by GCHP within 60 calendar days of the Member obtaining Medi-Cal eligibility or it will be denied for non- timely submission.

Medical Services Requiring Prior Authorization

Medical services or procedures that require ***Prior*** authorization include:

- Allergy desensitization treatment
- MRIs and CT scans
- Outpatient surgery
- Dermatology therapy
- Podiatric treatment
- Home Health services
- Physical, occupational and speech therapy
- Non-emergency hospitalizations, except for an obstetrical delivery
- Medical supplies and Durable Medical Equipment (DME)

- Requests for referral to an out-of-area provider/facility or a non-contracted provider/facility (referred to as "out-of-plan" or "non-par" to indicate a non-participating or non-contracted provider)
- Drugs or treatment interventions not included in our Formulary (or if the quantity requested is more than a 90-day supply for maintenance drugs, and a 30-day supply for all other agents)
- Two (2) ultrasounds **per pregnancy** are allowed **without** prior authorization. After that prior authorization is required demonstrating medical necessity.

You will find a more detailed list of services that require either a request for Direct Referral or Prior Authorization on the GCHP website: **www.goldcoasthealthplan.org**

Self-Referral: No Authorization Required

GCHP Medi-Cal Members may access certain services without a referral from a PCP, as long as the Provider they choose is a Member of the GCHP network and is within GCHP's service area for:

- Asthma education.
- Diabetes education.
- Other health education programs.
- Limited allied health services, such as occupational or speech therapy, and podiatry services (all allied health services are limited to two visits per month without PCP referral or prior authorization). *Pre Authorization required after two visits*.
- Female GCHP Members may self-refer to any willing OB/GYN specialty provider who is contracted with the Plan and is within GCHP's service area for routine well woman care.

Prior Authorization is not required for emergency services, urgent services or emergency hospital admissions.

Emergency admissions – While the admission for emergencies does not require prior approval, hospitals MUST notify Gold Coast Health Plan Health Services department within 24 hours or the next business day of the patient admission. All days will be reviewed for medical necessity.

Emergency Services are covered as necessary to enable stabilization or evaluation of an emergency medical condition. An emergency medical condition is a condition that manifests itself by acute symptoms of sufficient severity (including severe pain) 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:

- Serious jeopardy to the health of the individual or, in case of a pregnant woman, the health of the woman or her unborn child.
- Serious impairment to bodily functions.
- Serious dysfunction of a bodily organ or part.
- Death

For emergency hospital admissions and emergency room outpatient services, the hospital should verify the Member's status by telephoning our Eligibility Verification System or Eligibility Clerk at **1-888-301-1228**. While the admission for emergencies does not require prior approval, hospitals MUST notify Gold Coast Health Plan Health Services department within 24 hours or the next business day of the patient admission. All days will be reviewed for medical necessity

When a Member presents with an emergency condition at a hospital or other provider facility and is admitted for inpatient services, the hospital/treating provider should notify the PCP and GCHP within one working day of admission.

Administrative Members

Members with other healthcare coverage may self-refer to any "willing" in county Medi-Cal provider for covered benefits. In addition, authorization from GCHP is not required for Members with other health coverage including full scope. For members who exhaust their other coverage, GCHP must be notified to ensure ongoing coverage of services. In some cases a member's care may be transitioned to an in-network GCHP provider.

Family Planning and Sensitive Services: No Prior Authorization Required

GCHP Medi-Cal Members also may self-refer to any willing Medi-Cal Provider for family planning and sensitive services without prior-authorization.

Family planning services include birth control and pregnancy testing and counseling. Sensitive services include pregnancy testing and counseling, birth control, AIDS/HIV testing, sexually transmitted disease testing and treatment, and termination of pregnancy. These services are listed alphabetically below:

- Abortion (legal, unspecified, failed)
- Candidiasis/monilia
- Condyloma acuminatum
- Contraception and contraceptive management
- Diagnosis and treatment of STDs if medically indicated
- Dysplasia
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider.
- Genital herpes
- Health education and counseling necessary to make informed choices and understand contraceptive methods
- High-risk sexual behavior
- Inflammatory disease of uterus, except cervix
- Some Laboratory tests, if medically indicated as part of decision-making process for choice of contraceptive methods
- Limited history and physical examination
- Observation following alleged rape or seduction
- Pregnancy exam or test, pregnancy unconfirmed
- Provision of contraceptive pills/devices/supplies
- Rape examination
- Scabies
- Screening, testing and counseling of at-risk individuals for HIV and other STDs and referral for treatment Syphilis and other venereal diseases
- Termination of pregnancy
- Trichomonas
- Tubal ligation
- Essure
- Vasectomy
- Viral warts, both specified and unspecified

How to Submit a Request for Prior Authorization:

Electronically

Electronic submission is the preferred, most efficient way for providers to submit a request for Prior Authorization. This can be performed by using the Provider Web Portal. To do so, please first complete the registration process using your GCHP provider ID number.

- To register go to **www.goldcoasthealthplan.org** and visit the "Providers" section.
- At the menu, select Provider Web Portal and follow the instructions.
- The "Provider Portal User Guide" walks through the process, step by step.

Fax

- Complete the Preauthorization Request for Treatment Form
- Fax the form to GCHP at **1-855-883-1552**

Member Requests

When a Member requests a specific service, treatment, or referral to a Specialist, it is the PCP's responsibility to determine Medical Necessity. If the service requested is not medically indicated, discuss an alternative treatment plan with the Member or his/her representative.

Routine Pre-Service Requests

You must complete a Preauthorization Request before the service is performed. For routine pre-service requests, GCHP will usually make a determination ***within 5 business days*** from receipt of the request and appropriate documentation of Medical Necessity.

In certain circumstances, a decision may be deferred for up to 14 days when the Member or Provider requests an extension, or if the original request did not contain sufficient clinical information.

Decisions to approve requests will be made and communicated to the Provider by FAX ***within one business day*** of the decision; providers inform the Member about the decision.

Decisions to modify or deny will be communicated to the Member in writing ***within two business days*** of the decision; a copy will be sent to the Provider. When a request is concurrent with services being provided, GCHP will ensure that Medically Necessary care is not interrupted or discontinued until the Member's treating Provider has been notified of the decision and a care plan has been agreed upon by the treating Provider/PCP that is appropriate for the medical needs of the patient.

Expedited/Urgent Requests

In medically urgent situations, you may request an expedited review by calling our Customer Service Department at **1-888-301-1228**. Expedited Preauthorization Requests will be reviewed within three business days after receipt of the request when the Provider indicates that following a standard timeframe could seriously jeopardize the Member's life or health, or ability to attain, maintain or regain maximum function.

Out-of-Area and Out-of-Plan Referrals

The majority of the time, when a Member needs specialty care or procedures, the Member's PCP should refer the Member to a participating Provider available within the Ventura County service area. The PCP may refer the Member to a non-contracted provider ("non-par provider") within the service area only with Plan approval. Please refer to the next section, Specialist Referrals, for the appropriate process to refer Members to participating and non-participating Providers.

In general, the reasons for referring to a provider out of our service area or out-of-Plan are:

- The necessary procedure or service is not available through one of our in-area Network Providers.
- The expertise required for consultation is beyond what is available through our in-area Provider Network.
- The Member's medical needs are sufficiently complex to require service out of the area.

In the event of an urgent/emergent medical situation outside of the GCHP service area, the non contracted ("non par") provider or facility providing the service is required to contact us within one business day to confirm eligibility and service authorization.

All services requested will be reviewed for clinical appropriateness by a GCHP nurse, with final decisions made by the Medical Director and Health Services.

For more information on out-of-area or out-of-plan ("non par") referrals, please call our Health Services Department at **1-888-301-1228**.

Specialist Referrals

PCPs should use a Direct Referral Authorization Form (DRAF) when referring Members for specialty care to a contracted Provider ("par") within GCHP's service area. PCPs should use a PRFT when referring Members for specialty care to a provider outside of GCHP's Provider Network or Ventura County Service Area ("non-par"). Likewise, any subsequent referrals to another specialist must come from the Member's linked PCP. As with PRFTs, DRAFs are not required for Administrative Members.

Some examples of situations in which a Referral is required include:

- Outpatient hospital service.
- Laboratory and diagnostic testing (non-routine, out-of-network).
- Specialty consultation/treatment.
- All elective services.

Specialists need the medical information on the Referral to be as specific as possible. Care should be taken by the PCP in completing Referrals since what is authorized will determine the scope and duration of services and claims paid for these services. You and/or other referring Providers are responsible for verifying the list of par Providers for all Referrals to ensure that the referral is being made to an appropriate GCHP Network Provider. Referrals to non-contracted and/or out-of-network providers will only be authorized under compelling medical circumstances and/or when Medically Necessary services are not readily available within the GCHP Network.

The Referral Specialist is responsible to inform you, as a PCP, of the patient's status and proposed interventions throughout the course of treatment. You are responsible for maintaining the referral tracking system.

Unless otherwise specified, a standing referral will expire in 180 days; if indicated on the Referral, however, the authorization may be valid for up to one year, after which a new Referral is required.

Post-Service Authorization Requests

If it was not possible for the Provider to obtain authorization before providing a Medically Necessary service, we will respond to a post-service PRFT if we receive it within 60 calendar days of initiation of the service; if received later, the retrospective PRFT will be denied for non-timely submission. Please note that a post-service PRFT must be accompanied by documentation explaining why the authorization was not requested earlier. Our response will inform the Provider of the decision to approve, modify or deny the PA, including communication to the Provider and the Member or his/her designated representative.

While elective surgery requires Preauthorization, under exceptional medical circumstances we may provide authorization after the fact.

If a PRFT is submitted for a Member who has obtained retroactive Medi-Cal eligibility, it must be received by GCHP within 60 calendar days of the date on which the Member obtained Medi-Cal eligibility or it will be denied for non-timely submission.

Following are conditions whereby a PRFT may be submitted for post-service consideration:

- Member's Medi-Cal eligibility was delayed
- When "other health coverage" (OHC) will not pay the claim
- Wheelchair repairs exceeding $500.00
- When the patient fails to properly disclose Medi-Cal eligibility

For more information on timely submission of Preauthorization requests, please go to the Request for Authorization menu item at our website, **www.goldcoasthealthplan.org**.

Authorization Requests for Ancillary Services

Preauthorization is required for ancillary services such as home healthcare, medical supplies, rehabilitation services and DME. Ancillary services requiring Preauthorization include, but are not limited to, the following:

- Durable Medical Equipment (purchase or rental)
- Physical/occupational therapy
- Speech pathology and audiologic services
- Home Health Agency services
- Certain medical supplies
- Non-emergency medical transportation services

Hospital Inpatient Services

Admissions to an acute-care facility or Ambulatory Surgery Center for scheduled surgery require Preauthorization. All requests must be accompanied by the appropriate medical documentation including, but not limited to:

- Laboratory test results
- X-rays
- Medical records
- Other reports that have relevance to the planned admission (e.g., pre-operative history and physical examination report)

Emergency and urgent admissions do not require prior authorization. However, GCHP must be notified by the facility of emergency admissions within one business day.

Discharge planning is initiated upon admission to facilitate the transition of beneficiaries to the next phase of care. The discharge planning team is multi-disciplinary and consists of the treating Provider and hospital discharge planners.

Provider responsibility includes participation in coordinating Member discharge planning and referrals to appropriate post-discharge settings. GCHP staff will work with the hospital's discharge planning staff, as needed, in determining the most appropriate post-discharge setting.

Adherence to the following checklist for effective submission of a Preauthorization Request For Treatment form will assure the most timely decision:

- Please type the form — an illegible handwritten form may be returned to the Provider.
- Be sure to include your name, address, contact number and FAX number.
- Be sure to include Member's name, address, age, sex, date of birth, and identifying information such as the Member ID number.
- The Medi-Cal identification number must be correct. Refer to the Medi-Cal card if necessary.
- Enter into the appropriate box the description of the diagnosis and ICD-9 or CPT code with appropriate modifiers that most closely describe the Member's condition.
- Use the correct GCHP provider identification number. If the patient is hospitalized, the hospital name or provider number must be used.
- Attach documentation that supports the Medical Necessity of the request to the form (in addition to providing documentation required in the History/Medical Justification area).
- Be sure to sign and date the form (if required, it must be signed by the referring Provider).
- Submit a separate PRFT for each service request per Member; the PRFT will be given a unique number that is used to facilitate reimbursement.

Nursing Facilities

GCHP is responsible for Medi-Cal covered long-term care services. GCHP pays the facility daily rate of Members who need out-of-home placement in a long-term care facility due to their medical condition. Medi-Cal does not pay for assisted living or board and care facility services.

Nursing Facilities Include:

- Long Term Care Facilities (LTC)
- Skilled Nursing Facilities (SNF)
- Intermediate Care Facilities (ICF)
- Intermediate Care Facilities of the Developmentally Disabled (ICF/DD), Developmentally Disabled Habilitative (ICF/DDH) or Developmentally Disabled Nursing (ICF/DDN)
- Subacute Care Facilities

Nursing Facility Authorizations

It is Gold Coast Health Plan's responsibility to assist our nursing facility providers with instructions for the submission requirements of pre authorization requests. In order to expedite approvals and claims processing in a timely manner it is essential that the documents submitted are completed and legible. The admitting facility is required to submit medical justification and obtain authorization from GCHP within 5 business days of the member's arrival to the facility.

The physician referring the Member, or ordering the admission, will be responsible for providing the following information about the Member:

- Medications, diet, activities and medical treatments; wound care and labs
- Current history and physical
- Diagnosis/diagnoses
- The name of the physician who will be following the Member once he/she is admitted to the facility

Nursing Facility Admission notification

Nursing facilities must notify GCHP when GCHP members are in their respective facility. The notification must include those GCHP members with other health coverage. Your facility must complete a prior authorization request and submit it to the Gold Coast Health Plan Health Services Department. Remember that GCHP is the Medi-Cal provider and Medi-Cal is always the payer of last resort.

Monthly census notification process

GCHP will contact the participating nursing facilities on a monthly basis, in order to obtain an accurate census. Census documentation is required for all the GCHP members in nursing facilities; these should also include hospice members.

Other health coverage (OHC)

If a member has Other Health Coverage (OHC) and the skilled level of care is denied by the member's primary insurer, then GCHP will require a denial letter from the OHC. If the member has Medicare as their primary insurance then the nursing facility should notify GCHP on or before the 21st day of their stay.

Reauthorization request

A request for reauthorization should be submitted to GCHP prior to the expiration of a current authorization.

Long-Term Care

The following is required for a Long Term Care admission review:

1. Pre-authorization Treatment Request Form (PTRF). The Preauthorization Treatment form is available at **www.goldchoasthealthplan.org**, select "Providers", "Resources", "Request for Authorization" and lastly "Pre-Authorization Treatment Request Form. (This form is to be used for each admission and reauthorization).
2. Preadmission Screening/Preadmission Screening Resident Review (PAS/PASARR). The sections I through VII are required. The form is available at **www.medi-cal.ca.gov**, select "References", "Forms", and then "TAR Supplemental Forms".
3. Medicare or other health care insurance denial letter.
4. Minimum Data Set (MDS)
   - Version 3.0 Nursing Home Comprehensive (NC) Version 1.10.4 Effective 4/1/2012. (Admission)
   - Version 3.0 Nursing Home Quarterly (NQ) Version 1.10.4 Effective 4/1/2012. (Need for Authorization)
   - Include all the sections listed below:
     a. Identification, admission information
     b. Hearing, speech, vision
     c. Brief Interview for Mental Status (BIMS)
     d. Behavior: wandering, inappropriate behavior, refusing or rejecting care
     e. Functional status
     f. Bowel and bladder
     g. Active Diagnosis. On admission and as condition changes.
        Confirm Principal Diagnosis Code by checking; List of Unacceptable Diagnosis Codes, Manifestations Not Allowed as Principal Diagnosis and Questionable Admissions. Available from **www.goldcoasthealthplan.org**, select Providers, Resources, Provider Operations Bulletins, Provider Bulletin 2/26/2013. Section 10, there are 3 parts.
     h. Swallowing, nutrition, G-Tubes
     i. Skin ulcers, wounds, precautions
     j. Special treatments, oxygen, dialysis
5. Sufficient chart documentation to justify the level of care requested.

Short Term Skilled Nursing Care

The following is required for a Short Term Skilled Nursing admission review:

1. Pre-Authorization Treatment Request Form.
2. Physical Therapy, Occupational Therapy, and Speech Therapy clinical notes submitted every 2 weeks.
3. Sufficient chart documentation to justify level of care requested.

Intermediate Care

The following is required for an Intermediate Care nursing admission review:

1. Pre-authorization Treatment Request Form.
2. Certification from Tri-County Regional Health HS 231. Available from **www.medi-cal.ca.gov**, select "References", "Forms" and then "TAR Supplemental Forms".

Sub-Acute Level of Care

The following is required for a Sub-Acute level of care admission review:

1. Pre-authorization Treatment Request Form.
2. Preadmission Screening/Preadmission Screening Resident Review (PAS/PASARR).
3. Information for **Authorization/Reauthorization** of Sub Acute Services-Adult Sub Acute Program DHCS 6200 A.
   - Available at **www.medi-cal.ca.gov**, click on "References", "Forms", "TAR Supplemental Forms".
4. Sufficient chart documentation to justify level of care requested.

Hospice Care

The following is required for hospice care review:

1. Pre-authorization Treatment Request Form (PTRF).
2. Certificate of Terminal Illness. (Use the form adopted by your Hospice Agency or Referring MD).

Serious and Complex Medical Conditions

Providers should develop a written treatment plan for Members with complex and serious medical conditions. The plan must provide for a standing referral or extended referral to a Specialist, as appropriate. Regardless of the length of the standing referral, all Specialist Providers are required to send the PCP regular reports on the care and status of the patient.

The written treatment plan should indicate whether the patient will require:

- Continuing care from a Specialist or specialty care center over a prolonged period of time.
- Standing referral visits to the Specialists.
- Extended access to a Specialist because of a life threatening, degenerative or disabling condition involving coordination of care by a specialty care practitioner. (For extended specialty referrals, the requesting Provider should indicate the specific healthcare services to be managed by the Specialist vs. the requesting Provider.)

Standing Referrals to an HIV/AIDS Specialist

Patients with HIV or AIDS are designated as Administrative Members and are deemed as having "a condition or disease that requires specialized medical care over a prolonged period of time and is life threatening, degenerative, or disabling" — thus assuring that the Member has a standing referral to a specialty HIV/AIDS provider.

- To qualify as an HIV/AIDS Specialist, a Provider must have a valid license to practice medicine in the State of California and meet at least one of the following criteria:
  - Credentialed as an HIV Specialist by the American Academy of HIV Medicine.
  - Board certified, or earned a Certificate of Added Qualifications, in the field of HIV medicine granted by the American Board of Medical Specialties.
  - Board certified in the field of infectious diseases by the American Board of Medical Specialties and has, in the immediately preceding 12 months, both effectively managed the medical care for a minimum of 25 patients with HIV and successfully completed a minimum of 15 hours of Category 1 CME in the prevention of HIV infection, combined with experience in diagnosis, treatment, or both, of HIV-infected patients.
- In the immediately preceding 24 months, has effectively managed the medical care for a minimum of 20 patients infected with HIV and has completed any one of the following:
  - In the immediately preceding 12 months, has obtained Board certification or recertification in the field of infectious diseases from the American Board of Medical Specialties.
  - In the immediately preceding 12 months, has successfully completed a minimum of 30 hours of Category 1 CME in the prevention of HIV infection, combined with experience in diagnosis, treatment, or both, of HIV-infected patients.
  - In the immediately preceding 12 months, has successfully completed a minimum of 15 hours of Category 1 CME in the prevention of HIV infection, combined with experience in diagnosis, treatment, or both, of HIV-infected patients, and has successfully completed he HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

You will find a more detailed list of Medi-Cal services that require either a Referral or Prior Authorization at the end of this Provider Manual in Appendix 2.

Obtaining a Second Opinion

Members may request a second opinion about a recommended procedure or service. GCHP honors all requests for second opinions without the need for a Prior Authorization as long as the second Provider is within the GCHP Participating Provider Network and Ventura County Service Area.

Second opinions may be rendered only by a Provider qualified to review and treat the medical condition in question. Referrals to non-contracting medical providers or facilities may be approved only when the requested services are not available within the GCHP network. Second opinions should not be sought from providers affiliated with the same provider who rendered the first opinion.

If the Provider giving the second opinion recommends a treatment, diagnostic test, or service that is Medically Necessary and covered by GCHP, the PCP must provide or arrange for the service.

Status of Authorization Requests

Our Prior Authorization nurse coordinators will review PRFT forms for completeness and will help you with any aspect of the process, including answering questions regarding the status of PRFTs. Please call **1-888-301-1228** for assistance.

Deferrals and Denials

Decisions about requests for authorization may be deferred or denied. The most common reasons for such decisions are outlined in the chart below.

Deferrals occur when the request is forwarded to another agency, such as CCS, for review and possible coverage determination by the other agency. When a request is denied, a Notice of Action letter will be mailed to the Provider, requesting facility, and the Member no later than the second business day after the decision, with a copy sent to the Provider. If the denial is a result of insufficient information from the Provider, we will inform the Member that the case will be reopened when complete information is received. The denial letter will explain the reason for denial of the request and will provide information about the Member's right to appeal the decision. If you need clarification of the reason your request was denied, please call Customer Service at **1-888-301-1228**.

Assistance with Referral Consultation Requests

If you are unable to determine if a referral is required after reading this chapter, please call Customer Service at **1-888-301-1228**.

If the Member does not meet the criteria for Nursing Facility Care, if no PRFT form was ever submitted, or if the facility is unable to meet the Member's nursing needs, a denial notice will be sent to the Member, the PCP and the admitting Provider. The notification will include the process to appeal the denial decision.

Unless otherwise determined, the PCP and Member relationship continues during the limited Long-Term Care stay.

Section 10: Claims and Billing

How GCHP Claims are Paid

An objective of GCHP is to ensure timely and accurate claims processing. To that end, this section is intended to provide guidance to Provider Billing Offices for complete and precise medical claim filing. These guidelines do not, however, supersede any regulatory or contractual requirements published in legally binding documents or notices.

We strive to process all claims in a timely manner and respond courteously to all inquiries from Providers. We are contractually bound to process clean claims within 30 days of receipt of claim. All claims are processed daily on a first-in / first-out basis. Claim checks are generated and mailed weekly.

GCHP processes medical claims primarily per Medi-Cal guidelines, and utilizes key industry standard codes. Each claim is subject to a comprehensive series of edits and audits. All information is validated to determine if the claim should be paid, contested or denied.

Claims that fail an edit, or audit check, will pend for manual review by a claims examiner. Claims examiners cannot correct errors. Claims requiring medical review will be reviewed by a qualified medical professional in accordance with the California Code of Regulations (CCR), Title 22 and policies established by the Department of Health Care Services.

Refer to the Provider Web Portal at our website **www.goldcoasthealthplan.org** to view claim status and details online. For questions about a claim, please call Customer Service at **1-888-301-1228** between 8 am – 6 pm, Monday through Friday, except holidays. There are two methods for submitting a claim:

- Electronic Data Interchange (EDI)
- Paper or “hard copy”

Electronic Data Interchange (EDI)

GCHP strongly encourages electronic claims submission. Electronic claims submission is cost effective. Providers receive an electronic confirmation of claim submission. Electronic claim submission promotes effective utilization of staff resources.

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

If you use EDI, you must include:

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

You are strongly encouraged to include your unique National Provider Identifier (NPI) to speed up claims payment. Contact your vendor or billing service for instructions about how to ensure that the Plan Provider ID is coded as a Gold Coast Health Plan NPI.

You are also encouraged to include your unique NPI. Contact your vendor or billing service to determine how to submit.

If you are not currently submitting claims electronically and would like to learn more about EDI and how to get connected, please go to the GCHP website at **www.goldcoasthealthplan.org**. Visit the Providers Resources menu option for "Electronic Claims Submission." Refer to the instructions to learn how to register to become a Trading Partner. If you utilize the services of a clearinghouse to submit electronic claims on your behalf, please refer your clearinghouse to our website in order for them to register.

Paper Claim Submission

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

- Use the correct form type and be sure the form meets Centers for Medicare and Medicaid Services standards (see **http://www.cms.hhs.gov/**).
- Use black or blue ink; do not sue red ink, as the scanner may not be able to read it.
- Use the Remarks field for messages.
- Do not stamp or write over boxes on the claim form.
- Send the original claim form to us and retain the copy for your records.
- Separate each individual claim form. Do not staple original claims together, as we would consider the second claim an "attachment" and not an original claim to be processed separately.

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

Mail paper claims to GCHP using the following address to facilitate timely processing and payment:
ATTN: CLAIMS
Gold Coast Health Plan
PO Box 9152
Oxnard, CA 93031

Clinical Submission Categories

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

Claims involving pre-certification/prior authorization/pre-determination (or some other form of utilization review) including, but not limited to:

- Claims pending for lack of pre-certification or prior authorization
- Claims involving medical necessity or experimental/investigative determinations
- Claims for pharmaceuticals requiring prior authorization
- Claims involving certain modifiers
- Claims involving unlisted codes
- Claims for which we cannot determine from the face of the claim whether it involves a covered service. Thus the benefit determination cannot be made without reviewing medical records (including, but not limited to, pre-existing condition issues, emergency service and benefit exclusions.
- Claims that GCHP have reason to believe involve inappropriate (including fraudulent) billing
- Claims that are the subject of an audit (internal or external) including high-dollar claims

- Claims for individuals involved in a care management or disease management
- Claims that have been appealed (or that are otherwise the subject of a dispute, including claims being mediated, arbitrated, or litigated
- Other situations in which clinical information might routinely be requested
- Credentialing
- Coordination of benefits (COB)

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

GCHP cannot be responsible for claims never received. Providers must work with their vendors to ensure files are successfully submitted and proper follow up on paper submitted claims. Failure of a third party to submit a claim to GCHP may risk the provider's claim being denied for untimely filing if those claims are not successfully submitted during the filing limit.

Claims Processing

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

Claims entering the system are processed on a line-by-line basis, except for inpatient claims. Inpatient claims are processed on an entire claim basis. Each claim is subject to a comprehensive series of check points called "edits" The edits verify and validate all claim information to determine if the claim should be paid, denied, or suspended for manual review.

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

Claim Return for Additional Information

If a claim is returned to the provider for correction or additional information, we refer to this claim as a Mailback Form, which is our request for additional information from the provider that is necessary for us to process the claim. The provider has 90 days from the date on the information Request/Mailback to submit the corrected claim information to us. If the provider does not resubmit within this time frame, the claim is denied. Refer to timely filing section for information.

Claims Filing with Another Payor

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

Claims Payment

Upon receiving claims, we analyze the claims for covered services and the corresponding amount to be paid. We then generate a Remittance Advice (RA), summarizing services rendered and payor action taken, and send the appropriate payment amount to the provider.

Providers should receive a response from us within 30 business days of the Plan's receipt of a clean claim.

If the claim contains all required information, we enter the claim into our Claims Processing System and send the Provider an RA at the time the claim is finalized.

CHDP Claims Submission

All encounters and claims for CHDP should be submitted to GCHP using the American Medical Association (AMA) Current Procedural Terminology (CPT) codes along with the PM-160 Information Only form for appropriate reporting to the State.

The following Preventive CPT codes when utilized for CHDP are to be billed with an EP modifier:

New Patient	
99381	Initial Evaluation and Management of Healthy Individual < 1yr of age
99382	Early Childhood – age 1 to 4 years
99383	Late Childhood – age 5 to 11 years
99384	Adolescent – age 12 to 17 years
99385	18- 39 years (up to age 21 years)

Established Patient	
99391	Periodic Re-evaluation and management of Healthy Individual < 1 yr of age
99392	Early Childhood – age 1 to 4 years
99393	Late Childhood – age 5 to 11 years
99394	Adolescent – age 12 to 17 years
99395	18- 39 years (up to age 21 years)

Claims Forms by FAX

Gold Coast Health Plan is unable to accept or process claims submitted by FAX. Please use either the Electronic Claims submission as indicated above or submit claims to us via mail to the P.O. Box identified above.

Pharmacy Claims

ScriptCare is the Pharmacy Benefits Manager (PBM) contracted by GCHP for processing and paying pharmacy claims billed with NDC numbers. Please do not submit pharmacy claims to Gold Coast Health Plan.

Claim Forms Used by Different Types of Providers*

Claim Form	Type of Provider	Services Billed on this Form
CMS-1500	PCPs	All professional services
CMS-1500	Referral Specialists	All professional services
CMS-1500	Clinics	All professional services
CMS-1500	Pharmacies	Pharmacies may also use this for DME, medical supplies, incontinence supplies, orthotics and prosthetics.
CMS-1500	Medical Laboratories	All Covered Services not requiring PA
CMS-1500	Allied Health Practitioners	All Covered Services delivered by Allied Health Care Professionals
PM-160	PCPs	Child Health & Disability Program (CHDP) services only-and only for Medi-Cal Members
UB-04	Hospitals/Clinics/SNF	All professional or facility services
CMS-1500	Imaging Centers	Professional Xray & related services
25-1C	SNF's	All SNF/LTC services

* ***All claims should be submitted no later than 180 days from Date of Service, with the exception of another carrier. If there is another carrier involved (i.e., Medicare, commercial health insurance, etc.) then the claim must first be submitted to the other carrier since Medi-Cal is never primary. Once the primary carrier has adjudicated the claim, the provider may then submit the primary carrier's Explanation of Benefits form ("EOB") to Gold Coast Health Plan with its claim within 180 days of the primary carrier's EOB. The Plan will then consider the claim as the secondary carrier and will pay the claim as appropriate up to the maximum Medi-Cal maximum allowable payment amount.***

Section 11: Coordination of Benefits

Some GCHP Members have other health coverage (OHC) in addition to their GCHP coverage. Specific rules govern how benefits must be coordinated in these cases. State and Federal laws require that all available health coverage be exhausted before billing Medi-Cal. Thus, when a Medi-Cal Member has other health coverage (OHC), GCHP becomes the secondary payer, with Medi-Cal always the payer of last resort.

Other health coverage includes any non Medi-Cal health coverage that provides or pays for healthcare services. This can include but is not limited to:

- Commercial health insurance plans (individual and group policies).
- Prepaid health plans.
- Health Maintenance Organizations (HMOs).
- Employee benefit plans.
- Union plans.
- Tri-Care, Champus VA.
- Medicare, including Medicare Part D plans, Medicare supplemental plans and Medicare Advantage (Preferred Provider Organization PPO, HMO, and fee-for-service) plans.

When a GCHP Medi-Cal Member also has another primary Medical insurance, or Other Health Coverage OHC, s/he must treat the other insurance plan as the primary insurance company and access services under that company's rules of coverage. For example, if the other coverage is a PPO plan with a closed panel, the Member must see a provider within the PPO network. If it is an HMO or a Medicare Advantage plan, the Member must receive services from his or her provider under that plan. Any referrals or prior authorizations required by the primary insurance must be obtained before providing services.

If the Member has an HMO as his/her primary insurance, and the HMO requires a referral in order for a Member to see a specialist or other provider, the referral will need to come from the Member's PCP in the primary insurance plan. If a Member is eligible for the California Children's Services (CCS) Program, please contact CCS for a referral. If a Member with other health coverage needs services that require prior authorization, the provider must obtain the authorization from the *primary insurance* company.

GCHP/Medi-Cal is not liable for the cost of services for Members with other health coverage who do not obtain the services in accordance with the rules of their primary insurance. If a Member elects to seek services outside of the framework of his or her primary insurance, the Member is responsible for the cost.

Dual Coverage by Medicare and Medi-Cal (Medi/Medi)

GCHP does not currently have electronic data exchange with Medicare to receive automated claims information. To submit Medi-Medi claims, please use the following procedures:

- Send a hardcopy copy or an original Medicare claim. Confirm that your National Provider Identifier (NPI) number is on the claim and the appropriate Medi-Cal procedure codes and modifiers are present. You may bill us in the same manner as you billed Medicare, using the same procedure codes and modifiers. While place-of-service codes may be either Medicare or Medi-Cal codes, it is essential that a code be given to indicate the place of service.
- Attach a hardcopy of the Medicare explanation of benefits. The dates and procedures must match those on the claim submitted to GCHP. Please draw a line through all other patient names and identifying numbers.

GCHP is responsible for the processing and coordination of Medi-Medi claims. Do not send claims to the State for coordination; they will be denied.

Exceptions to the six-month billing limit can be made with Medi-Medi claims based on the date of the Medicare EOB. You have six-months from the date of the Medicare EOB to submit (crossover) the claim to GCHP.

The exceptions to this are the copayments a dual eligible Member would have for his/her Medicare Part D drug plan. As mentioned earlier, you must bill the primary insurance first and then bill GCHP, including an EOB issued by the primary carrier with your claim.

You will not receive additional reimbursement for crossover patients on your case-management list if the service billed is one of the capitated procedures — even for deductible amounts resulting in no payment from Medicare. (The deductible is reflected in the monthly capitation payment for these Members.)

If Medicare covers the service and GCHP does not pay as prime, procedures which normally require prior authorization by GCHP will not require it (with the exception of pharmacy services).

Medicare/Medi-Cal (Medi/Medi) Crossover Claim Process

Medi-Cal or GCHP pays a Medicare/Medi-Cal Crossover Claim according to the Welfare and Institutions Code limits, will not exceed the Medicare co-insurance or deductible amounts or the maximum Medi-Cal allowable. GCHP will pay for co-insurance and/or deductible amounts as if all Medi-Medi members were Quality Medicare Beneficiary (QMB) qualified.

For example (1), you file a claim for $70.00. The Medi-Cal allowable amount is $32.90. Medicare's allowable is $62.00 and made a payment of $55.00, leaving a beneficiary co-insurance amount of $7.00. The Medi-Cal payment from GCHP on this claim would be $7.00, not the denial that Medicare payment exceeded Medi-Cal's allowable.

Share of Cost (SOC)

Patients with SOC are not eligible for Medi-Cal benefits coverage until they meet their SOC for the month of service. The Share of Cost is comparable to a commercial health insurance "deductible" in that the carrier does not pay until the deductible is met.

The Provider should ask for or accept obligation from the patient for his/her Medi-Cal share of cost. Remember that when Medi-Cal pays for any portion of the service, the total reimbursement received for the service may not exceed the Medi-Cal maximum allowable amount.

Examples of two SOC scenarios for a patient with dual coverage are presented in the chart below.

Examples of Share of Cost: Medi-Cal + Medicare

EXAMPLE A	EXAMPLE B
Provider's Charges = $250.00	Provider's Charges = $250.00
Medicare Allows $200.00	Medicare Allows $200.00
Medicare Pays (80% allowed of $200.00 = $160.00	Medicare Pays (80% allowed of $200.00 = $160.00
Medicare Allowable $180.00 Difference = $20.00	Medicare Allowable $190.00 Difference = $30.00
Share of Cost = $25.00 Medi-Cal would pay $0.00	Share of Cost = $25.00 Medi-Cal would pay $5.00

GCHP Members with Veterans Benefits

If the GCHP Member is a Veteran and is eligible for VA Healthcare benefits, s/he may choose to use VA services (hospitals, outpatient and other government clinics). A description of these services offered to Veterans can be found at this website:
www.va.gov/healtheligibility/coveredservices/StandardBenefits.asp.

Members with VA benefits may use their own discretion in choosing whether to receive their care through the VA system or GCHP — we cannot require or request that they do so; but, if the Member wishes, we will facilitate and coordinate their care.

Section 12: Member Services

The Member Services Department supports Providers by helping Medi-Cal Members to:

- Choose or change their Primary Care Provider (PCP) which may be a clinic or physician.
- Understand how to access care within a managed-care health plan.
- Understand their benefits and how to access services.
- Communicate with and work with their doctors.
- Understand their rights and responsibilities as Members.
- Resolve problems or concerns they may have with a Provider or GCHP.

New Members receive a mailing, which includes:

- A Welcome letter and a form to select a Primary Care Provider from our Provider Directory which is included.
- A GCHP ID card will be issued after the member's first month of enrollment that will have the name of the member's PCP, along with a Member Handbook that serves as the state-required Evidence of Coverage brochure that explains how to use the Health Plan.
- An Administrative Member will receive a Welcome letter with their GCHP ID card along with a Member Handbook that serves as the state-required Evidence of Coverage brochure that explains how to use the Health Plan.

Member Services Representatives may call new Members personally to provide assistance to the Plan and to help them select a PCP in the event difficulties are encountered.

Members receive 3 newsletters per calendar year, which include articles on health education topics, service and benefit reminders, and information about how to use the health plan.

Member Services Staff

You may seek assistance and support in dealing with Member Service issues by calling our Member Services Department at 1**-888-301-1228**.

New Members have 30 days to choose a PCP, during which time they are able to access care from any willing Medi-Cal provider within GCHP's Ventura County Service Area. If a Member does not choose a PCP, we will assign one automatically based on the Member's street address, language preference, and other factors. Members may change their PCP by calling Member Services; the change will be effective the first of the following month. If a Member loses eligibility for Medi-Cal but returns as a Member within 6 months, s/he will remain linked to his/her previous PCP unless that Participating Provider is closed to new patients or no longer available.

Interpreter Services – Language Access Program Services

Gold Coast Health Plan adheres to federal and state guidelines that require health plans to ensure that limited English proficient (LEP), non-English-speaking or monolingual Medi-Cal beneficiaries have access to interpreters at all key points of medical points of service. Interpreter services are available on a 24-hour basis for medical encounters. Members are NOT required to bring an interpreter. Gold Coast Health Plan provides telephonic interpreter services for Members, please call Member Services at **1-888-301-1228** or the Health Education Department at **805-981-5367** for assistance with coordinating interpreter services.

Gold Coast Health Plan works with a vendor to provide telephonic interpreter services for spoken language. Please contact Member Services for assistance with telephonic interpreter services. GHCP provides face-to-face interpretation under special circumstances, please contact the Health Education Department at **805-981-5367** for assistance.

Gold Coast Health Plan complies with the American Disability Act to ensure that deaf and hard of hearing Members receive interpreter services. Gold Coast Health Plan has contracted with an agency to provide Sign Language interpretation for the deaf and hard of hearing Members for medical appointments.

How to Request Interpreter Services

- Provider(s) may call . Member Services at **1-888-301-1228** for assistance or may call directly to **LIFESIGNS at 1-888-930-7776**.
- For Emergency/Last minute request during business hours, please call the local area number at **1-323-550-4210** for **LIFESIGNS**.
- Please confirm Member's Medi-Cal eligibility before scheduling ASL interpreter.
- Request for an interpreter should be made, if possible, 5 to 7 working days in advance of any scheduled Member appointment. There is no guarantee that interpreter services are available if the required notice is not provided. Every effort will be made to secure an interpreter.
- Cancellation policy: Members and/or Providers must give advance notice prior to cancelling interpreter services.
- Cancellation for assignments lasting two hours or less will require 25 business-hour advance notice of cancellation. Cancellation for assignments lasting longer than two hours will require a 49-business hour advance notice for cancellation.
- "No Show" appointment – providers must call LIFESIGNS and inform them of any Member missing a scheduled appointment.

Please be sure to indicate the type of appointment; the name, address, and phone number of the Provider who will be seeing the Member; and the date and time of the medical appointment.

Cultural & Linguistic Services

Cultural issues are important in understanding health beliefs and practices. Health education materials and programs are designed to reflect the cultural diversity and the linguistic needs of our Members. Health education materials are assessed for their readability. Health literacy and cultural diversity are key factors to building a health community. Plan Providers who have Members that have Limited English Proficiency (LEP) and/or low health literacy may contact our health education office at **1-888-301-1228** for assistance and additional resources.

Section 13: Health Education and Disease Management Programs

Introduction

Gold Coast Health Plan (GCHP) Health Education Program is designed to ensure that all Members have access to health education services, health promotion programs and classes. GCHP will work collaboratively with local health agencies, clinics, hospitals, and primary care providers (PCPs) to provide quality health education classes and materials at no charge to all GCHP Members. Members may self-refer or be referred by the PCP or by GCHP's Health Educator. ***No prior authorization is necessary for Members to attend and participate in health education and health promotion activities.*** For more program details, Providers may call Customer Service at **1-888-301-1228** to reach GCHP Health Education Services.

Health Education Contract Requirements for Plan Providers

Providers must make available to Members health education programs and services at no charge. All health education activities must be documented in the Member's medical record.

Health Promotion & Disease-Prevention Programs

As a benefit of partnering with GCHP, we offer our Providers helpful information about health promotion and disease prevention programs. Providers can access our website to download health education materials and information about local health education activities.

Below is a sample of health education services available for Members. To obtain a complete listing, visit **www.goldcoasthealthplan.org** or call Customer Service at **1-888-301-1228** to reach our Health Education staff.

- **Asthma** – GCHP will work with local Providers, clinics, and hospitals to identify appropriate Asthma health education classes. GCHP will work with providers and local community agencies identifying asthma related information about self- management classes and/or support groups.
- **Diabetes Education** – GCHP will work with providers and local agencies in identifying diabetes self-management classes and support groups.
- **Weight Management & Physical Activity** – GCHP will collaborate with local public health agencies, community clinics, hospitals, and doctors to ensure that Plan Providers have information about local support groups, exercise and nutrition classes.
- **Breastfeeding Support** – GCHP and Ventura County Women, Infants and Children Nutrition Program (WIC) have entered into a Memorandum of Understanding (MOU) for the delivery of WIC program services to Members who are served by both parties. GCHP will work with Plan Providers on the benefits of breastfeeding during the first year and breastfeeding promotion and support groups available to women.
- **Smoking Cessation** – GCHP will collaborate with various agencies to promote smoking cessation classes throughout the county. For free smoking cessation classes, support groups and nicotine patches and gum, call GCHP Health Education services for more information or the California Smoker's Helpline.

  The California Smoker's Helpline offers information in a variety of languages:

English	**Spanish**
1-(800) NO-BUTTS	1-(800) 45 NO-FUME
1-(800) 662-8887	1-(800) 456-6386

Women's Health

Plan Providers may access the GCHP website to obtain additional information to help support women's efforts to stay healthy. Information and education about routine breast and cervical cancer screening exams can also be found on the GCHP website.

Health Promotion Materials

GCHP will continue to collaborate with local clinics and other agencies to promote support groups and classes to Members. Below is a list of additional health promotion, disease prevention topics GCHP Providers may access. Please contact GCHP Health Education staff for more details on how to obtain materials.

- AIDS/HIV Screening
- Asthma
- Breast Health
- Childhood Obesity
- Children's Health
- Diabetes
- Drug/Alcohol Use
- Family Planning
- High Blood Pressure
- High Cholesterol
- Immunization
- Men's Health
- Pregnancy
- Sexually Transmitted Disease (STD)
- Tobacco use prevention

Materials on Other Topics or In Different Languages

GCHP acknowledges the role that language barriers can play in reducing the quality of care to monolingual and Limited English Proficient (LEP) Members. Health Education Services will work with Plan Providers to ensure that (1) health promotion materials are available for distribution and (2) that equal access is provided for services to Members of all ethnic and cultural groups, Members with LEP and Members with hearing or speech impairment. Call Customer Service at **1-888-301-1228** to reach our Health Education staff.

Outreach to Members and Providers

GCHP also reaches out to Plan Providers and Members on a regular basis to encourage health maintenance, disease prevention, and a healthy lifestyle. Following are some of the tools we utilize in our outreach program:

- GCHP's Member newsletter.
- Health programs update in the periodic GCHP Provider Bulletin.
- Posting at the GCHP website **www.goldcoasthealthplan.org** with health education resources for both Providers and Members.
- Participation at numerous community events, health fairs and other health promotion activities.
- Collaboration with local agencies on outreach programs for breastfeeding, childhood obesity, diabetes, immunization, and other healthcare issues.

GCHP offers a Disease Management program to Members with diabetes, asthma and other chronic diseases. The ultimate goal is to improve the patients' current health status, achieve optimal health outcomes, and avoid future complications of chronic disease.

For additional information about GCHP Health Education services and Disease Management programs as well as calendar of events, please see our website at **www.goldcoasthealthplan.org**. As stated above, we have numerous agreements with other public agencies, and we are in constant communication with our participating hospitals, clinics and other providers which offer classes and instruction on a variety of healthcare topics throughout the community. GCHP posts appropriate website links for Providers to access any upcoming health promotion and disease prevention classes. You may also call our Health Education staff or Member Services at **1-888-301-1228** for current information and upcoming events.

Section 14: Pharmacy

Drug Formulary

GCHP has its own Drug Formulary, developed by our Pharmacy and Therapeutics ("P&T") Committee. Our formulary, which is not the same as the State formulary, is reviewed and updated periodically especially in light of rapid changes and advances in therapeutic treatment regimens and new pharmaceuticals coming on to the market. Please refer to the GCHP Formulary posted in the menu options under the Providers Portal at our website, **http://www.goldcoasthealthplan.org** to find out if a particular medication is listed. You may download a copy of the Formulary directly from the website.

Step Therapy Protocol

Members receiving a new prescription for a Step Therapy drug will be required to receive an alternative drug before the Step Therapy drug will be approved. The pharmacist will receive a message from the Script Care system when a prescription for a Step Therapy drug is presented along with the alternative drug(s). The pharmacist will contact the prescribing physician to obtain approval to dispense the alternative drug. If the alternative drug fails to produce the desired results within a specified time period, the Step Therapy drug will be approved and dispensed.

- Step Therapy is based upon current medical findings, FDA-approved manufacturer labeling information, and cost and manufacturer rebate arrangements.
- Alternative drugs and their corresponding Step Therapy drugs are FDA-approved and are used to treat the same conditions.
- If Medically Necessary, it is possible to obtain coverage for a Step Therapy drug without trying an alternative drug(s) first. The physician must request coverage for a Step Therapy drug as a medical exception. If approved, the drug will be covered.

Authorizations for Non-Formulary Drugs

Approval of a non-formulary drug will be given if the patient has failed treatment with formulary alternatives or has intolerable side effects or contraindications to formulary alternatives.

We issue the pharmacy a pre-authorization number, which you will need to process prescriptions that require a PRFT. If you need to speak to our pharmacy staff, please contact:

GCHP Pharmacy Department at Script Care: **1-888-531-0998**

GCHP has contracted with Script Care, Inc. as its pharmacy benefits manager (PBM) to manage Gold Coast pharmacy services to all Members. Members must go to a GCHP-participating pharmacy that has contracted with Script Care for filling of their prescriptions. There are numerous participating pharmacies located conveniently throughout Ventura County. In addition, many of our Participating Providers have their own pharmacy on site at their clinic location.

Please see the Pharmacy listing in our Specialist Directory at our website for in-network pharmacy locations and contact information. The Directory is posted at the Providers Resources section on the GCHP website at **www.goldcoasthealthplan.org**.

Section 15: Outpatient Clinical Laboratory & Outpatient Imaging Services

Overview of Outpatient Clinical Laboratory Services & Outpatient Imaging Centers

Clinical Laboratory Services—Lab Specimens and Drawing Stations

Providers are able to select a clinical laboratory of their choice as long as it is contracted with GCHP or offered directly by a Participating Provider (such as a Clinic or Hospital). There are numerous locations throughout the Ventura County Service Area where Members may go to have their blood drawn and lab tests performed. In addition, direct pick-up of lab specimens from the Providers' offices may also be arranged. Outpatient Clinical Lab Providers are identified in the Specialist Provider Directory. A list of our contracted labs, locations and phone numbers is posted on our website under the menu item Provider Directories in the Providers Portal at **www.goldcoasthealthplan.org**.

Outpatient Imaging Centers

There is a wide range of contracted Imaging Centers located conveniently throughout the Ventura County Service Area. Providers are able to select the outpatient imaging center of their choice as long as it is contracted with GCHP. In addition, several Clinic Providers have their own in-house imaging center that is contracted to provide services for GCHP. A list of our contracted imaging centers, their locations and phone numbers are available in the Specialist Directory in the Providers Portal at our website: **www.goldcoasthealthplan.org**.

Lab Tests Performed in the Provider's Office

GCHP will also reimburse par-Providers for certain Clinical Laboratory Improvement Amendments (CLIA) waived lab tests that are performed in a Provider's office, if the Provider meets the requirements of 42 USC Section 263a (CLIA) and provides GCHP with a current CLIA Certificate of Waiver. These GCHP-approved waived tests include certain testing methods for glucose and cholesterol; pregnancy tests; fecal occult blood tests; rapid group A strep test; hemoglobin; and some urine tests.

A list of approved CLIA waived lab tests is provided below and is also available on our website. Primary Care Providers have some basic laboratory tests included in their list of capitated services for which they are prepaid by Medi-Cal aid code.

CODE	DESCRIPTION
	Streptococcus, Group A
87650	Streptococcus, Group A, direct probe technique
87651	Streptococcus, Group A, amplified probe technique
87652	Streptococcus, Group A, quantification
87430	Streptococcus, Group A
	Fecal Occult Blood
82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided three cards or triple card for consecutive collection)
82271	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided three cards or triple card for consecutive collection), other sources
82272	Blood occult, by peroxidase activity (e.g., guaiac), qualitative; feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening
82274	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative feces, 1-3 simultaneous determinations
	Glucose Performed on Waived Meter
82962	Glucose, blood by glucose monitoring device(s) cleared by FDA specifically for home use
82947	Glucose; quantitative, blood (except reagent strip)
82948	Glucose; quantitative, blood, reagent strip
82950	Glucose; quantitative, blood (excent reagent strip), post glucose dose (includes glucose)
	Hemoglobin (Hgb)
85018	Hemoglobin (Hgb)
	Infectious Mononucleosis Antibodies
86663	Epstein-Barr (EB) virus, early antigen (EA)
86664	Epstein-Barr (EB) virus, nuclear antigen (EBNA)
86665	Epstein-Barr (EB) virus, viral capsid (VCA)
86308	Heterophile antibodies; screening
	Spun Microhematocrit
85013	Spun Microhematrocrit
	Urine Dipstick or Tablet Analytes, non-automated
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
	Urine Pregnancy
81025	Urine pregnancy test, by visual color comparison methods
	Influenza Testing (A and B)
87276	Influenza A virus Influenza
87275	B Virus
87400	Influenza, A or B, each
86580	Skin test; Tuberculosis, Intradermal

Section 16: Resolution of Disputes and Grievances

GCHP Members and Contracted Providers may access our grievance process at any time. To download the necessary forms, go to the Forms and Documents menu in the Providers Portal section at our website at **www.goldcoasthealthplan.org**.

Provider Disputes

Providers may file disputes regarding administrative, contract, claims, and payment issues. Such disputes must be filed with GCHP within 365 days of the action or decision being disputed or, in a case where the dispute addresses GCHP's inaction, within 365 days of the expiration of our time to act. Providers must exhaust this dispute resolution process before pursuing other available legal remedies.

Dispute Resolution Process

Disputes must be submitted in writing. You should mail your dispute to:

By mail: Gold Coast Health Plan
ATTN: Provider Grievances
P.O. Box 9176
Oxnard, CA 93031

Please be sure that any dispute includes all of the following information:

- Provider and Group Association name.
- Provider GCHP ID, NPI or Tax ID number.
- Provider contact information, including email address.
- A clear explanation of the issue in question.
- Your position on the matter.
- If the dispute involves a claim or request for reimbursement of overpayment, you also must include:
  - The original claim number, which will become the dispute number for tracking purposes.
  - A clear identification and description of the disputed item.
  - The date of service.
- A clear explanation of why you believe the payment or other action is incorrect.
- If the dispute involves a Member, you must include the Member's full name, Date of Birth and complete 9-digit GCHP ID number.

You also may include additional supporting clinical information if applicable. Please note that, if the dispute does not include the above information and we cannot readily obtain it, we will return the dispute to you for more information. Providers have 30 working days to submit an amended dispute to GCHP.

If a Provider has multiple disputes addressing a single issue s/he may file a single dispute using the system described below. Please include a list of each claim associated with such individual issue, along with all other information required for filing a multiple dispute.

GCHP will acknowledge the dispute within five (5) days of receiving it. GCHP will send a written resolution to the dispute withing thirty (30) calendar days of the date we receive the dispute for assistance in filing a dispute, please call our Customer Service at **1-888-301-1228** to reach the Provider Relations Department.

Member Complaints

GCHP Members have the right to file complaints about their experiences with us or with our Providers. While most Providers have their own internal mechanisms for resolving patient complaints, we provide Grievance forms (in English and Spanish) and operate our own grievance and Member complaints resolution process. To download a Member Grievance & Appeals Form, please visit Member Resources at our website.

Provider Responsibilities

When a Member brings a complaint to your attention, you must investigate and try to resolve the complaint in a fair and equitable manner. In addition, Providers must cooperate with GCHP in identifying, processing and resolving all Member complaints. Cooperation includes: meeting with representatives of the Plan if asked to do so; providing us with information pertinent to the complaint and taking all reasonable actions suggested by our staff to resolve a Member's complaint.

If a Member asks to file a complaint, your office can give him/her the appropriate forms and instructions

You also may refer Members with complaints to our Member Services Department for assistance, or to our website. Our Member Grievances & Appeals Form and instructions are available there under Member Resources: **www.goldcoasthealthplan.org**.

Members have the right to express their dissatisfaction with any aspect of the Plan or its Providers. A complaint may be filed by a Member or a Member's authorized representative:

- In person, by meeting with a Member Services Representative at our offices Monday – Friday 8 a.m. to 5 p.m.:
  2220 E. Gonzales Road, Suite 200
  Oxnard, CA 93036
  Phone: **1-888-301-1228**
- By calling a Member Services Representative at: **1-888-301-1228** [or the TTY line for the deaf and hard of hearing at: **1-888-310-7347**].
- By filling out a complaint form or putting the complaint in writing and sending it to the Member Services Department at:
  Gold Coast Health Plan
  GCHP Grievance & Appeals Department
  2220 E. Gonzales Road, Suite 200
  Oxnard, CA 93031
- Electronically, by visiting our website at: **www.goldcoasthealthplan.org**

Within five calendar days after receipt of the complaint, our Member Services Department will send an acknowledgement letter to the Member, reiterating the issue(s) of concern as we understand it. We will also identify the Member Services Representative as the contact person for the complaint, notify the Member of his/her rights in the grievance process, and tell the Member that s/he will receive a proposed resolution letter within 30 calendar days from the date the complaint was received.

Written acknowledgement and response is not required for complaints received over the telephone that are *not* coverage disputes, disputed healthcare services involving Medical Necessity or experimental or investigational treatment, and are resolved by the next business day.

A Member with Medi-Cal coverage does not have to use the GCHP grievance process to resolve his/her complaint. S/he can request a State Fair Hearing, as long as the request is made within 90 days from the date of the event that caused the Member to be dissatisfied. Members may file their requests directly with the California Department of Social Services (DSS) by calling **1-800 952-5253** (**TTY: 1-800-952-8349** for the deaf and hard of hearing) or by contacting the following office in Ventura County:

Human Services Agency
Attn: Fair Hearings Officer
855 Partridge Drive
Ventura, CA 93003-5405
Phone: **1-805-477-5100**

If the Member has any questions about the steps in the Member grievance process, please have him/her call the Customer Service Department **1-888 301-1228**. The Member may also call to make an appointment to come into our office to speak with someone in person.

Member Rights in the GCHP Grievance Process

- The Member may authorize a friend or family member to act on his/her behalf in the grievance process.
- If the Member does not speak English fluently, s/he has the right to interpreter services by phone via the Customer Services Call Center at **1-888-301-1228**.
- The Member has the right to obtain representation by an advocate or legal counsel to assist him/her in resolving the grievance.

The State Office of the Ombudsman will help Medi-Cal Members who are having problems with GCHP. The Member may call **1-888 452-8609** and request assistance.

Fraud, Waste and Abuse Identification Policy and Procedures

Purpose:

To establish a formalized organizational process for detecting, investigating, documenting and reporting suspected fraud, waste or abuse of any Gold Coast Health Plan (GCHP) or program by a member, provider employee, or any other person, in accordance with GCHP 's contract with the Department of Health Care Services (DHCS) and federal and state regulations.

Policy:

A. GCHP maintains a zero tolerance policy towards fraud, waste and abuse.
B. GCHP complies with applicable statutory, regulatory and other governmental requirements, and contractual obligations or commitments related to the delivery of GCHP covered benefits, which include, but are not limited to, federal and state False Claims Acts, Anti-Kickback statutes, prohibitions on inducements to beneficiaries, Health Insurance Portability and Accountability Act, and other applicable statutes.
C. All GCHP employees, contractors, temporary staff, vendors, providers and practitioners are responsible for reporting any suspected fraud, waste and abuse to GCHP. GCHP reports suspected fraud, waste or abuse to DHCS in accordance with its DHCS contract and this policy.
D. GCHP maintains a policy of non-retaliation toward employees, contractors, providers and practitioners who make such reports in good faith. GCHP employees, contractors, temporary staff, vendors, providers and practitioners are protected from retaliation under Title 31, United States Code, Section 3730(h), for False Claims Act complaints, as well as any other anti-retaliation protections.

E. GCHP provides a Compliance Program for complete investigation of all reported suspected fraud, waste and abuse allegations. GCHP Compliance staff, under the supervision of the GCHP Compliance Officer, is responsible for activities associated with the investigation and reporting of suspected fraud waste and abuse. Compliance staff will perform the compilation of supporting evidence for the investigation, consult with legal counsel as appropriate, and function as the liaison between GCHP, Department of Health Care Services, the Medical Board, the State Board of Pharmacy, other licensing, law enforcement, and other relevant entities as appropriate and cooperate with those agencies related to any fraud, waste and abuse investigations or audits.
F. GCHP investigative processes ensure appropriate confidentiality protocols are followed relating to any investigation of a suspected fraud, waste or abuse violation. GCHP's Compliance Officer will report the status and results of all suspected fraud, waste or abuse investigations to the GCHP Compliance Committee.
G. GCHP's Compliance Program provides for regular training and information sessions for all GCHP employees, contractors, temporary staff, network providers and practitioners regarding GCHP's fraud, waste and abuse policies and procedures. GCHP members will also be informed via Evidence of Coverage, Member Handbook and/or Newsletters about how to report fraud, waste and abuse.

Definitions:

A. Fraud: An intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law (Title 42 CFR 455.2; Welfare and Institutions Code 14043.1(i))
B. Waste: Overutilization of services and/or misuse of resources not caused by a violation of law.
C. Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (Title 42 CFR 455.2; Welfare and Institutions Code 14043.1(a))
D. Retaliation: Adverse punitive action taken against an employee who reports fraud, waste or abuse.
E. Whistleblower: An employee, former employee, or member of an organization who reports misconduct, including but not limited to fraud waste or abuse, to people or entities that have the power to take corrective action.

Procedure:

A. **Training of GCHP Staff & Provider Network**
GCHP's Compliance staff will provide the training of new employees and providers (in coordination with Provider Relations Department) including scheduled annual reviews, regarding the process for detecting suspected fraud, waste and abuse, the specific provisions regarding fraud waste and abuse under the False Claims Act, the reporting process, and the protections afforded to those who report such concerns in good faith. All trainings will be documented with all attendees noted. GCHP employees, contractors and temporary staff will also attest to understanding of materials and responsibility of reporting suspected fraud, waste and abuse.
B. **Identification of Fraud, Waste or Abuse**
   1. GCHP employees, contractors, temporary staff, vendors, members, providers and practitioners may detect fraud, waste or abuse perpetrated by a member in circumstances that include but are not limited to, the following:
      a. Using another individual's identity, Benefits Identification Card (BIC), GCHP identification card, Medi-Cal number, or other documentation of Medi- Cal or GCHP program eligibility to obtain covered services, unless such person is an authorized representative who is presenting such document or information on behalf of a member to obtain covered services for that member;

   b. Selling, loaning, or giving a member's identity, benefits identification card (BIC), GCHP identification card, Medi-Cal number, or other documentation of Medi-Cal and GCHP program eligibility to another individual to obtain covered services, unless such person is an authorized representative who is obtaining services on behalf of a member. Making an unsubstantiated declaration of eligibility.
   c. Using a covered service for purposes other than the purposes for which it was prescribed or provided, including use of such covered service by an individual other than the member for whom the covered service was prescribed or provided. Soliciting or receiving a kickback, bribe, rebate or other financial incentive as an inducement to receive or not receive covered services.
2. GCHP employees, contractors, temporary staff, vendors, members, providers and practitioners may detect fraud, waste or abuse by a provider, provider group or practitioner in circumstances that include, but are not limited to, the following:
   a. Unsubstantiated declaration of eligibility to participate in the Medi-Cal program or the GCHP program as a provider, provider group or practitioner.
   b. Submission of a claim or a request for payment for:
      i. Covered Services that were not provided to the member for whom such covered services were claimed.
      ii. Covered services substantially in excess of the quantity that is medically necessary for the member.
      iii. Covered Services using a billing code that will result in greater payment than the billing code that reflects the covered services actually provided.
   c. Soliciting, offering, receiving, or paying a kickback, bribe or rebate as an inducement to refer or fail to refer a member.
   d. Failing to disclose any significant beneficial interest in any other provider to which the provider or practitioner may refer a member for the provision of covered services.
   e. False certification of medical necessity.
   f. Attributing a diagnosis code to a member that does not accurately reflect the Member's medical condition for the purposes of obtaining higher reimbursement.
   g. Submitting files or reports that contain: unsubstantiated data, data that is inconsistent with underlying clinical, encounter, or payment records or data that has been altered in a manner or for a purpose that not consistent with GCHP's policies, contract, or applicable regulations and statutes.
3. GCHP providers' responsibilities for fraud prevention and detection include, but are not limited to, the following:
   a. Training provider staff, contracting physicians and other affiliated or ancillary providers, and vendors on GCHP and provider's Fraud Prevention Program and fraud prevention activities at least annually.
   b. Developing a fraud program, implementing fraud prevention activities and communicating such program and activities to contractors and subcontractors.
   c. Communicating awareness, including identification of fraud schemes, detection methods and monitoring activities to contracted and subcontracted entities and GCHP.
   d. Notifying GCHP of suspected fraudulent behavior and asking for assistance in completing investigations.
   e. Taking action against suspected or confirmed fraud, including referring such instances to law enforcement and reporting activity to GCHP.
   f. Policing and/or monitoring own activities and operations to detect and/or deter or prevent fraudulent behavior
   g. Cooperating with GCHP in fraud detection and awareness activities, including monitoring, reporting, etc., as well as cooperating with GCHP in fraud investigations to the extent permitted by law.

C. **Reporting of Fraud, Waste or Abuse**

GCHP provides for the reporting of suspected fraud, waste or abuse through various mechanisms, such as the GCHP website and toll-free telephone numbers. GCHP's compliance unit, through an established process, tracks, trends, and analyzes data for suspected fraud, waste and abuse.

1. Suspected Fraud, Waste and Abuse Referral Form with accompanying information. This from is available from GCHP's website, Provider Manuals, Member Services upon request, and should be submitted to the attention of the Compliance Officer.
2. Fraud Hotline at **866-672-2615** or via the Internet at **http://gchp.alertline.com** can be used to anonymously report a suspected fraud, waste or abuse incident. This hotline number is provided to employees, contractors, temporary staff, vendors, members, providers, and practitioners.
3. In the event an allegation is received relating to any employee-related allegation it will be referred to the Human Resources Director

D. **Investigation and Research**

GCHP treats the detection of suspected fraud, waste or abuse in a confidential manner by ensuring that Compliance staff adhere to GCHP's HIPAA confidentiality protocols in compiling only the information needed for the investigation to determine if the suspected violation is valid and ensure that GCHP will not retaliate or make retribution against any GCHP employee, provider, practitioner, or member for such detection. Upon receiving a report of a suspected fraud, waste or abuse incident, Compliance staff will review and perform an initial triage of the case and will:

1. Determine whether the case relates to GCHP programs and is appropriate for investigation by GCHP. (For example if the claim is in regards to a Medicare issue/allegation that type of case will be redirected).
2. In the event the report is determined not to be subject to investigation by GCHP, an acknowledgement letter will be sent to the reporting person with an explanation.
3. Once it is determined the allegation is valid for GCHP to pursue the Compliance Specialist(s) will:
   a. Assign the case a unique tracking number and establish a file to maintain documents, reports, evidence, and correspondence pertaining to the suspected fraud, waste or abuse, to include: the reported individual allegation or incident, by date, summary results of the investigation, resolution, and reports to/correspondence with the appropriate agency.
   b. Upon the receipt of a Suspected (FW A) Referral Form, GCHP's Compliance staff will transmit an acknowledgement notice to the party who submitted the Suspected Fraud Waste or Abuse Referral Form, including a request for additional documents (if needed) with a due date.
   c. Involve the appropriate department(s) based upon the nature of the case in order to gather the appropriate documentation, i.e. member profiles, claims history etc. The department(s) notified will review the allegation and gather any additional information as deemed necessary for a comprehensive report.
   d. The departments will return a written report of all necessary documents and information to Compliance within 5 business days of receiving the request.
   e. If necessary and upon request, Compliance will coordinate the investigation independent of other GCHP departments including procuring the services of contracted investigators as or if needed.
   f. In the event there is reason to believe that an incident of fraud and/or abuse has occurred based on preliminary findings, Compliance will utilize the material reviewed by the department(s) in preparation to report and notify DHCS Medi- Cal Managed Care Division /Program Integrity Unit of the suspected fraud, waste or abuse by submitting a MC609 form: Confidential Medi-Cal Complaint Form.
4. GCHP's Compliance staff will conduct, complete, and report to DHCS, the results of its preliminary investigation of the suspected fraud and/or abuse within ten (10) working days of the date GCHP first becomes aware of, or is on notice of, such activity.

E. **Monitoring**
GCHP's Compliance Officer will provide quarterly reports and annual summaries that identify any trends for review and discussion for possible corrective action plans as appropriate, to the Compliance Committee and the GCHP governing body.

F. **Forms**
1. Suspected Fraud, Waste or Abuse Referral Form.
2. Acknowledgement of Receipt of Suspected Fraud, Waste or Abuse Referral Form.
3. Form MC609, Confidential Medi-Cal Complaint Form.

References:

GCHP Contract with the Department of Health Care Services.
42 C.F.R. § 455.2
42 C.F.R. § 438.608

Section 17: Forms

We are continually posting forms to our website. If you require a form and it is not posted, please call our Customer Services Center at **888-301-1228**. Below you will find a list of forms, along with a brief description for their intended use. To view or to download these or other GCHP-related business forms, please go to the GCHP Forms and Documents section at **www.goldcoasthealthplan.org**.

Claims

- Claim Correction Form – This form is to be used when submitting corrected claims. Corrected claims should be either stamped with "CORRECTION" or "CORRECTED CLAIM", or submitted with the new form to ensure appropriate routing and processing.

Finance—Please see Appendix 6

- Provider Grievance Form – This form is used by a Participating Provider to file a billing dispute with GCHP.

Health Services

- Preauthorization Treatment Request Form – This form is used by Providers to request prior authorization from the Plan for certain specified services that require advance approval.
- Direct Referral Authorization Form – This form is used by PCPs and Specialists to refer a Member to another contracted ("par") provider located in Ventura County.
- Care Management Referral Form – The form used to request assistance with a Member with unique or special needs.

Member Services

- Member Grievance Form – This form can be printed out and handed to Members who are interested in filing a complaint with GCHP's Member Services Department. This form contains both English and Spanish versions of the Frequently Asked Questions and Member Rights and Complaint Form.

Provider Relations

- Provider Grievance Form – Form for providers who have grievances regarding Claims, Health Services, or Refunds.
- Provider Information Update Form – This form is used to update provider contact and practice information. Information includes Provider address, phone number, contact information, payment address, and tax ID number.
- Certification Regarding Lobbying – Exhibit D(F) Att 1 and 2 – If payments to a Provider under the GCHP Services Agreement total $100,000 or more, the Provider must submit the "Certification Regarding Lobbying" to GCHP. Download the form at: **www2.ed.gov/fund/grant/apply/appforms/sflll.doc**

If you require a form not found on this list or our website, please call our Provider Relations Department for assistance at 1-888-301-1228 or send an email to **ProviderRelations@goldchp.org**.

Appendix 1: Functions of Committees and GCHP Staff

Quality Improvement Committee (QIC)

This Committee is chaired by the Chief Medical Officer, and is responsible to advise Plan staff and the GCHP Board of Commissioners on the Quality Improvement program, including:

- Critically examine, evaluate and make recommendations on all quality functions of the health plan including: quality improvement over and underutilization peer review of licensed professionals and their contracted activities in service to the enrolled Members and promote educational activities for providers for best cost effective quality care.
- Review activities of the Credentials, Medical Advisory and Pharmacy & Therapeutics Committees, and monitor the functions of all of the Committees that review the quality and safety of care provided to Members.
- Is responsible for medical abstracts and reports for HEDIS measurements.
- Approve and/or recommend changes to health plan policies, practice guidelines and reporting Committees' proposed action plans.
- Present reports on Quality Improvement activities to the Board on a quarterly basis, and annually review and approve the QI Program Evaluation, QI Program and QI Work Plans.
- Submit annually the QI Program and the QI Work Plan to Board for approval.

Pharmacy & Therapeutics (P&T) Committee

Chaired by the Chief Medical Officer, staffed by the GCHP Pharmacy Director and comprised of local physicians and pharmacists, the P&T Committee meets quarterly with the primary responsibility of developing, maintaining and monitoring a dynamic clinical formulary that ensures cost effective and quality drug management for GCHP Members. The P&T Committee members are appointed by the CMO for a renewable two-year term. The GCHP formulary shall be reviewed at its quarterly meeting and revised by the P&T Committee as deemed necessary. The P&T Committee reports to the Board through the Chief Medical Officer and the Quality Committee.

Credentials Committee (CC)

Chaired by the Chief Medical Officer and staffed by the Provider Network Manager, the Credentials Committee includes Physicians from major disciplines, including Primary Care and Specialty practices. The Credentials Committee at its discretion may invite additional Specialists to review case records, either in writing or in person. Participants are bound by confidentiality and conflict of interest rules.

Medical Advisory Committee

Chaired by the Chief Medical Officer, the Committee includes Physicians from all the major disciplines. Its function is to review and advise medical utilization/care management and their policies.

Health Education, Cultural & Linguistics Committee (HE/CL Committee)

The HE/CL Committee is chaired by the Manager of Health Education and staffed by the Quality Improvement Manager, Provider Network Manager , Health Services Director, Member Services Manager and others, as appropriate. The Committee shall meet no less than quarterly, and reports to the QI Committee.

GCHP HE/CL Department includes interpretation and translation services, Provider education and resources, and cultural competence training for GCHP staff and contracted staff. Committee objectives are to increase access to high quality care for all GCHP Members, reduce health disparities among different cultural groups, and to improve communication among staff, Providers and Members.

Provider Advisory Committee (PAC)

Chaired by the GCHP Provider Network Manager and comprised of a broad spectrum of Community providers, the PAC meets quarterly and offer input to the Chief Medical Officer, Commission and management team regarding GCHP policies that involve provider activity and the integrity of the Provider Network. The GCHP Board appoints PAC members to a one-year term that is renewable. Recommendations for policy revisions and innovations, if adopted as resolutions by a majority of the appointed members of PAC, are forwarded to the GCHP Governing Commission.

Chief Medical Officer (GCHP Medical Director)

The principal GCHP medical staff position for the oversight of the providers credentialing process, quality monitoring, evaluation and improvement activities.

The Chief Medical Officer shall be responsible for day-to-day guidance and direction of quality monitoring and improvement activities, and seek input from Specialists as needed to provide guidance in addressing quality issues relevant to a specific area of expertise.

Specific functions include:

1. Fulfillment of and adherence to QI Program goals and all regulatory agency and accreditation body requirements.
2. Fulfillment of and adherence to UM/CM Program goals and all regulatory agency and accreditation body requirements.
3. Development and coordination of the peer review process.
4. Serve as Chair for the Credentials Committee.
5. Remain on-site or available via telephone for consultation with the Health Services Director, UM Director, Quality Director and other staff, as appropriate.
6. Guide and assist in the development and revision of quality improvement criteria, practice guidelines, new technology assessments and performance standards, as appropriate, and the development and implementation of quality improvement strategies.
7. Present periodic updates on quality improvement and utilization management activities to Committee Chairs and to the Commission as appropriate.

Appendix 2: FAQs about Claims and Electronic Billing

1. Does GCHP follow the same timeliness guidelines as Medi-Cal?

Yes. GCHP follows Medi-Cal Timeliness and Delay Reason Codes guidelines — please see the section in the Medi-Cal Provider Manual relevant to your specialty at **http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp** for further information.

2. What should I do with suspended claims on my Explanation of Payments?

The Remittance Advice (RA) will contain at least one of the following possible claim status categories:

PAID:	The claim detail line has been processed for payment by GCHP.
ADJUSTED:	The claim detail line has been adjusted either positively or negatively.
DENIED:	The claim detail line has been processed as a denial by GCHP.
SUSPENDED:	The claim detail line is on hold and requires additional clarification for final processing. Suspended claims will appear one time on the RA until GCHP staff has removed the hold and either denied or approved the line for payment.

Please note that each claim line will be assigned its own Explanation Code(s); to assist you with account reconciliation and posting. A code key is provided on the last page of the EOP.

3. What is GCHP's processing time for my claims?

We are contractually bound to process clean claims within 30 days of receipt of the claim. Generally hard-copy turnaround time for clean claims is within 15-21 days; Electronic Data Interchange (EDI) turnaround time is generally within 12-16 days. Claims are processed daily. Hardcopy checks are prepared and released once a week. When a holiday occurs on a check run day, checks will be processed on the next business day.

4. What is GCHP's capitation check schedule?

We process capitated checks to PCPs on the 10th of each month. When a holiday occurs on a check run day, checks will be processed on the next business day.

5. Am I required to notify GCHP with claim forms for capitated services for Members linked to my practice?

Yes. We require and specify in our contracts that all capitated service encounters must be reported every month as "shadow claims" or "dummy claims" that are not paid.

6. Will GCHP accept electronic claims?

Yes. We accept and encourage Electronic Claims Submission by network Providers. If your practice or facility is interested in submitting claims electronically please see complete information about becoming a Trading Partner and Electronic Claims Submission available at the GCHP website, **www.goldcoasthealthplan.org** or call EDI Support at 800-952-0495. If you use a clearinghouse, please provide this information to your clearinghouse vendor.

7. When and how should I follow up on claims that I believe have not been processed by GCHP?

Please consider the date that the claim was mailed to estimate an appropriate follow-up/rebill period. We process claims based on the date they are received in our office. For most practices, the appropriate timeframe for follow up would be 45 days after the claim was originally mailed. We suggest that Providers utilize the electronic tracking of claims available through the Provider Web Portal or contact Customer Service at **888-301-1228** before resubmitting any claims.

8. What about the ability to resubmit via the web?

Providers can use GCHP's Provider Web Portal to search for claims and can resubmit previously denied claims through EDI. If your office has not registered and is not using the Provider Web Portal, please do so. Complete instructions to register for the Web Portal and EDI are available at the GCHP website, **www.goldcoasthealthplan.org** or contact our Provider Relations Department at **888-301-1228**.

9. What form should I use to bill CHDP claims?

CHDP services are billed on a CMS-1500 claim form (formerly known as HCFA-1500). The brown PM-160 informational form should also be sent for reporting purposes.

GCHP is following the CHDP guidelines provided by the State of California.

10. How should claims for newborns be submitted?

Services rendered to an infant may be billed with the mother's ID for the month of delivery and the following month if the child has not received their own Medi-Cal ID number. After this time, the infant must have his/her own Medi-Cal ID number. Additionally when billing for NICU infants, bill using the child's ID number, if you are billing using the mother's ID, please add the mother's ID and information in box 80 of the UB form.

11. How does GCHP handle claims for children Eligible for CCS?

CCS services are carved out of the GCHP contract with the state of California. Original claims billed with a CCS diagnosis and/or CCS-Eligible condition will be returned to you with a denial letter that includes CCS billing instructions. A denial will also appear on a subsequent RA. GCHP's review of potential CCS claims centers on the Member's diagnosis,

12. How should I handle Share-of-Cost (SOC) collection and billing?

Share-of-Cost (SOC) collection and billing is an important function for every Provider.
The Medi-Cal website at **https://www.medi-cal.ca.gov/Eligibility/Login.asp** will inform you of a Member's outstanding SOC and allow you to clear the amount collected (or the amount that the patient is obligated to pay). Once the amount collected (or obligated) is cleared, the Member will be a GCHP Member (or will be closer to Eligibility if there is a remaining SOC amount). It is important for all Providers to collect and clear SOC each month to ensure a Member's ability to obtain services from other Providers later that month.

Once an SOC has been collected, we will apply coordination-of-benefits — we will compute the Medi-Cal allowance and subtract the amount already paid by the Member. If the Member's payment exceeds the Medi-Cal allowance, then the GCHP reimbursement will be $0. (In such a case, you would not need to bill GCHP for the services because you will have been paid more than Medi-Cal allows.). If the Member's payment is less than the Medi-Cal allowance, then the net reimbursement will be the difference.

When using the CMS-1500 Claim Form: Enter the amount collected (or obligated) in box #10d or #19 of the CMS claim form. The amount collected (or obligated) should also be entered in box #29 and should be subtracted from the total balance due (box #30). Further explanation and samples can be found in the SOC tutorial section of the Medi-Cal website.

When using the UB-04 Claim Form: Enter code "23" and the amount of the patient's SOC in box 30. In box 55 enter the difference between "Total Charges" (box 47) and SOC collected. Further explanation and samples can be found in the SOC tutorial section of the Medi-Cal website.

When using the UB-04 Claim Form for Long Term Care Billing: Enter one of the approved value codes RL, 23, 02, 31 or FC. When using these value codes the monetary amount submitted should only be the net for the claims statement period being billed.

13. How are refunds or reversals/take backs processed?

GCHP Recoveries Department assesses and identifies overpayments on claims. Research is completed to identify overpayments related to over-utilization of procedures, claims billed incorrectly, duplicate payments, overpayments due to lack of coordination of benefits with Members' primary healthcare insurance policy (such as private health insurance, Medicare coverage, or an open case with CCS).

Typically the overpaid amount is recovered either by the Provider issuing a lump-sum check payable to GCHP and mailed to:

Gold Coast Health Plan
Attn: Claims Department
P.O. Box 9152
Oxnard, CA 93031

Alternatively, overpayment may be reversed from monies due to the Provider on the same NPI until the recovery is completed. This will only be done as a last resort if the Provider does not respond in writing to the notification from the Plan that there is an overpayment that must be reconciled.

When an overpayment is identified by GCHP, the provider will be notified with a letter explaining the overpayment and a request for a refund check in the amount of the overpayment. If the provider does not remit the overpayment, GCHP will notify the provider of its intent to offset the overpayment from future claim payments.

If a Provider is not expected to receive money in future payments or does not have a large volume paid out for a particular NPI number from GCHP to reimburse the overpayment, the takeback(s) must be completed by using the same NPI that were initially paid incorrectly. Example: A claim was paid for services rendered to John Doe, Recoveries discovers that Mr. Doe is not your patient and takes back the payment. The initial payment was paid to NPI #1234567890; therefore, GCHP should be able to recoup the monies owed (excluding any issue beyond our control) from any following payment made to that NPI. The Claims Department will mail, fax, or e-mail an "Identification of Overpayment" request if take backs are not viable; payments are expected within 30 days from receipt of this notice.

If you have additional questions or concerns, please contact the Claims Department at **1-888-301-1228**.

14. What do I do if I disagree with how a claim was paid or denied?

Claims are processed using Medi-Cal and CPT guidelines. Providers may disagree with either how a claim was priced/paid or whether or not it was denied appropriately. These issues often can be handled directly by the Claims Department without the involvement of Provider Relations or Health Services. Please contact the Customer Service Department Monday-Friday between 8am – 5pm at **1-888-301-1228**. For further information, please see the dispute resolution process in Section 16 of this Provider Manual.

15. When can I bill a GCHP Member for an unpaid service?

You may not bill a GCHP Member for any un-reimbursed amount, including a deductible/co-insurance or co-pay amount, unless one of the following exceptions applies:

- The Member has an unmet monthly Medi-Cal share-of-cost amount.
- The Member does not disclose his/her GCHP/Medi-Cal coverage.
- The Member consents to receive services that are not covered by GCHP.
- The Member chooses to see a physician/provider who does not accept Medi-Cal or is not a Medi-Cal provider.
- The Member waives his/her Medi-Cal benefits.
- The Member does not obtain or access primary insurance benefits correctly.
- A Member may be charged when he/she does not obtain primary insurance benefits correctly. Note also that, unless you have provided benefits to the Member according to the primary insurance authorization/benefit requirements, you may not charge the GCHP Member for the service.

July 1, 2013 GCHP will be processing out-of-network Emergency Room and Sub-Acute using APR-DRG processing methodology to replace the current Rogers Amendment Rates.

Appendix 3: FAQs about Submitting a CHDP Claim

1. For vision, do we have to add results if they pass?

Results are only required if the patient does not pass their Vision Screening exam.

2. For the Snellen or Equivalent test and Hemoglobin/Hematocrit, what is the protocol for indicating which one was performed?

There is no need to indicate which is used when billing the Snellen or Equivalent tests as only one or the other is used. For the Hemoglobin or Hematocrit you fill in the designated box.

3. Do we have to write procedure codes (labs and vaccines) on the right side of the claim in addition to fields on the left?

No.

4. Do partial screens need the tobacco question filled out?

No, this is only required for full screenings.

5. On partial exams, is marking the Partial box required?

Yes, you should check the Partial box and include the date of the prior full CHDP screening unless the patient is new and the date of the previous full screen is not known. In this case you would not check the box but you must note the reason in the Comments/Problems box.

6. Is the body mass index (BMI) required to be noted on the CHDP form for children over 3 years of age?

Yes, there is a field on the new PM-160 for this data.

7. Does follow up code 3 need appropriate ICD-9 codes to be documented?

GCHP does not require secondary diagnoses for claim processing. CHDP would like to see diagnoses for follow up codes 2, 3 and 4.

8. Procedure code/line 12, if the PPD measured at 0 mm do we have to fill in the date the PPD was read?

GCHP does not screen for this but CHDP would like it noted.

9. Does the PM-160 require an original signature?

Yes, claims must be signed by authorized personnel.

10. How many times a year does GCHP allow PPDs to be performed?

GCHP does not track this but per ACS guidelines, follow up code 2 allows for one recheck.

11. Is it mandatory to fill out WIC boxes?

GCHP does not require this; however, CHDP would like to see this filled out for children ages 5 and under.

12. For a partial screen, do we need to include V202 diagnosis?

No, a diagnosis is required only for the full screen.

13. Do we need to include next CHDP exam date for partial screens?

No, only for the full screen.

14. On the PM-160, do we need to add what series of the vaccine (e.g., hep 1, hep 2) was given?

No.

15. Do we bill an EKG on a PM-160 if done same day as a CHDP full exam?

No, this needs to be billed on a CMS-1500 with the appropriate diagnosis.

16. Do children three and older have to get vision or audio done every year?

As per CHDP, yes. GCHP does not track this.

17. If we have claims submitted with EOBs attached that were paid in full, are we supposed to be coordinating benefits?

Yes, claims with EOBs need to be coordinated. If you have any examples of this not occurring, please call 888-301-1228 with specific examples.

18. Are claims returned for adding the series of the specified vaccine administered?

No.

19. For kids in group homes, do we have to include the group home information in the responsible party boxes?

No, as long as the Member # is correct, our system will fill in the demographic data.

20. What is an ICD-9?

International Classification of Disease - Ninth Edition (AKA: diagnosis code).

21. Can we bill for a pap smear as part of a CHDP exam?

The CHDP manual does provide a code for the collection and handling of a pap smear, but it strictly says that a smear is included in the fee for the pelvic exam. The payable amount for the code is $0.00.

22. For combination vaccines, do we fill out the name of what is in the vaccine on separate lines (ex: Pediatrix: Dtap, Tetanus, Pertussis, Hep B and Polio)?

No, only the code and the name of the combination vaccine is required to prevent returns or overpayments.

Appendix 4: Financial Disclosure and Reporting

By the terms of its contract with the state of California, Gold Coast Health Plan (GCHP) is required to monitor the financial viability of its Contracting Providers and Plan Partners. The purpose is to establish that they are financially solvent and that their financial status is not deteriorating over time. The requirements for Contracted Providers are different from those of Plan Partners.

GCHP will exercise discretion to only collect financial information from Contracted Providers if and when there is a clear need to do so in order to fulfill its obligations to the State. For example, PCPs who have only a small or limited number of Members on their panel will not have to comply with these provisions. Nor will tertiary care out-of-area providers that rarely treat our Members or Providers that are compensated on a straight fee-for-service rate schedule or case rate basis.

Annually Plan Partners, must submit financial statements for the first three quarters[1] of the fiscal year to the Compliance Department of GCHP no later than 45 calendar days after the close of each applicable quarter for the fiscal year. For the purpose of this section, the quarterly financial statements will consist of the balance sheet, income statement, statement of change in net worth and cash flow statement The Provider's financial statements should be prepared in accordance with GAAP (Generally Accepted Accounting Principles). Plan Partners financial statements will be in the same format and content as the Quarterly Financial Reporting Forms (previously "Orange Blank") submitted to California Department of Managed Health Care (DMHC).

On an annual basis, Plan Partners shall submit to the Compliance Department of GCHP, financial statements audited by an independent Certified Public Accounting Firm. Audited annual financial statements must be filed within 120 days of the end of each fiscal year and will be in the same format and content as the Annual Financial Reporting Form (previously "Orange Blank") submitted to DHCS. DMHC.

GCHP will review the financial statement(s) to determine if the selected Contracting Providers and all Plan Partners meet minimum acceptable liquidity, profitability, efficiency, and stop-loss protection levels.

The financial viability of each selected Contracting Provider and all Plan Partners will be determined based on established criteria and DMHC required grading criteria. For example, the following information will be calculated and analyzed:

Liquidity:

- Current and quick ratios to be equal to or greater than 1.0.
- Acid Test Ratio of liquid assets (cash) to current payables to be equal to or greater than 0.50 (DMHC required grading criteria).
- A positive working capital of 1.0 or above (DMHC required grading criteria).
- A positive tangible net equity (TNE) or net worth of 1.0 or above (DMHC required grading criteria).

[1] GCHP reserves the right to request more frequent submissions.

In addition, Plan Partners shall estimate and document, on a monthly basis, the organization's liability for incurred but not reported (IBNR) claims using a lag study, an actuarial estimate, or other reasonable method.

On a discretionary basis, the GCHP Compliance Department will have the right to periodically schedule audits to ensure compliance with the above requirements. Since the financial solvency standards apply to the entity as a whole, the audits will be conducted for all books of business, not only for the lines of businesses contracted with GCHP. Representatives of the Contracted Providers and Plan Partners shall facilitate access to records necessary to complete the audit.

Appendix 5: FAQs from Members on Complaints/Grievances

NOTE: This FAQs guide is provided to give basic assistance to provider offices in dealing with the types of questions they may receive from our Members. For more complicated matters, please refer Members to GCHP at 888-301-1228 TTY 888-310-7347.

1. What is the GCHP grievance process?

It is the way in which we work closely with Members in order to provide them with the means to voice complaints, resolve disputes and settle any concerns they may have about the services they get as GCHP Members.

2. When would a Member file a complaint/grievance?

You could file a complaint/grievance if:

- You are having a problem getting services you feel you need (for example, if you are having problems getting medication or medical equipment, problems getting an appointment with your doctor or problems getting treatment at the hospital).
- You are not happy with the services you got from a healthcare provider.
- You disagree with us when we deny a service you feel you need.
- You are unhappy with any aspect of your health care.
- You feel that a health care Provider or GCHP has not respected your privacy.

In most cases, you must file your complaint/grievance within 180 days of the event that caused you to be dissatisfied. If you are filing a complaint because we have denied or modified a request for Prior Authorization, you must file your appeal within 90 days from our Notice of Action.

3. How do I file a complaint/grievance?

You can file a complaint/grievance one of the following ways:

- Calling our Member Services Department at **1-888-301-1228 TTY 888-310-7347**.
- Writing your complaint/grievance and mailing it to:
  Gold Coast Health Plan
  Attn: Grievance & Appeals
  P.O. Box 9176
  Oxnard, CA 93036
- Going to our website to download a complaint/grievance form and mail to the address above: **https://www.goldcoasthealthplan.org**

Coming to the GCHP office and filing your complaint/grievance in person: Monday - Friday, 8:00 a.m. to 5:00 p.m.

Our office located at: 2220 E. Gonzales Rd. Suite 200 Oxnard, CA 93036

4. What if I prefer to speak a language other than English?

GCHP has staff who speak Spanish. Translation services are available for other languages through Member Services at **888-301-1228**.

5. Do I have to use the GCHP grievance process to resolve my problem?

If you are a Medi-Cal Member, No. If you are on Medi-Cal, you can ask for a State Fair Hearing. You must ask for the hearing within 90 days from the date of the event that caused you to be dissatisfied. The California Department of Social Services (DSS) can help you. You can call the State at **(800) 952-5253 (TTY: 800-952-8349** for the deaf and hard of hearing) and tell them you want a hearing. You can also ask for a State Fair Hearing by mail, telephone or in person by contacting the local office in Ventura County:

Human Services Agency
855 Partridge Drive
Ventura, CA 93003
805-477-5100

As a GCHP Member, you also have the right to file a complaint with the Department of Health and Human Services at any time if you feel that your privacy has not been respected. You can file your complaint by contacting:

Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

6. Can I have someone help me file my complaint/grievance?

Yes, you may have a family member or a friend help you. The State Office of the Ombudsman will help Medi-Cal Members who are having problems with their health plan. You can call them toll-free at **(888) 452-8609**.

7. What happens after I file my complaint/grievance?

The Member Services Department will send you a letter within 5 days after you file your complaint/grievance. This letter tells you that we received your grievance. It explains your rights in the grievance process.

8. How does my complaint/grievance get settled?

Depending on the type of complaint you have, our staff may be able to resolve it right away to your satisfaction. If this is not possible, your complaint/grievance will be referred to the appropriate department within GCHP to be reviewed and resolved.

If we need more information we will ask for it. For example, if the Chief Medical Officer wants more information, we may ask for medical records from the doctors involved. The Member Services Department will send you the resolution in a Proposed Resolution Letter.

9. How long do I have to wait until I get the Proposed Resolution Letter?

The Member Services Department will send you the proposed resolution letter within 30 days from the day your grievance was received.

10. What if my complaint/grievance involves an immediate or serious threat to my health and well-being?

If you feel there is an immediate or serious threat to your health or well-being, you can request an expedited review of your complaint. If your complaint meets the criteria for an expedited review, the Member Services Department will let you know within one business day that your complaint has been received, and will have a decision for you within 3 days.

11. What can I do if I don't agree with the Proposed Resolution Letter?

If you are on Medi-Cal, you have the right to request a State Fair Hearing. You must ask for the hearing within 90 days from the date of the proposed resolution letter. The telephone number for requesting State Fair Hearings is **805-477-5100**.

12. What if I have a complaint about my privacy?

You have the right to file a complaint with the Department of Health and Human Services at any time by contacting:

Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

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A Public Entity

For questions and Gold Coast Health Plan information, please call 1-888-301-1228
www.goldcoasthealthplan.org

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