Gold Coast Health Plan℠
A Public Entity

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

2015
PROVIDER MANUAL

1-888-301-1228
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 in Ventura County. The COHS is governed by the Ventura County Medi-Cal Managed Care Commission (also referred to as VCMMCC or "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: the Provider Advisory Committee (PAC) and the Consumer Advisory Committee (CAC). The commission meets monthly to review local concerns about health care issues, receive advisory input, and revise GCHP policies, as appropriate. GCHP's policies are responsive to local input due to the Plan's local governance and operations.

Organization of the Provider Manual

This Provider Manual describes operational policies and procedures of GCHP, which is referred to throughout the manual as GCHP or the Plan. Topics covered are included in the Table of Contents at the beginning and Index of Topics at the end of the Provider Manual. You also may access this Provider Manual online by visiting GCHP's 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 on the website. The manual will be updated and revised periodically as needed to reflect the Provider Operations Bulletin (POB), which is released quarterly. 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 the status of a claim and query and submit prior authorizations. Providers must register using their GCHP Provider Identification Number (PIN) to access the portal. To access and utilize these services, go to the Providers section of GCHP's website, go to "Provider Web Portal" and complete the registration process. For assistance, please contact the Plan's Customer Service department at **1-888-301-1228** or e-mail **ProviderRelations@goldchp.org**.

Other Resources on the GCHP Website

Visit GCHP's website at **www.goldcoasthealthplan.org** to access resources and tools, such as:

- **Provider Directories:** The PCP Directory and the Specialist Physicians and other Non-PCP 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 GCHP can improve its service to providers or members, please email them to **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: The following are considered Administrative Members:

- Share of Cost (SOC): A member who has Medi-Cal with an SOC requirement.
- Long-Term Care (LTC): A member who is residing in a skilled or intermediate-care nursing facility and has been assigned an LTC Aid Code.
- Out of Area: A member who resides outside GCHP's service area but whose Medi-Cal case remains in Ventura County.
- Other Health Coverage: A member who has other health insurance that is primary to his/her Medi-Cal coverage. This includes members with both Medi-Cal and Medicare, as well as members with both Medi-Cal and commercial insurance. Medi-Cal is the payer of last resort; therefore, GCHP members with other health coverage must access care through their primary insurance.
- Members who are enrolled under special aid categories, such as Breast and Cervical Cancer Treatment Program.
- Hospice: If Medi-Cal enrollment file indicates a Hospice Restricted Services Code.
- Administrative members or those residing outside of Ventura County will be identified as such on their GCHP ID cards. Regular members will have their PCP listed on their ID cards.

Appeal: A formal request to an organization by a provider 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 PCP for their medical care.

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 PCP, 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 to a particular PCP (physician or clinic) by a pre-determined process. It only occurs when the member has been unable to complete the selection process within the 30 days allowed upon initial enrollment. The auto assignment is based on the zip code of member's residence and location of PCP office, past history with a specific PCP, mother – child and family link, 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 GCHP and select a new PCP. If the member completes the PCP 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 PCPs (or a group of PCPs) 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 PCP Medical Services Agreement.

Care Manager: GCHP Care Managers are licensed registered nurses 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. The GCHP Utilization Management team may also assist in the 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., heart transplant cases).

Chief Medical Officer (CMO): The medical director of the Plan or his/her designee; a physician licensed to practice medicine in the state, who is employed by the Plan to monitor quality improvement and to implement the quality improvement activities of the 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.

Claim Form: The UB-04 is used by participating hospitals and other facilities to report to the Plan the provision of covered services to Medi-Cal members. The CMS-1500 claim form is primarily used by participating physicians to report to the Plan the provision of covered services to Medi-Cal members. This may also include other forms as deemed appropriate, such as the PM-160 Information Only form to report CHDP services.

Clean Claim: A claim in which all information necessary to determine payer liability for the adjudicating of the claim is present (Health and Safety Code Section 1371).

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.

Complaint or Grievance: If a Plan provider is not satisfied with any aspect of the provider's dealings with the Plan, 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, and 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, the Plan will notify the provider of the status and expected date of 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 behavior and health education. This approach is shown to reduce both low birth weight rates and overall 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 the Plan.

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

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.

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 Billed Charges: This is the amount charged by a provider for services that are covered Medi-Cal benefits. This amount may be different from the total billed charges as some of the billed charges may be for non-covered services. GCHP will deduct the total amount of charges for non-covered services from the total billed amount to determine the Covered Billed Charges.

Covered Services: All medically necessary services to which members are entitled from the Plan, as set forth in the Member Handbook, including primary care services, referral specialist, medical, hospital, preventive, ancillary, emergency and health education services.

Crossover Claim: A claim for a member who is eligible for both Medicare and Medi-Cal, where Medicare pays a portion of the claim and Medi-Cal is billed for any remaining deductible and/or coinsurance. These members are often referred to as "Medi-Medi" or dually eligible members.

Department of Health Care Services (DHCS): A state regulatory organization that finances and administers a number of individual health care service delivery programs, including the California Medical Assistance Program (Medi-Cal). Its 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 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 and/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 Data: Captures the interaction between a patient and a provider who delivers services to the patient. It includes detailed information about the individual services rendered by a provider contracted with a managed care entity.

Enrollment: The process by which the Ventura County Human Services Agency (HSA) determines the Medi-Cal benefit eligibility of an individual. The agency then communicates the eligibility status 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 Medi-Cal eligible children at 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 FFS 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 the Plan pursuant to its written service agreement will be compensated by the Plan at the lowest allowable FFS 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.

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 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.

Gold Coast Direct Members: A Gold Coast Direct Member is an eligible Medi-Cal beneficiary who is enrolled with GCHP and is assigned to a PCP. These members will have an Aid Code of L1, M1 or 7U.

Governmental Agencies: The state 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 the Plan or Medi-Cal (Medicaid).

Health Insurance Portability and Accountability Act (HIPAA): Enacted in 1996 by 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 (PHI).

Hospital: Any acute general care facility.

Hospital Day: Any period up to 24 hours commencing at 12 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 Plan's logo and contains the member's: a) Name and ID number, b) PCP 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 with the Plan, but not as a primary hospital since it is located outside of Ventura County. (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.

Managed Members GCHP: An eligible Medi-Cal beneficiary who is enrolled with GCHP and is not required to select a PCP. An example of these members are foster care children.

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, medical necessity is expanded to include the services that are necessary to correct or ameliorate the defects and physical and mental illnesses and conditions discovered by EPSDT screening services.

Medi-Cal Managed Care Program: The program that the Plan operates under its Medi-Cal agreement with the DHCS for the service area.

Medi-Cal Provider Manual: DHCS' provider manual, issued by the DHCS Fiscal Intermediary for the state.

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 GCHP and is required to select a PCP. Enrolled members will have the name of their PCP listed on their GCHP ID cards.

Member Handbook: The GCHP 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 GCHP and the Medi-Cal member.

Non-Emergency Medical Transportation (NEMT): 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 eight hours (not to exceed 24 hours) during which services furnished by a participating hospital on the hospital's premises, including the 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 the Plan's 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 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 the Plan, to Medi-Cal members through a written agreement between the participating hospital and the Plan.

Participating Provider: A health professional, facility or vendor typically licensed by the state and credentialed to provide covered services to members which has executed an agreement with the 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 VCMMCC, doing business as Gold Coast Health Plan, serving Ventura County's Medi-Cal eligible beneficiaries.

Plan Partners: A health care service plan, subject to regulation by the DMHC, which contracts directly with GCHP and:

- Is responsible for providing health care service for GCHP members.
- 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 the Plan, when a member is clinically stable for discharge from the participating hospital but the member cannot be discharged for reasons outside of the hospital's control. Hospital staff shall contact the Plan's UM staff 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 the Plan to provide primary care services. The individual must be licensed by the appropriate professional state board and enrolled in the state's Medi-Cal program. The PCP 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 PCP. PCPs 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 PCPs and clinics that is periodically updated and published by the Plan. It is provided to members to help them in their selection of a PCP for each member of their family. Members of the family do not have to select the same PCP from the directory and members are able to change their selection if they so desire. (See: Auto Assignment).

Primary Care Services: Those services defined in Attachment C to the PCP Service Agreement and are provided to members by a PCP. These services constitute a basic level of health care usually rendered in ambulatory settings and focus on general health needs. (See: Capitation Payment.)

Primary Hospital: Any hospital affiliated with participating PCPs 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 affect the interaction between physicians and the Plan.

Provider Manual: The manual of operational policies and procedures for the 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 the Plan's agreement with the DHCS. The QIP consists of processes which measure the effectiveness of care, identiy problems, and implements improvement on a continuing basis towards an identified target outcome measurement. The Plan's QIP is overseen by the Quality Improvement Committee (QIC).

Referral Physician (also referred to as a Participating Provider): 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 PCP may refer any member for consultation or treatment.

Referral Services: Covered services, which are not primary care services, provided by specialist physicians on referral from the PCP.

Service Agreement: Agreement entered into between a licensed physician, hospital, allied health care professional (non-physician, non-hospital), or other such health care providers and the VCMMCC, 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 Plan's contracted optometrists, VSP. Lenses must be provided by the Prison Industries Authority (PIA) under contract with the DHCS.

Section 3: Provider Application, Credentialing and Contracting

Initial Application Process and Re-credentialing

To participate in the GCHP network all providers must have their credentials approved by the Plan's credentials committee and sign a service agreement with the Plan. Providers are re-credentialed within 36 months of 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-requisites. For example, pediatricians and family practice specialists who care for children should also be paneled by the CHDP in order 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 GCHP's Provider Relations department at **ProviderRelations@goldchp.org**.

CAQH and Gemini Diversified Services (GDS)

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, 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 to approve or deny admission to the GCHP network. All initial credentialing and re-credentialing decisions are the sole responsibility of the GCHP Credentials Committee.

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, including license status, wheelchair access, fire extinguishers, etc, the 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 designe 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 GCHP immediately by phone (followed up with written notification) if any of the following actions are taken against 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 Credentials 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. Upon notification in writing by GCHP of a notice of action or proposed action to the provider, the provider will have 30 days following the date of receipt of the written notice to request a fair hearing. The provider must submit a written request to GCHP directed to the Quality department director no more than 30 days following the date or receipt of GCHP's notice of an adverse action. Failure to request a hearing within the 30 day time period will be deemed a waiver of the right to a hearing on the matter that is the subject of the notice.

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 the Plan's 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 members until the matter is resolved to the Plan'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 Medi-Cal Program and, therefore, must certify that it has not been debarred or otherwise excluded from receiving these funds. Because GCHP receives this indirect federal funding, GCHP is considered a "lower tier participant" under this rule.

As subcontractors, GCHP's providers — who essentially receive federal funding by nature of their agreement with the Plan — 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 the Plan any incident of fraud, waste and/or abuse that may have occurred by members, providers, or employees, within 10 days from the date when you first became aware of, or were put on notice of, such activity.

To report fraud, waste and abuse, call GCHP'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. Please refer to Section 17 for further details.

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, GCHP assures continuity of care for its 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 15 business days of receipt of issuance of the termination notice from the provider and at least 30 calendar days prior to the effective date of the termination.

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

If GCHP terminates a 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 30 days of 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 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: California State Programs

Coordination of Care

GCHP encourages and supports coordination and continuity of care across the care continuum. PCPs play an important role in coordinating their GCHP members' care. To ensure that PCPs understand the importance of their role in coordinating care, provider training, provider bulletins and other means of communication are employed.

Community agencies also provide critically needed support to the GCHP membership. Some of the community agencies integral to service delivery include:

- Ventura County Child Health and Disability Prevention (CHDP) Program
- Ventura County California Children's Services (CCS)
- Ventura County Behavioral Health Department (VCBHD)
- Ventura County Regional Centers
- Women, Infants, and Children (WIC) Program
- Ventura County Public Health Department (VCPHD)
- School-based program(s)

To assist in facilitating collaboration with the Ventura County Public Health Agencies, GCHP develops and signs Memorandums of Understanding (MOU). These MOUs provide a framework for working collaboratively to ensure coordination of the member's care.

California Children's Services (CCS)

CCS is a statewide program managed by the DHCS and administered by the VCHCA's 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 health care 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 GCHP's 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 health care 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, GCHP 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, contact the local CCS office at **1-805-981-5281**.

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 receive prior certification from CHDP to join the GCHP network. Providers interested in becoming an approved CHDP provider should contact the local CHDP office at **1-805-981-5291**.

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 **www.dhcs.ca.gov/services/chdp**.

Comprehensive Perinatal Services Program (CPSP)

The CPSP 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. This comprehensive approach has proven to reduce problems and medical complications caused by low birth weight infants, thus reducing costs of care and adverse outcomes.

For more information, refer to the CPSP website at: **http://www.cdph.ca.gov/programs/CPSP** or call CPSP Perinatal Services Coordinator at **1-866-241-0395**.

Members with Developmental Disabilities or Developmental Delay

The 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 originate before the age of 18, 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 an MOU with various agencies to coordinate its 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 the AAP 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:

- The child has a developmental delay in either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing.
- The child has an established risk condition(s) of known etiology, with a high probability of resulting in delayed development.
- The child is at high risk of having a substantial developmental disability due to a combination of risk factors.

State legislation requires that you refer children between 0 to 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. The referral must take place within 48 hours of the assessment.

GCHP has entered into an MOU with the local Early Start Program administered by Tri-Counties Regional Center in order to coordinate services to members.

Community-Based Adult Services (CBAS)

GCHP manages the CBAS benefit for Medi-Cal members. The state eliminated the Adult Day Health Care (ADHC) benefit in 2012 and replaced it with the new Medi-Cal benefit.

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, you should refer the member to GCHP for an evaluation.

The qualification criteria is 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 GCHP.
- Prior authorization required for initiation of all CBAS services.
- Claims must be billed on a UB-04 claim form.
- Claims must be submitted within six months from the date of service.
- All required fields must be completed or your claim will be rejected.
- Providers and clearinghouses are required to enroll as a trading partner to submit claims electronically.

For more information about CBAS benefits, including eligibility and referral to 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 he/she 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 him/her contact GCHP's Member Services department at **1-888-301-1228** to obtain the necessary forms and instructions on how members may apply for HIPP.

Objectives of HIPP

The 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 1412491) and the California Code of Regulations (CCR, Title 22, Section 50778). These statutes authorize GCHP to pay private health coverage premiums for its 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 V12617b 3F), Title V Programs (1902) (i.e., 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 and signed Health Insurance Questionnaire (HIQ/DHS 6155)
The applicant is a resident of Ventura County.	A completed and signed HIPP Application (DHS 6172), along with: • Release of Information form • Payee Data Record • HIPP Disclosure Statement • A copy of current insurance card and policy booklet
The applicant has a high cost chronic medical condition.	A signed and dated provider's statement of diagnosis, prognosis and 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 state's 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 seriously chronic high cost medical condition.	A list of current medications including dosage and cost.

Despite a member's participation in HIPP, he/she 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, each case must be re-evaluated 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 the Plan's 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 required forms: • Release of Information Form • Payee Data Record • HIPP Disclosure Statement • Medical Statement of Diagnosis Medical Report	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 required forms accurately and legibly, including: beneficiary's name, address, social security number, 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 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. As of July 26, 2010, the state 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 pay for eyeglasses, contact lenses or other corrective measures to assist with vision needs for the following members:

- Pregnant women, only if the doctor says that not having eyeglasses will be harmful to the baby or pregnancy.
- People under 21 years of age who have full scope Medi-Cal.
- Members who live in a nursing home.
- Members with diabetes are entitled to an annual eye exam.

Services for new eyeglasses or to repair eyeglasses will continue to be available every two years for members under 21years of age.

The eye examination, eyeglass prescription and basic low-cost frames will be provided by GCHP contracted optometrists, but lenses must be provided by the Prison Industries Authority (PIA) under contract to the DHCS. For more information about this benefit, contact the DHCS 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 GCHP's 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 phone number is **1-800-877-7195**.

For information on becoming a participating provider with VSP for GCHP, please call the VSP Provider Network department at **1-800-852-7600 ext. 5339**.

Carved-Out Services and Limited Benefits

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: Call Denti-Cal at **1-800-322-6384** for assistance in locating a Medi-Cal dentist or to obtain prior authorization for service.
- Specialty Mental Health: Providers are required to provide assistance to GCHP/Medi-Cal members needing specialty mental health services (for serious emotional disturbance) 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. Contact the Ventura County Behavioral Health Department, STAR Program and/or Crisis Team at **1-866-998-2243** for referral information.
- Substance Use Disorder Services: Treatment for substance use disorders are available through Ventura County Behavioral Health Department Alcohol and Drug Programs, **1-805-981-9200**. Voluntary inpatient detoxification is also a Medi-Cal benefit.
- Laboratory services provided under the state serum alpha-fetoprotein testing program administered by the Genetic Disease Branch of the DHCS.
- 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). 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. Call GCHP's CCS Liaison Care Manager at **1-888-301-1228**. The number for CCS in Ventura County is **1-805-981-5281**.
- Early Start Program for early intervention and medically necessary diagnostic and therapeutic services provided to infants and children ages 0 to 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, call GCHP's Customer Service department at **1-888-301-1228** to obtain current referral or contact information.

LIMITED BENEFITS

Audiology

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

- Pregnant women (only as 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:

- Referral by a PCP to an Otolaryngologist.
- Referral for hearing aid evaluation from an 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.

For members who do not qualify for audiology services under Medi-Cal, the evaluation by an audiologist is performed at the members expense.

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).

Behavioral Health Care

Outpatient mental health services for the treatment of mild to moderate mental health conditions are a benefit covered by GCHP/Beacon Health Strategies. Contact Beacon Health Strategies at **1-855-765-9702**. These services are for the treatment of mild to moderate mental health conditions, which include:

- Individual and group mental health testing and treatment (psychotherapy).
- Psychological testing to evaluate a mental health condition.
- Outpatient services that include lab work, drugs, and supplies.
- Outpatient services to monitor drug therapy.
- Psychiatric consultation.

Services for relational problems are not covered. This includes counseling for couples or families for conditions listed as relational problems. Relational problems are problems with your spouse or partner, parent-child problems, or problems between siblings.

Specialty Mental Health: Providers are required to provide assistance to GCHP/Medi-Cal members in need of specialty mental-health services (for serious emotional disturbance) by referring them to the appropriate local mental-health agency. Contact the Ventura County Behavioral Health Department, STAR Program and/or Crisis Team at **1-866-998-2243** for referral information.

Beginning Nov. 1, 2015, members receiving Applied Behavioral Analysis (ABA) for the treatment of autism spectrum disorder (ASD) from Tri-Counties Regional Center (TCRC) will transition to ABA care under GCHP/Beacon Health Strategies. Any member with a new ASD diagnosis not associated with TCRC will begin ABA therapy with GCHP/Beacon Health Strategies directly. The following elements apply:

- Any GCHP member diagnosed with ASD up to age 21 will be eligible for ABA services. The ASD must be severe enough to significantly interfere with home or community activities.

- After a diagnostic work-up and prescription from a physician or psychologist is obtained, ABA therapy can be provided by a qualified autism service provider or a service professional or paraprofessional supervised by a qualified autism service provider.

- The diagnosis of ASD must be made by a physician or psychologist and a prescription for ABA therapy is necessary before services can be provided. If a physician feels qualified to make this diagnosis, a prescription for ABA must be written and a referral to Beacon should be made.

Beacon providers will then perform a comprehensive diagnostic evaluation (CDE) and develop an ABA treatment plan. If a physician does not feel comfortable making this diagnosis, the member can be referred to Beacon to obtain the diagnosis from a licensed psychologist.

The following ASD services are not covered:

- Respite care
- Custodial care
- Educational services

Services cannot duplicate care received by other agencies such as those outlined in an Individualized Educational Program (IEP) from a Local Educational Agency (LEA).

You can contact Beacon Health Strategies at **1-855-765-9702**.

Chiropractic

Effective Jan. 26, 2015, chiropractic treatment is available to GCHP members when provided at a contracted Federally Qualified Health Center (FQHC) or Regional Health Center (RHC). GCHP covers chiropractic services only when they are:

- Limited to a maximum of two services per calendar month.
- Limited to treatment of the spine by means of manual manipulation.

Note: Only one chiropractic manipulative treatment code (98940 – 98942) is reimbursable when billed by the same provider, for the same recipient and date of service.

- The diagnosis must show sprain, strain or dislocation of the spine or neck.

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, the VCHSA and the Social Security Administration (SSA) for members with Supplemental Security Income (SSI). There are more than 160 categories of Medi-Cal eligibility, also known as aid codes. These aid codes are assigned by eligibility staff at VCHSA, or the SSA (for members with SSI), 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 on the Medi-Cal eligibility website. The aid codes for GCHP members can be found when checking eligibility on 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 VCHSA 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 health care 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 SOC.

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 an SOC. 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), pregnancy-only, and minor-consent services.

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 what a commercial health insurance plan payment refers to as a "deductible." For example, if a person has an SOC of $150, he/she 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 day the member paid for the service). Call the POS/ Internet Help Desk 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 has been assigned to a PCP. An "administrative" member is one 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 SOC. The SOC is similar to a private insurance plan's out-of-pocket deductible.
- Long-Term Care (LTC) — A member who is residing in a skilled or intermediate-care nursing facility and has been assigned an LTC code.
- Out-of-Area — A member who resides out of GCHP's service area but whose Medi-Cal case remains in Ventura County.
- 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 PCP. 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.
- Hospice: If Medi-Cal enrollment file indicates a Hospice Restricted Services Code.

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 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 in accordance with the state fee schedule during the effective dates of service.

Eligibility, Enrollment and Member ID Cards

Individuals and families apply for Medi-Cal through the VCHSA. Elderly and disabled individuals who receive 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 with GCHP before delivery of services — the GCHP ID card alone is not a guarantee of eligibility.

Selection of a PCP

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 PCP 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 last business day of the month, the member will be enrolled with their PCP on the first calendar day of the following 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 if request is made prior to the last business day of the month.
- 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 online, you will be required to register at the Provider Web Portal. When you visit the portal on GCHP's website, you will find the portal link and will be guided through the registration process by using the Web Portal User Guide. Please refer to the state Medi-Cal website at **https://www.medi-cal.ca.gov/Eligibility/Login.asp** if you need to verify fee-for-service Medi-Cal status.

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

- The member's PCP.
- Whether the member is an administrative or regular member.
- The member's eligibility for CCS (if applicable, on the Medi-Cal website).

Other ways to verify eligibility are to:

Call the GCHP Member Services department at **1-888-301-1228** (Mon-Fri, 8 a.m. to 5 p.m.).

When you call, please provide all of the following:

- The member's full name.
- The member's GCHP ID number.

- The member's date of birth.
- The 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 website at **https://www.medi-cal.ca.gov/Eligibility/Login.asp**.

Member ID Card

The state issues a plastic Medi-Cal ID card known as the Benefits ID Card (BIC). The BIC shows the member's name, date of birth, 14-digit ID number, and the date the card was issued. Use this information to verify eligibility with the state. VCHSA 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 ID 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 on GCHP's website 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 and not assigned to GCHP, 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 health care plan.

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

If you become aware of GCHP members who have moved, or are planning a permanent move out of GCHP's service area, please contact the Plan's Member Services department at **1-888-301-1228** and provide the out-of-area address so that it may be confirmed 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 to 2 months.

Circumstances in which residence or relocation out of the Plan's service areas will not result in a change of responsible county include: the placement of foster/adoptive children out of the Plan's service area or other out-of-area placement of children or residents of LTC 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 on GCHP's 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 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 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 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 PCP. PCPs 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.
- PCPs who administer vaccines to children are required to participate in the Vaccine for Children (VFC) Program.
- PCP should ensure access to care 24 hours per day, seven days per week. The PCP office should have an adequate phone system to handle the member volume.
- PCP should ensure or facilitate patient access to the health care 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 members calling after hours. The members should be advised by a recorded outgoing message that if the situation is a true Medical Emergency, 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 four 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 the 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 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)

DHCS requires that each PCP complete a comprehensive IHA and IHEBA 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 should consist of a comprehensive history and physical examination and the IHEBA. Providers shall document that IHA and IHEBA were 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 the member to schedule an IHA. At least three documented attempts that demonstrate the provider's unsuccessful efforts to contact a member to schedule an IHA and IHEBA are required. Contact methods must include at least one phone call and one mail notification.

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

- If the SHA is completed by the member, providers should explain to the member the SHA's purpose and how it will be used by the PCP.
- Providers shall offer SHA translation, interpretation, and accommodations for any disability, if necessary.
- 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, providers shall document the refusal on the SHA and refer to the SHA instruction sheet for information on documenting the refusal in the medical record. The SHA provider instructions may be found on the GCHP or DHCS websites.
- A parent/guardian must complete the SHA for children under 12.
- For those ages 12 to17, providers may encourage patients to complete the SHA without a parent or guardian.
- Providers may give the adult or senior SHA that is best suited for the member.

Specialty Care

Whenever possible, specialty care will be provided by GCHP providers within the Plan's service area. If a medically necessary specialty service is unavailable within the Plan's service area, contact GCHP staff to coordinate care outside of the area.

Specialist (SPC) responsibilities include, but are not limited to, the following:

- Appointment with an SPC within 15 business days of the request.
- SPC should ensure access to care 24 hours per day, seven days per week. The SPC office should have an adequate phone system to handle the member volume.
- SPC is to ensure that each GCHP member chart includes 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.
- SPC is responsible for establishing a good system for tracking regularly scheduled routine appointments, failed scheduled appointments and for procedures needing completion prior to the patients next scheduled visit.
- SPC 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. SPC office should also recognize any patient complaints or comments and take them into consideration when making changes to the access and availability of care.
- SPC will be responsible for ensuring backup coverage during the SPC's absence, including while the SPC is currently handling an emergency call at a hospital.
- SPC 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.
- SPC shall consider the special needs of GCHP members when scheduling appointments.
- SPC office should have recorded after-hours directions for members calling after hours. Members should be advised by a recorded outgoing message that if the situation is a medical emergency, they should hang up and call 911 or go to the nearest hospital. This message should be recorded in English and Spanish and possibly other languages if the provider has GCHP members that speak other languages.
- SPC office with after-hours answering service should contact the SPC or designated covering physician within 30 minutes for urgent questions. The SPC or designee is required to call the member back within 60 minutes for probable urgent problems and within four hours for probable non-urgent matters.

First Prenatal Visit

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

Preventive Care

As a PCP you are required to provide preventive health care 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 (CDC) 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 health care professional or a physician will be available 24 hours per day, seven 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 24 hours (no Preauthorization required)
Primary care	Within 10 business days of request for appointment
Specialty care	Within 15 business days of request for appointment
Phone wait time	Within 3 to 5 minutes whenever possible
Ancillary services for diagnosis or treatment	Within 15 business days of request for appointment
Initial Health Assessments (IHA) and Individual Health Education Behavioral Assessments (IHEBA)	Within 120 calendar days after enrollment
Waiting time in office	Not to exceed 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 records for claims and service authorization. All medical records should be maintained in a manner consistent with professional practices and prevailing community standards. Providers are required to maintain records for seven years after the termination of the contract with GCHP and for the period of time required by state and federal laws 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

GCHP's Health Services, Quality Improvement or Compliance departments may request records from your office for a covered member for several reasons, including:

- Quality Improvement studies mandated by the state such as Healthcare Effectiveness Data and Information Set (HEDIS®) or Consumer Assessment of Healthcare Providers and Systems (CAHPS®).
- Pre-authorization 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 GCHP.

Reporting Encounter Data

Encounter data is detailed information 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 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. The Plan requires 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 the Plan's payments to 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 GCHP's Customer Service at **1-888-301-1228** for assistance and possible referral the Plan's Information Technology (IT) 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 – it is a measure not taken lightly. Policies and procedures governing a PCP request for member reassignment are as follows::

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 the doctor and patient. In such cases, the PCP and the 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 GCHP's Member Services and Provider Relations departments in writing regarding the PCP's desire to reassign a member from their practice. Complete documentation regarding the nature of the problem must be included with the request. Requests to reassign 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 reassignment, 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 as of the date of the reassignment. GCHP's Member Services department will contact the patient to facilitate enrollment with a new PCP.
    5. PCP will send copy of the letter to the Provider Relations department for storage.
    6. Exceptions to this policy will be considered on a case-by-case basis.
    7. 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.
    8. 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 require special review by the Plan's CMO. 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, GCHP reimburses the hospital for the cost of transportation. However, the Plan does 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.

NEMT Requests

NEMT services are a Medi-Cal covered benefit. If a GCHP member is not able to ride public or private transportation, he/she may qualify for NEMT services under his/her Medi-Cal benefit.

Who Qualifies for the Medi-Cal NEMT Benefit?

NEMT is covered only when a member's medical and physical condition does not allow the member to travel by bus, passenger car, taxicab or another form of public or private conveyance. A member meets the NEMT benefit if he/she:

- Is in a wheelchair and is not able to move in and out of the chair into a seat, or is not able to move the wheelchair without assistance.
- Needs to travel with specialized services, equipment or a caregiver.
- Is not able to sit up and must ride lying down.

How Does the NEMT Benefit Work?

A few important points about the NEMT benefit:

- A physician or specialist must provide an NEMT form which constitutes a prescription and attestation of the medical necessity for transportation service.
- All NEMT services are subject to GCHP review and NEMT form verification process.
- The verification process for the NEMT form takes no longer than five business days.
- Transportation requires at least 48-hour notice for all standard requests.
- If the transportation request is of an urgent nature and needs to occur in less than 48 hours, call GCHP Member Services at **1-888-301-1228**.
- Transportation is not covered if the member is seeking care that is not a Medi-Cal or Medicare covered service.

How to Request NEMT Services for a Member

1. Verify the member's eligibility using GCHP's Provider Portal, GCHP's IVR System, Medi-Cal's AEVS system, or Medi-Cal's eligibility website.
2. Provider must complete the NEMT form. To obtain a copy of this form, visit GCHP's Provider Resources page at **www.goldcoasthealthplan.org**.
3. Fax the NEMT form to GCHP's Health Services department at **1-855-883-1552**.
4. After GCHP receives the NEMT form, GCHP will begin the verification process of the form.
5. Once the NEMT form is verified by GCHP, GCHP will then forward the form to the transportation vendor.
6. NEMT vendor will contact the member and provider to schedule and verify the medical appointment.

What is included on the NEMT Form?

These elements must be completed on each NEMT form for each medical appointment:

1. The medical purpose of the transportation.
2. The frequency of the necessary medical transportation or inclusive dates of the requested medical transportation.
3. Caregiver request and reason the member needs a companion for his/her medical appointment.
4. Medical or physical condition that makes normal public or private transportation inadvisable.
5. The NEMT form must be signed by a physician and dated.

For Questions, Call GCHP Member Services at 1-888-301-1228.

Member Procedures/Rights for Emergency Care

- All providers should have a phone prompt that says, "If this is an emergency, please hang up and call 911."

In any emergency, in accordance with GCHP's Member Handbook, members have a right to access care at any hospital or facility. Once the member is post-stabilized, he/she will be moved to a contracted facility if it is medically necessary.

Section 7: Quality Improvement

GCHP'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, GCHP's Quality Improvement Program (QIP) strives 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.

The *scope* of the QIP 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
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 QIP goals include:

- Continuously improving the quality, appropriateness, availability, accessibility, coordination and continuity of health care services to members across the continuum of care.
- Measuring and enhancing member satisfaction with the quality of care and services provided by the Plan's network providers.
- Maintaining compliance with state and federal regulatory requirements.
- Identifying opportunities and making improvements based on the measurement, validation and interpretation of data.
- Providing oversight of delegated entities to ensure compliance with GCHP standards as well as state and federal regulatory requirements.

GCHP's Quality Improvement Committee (QIC) 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 VCMMCC.

QIC Objectives:

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

QIC Responsibilities:

- Facilitate data-driven indicator development for monitoring Access, Care and Service and Quality Improvement projects interventions.
- Review quarterly committee meeting minutes, action item logs and reports regarding monitoring of health plan functions and activities. Suggest interventions or corrective actions that adhere to the rapid cycle improvement methodologies.
- Oversee the annual review, analysis and evaluation for achievement of goals and effectiveness of the QIP, quality improvement policies and procedures and QI Work Plan for presentation.
- Recommend policy changes or implementation of new policies to GCHP's administration and commission.

External Accountability Set (EAS) Performance Measures

The DHCS selects a set of performance measures annually, referred to as the EAS, to evaluate the quality of care delivered by the Plan to its members. DHCS selects most EAS measures from the 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. For this requirement, providers will receive a request for electronic or hard copies of medical records each year.

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 it 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 its 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.

Facility Site Review (FSR)

GCHP conducts a DHCS-required, full-scope facility site review (FSR), medical records review (MRR) and physical accessibility review survey (PARS) of PCP sites as part of its provider credentialing and re-credentialing process. GCHP utilizes state-mandated tools prior to the PCP being assigned members. PCPs are not eligible to be assigned members until they pass the DHCS-required Site Review Survey. GCHP conducts an FSR every three years for each primary care site. GCHP staff will contact the provider about scheduling the full-scope FSR.

The purpose of the FSR, MRR and PAR is to ensure that GCHP's PCPs meet certain minimum state-required standards for their office sites for maintenance of patient medical records and to ensure physical accessibility for members with disabilities.

The FSR includes an on-site inspection and interview with the office personnel.

The MRR is based upon a survey of 10 randomly selected medical records per PCP and is comprised of five pediatric and five adult (or obstetric) records. The MRR review includes, but is not limited to, a review of format, legal documentation practices, and documentary evidence of the provision of preventive care and coordination of primary care services.

PAR surveys the facility site access for members with disabilities to parking, the building, elevators, doctor's office, exam rooms and restrooms. The survey will also identify if an exam room has a height adjustable exam table and accessible weight scale for those with disabilities.

If GCHP identifies deficiencies during the full scope facility site review, GCHP will give the provider office a Corrective Action Plan (CAP), which will include specific time frames for addressing identified deficiencies to provide care to its members until the identified deficiencies have been corrected.

Performance Improvement Projects (PIP)

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

For more information about GCHP's Quality Improvement System, please call the Plan's Quality Improvement department at **1-888-301-1228** for referral to the appropriate resource.

Delegation

GCHP delegates activities in accordance with the terms and conditions identified in individual contracts.

GCHP will perform oversight of an entity's applicable activities to ensure full compliance with applicable GCHP policies, delegation agreements and the most current National Committee for Quality Assurance (NCQA), federal, state and GCHP standards.

GCHP monitors each entity's compliance with delegated functions and responsibilities, makes recommendations for improvement and monitors corrective actions.

Delegation oversight includes the following components:

- Desktop and annual onsite reviews.
- Monitoring.
- Continuous improvement activities.

Annual Audit

Each delegate is audited at least annually to verify compliance with GCHP requirements and continued ability to perform delegated functions. The Delegation Oversight Audit evaluates the delegate's capabilities in QI, Utilization Management (UM), Credentialing, Member Rights (MR), DHCS (when applicable) and GCHP standards.

Audit Process

Delegation Oversight Audits are performed using the following audit tools which utilize the most current NCQA, state, federal and GCHP standards:

- Credentialing: Most current ICE Tool
- Claims: Most current ICE Tool
- QI: GCHP QI Delegation Oversight Audit Tool
- UM: GCHP UM Delegation Oversight Audit Tool
- RR: GCHP RR Delegation Oversight Audit Tool

Reporting Requirements

Reporting requirements are identified in the Delegated Service Standards/Delegation Agreement included as an attachment to each contract. Delegates are responsible for the timely submission of reports as outlined in the contract.

Non-Compliance

Findings from the annual evaluation, file audit and reports are used to identify areas of improvement and to implement a CAP when warranted. GCHP reserves the right to revoke the delegation of responsibilities when delegate entities demonstrate non-compliance.

Section 8: Care Management Program

CARE MANAGEMENT PROGRAM

The GCHP Care Management (CM) Program is a collaborative process that includes phone contact with the member and communication with the medical management team lead by the PCP.

The Plan's CM Program is designed to support the GCHP mission to improve the health of the member through provision of the best possible quality care and services. GCHP strives to empower high risk and potentially high risk members to gain control of their health care needs by coordinating quality services through an appropriate, cost-effective, and timely care management plan.

The Care Management Program is 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. The Plan's care managers are licensed registered nurse professionals and licensed clinical social workers with specialty certifications specific to their role.

The purpose of the CM program is to:

- Facilitate improvement in the health status and quality of life of members with both complex and non-complex medical needs.
- Decrease unnecessary hospitalization and emergency room (ER) visits by facilitating improvement in member self-management skills.
- Provide proactive coordination of care and services to members who have experienced a critical event or diagnosis requiring the extensive use of resources and who needs assistance navigating the health care system.
- Coordinate care with community agencies to provide additional services not available from the Health Plan.

Care Management Process

Through telephonic interaction with the member, the member's significant other(s), and providers, the care manager collects and analyzes data about the actual and potential care needs for the purpose of developing a care plan. Care managers strive to empower members to exercise their options and access the services appropriate to meet their individual health needs, promoting quality outcomes.

This is done by following GCHP's guiding principles:

- Building a trusting partnership with members through evidence-based intervention.
- Utilizing a comprehensive, holistic approach.
- Empowering members by providing education through evidence-based techniques, informed choice, and linkage to community resources.
- Facilitating member understanding of physician and treatment plans.
- Facilitating self-care management of chronic conditions through evidence-based care models.
- Facilitating the improvement of health outcomes by utilizing evidence-based behavioral change models.

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.

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.

Members eligible for care management services may include those with:

- Multiple medications and difficulty with adherence.
- Non-adherence to the medical treatment plan.
- Psychosocial barriers that may prevent progress.
- Resource barriers who may require assistance from a social worker.
- An organ transplant.
- A catastrophic illness.
- Multiple co-morbidities.
- A complex history with current complex needs.
- Frequent hospitalizations or emergency room visits.
- High risk obstetrical members 35 weeks and below.
- SPD (Seniors and Persons with Disabilities) members
- Children who do not qualify for CCS coverage but have any of the above qualifiers
- Members who do not meet any of the above criteria but are of such intensity that they warrant clinical care management and scrutiny

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 their use of available benefits.
- Improve member and provider satisfaction.
- Assure timely interventions that increase the effectiveness and efficiency of care/services provided to the member.
- Promote effective utilization and monitoring of health care resources while ensuring that the services coordinated for the member are appropriate.
- 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 GCHP's website (Health Services > Care Management): **http://goldcoasthealthplan.org/health-services/care-management.aspx**

The form can be completed and emailed to **CareManagement@goldchp.org** or faxed to **1-855-883-1552**.

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 pre-authorization 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 on evidence-based GCHP policies as well as nationally recognized standards including:

- MCG 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, but are not limited to, the following:

- Allergy desensitization treatment
- MRIs and CT scans
- Outpatient surgery
- Dermatology therapy
- Home health services
- Physical, occupational and speech therapy
- Non-emergency hospitalizations, except for an obstetrical delivery

- 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)
- Drug or treatment interventions not included in GCHP's 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)

You will find a more detailed list of services that require either a request for Direct Referral or Prior Authorization on GCHP's 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:

- Diabetes education.
- Other health education programs.
- Limited allied health services, such as occupational or physical therapy, (physical and occupational therapy visits are limited to one evaluation and nine follow-up visits). *Pre Authorization is required after ten 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 GCHP's Health Services department within 24 hours of the patient admission or the next business day. 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 the 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

Post Stabilization Services - Covered services related to an emergency medical condition that a treating physician views as medically necessary after an emergency medical condition has been stabilized to maintain the member's condition. Prior authorization is not required for coverage of post-stabilization services when these services are provided in any Emergency Department or for services in an observation setting by a provider. GCHP has a plan health professional available 24 hours a day, seven days a week to coordinate a member's transfer of care when their emergency condition is stabilized, to authorize medically necessary post-stabilization services, and for general communication with Emergency Room personnel. Please call **1-888-301-1228**.

Administrative Members

Members with other health care 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 without prior authorization to any willing Medi-Cal provider for family planning and sensitive services.

Family planning services include birth control, 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
- Essure
- 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 the 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 of Syphilis and other venereal diseases
- Termination of pregnancy
- Trichomonas
- Tubal ligation
- 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, 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 Pre-authorization 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 Pre-authorization Request before the service is performed. For routine pre-service requests, GCHP will usually make a determination ***within five 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/mail ***within one business day*** of the decision. It is the responsibility of the provider to 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, the provider may request an expedited review by calling GCHP's Customer Service department at **1-888-301-1228** or by indicating URGENT on the Pre-Authorization Request form. Expedited pre-authorization 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

When a member needs specialty care or procedures, the member's PCP should refer the member to a participating provider available within Ventura County. The PCP may refer the member to a non-contracted provider (non-par) 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 GCHP's service area or out-of-plan are:

- The necessary procedure or service is not available through one of the Plan's in-area network providers.
- The expertise required for consultation is beyond what is available through the Plan's 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 GCHP 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 a GCHP Physician Reviewer.

For more information on out-of-area or out-of-plan (non-par) referrals, please call GCHP's Customer Service department at **1-888-301-1228**.

Specialist Referrals

A Direct Referral Authorization Form (DRAF) is used when referring members for specialty care to a contracted provider (par) within GCHP's service area. This form is sent directly to the specialist by the referring provider.

PCPs must use a Pre-Authorization Treatment Request Form (PTRF) when referring members for specialty care to a provider outside of GCHP's provider network or Ventura County (non-par). As with PTRFs, DRAFs are not required for administrative members.

The referring provider is responsible for verifying the list of contracted 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 be reviewed by a GCHP physician reviewer and will 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 for informing the PCP of the patient's status and proposed interventions throughout the course of treatment. The PCP is responsible for maintaining the referral tracking system.

Post-Service Authorization Requests

If it was not possible for the provider to obtain authorization before providing a medically necessary service, GCHP will respond to a post-service PTRF if it is received within 60 calendar days of initiation of the service. If it is received later, the retrospective PTRF will be denied for non-timely submission. Please note that a post-service PTRF must be accompanied by documentation explaining why the authorization was not requested earlier. The Plan's 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 pre-authorization, under exceptional medical circumstances the Plan may provide authorization after the fact.

If a PTRF 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.

Conditions whereby a PTRF 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.
- When the patient fails to properly disclose Medi-Cal eligibility.

For more information on timely submission of pre-authorization requests, please go to the Request for Authorization menu item on GCHP's website, **www.goldcoasthealthplan.org**.

Authorization Requests for Ancillary Services

Pre-authorization is required for ancillary services such as home health care, rehabilitation services and durable medical equipment (DME). Ancillary services requiring pre-authorization 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.
- Non-Emergent Medical Transportation Service (NEMT).

It is the provider's responsibility to determine eligibility and medical necessity for a member to receive NEMT services. The provider must complete the NEMT form and fax it to GCHP at 1-855-883-1552. GCHP will review the form for completeness and communicate NEMT eligibility to Ventura Transit System (VTS). The verification process will not take longer than five business days. Once verified, VTS will then contact the member within 48 hours to arrange transportation. If the transportation request is of an urgent nature and needs to occur in less than 48 hours, please call GCHP Customer Service at 1-888-301-1228.

The NEMT Services Prescription/Attestation of Medical Necessity Form is available on GCHP's website (refer to Section 19: Forms and Resources).

Hospital Inpatient Services

Admissions to an acute-care facility or Ambulatory Surgery Center for scheduled surgery require pre-authorization. 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 pre-authorization Request For Treatment form will assure the timeliest decision:

- Please type the form — an illegible handwritten form may be returned to the provider.
- Be sure to include your name, address, phone 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 ID number must be correct. Refer to the Medi-Cal card if necessary.
- Enter the description of the diagnosis and ICD-9 or CPT code into the appropriate box with modifiers that most closely describe the member's condition.
- Use the correct GCHP provider ID 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 the 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 PTRF for each service request per member. The PTRF will be given a unique number that is used to facilitate reimbursement.

Hospital Observation

Observation stays do not require prior authorization. Hospitals are limited to one day observation. Any hospital stay 24 hours or greater will be considered inpatient and will require authorization.

Observation is defined as the following: A period of less than 24 hours and for a minimum of eight hours in a duration during which services furnished by a hospital on the hospital's premises include the 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 an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient.

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)
- Sub-acute Care Facilities

Nursing Facility Authorizations

It is GCHP's responsibility to assist its nursing facility providers with instructions for the submission requirements of prior 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 five business days of the member's arrival to the facility. All admissions for Skilled Nursing level of care require prior authorization.

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

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

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. The facility must complete a prior authorization request and submit it to the GCHP Health Services department. Remember that GCHP is a Medi-Cal provider and as such, 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 and should also include hospice members.

Other Health Coverage (OHC)

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

Reauthorization request

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

Long-Term Care

The following is required for a LTC admission review:

1. Pre-authorization Treatment Request Form (PTRF). The Pre-authorization Treatment form is available at **www.goldcoasthealthplan.org**. Select Providers > Resources > Request for Authorization > 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). Sections I through VII are required. The form is available at **www.medi-cal.ca.gov**. Select References > Forms > 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 two weeks.
3. Sufficient chart documentation to justify the 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 > 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**. Select References > Forms > TAR Supplemental Forms.
4. Sufficient chart documentation to justify level of care requested.

Hospice Care

Only general inpatient hospice requires prior authorization following the standard prior authorization process.

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 health care 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 and meet at least one of the following criteria:
  - Credentialed as an HIV specialist by the American Academy of HIV Medicine.
  - Board certified or 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.

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

GCHP's prior authorization nurse coordinators will review PTRF forms for completeness and will help you with any aspect of the process, including answering questions regarding the status of PTRFs. 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. The requesting provider will receive a letter notifying of deferral.

When a request is denied by another agency, a Notice of Action letter will be mailed to the provider, the requesting facility, and the member. When a request is denied by GCHP, a denial letter will be mailed to the provider, requesting facility and the member no later than the second business day after the decision. If the denial is a result of insufficient information from the provider, the Plan will inform the member that the case will be reopened when complete information is received. The denial letter will explain the reason for denial 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 regarding the claims submission process. These guidelines do not, however, supersede any regulatory or contractual requirements published in legally binding documents or notices.

GCHP strives to process all claims in a timely manner and respond courteously to all inquiries from providers. GCHP is contractually bound to process 90% of clean claims within 30 calendar days of receipt of the claim. All claims are processed daily on a first-in / first-out basis. Claim payments 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 be pended for manual review by a claims examiner. Claims examiners cannot correct claim submission 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 DHCS.

Refer to the Provider Web Portal on GCHP's 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 a.m. and 5 p.m., 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
- Member's name as it appears on the member's GCHP ID card
- National Provider Identifier (NPI)

Contact your vendor or billing service for instructions about how to ensure that the Plan Provider ID is coded as a GCHP 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 GCHP's website, **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 the Plan's 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 (CMS) standards (see **http://www.cms.hhs.gov/**).
- Use black or blue ink; do not use red ink, as the scanner may not be able to read it.
- Use the Remarks field for messages.
- Do not stamp or write over boxes on the claim form.
- Send the original claim form to us and retain the copy for your records.
- Separate each individual claim form. Do not staple original claims together, as GCHP would consider the second claim an "attachment" and not an original claim to be processed separately.
- Use member's name as it appears on the member's GCHP ID Card.

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 the Plan 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 it cannot be determined 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, emergency service and benefit exclusions).
- Claims that GCHP has 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 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 that there was proper follow up on paper 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

Once a claim is received by GCHP, it is assigned a unique Document Control Number (DCN). The DCN identifies and tracks claims as they move through the Claims Processing System. The 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, GCHP refers to this claim as a rejected claim. GCHP will indicate what information is missing or needs to be corrected by the provider in order to process the claim. Timely filing requirements still apply.

Timely Filing Requirements

Claims must be submitted within six months from the date of service. Claims received after six months from the date of service will be denied for timely filing unless circumstances prevented the claims from being filed within six months. An example of that would be if the member has other insurance and the provider has to wait for the primary carrier to process the claim before being able to submit the claim to GCHP.

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

Claims Payment

Upon receipt of a provider's claim, the claim is analyzed to determine if the services are covered and identify the corresponding amount to be paid. Once the claim is finalized, GCHP generates a Remittance

Advice (RA) summarizing services rendered and payer action taken, and then sends the appropriate payment amount to the provider.

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

If the claim contains all required information, the claim is entered into GCHP's Claims Processing System and the provider is sent an RA at the time the claim is finalized.

CHDP Claims Submission

Providers must be CHDP paneled in order to provide CHDP services. Only providers who are paneled will be reimbursed for these services.

All encounters and claims for CHDP should be submitted to GCHP on a CMS 1500 form, using the American Medical Association (AMA) Current Procedural Terminology (CPT). The PM-160 Information Only form should also be submitted to GCHP for appropriate reporting to the state.

The following Preventive CPT codes when utilized for CHDP are to be billed with the 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 to 39 years (CHDP services are only covered 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 to 39 years (CHDP services are only covered up to age 21 years)

Claims Submission by FAX

GCHP is unable to accept or process claims submitted via FAX.
Claims must be submitted either electronically via EDI or by paper to the P.O. Box indicated 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 GCHP.

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 (Information Only Form)	PCPs	Child Health & Disability Program (CHDP) services (the Information Only Form) and only for Medi-Cal members. CHDP services must be billed on the CMS-1500 form using standard CPT E&M codes and the EP modifier.
UB-04	Hospitals/Clinics/SNF's/ Surgicenters	All professional or facility services.
CMS-1500	Imaging Centers	Professional X-ray and related services.
25-1C	LTC's	All LTC services.

* ***All claims should be submitted no later than 180 days from the Date of Service, with the exception of other health coverage. If there is another carrier involved (e.g., Medicare, commercial health insurance, etc.) then the claim must first be submitted to the other carrier since Medi-Cal is the payer of last resort. Once the primary carrier has processed the claim, the provider should submit the claim, along with the primary carrier's Explanation of Benefits (EOB) form to GCHP within 180 days from the date of primary carrier's EOB. GCHP will then consider the claim as the secondary carrier and will determine if any additional payment is due as appropriate up to the Medi-Cal maximum allowable payment amount.***

Transition to ICD-10

GCHP requires the use of ICD-10 codes for services incurred on or after Oct. 1, 2015. The following chart is provided to assist you in determining which code set to use as you transition to ICD-10:

	Scenario	Examples
Inpatient	Dates of Service Prior to 10/1/15 – ICD-9 diagnosis and ICD-9 procedure codes are required.	
	Dates of Service On/After 10/1/15 – ICD-10 diagnosis and ICD-10 procedure codes are required.	
	Dates of Service Span 10/1/15 – Providers must split bill any claim that spans the compliance date of 10/1/15; follow the above rules to determine the correct code set to use.	Requires Split Billing (two separate claims) DOS 09/28/15 – 10/07/15 1st claim: 09/28/15 – 9/30/15 ICD-9 codes 2nd claim: 10/01/15 – 10/07/15 ICD-10 codes
Outpatient	Dates of Service Prior to 10/1/15 – ICD-9 diagnosis and ICD-9 procedure codes are required.	
	Dates of Service On/After 10/1/15 – ICD-10 diagnosis and ICD-10 procedure codes are required.	

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. As such, when a Medi-Cal member has other health coverage (OHC), GCHP becomes the secondary (or sometimes tertiary) 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 health care 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, he/she 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 receiving 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 CCS program, please contact CCS for a referral. If a member with other health coverage needs services requiring 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/her primary insurance, the member is responsible for the cost.

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

GCHP currently has electronic data exchange with Medicare to receive automated claims information for Medicare Part B Claims only.

GCHP began to accept electronic Crossover Claims for Dual Eligible members (Medi-Medi) for Medicare Part B claims starting in April 2015.

GCHP automatically receives a Medicare Part B Medi-Medi Crossover Claims file from the DHCS on a weekly basis. As a result, providers will no longer need to submit to GCHP hard copy (paper) claims for Part B services with the Medicare Explanation of Benefits (MEOB) attached. This change is effective for claims with dates of service on or after April 1, 2015. There are certain claim types where GCHP is not receiving all the information necessary to process the claim using the Crossover Claims file. In those instances, GCHP will deny the claim and request that the provider re-bill GCHP on a paper claim with the MEOB attached.

GCHP only receives an electronic claims file from DHCS for Part B claims. Providers will still need to submit claims for Part A services for Medi-Medi members in hard copy format to GCHP, with the MEOB attached, according to the following instructions:

- Send a hard copy or an original Medicare claim. Confirm that your NPI number is on the claim and that the appropriate Medi-Cal procedure codes and modifiers are present. You may bill GCHP in the same manner as you billed Medicare, using the same procedure codes and modifiers. However, the member ID on box 1a should be the GCHP/Medi-Cal CIN. The member ID on box 9a should be the Medicare ID. 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 hard copy of the MEOB. The dates and procedures must match those on the claim submitted to GCHP. If there are other patients listed on the MEOB, please de-identify 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 MEOB. You have six-months from the date of the MEOB 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

California law limits Medi-Cal reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum allowed for similar services. (Refer to Welfare and Institutions Code, Section 14109.5.) The following provides three different examples of crossover claims processing results (dollar amounts are for demonstration only and do not reflect actual allowed amounts for either Medicare or Medi-Cal):

CPT Code	Billed Amount	Medicare Allowed	Deductible/ Coinsurance	Medicare Paid	Medi-Cal Allowed	Medi-Cal Paid
99215	300.00	100.00	20.00	80.00	50.00	0.00
No payment is due under Medi-Cal as the Medicare payment exceeds the Medi-Cal allowance.						
This is referred to as a "zero pay" claim.						
71020	100.00	80.00	16.00	64.00	70.00	6.00
$6.00 of the Medicare deductible/coinsurance can be picked up under Medi-Cal as that is the difference between what Medicare paid and the Medi-Cal allowance.						
10160	50.00	25.00	5.00	20.00	35.00	5.00

The entire Medicare deductible/coinsurance amount of $5.00 can be picked up as that amount combined with the Medicare paid amount of $20.00 does not exceed the Medi-Cal allowance.

Providers who accept persons eligible for both Medicare and Medi-Cal cannot bill them for the Medicare deductible and coinsurance amounts. These amounts can be billed only to Medi-Cal for consideration. Providers should, however, bill Medi-Cal members for any SOC.

Note: Providers are strongly advised to wait until they receive the Medicare payment before collecting SOC to avoid collecting amounts greater than the Medicare deductible and/or coinsurance.

Claims for Medi-Medi members must be submitted to Medicare prior to billing GCHP, except for services that Medicare does not cover. GCHP may reimburse providers for non-covered, exhausted or denied services when billed to GCHP with the appropriate Medicare denial attached.

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 SOC 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 SOC. 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 health care benefits, he/she 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 care through the VA system or GCHP — GCHP cannot require or request that they do so; but, if the member wishes, the Plan 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 PCP, which may be a clinic or physician.
- Provide member eligibility and benefits.
- Provide claim status.
- 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 the rights and responsibilities of members.

New members receive a mailing, which includes:

- A welcome letter and a form to select a PCP from the Provider Directory, which is also 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 navigate the 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 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 three newsletters per calendar year, which include articles on health education topics, service and benefit reminders, and information about how to use the Plan.

Member Services Staff

You may seek assistance and support in dealing with member service issues by calling GCHP's Member Services department at **1-888-301-1228**.

New members have thirty 30 days to choose a PCP, during which time they are able to access care from any willing Medi-Cal provider within GCHP's service area. If a member does not choose a PCP, GCHP 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 calendar day of the following month. If a member loses eligibility for Medi-Cal but returns as a member within six months, he/she will remain linked to his/her previous PCP unless that participating provider is closed to new patients or no longer available.

Section 13: Cultural and Linguistic Services

Language Access Program Services

GCHP is committed to delivering culturally and linguistically appropriate health care services to members. GCHP 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 and translation services at all key points of medical services. All LEP and Seniors and Persons with Disabilities (SPD) beneficiaries are entitled to free interpreter and translation services when accessing medically necessary covered services and/or access to alternative formats or through other methods that ensure communication.

GCHP Cultural and Linguistic Services coordinates interpreting and translation services. GCHP trains Plan providers and their staff on the language access program, cultural diversity, and sensitivity related to seniors and persons with disabilities.

Providers may request interpreter services for GCHP members with LEP. Providers may also request telephonic or face-to face interpreting services.

Telephonic Interpreting Services

Telephonic Interpreting services are available 24 hours per day, seven days a week for medical encounters. Members are NOT required to bring an interpreter. GCHP discourages using family or friends, especially children, as interpreters. GCHP provides telephonic interpreter services at no cost to members. Please call Customer Service at **1-888-301-1228/TTY: 1-888-310-7347** or Cultural and Linguistic Services at **1-805-437-5604** for assistance with coordinating interpreter services.

Face-to-Face Interpreting Services

GCHP works with various vendors to provide telephonic and face-to-face interpreter services. Please contact Member Services or Cultural and Linguistic Services for assistance. An interpreter request form can also be downloaded at www.goldcoasthealthplan.org or requested via email at **CulturalLinguistics@goldchp.org**.

Sign Language Interpreting Services

GCHP complies with the Americans with Disabilities Act (ADA) to ensure that deaf and hard of hearing members receive interpreter services. GCHP has contracted with an agency to provide American Sign Language interpreters for deaf and hard of hearing members for medical appointments.

How to Request Interpreter Services

- For assistance, provider(s) may call GCHP's Customer Services department at **1-888-301-1228/ TTY: 1-888-310-7347**, GCHP's Cultural and Linguistic Services at **1-805-437-5500**, or LifeSigns at **1-888-930-7776**.
- For emergency/last minute request during business hours, please call the local number for LifeSigns at **1-323-550-4210**.
- Please confirm the member's Medi-Cal eligibility before requesting a sign language interpreter.
- Requests for an interpreter should be made, if possible, 5 to 7 business days in advance of any scheduled member appointment. There is no guarantee that interpreter services will be 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 of assignments lasting two hours or less will require 25-hour notice of cancellation. Cancellation for assignments lasting longer than two hours will require 49-hour notice of cancellation.
- Email interpreter request forms to GCHP Cultural and Linguistic Services at **CulturalLinguistics@goldchp.org**.
  You may also submit your request via fax to 1-805-437-5134 and LifeSigns at **1-888-227-5021**.

When submitting your request, please be sure to indicate the member's name and GCHP ID number; 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 and Linguistic Services

Cultural issues are important in understanding health beliefs and practices. GCHP provides LEP members with written information in the member's primary threshold language. In addition, health education materials and programs are designed to reflect the cultural diversity and the linguistic needs of the Plan's 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 LEP members and/or those with low health literacy may contact GHCP's Cultural and Linguistic Services office at **1-888-301-1228** for assistance and additional resources.

Cultural and Linguistic Resources

GCHP routinely distributes information promoting interpreting and translation services to provider offices. GCHP makes promotional/educational materials for providers to assist with cultural and linguistic (C&L) requirements, services, and resources. Provider offices are required to post the C&L materials in the medical office. Providers can request a Cultural and Linguistic Services Material Order Form at: **CulturalLinguistics@goldchp.org**. Additional provider tools can be found on GCHP's website, **www.goldcoasthealthplan.org**, under Health Services > Cultural and Linguistic Services.

Section 14: Health Education

Introduction

GCHP's Health Education department 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 PCPs to provide quality health education classes and materials at no charge to GCHP members.

Members may self-refer or they may be referred by their PCP, Care Management or by GCHP's Health Education department. Contact the Health Education department for the referral form or utilize the GCHP website to obtain the Health Education referral form. ***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's Health Education department, or email: **HealthEducation@goldchp.org**.

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.

Staying Healthy Assessment (SHA)

The DHCS requires contracted PCPs to administer a SHA. The SHA is also known as the IHEBA. All new Medi-Cal managed care members must complete the SHA within 120 days of enrollment with GCHP and providers must periodically re-administer the SHA questionnaire during subsequent visits. The SHA forms may be found on GCHP's website or the DHCS website. The SHA is available in multiple languages.

Health Promotion and Disease-Prevention Programs

As a benefit of partnering with GCHP, the Plan offers its providers helpful information about health promotion and disease prevention programs. Providers can access GCHP's website to download health education materials and information about local health education activities. Additionally, GCHP's website has an enhanced calendar section which allows providers to view a list of upcoming events and health education classes for members. Providers can also view flyers for the corresponding classes for specific information, such as a detailed description of the event, date and time.

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 GCHP's Health Education department.

- **Diabetes Education** – GCHP will work with providers and local agencies in identifying diabetes self-management classes and support groups.
- **Weight Management and 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 the Ventura County WIC program have entered into an MOU for the delivery of services to members who are served by both organizations. GCHP will work with Plan providers to promote the benefits of breastfeeding and information on the support groups available to women.
- **Prenatal/Postpartum Care** – The Health Education department provides outreach representation at hospital tours for potential members to ask any questions that they may have and to provide them with valuable resources.

- **Smoking Cessation** – GCHP will collaborate with various agencies to promote smoking cessation classes throughout the county. GCHP also has a Quit Smoking brochure available for its members. The brochure outlines all the services available within Ventura County for members who want to Quit Smoking. For free smoking cessation classes, support groups and nicotine patches and gum, call GCHP's Health Education department for more information or the California Smoker's Helpline at 1-800-NO-BUTTS (1-800-662-8887) or in Spanish 1-800-45-NO-FUME (1-800-456-6386). Ventura County Public Health (VCPH) offers Free "Call it Quits" classes. The program consists of eight sessions, totaling an hour and a half per session. The program can be reached at 1-805-201-STOP (7867) or by email at **callitquits@ventura.org**
- **Urgent Care Brochure** – Health Education has also created a brochure for members who would like information on GCHP's contracted urgent care centers.
- **My Plate** – GCHP's Health Education department also encourages members to access the **ChooseMyPlate.gov** site, provided by the U.S. Department of Agriculture (USDA). Materials from the site are provided for members to use as a guide.
- **Rethink Your Drink** – Health Education also instructs members at health fairs on the sugar content of drinks. The campaign's purpose is to enable members to make informed decisions regarding drinks other than water.
- **CDC** – Health Education also utilizes the CDC's website to provide the Plan's members with the most current immunization schedules and other useful health information.

Women's Health

Plan providers may access GCHP's 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 be found there, as well as information on prenatal and postpartum care and OB tours.

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 and disease prevention topics that GCHP providers may access. Contact GCHP's Health Education department for help completing a provider order form. The Health Education department can be reached at **HealthEducation@goldchp.org**.

- AIDS/HIV Screening
- Breast Health
- Childhood Obesity
- Children's Health
- Diabetes
- Family Planning
- High Blood Pressure
- High Cholesterol
- Immunization
- Men's Health
- Pregnancy
- Breastfeeding
- Sexually Transmitted Infection (STI)
- 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 LEP members. The Health Education department works with Plan providers to ensure that health promotion materials are available for distribution and that equal access is provided for services to members. Contact GCHP's Health Education department at **HealthEducation@goldchp.org**.

For information on culturally-appropriate materials and services, see Section 13 of the Provider Manual.

Outreach to Members

GCHP also reaches out to members on a regular basis to encourage health maintenance, disease prevention, and a healthy lifestyle. The following are some of the tools GCHP utilizes in the outreach program:

- Community Health Fairs.
- GCHP's member newsletter.
- Health program updates in the quarterly GCHP Provider Operations Bulletin.
- Community Resource Guide and Resource Guide for Seniors, available on GCHP's website.
- Health Education Referral, also available on the Plan's website.
- Health Navigator program – GCHP's health navigators work directly with the member to assist him/her with doctor's appointments and avoid unnecessary emergency room visits. Health navigators work closely with clinical staff and refer members to care management if deemed appropriate. To learn more about the health navigator program contact the Health Education department **1-805-437-5500**.
- GCHP's website **www.goldcoasthealthplan.org** also has information for both providers and members.
- Members can participate at numerous community events, health fairs and other health promotion activities. Please view the calendar section on GCHP's website for more information.

Provider Order Form

The Provider Order Form is also available for providers to order brochures and educational materials directly from the Health Education department or to access a link that will allow providers to order materials directly from the source. The materials can also be delivered directly to the provider's office. Providers may contact the Health Education department for the form. Upon completion, providers can fax the form to **1-805-437-5134**. The materials that are available are:

- GCHP Mission Statement pamphlet
- GCHP Tobacco Education and Quit Smoking Resource Guide
- California Smokers Helpline
- Winning Health newsletters
- GCHP Health Education Referral Form
- GCHP Member Benefit Information Meetings
- GCHP Coloring Books
- DHCS – Staying Healthy Assessments (link provided on form and GCHP website)
- GCHP Community Resource Guide
- GCHP Mental Health FAQs
- GCHP LIHP FAQs
- Covered California (Covered Ventura County)
- DHCS – Newborn Referral Form MC 330
- First5 Kit for New Parents – (link provided on form for direct ordering)
- California Poison Control – (link provided on form for direct ordering)

- California Child Health and Disability Prevention pamphlet
- Ventura County Women, Infants and Children (WIC) – (link provided on form for direct ordering)
- CalFresh bookmark
- Safe Kids Ventura County
- Safe Kids Ventura County – Child Passenger Safety Car Seat Check Locations
- Choose My Plate (10 Tips to Build a Healthy Meal) – (link provided on form for direct ordering)

Provider Training

The Health Education department is available for provider trainings in a number of areas. The Health Education department has also partnered with UCLA to host the Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training. Contact the Health Education department if you have questions on specific trainings. The trainings are approximately an hour in length, and can be scheduled at the provider's convenience. The trainings are:

- SHA (Staying Healthy Assessment)
- Seniors and Persons with Disabilities Training
- Health Education and Nutrition (Review of MyPlate with members)
- Health Education Program Overview

Outreach Services

The Plan's Outreach department has representatives at various events throughout the county, ranging from Hospital Pregnancy Tours, to Health Fairs, to advocating for members at various meetings. The Outreach department is available if providers have questions about upcoming events or would like to request and/or refer GCHP's Outreach department to an event. The Outreach department can be reached by sending an email to **outreach@goldchp.org**. Providers can also view events on GCHP's website, and refer members to classes.

For additional information about GCHP's programs, services and events, visit the Plan's website at **www.goldcoasthealthplan.org**. GCHP has numerous agreements with other public agencies and is in constant communication with participating hospitals, clinics and other providers which offer classes on a variety of health care topics throughout the community. You may also call the Plan's Health Education department or Member Services at **1-888-301-1228** for information on upcoming events.

Section 15: Pharmacy

GCHP has contracted with Script Care, LTD., as its pharmacy benefits manager (PBM), to process prescriptions claims for all GCHP members. Members must go to a GCHP-participating pharmacy that has contracted with Script Care to fill their prescriptions. There are numerous participating pharmacies located conveniently throughout the county. In addition, many of GCHP's participating providers have a pharmacy on site.

Please see the Pharmacy Listing in GCHP's Specialist Directory on the Plan's website for in-network pharmacy locations and contact information. The directory is posted in the Providers Resources section on the GCHP website at **http://www.goldcoasthealthplan.org**.

Drug Formulary

The GCHP Formulary has been developed by the GCHP Pharmacy and Therapeutics (P&T) Committee. The formulary, is reviewed and updated quarterly due to advances in therapeutic treatment regimens and newly FDA-approved products. The updated formulary is posted by the first day of each calendar quarter (Jan. 1, April 1, July 1 and Oct. 1). Please refer to the GCHP Formulary posted in the providers page, under Pharmacy, on the Plan's 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. Please remember to update any formulary documents that were printed or downloaded with the most recent versions as they become available.

The formulary does employ several mechanisms to help manage drug utilization. These mechanisms are step therapy protocols, prior authorizations, quantity limits and age restrictions. All restrictions are noted on the formulary to the right of each covered drug listed. Please refer to this section as needed.

- CPA: Clinical Prior Authorization
- QL: Quantity Limit
- Step: Step Therapy
- Age > X or Age < X: age restriction

Providers may request a change to the formulary by submitting a written request to GCHP, which will be reviewed by the P&T committee. Please submit all written requests with clinical justification to GCHP at the following address:

Gold Coast Health Plan P&T Committee
Attn: Director of Pharmacy
711 E Daily Drive Suite 106
Camarillo, CA 93010

Step Therapy Protocol

Members receiving a new prescription for a drug with a step therapy requirement will be required to receive an alternative drug, generally a lower cost generic product within the same drug class before the drug can be covered. The pharmacist will receive a message from the PBM adjudication system when a prescription for a drug with a step therapy requirement is processed. Generally, the pharmacist will contact the prescribing physician to obtain approval to dispense the lower cost alternative drug. If the lower cost alternative drug is ineffective after an appropriate trial, or inappropriate for the member or the member's condition, then the originally requested drug may be covered.

- Step therapy is based upon current medical findings, FDA-approved labeling information, and cost.
- All drugs within a step therapy protocol are FDA-approved and are used to treat the same condition.

- If medically necessary, a drug may receive an exception to bypass the step protocol. The physician must request coverage for the drug as through the formulary exception process as described below. Please contact GCHP Pharmacy Services at Script Care at: **1-888-531-0998**.

Prior Authorizations Requirements

Some drug products are included on the GCHP formulary with a prior authorization. A prior authorization is needed before the drug will be covered by GCHP. In order to obtain an authorization, please contact the GCHP Pharmacy Services at Script Care at **1-888-531-0998**. Once all documentation has been received, the prior authorization request will be reviewed within 24 hours or one business day.

Generally, all of the following documentation is necessary in order to complete the prior authorization as expeditiously as possible:

- Completed prior authorization form
- Chart notes
- Prior tried and failed medications and outcomes
- Lab values
- Any other documentation to support the diagnosis and use of the requested drug product

Formulary Exceptions

Approval of a drug product not listed on the GCHP formulary, (called a non-formulary drug) for exceptions to the formulary restrictions (i.e., to obtain a quantity greater than the restriction noted) may be received. Generally, a member must have tried and failed treatment with all formulary alternatives or up to the current restriction and have documented treatment failures accompanied by claims history with GCHP or documentation in the member's medical record. Generally, all of the following documentation is necessary in order to complete an exception request as expeditiously as possible:

- Completed prior authorization form
- Chart notes
- Prior tried and failed medications and outcomes
- Lab values
- Any other documentation to support the diagnosis and use of the requested drug product

To request an exception, please contact the GCHP Pharmacy department at Script Care at: **1-888-531-0998**. Once all documentation has been received, the exception request will be reviewed within 24 hours or one business day.

Section 16: 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 county 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 GCHP's contracted labs, locations and phone numbers is posted on the Plan's website under Provider Directories in the Provider Portal at **www.goldcoasthealthplan.org**.

Outpatient Imaging Centers

There is a wide range of contracted imaging centers located conveniently throughout the county. 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 the Plan's contracted imaging centers, their locations and phone numbers are available in the Specialist Directory in the Provider Portal on the Plan's 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 the Plan's website. PCPs 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 (except 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 17: Resolution of Disputes and Grievances

GCHP members and providers may access the grievance process at any time. To download the necessary forms, go to the Forms and Documents menu in the Providers Portal section of the Plan's 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 the Plan's time to act. Providers must exhaust this dispute resolution process before pursuing other available legal remedies.

Provider Dispute Resolution (PDR) Process

If you have a dispute regarding a claim you submitted that has been adjusted, contested or denied, or to dispute a request for reimbursement of an overpayment, you may participate in GCHP's PDR process. Providers have 365 days from the date of last action to submit a PDR. PDRs should be submitted using the Provider Dispute Resolution Form. You should mail your dispute to:

Gold Coast Health Plan
ATTN: Provider Dispute Resolution
P.O. Box 9176
Oxnard, CA 93031

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

- Provider and/or group 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 nine-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 the Plan cannot readily obtain it, it will be returned 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 he/she 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 multiple disputes.

GCHP will acknowledge the dispute within 15 days of receiving it. GCHP will send a written resolution to the dispute within 60 calendar days of the date the dispute is received. For assistance filing a dispute, please call GCHP's Customer Service at **1-888-301-1228**.

Provider Grievances

The provider grievance process is a method for providers to express their dissatisfaction in writing regarding GCHP's action or inaction on some matters. Providers who previously submitted an appeal or a provider dispute and are dissatisfied with the outcome have the right to submit a grievance for the same issue. The grievance must be submitted in writing using the Provider Grievance form and should include all supporting documentation. Grievances related to medical necessity decision disputes must be submitted within 60 calendar days from the date of the decision letter. Grievances related to claim dispute decisions must be submitted within 180 calendar days from the date of the decision letter.

All provider grievances will be promptly acknowledged, reviewed and researched by the Grievance & Appeals team. Research may require the participation of staff from any relevant GCHP department depending on the nature of the grievance. All grievances must be acknowledged within five calendar days of receipt and resolved within 30 calendar days of receipt.

A provider grievance can be filed by completing the Provider Grievance form located on GCHP's website: **www.goldcoasthealthplan.org**, located under the Provider Resource tab in the Grievance & Appeals section. After completing the Provider Grievance form, please mail it to:

Gold Coast Health Plan
Attn: Provider Grievance & Appeals
P.O. Box 9176
Oxnard, CA 93031

Member Grievance/Appeal

Providers can file a grievance or an appeal on behalf of a member or offer assistance filing a grievance or an appeal.

GCHP members have the right to file a grievance about their experiences with the Plan or its providers. While most providers have their own internal mechanisms for resolving patient complaints, GCHP provides a grievance system for members to utilize to express their dissatisfaction.

GCHP members have the right to appeal a decision that they do not agree with. They have 60 calendar days from the date of the Notice of Action letter or decision to submit an appeal. This request can be made by the member, the member's authorized representative or the provider on behalf of the member.

If a member asks to file a grievance or an appeal, the provider's office can give him/her the appropriate forms and instructions, which are on the GCHP website: www.goldcoasthealthplan.org, located under Member Resources in the Grievance & Appeals section (forms are available in English and Spanish).

A grievance or an appeal may be filed using the following methods:

- In person, by meeting with a Member Services representative at GCHP's offices Monday-Friday from 8 a.m. to 5 p.m.
  711 E Daily Drive, Suite #106
  Camarillo, CA 93010
  Phone: 1-888-301-1228
- By calling a Member Services representative at 1-888-301-1228/TTY 1-888-310-7347.

- By completing a grievance or an appeal form and/or correspondence in writing and sending it to the Grievance & Appeals department:

  Gold Coast Health Plan
  Attn: Member/Grievance & Appeals
  P.O. Box 9176
  Oxnard, CA 93031

All grievances or appeals must be acknowledged within five calendar days of receipt and resolved within 30 calendar days of receipt.

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, but is not limited to, completing a provider statement, providing pertinent information related to the complaint, and/or speaking with GCHP Grievance & Appeals representatives to assist with resolving the complaint in a reasonable manner.

Expedited Review/Appeal

An expedited appeal can be requested in certain cases. This request can be made by the member, the member's authorized representative or by the provider on behalf of the member. GCHP supports a process to resolve appeals in an expedited manner when a delay in a decision may seriously jeopardize the member's life, health, or the ability to attain, maintain or regain maximum function. The expedited appeal can be filed orally or in writing. At the time the appeal is filed, the Grievance & Appeals specialist will inform the member of the limited time to submit supporting documentation.

The Grievance & Appeals specialist will facilitate resolution of the expedited appeal within three business days from the day GCHP receives the appeal if the appeal is deemed to be urgent. The timeframe may be extended an additional 14 calendar days if there is a need for additional information and if the delayed decision is not detrimental to the member. The process for review will include a physician who was not involved in the original decision. An attempt will be made to notify the member verbally of the decision based on the urgency of the request. If the appeal is not deemed to be urgent, the process will revert to the standard appeal process for resolution within 30 calendar days.

State Fair Hearings

All Medi-Cal beneficiaries have the right to request a State Fair Hearing to appeal a decision by GCHP or to file a grievance about the service they received from GCHP or one of its providers. The member must request the hearing within 90 days from the date of the action that the member is dissatisfied with. If the member requests a hearing from the state Department of Social Services, the case will be reviewed by an administrative law judge. The judge will send the decision on the case within 90 calendar days from the date of the scheduled hearing.

At any time during the grievance process, whether the grievance is resolved or unresolved, per state law, the member and/or his/her representative may request a hearing from the Department of Social Services by contacting or writing to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430
Phone: 1-800-952-5253

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, he/she has the right to interpreter services by phone via Customer Service 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 / TTY 1-800-735-2922** and request assistance.

Section 18: 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 GCHP program by a member, provider employee, or any other person, in accordance with GCHP's contract with the 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, the DHCS, the Medical Board, the state Board of Pharmacy, and other licensing, law enforcement, or other relevant entities as appropriate and cooperate with those agencies related to any fraud, waste and abuse investigations or audits.
F. GCHP's 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.
H. 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**
Compliance staff will provide the training of new employees, contract employees and temporary employees. Providers are informed about fraud via the Provider Manual. In addition, contracts with the providers have verbiage that is inclusive of fraud reporting. The trainings for staff are held on an annual basis. Trainings are held on a quarterly basis for all new associates to ensure new associates receive training. 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 are all reviewed during the trainings. All trainings are documented with all attendees noted. GCHP employees, contractors and temporary staff receive a certificate of completion for attending fraud, waste and abuse training.

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, BIC, GCHP ID 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, BIC, GCHP ID 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 a purpose other than that 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 purpose 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 is 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 to 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 activities and operations to detect and/or deter 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 phone numbers. GCHP's Compliance department tracks and analyzes data for suspected fraud, waste and abuse trends.

1. The Fraud Hotline at **1-866-672-2615** or at the website **http://gchp.alertline.com** can be used to anonymously report a suspected fraud, waste or abuse incident. The hotline number is provided to employees, contractors, temporary staff, vendors, members, providers, and practitioners.
   a. GCHP employees utilize the hotline provided by Global Compliance at **866 -672-2615** which provides a method to anonymously report suspected fraud, waste and abuse. Employees may utilize **http://gchp.alertline.com**. In the event an allegation is received via Global Compliance relative to any employee-related allegation that is not related to fraud, waste or abuse, the case will be referred to the Human Resources Director. If the report involves a Board of Director member, the Compliance Officer will contact General Counsel immediately. In the event the report involves the CEO, the Compliance Officer will contact the Board Chair and General Counsel.

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 response via Global Compliance will be available online. In addition, the reporter will also receive a report number and the reporter can contact Global Compliance 24/7 to request the status of their case.
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, the date, summary results of the investigation, resolution, and reports to/correspondence with the appropriate agency.
    b. Upon the receipt of a Suspected (FWA) 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, e.g. 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 five 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 the allegation warrants 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. Compliance staff will conduct, complete, and report to DHCS, the results of its preliminary investigation of the suspected fraud, waste and/or abuse within 10 business days after the conclusion of the date GCHP first becomes aware of, or is on notice of, such investigation 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. Form MC609, Confidential Medi-Cal Complaint Form.

References:

GCHP Contract with the Department of Health Care Services. Title 42. Code of Federal Regulations (C.F.R) Section 455.2
42 C.F.R. §Title 42, Code of Federal Regulations (C. F.R) Section 438.608

Section 19: Forms and Resources

GCHP is continually posting forms to its website. If you require a form and it is not posted, please call the Plan's Customer Service department at **1-888-301-1228**. Below you will find a list of forms, along with a brief description of their intended use. To view or to download these or other GCHP-related business forms, please go to the GCHP Provider Resources section of the Plan's website at **www.goldcoasthealthplan.org**.

Claims

- CLAIM CORRECTION FORM – Use this form to accompany corrected claim(s)
- ELECTRONIC CLAIMS SUBMISSION – Electronic Claims submission instruction process
- CLAIM SUBMISSION TIPS
- PROVIDER DISPUTE RESOLUTION (PDR) FORM (navigate to Grievance & Appeals – This form is to be used to submit for disputes related to claim denials, overpayment and underpayment.

HEALTH SERVICES

Request for Authorization

- PRE-AUTHORIZATION 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 (navigate to Health Services menu tab, Care Management and follow the 'click here' link at the bottom of page) – The form used to request assistance with a member with unique or special needs.
- NEMT PRESCRIPTION/ATTESTATION OF MEDICAL NECESSITY – This form is used by PCPs and specialists to determine eligibility and medical necessity for a member to receive NEMT services.

Member Services (navigate to the Members menu tab, Resources)

- PCP SELECTION FORM – This form can be printed from GCHP's website and handed to members who would like to change their PCP. This form is available in English and Spanish.
- MEMBER GRIEVANCE FORM (navigate to the Members menu tab) – 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 FAQs and the Member Rights and Complaint Form.

Provider Relations

- PROVIDER GRIEVANCE & APPEALS FORM – This form is to be used to submit complaints related to legal disputes, a complaint against a member, or if unsatisfied with the outcome of a previously filed claim dispute.
- PROVIDER INFORMATION UPDATE FORM – This form is used to update provider contact and practice information. Information includes the provider's address, phone number, contact information, payment address, and tax ID number.
- PROVIDER REQUEST FOR CONTRACT – If you are interested in becoming a GCHP provider and joining the Plan's network, please call Customer Service at **1-888-301-1228**

- 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: **http://www2.ed.gov/fund/grant/apply/appforms/appforms.html**

If you require a form not found on this list or on GCHP's website, please call the Plan's Provider Relations department for assistance at 1-888-301-1228 or email ProviderRelations@goldchp.org.

Appendix 1: Functions of Committees and GCHP Staff

Quality Improvement Committee (QIC)

This QIC is chaired by the chief medical officer and is responsible for advising Plan's staff and the GCHP Board of Commissioners on the QIP, including:

- Critically examining, evaluating and making recommendations on all quality functions of the Plan including: quality improvement over and underutilization peer review of licensed professionals and their contracted activities in service to the enrolled members and promoting educational activities for providers for best cost effective quality care.
- Reviewing activities of the Credentials, Medical Advisory and Pharmacy and Therapeutics committees and monitoring the functions of all of the committees that review the quality and safety of care provided to members.
- Being responsible for medical abstracts and reports for HEDIS measures.
- Approving and/or recommending changes to health plan policies, practice guidelines and reporting the committees' proposed action plans.
- Presenting reports on QI activities to the board on a quarterly basis, and annually reviewing and approving the QI Program Evaluation, QI Program and QI Work Plans.
- Submitting the QIP and the QI Work Plan to the board for approval annually.

Pharmacy & Therapeutics (P&T) Committee

The P&T committee is chaired by the CMO, staffed by GCHP's Pharmacy Director, and comprised of local physicians and pharmacists. The 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. P&T committee members are appointed by the CMO for a renewable two-year term. The GCHP formulary shall be reviewed at the quarterly meeting and revised as deemed necessary. The P&T committee reports to the board through the CMO and the QIC.

Credentials Committee (CC)

Chaired by the CMO and staffed by the Director of Network Operations, the CC includes physicians from major disciplines, including primary care and specialty practices.

At its discretion, the CC 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 CMO, 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 Health Education Manager and staffed by the QI and Member Services managers, the Network Operations and Health Services directors, and others, as appropriate. The Committee shall meet at least quarterly and reports to the QIC.

GCHP's HE/CL department includes interpretation and translation services, provider education and resources, and cultural competence training for GCHP 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)

Comprised of a broad spectrum of community providers, the PAC meets quarterly and offers input to the CMO, 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 the PAC, are forwarded to the commission.

Chief Medical Officer (GCHP Medical Director)

The Chief Medical Officer (CMO) is the principal GCHP position that provides oversight of the provider credentialing process, quality monitoring, evaluation and improvement activities.

The CMO shall be responsible for day-to-day guidance and direction of quality monitoring and improvement activities, and seeking 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 QIP 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. Serving as chair for the Credentials Committee.
5. Remaining on-site or available via phone for consultation with the Health Services, UM, and Quality directors and other staff, as appropriate.
6. Guiding and assisting 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. Presenting 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 requires providers to submit claims within six months from the date of service. If the member has Other Health Coverage, the claim must be received within six months from the date of the primary carrier's Explanation of Benefits.

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

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

3. What is GCHP's capitation check schedule?

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

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

Yes. GCHP requires and specifies in the Plan's contracts that all capitated service encounters must be reported every month as "shadow claims" or "dummy claims" that are not paid.

5. Will GCHP accept electronic claims?

Yes. GCHP accepts and encourages 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 on GCHP's website, **www.goldcoasthealthplan.org** or call EDI Support at **1-800-952-0495**. If you use a clearinghouse, please provide this information to your clearinghouse vendor.

6. 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. GCHP processes claims based on the date they are received in the Plan's office. For most practices, the appropriate timeframe for follow up would be 45 days after the claim was originally mailed. The Plan suggests that providers utilize the electronic tracking of claims available through the Provider Web Portal or contact Customer Service at **1-888-301-1228** before resubmitting any claims.

7. 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 on GCHP's website **www.goldcoasthealthplan.org** or contact the Plan's Provider Relations department at **1-888-301-1228** or **ProviderRelations@goldchp.org**.

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

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

GCHP is following the CHDP guidelines provided by the state.

9. How should claims for newborns be submitted?

Services rendered to an infant may be billed with the mother's ID number for the month of delivery and for the following month if the child has not received his/her 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, use the child's ID number. If you are billing using the mother's ID number, please add her ID number and information in box 80 of the UB form.

10. How does GCHP handle claims for children eligible for CCS?

CCS services are carved out of the GCHP contract with the state. 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 Explanation of Payment (EOP). GCHP's review of potential CCS claims centers on the member's diagnosis.

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

SOC collection and billing is an important function for every provider. The Medi-Cal website, **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, if there is a remaining SOC amount, will be closer to eligibility). 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, GCHP will apply coordination-of-benefits — the Plan 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, 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.

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

GCHP's Recovery 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 health care 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, an 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 or if the provider asks GCHP to offset the overpaid amount.

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 recoup the overpayment, the offset(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, GCHP 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 the Plan's control) from any following payment made to that NPI. The Claims department will mail, fax, or e-mail an "Identification of Overpayment" request if offsets 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**.

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

Claims are processed using Medi-Cal and standard National Correct Coding Initiatives (NCCI) 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 Customer Service Monday-Friday between 8 a.m. and 5 p.m. at **1-888-301-1228**.

For further information, please see the dispute resolution process in Section 16 of this Provider Manual.

14. 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 SOC 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. Please note 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.

Appendix 3: Financial Disclosure and Reporting

By the terms of its contract with the state, 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 the GCHP's members or providers that are compensated on a straight fee-for-service rate schedule or case rate basis.

Plan partners must submit financial statements annually for the first three quarters[1] of the fiscal year to GCHP's Compliance department 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 Generally Accepted Accounting Principles (GAAP). Financial statements shall be in the same format and have the same content as the Quarterly Financial Reporting Forms (previously "Orange Blank") that are submitted to the state DMHC.

On an annual basis, Plan partners shall submit to GCHP's Compliance department, 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 the DMHC.

GCHP will review the financial statement(s) to determine if the selected providers and partners meet the 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 4: FAQs from Members on Complaints/Grievances

*NOTE: This guide is provided to give basic assistance to provider offices in dealing with the types of questions they may receive from GCHP members. For more complicated matters, please refer members to GCHP at **1-888-301-1228/TTY 1-888-310-7347**.*

1. What is the GCHP grievance process?

It is the way in which GCHP works 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 health care provider.
- You disagree with the Plan when you are denied a service you feel you need.
- You are unhappy with any aspect of your health care.
- You feel that GCHP or a health care provider 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 the Plan has denied or modified a request for Prior Authorization, you must file your appeal within 90 days from GCHP's Notice of Action.

3. How do I file a complaint/grievance?

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

- Calling GCHP's 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 GCHP's website to download a complaint/grievance form and mailing it to the address above: **https://www.goldcoasthealthplan.org**
- Going to the GCHP office and filing your complaint/grievance in person:
  Monday - Friday, 8 a.m. to 5 p.m.

GCHP's office is located at:
711 E. Daily Dr. Suite 106
Camarillo, CA 93010

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 **1-888-301-1228**.

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 state Department of Social Services (DSS) can help you. You can call DSS at **1-800-952-5253 / TTY: 1-800-952-8349** and tell them you want a hearing. You can also ask for a State Fair Hearing by mail, phone or in person by contacting the local office in Ventura County:

Human Services Agency
855 Partridge Drive
Ventura, CA 93003
1-805-477-5100

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 **1-888-452-8609**.

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

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

8. How does my complaint/grievance get settled?

Depending on the type of complaint you have, GCHP's 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 the Plan needs more information, it will be requested. For example, if the Chief Medical Officer wants more information, the Plan 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 three 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 phone number for requesting State Fair Hearings is **1-805-477-5100**.

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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Gold Coast Health Plan℠
A Public Entity

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

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