Provider Manual

2012

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Gold Coast Health Plan Mission Statement

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

Welcome to Gold Coast Health Plan

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

Organization of the Provider Manual

This Provider Manual describes operational policies and procedures of Gold Coast Health Plan, which is referred to throughout the manual as GCHP. Topics covered are included in the Table of Contents at the beginning and Indexs of Topics at the rear of the Provider Manual.

You also may access this Provider Manual on-line by visiting our website at **www.goldcoasthealthplan.org**. For your convenience, a list of forms you may require can be found in Section 17 and are also available in printable format at the GCHP website.

The Manual will be updated and revised periodically as needed. Revisions and updates will be automatically incorporated into the online version of the Manual.

Provider Web Portal

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

Other Resources on the GCHP Website

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

➢ _Provider Directories_: The Primary Care Provider Directory and the Specialist Physicians and other Non-Primary Care Physician Directory are available in PDF format to download and print at your convenience.

➢ Drug Formulary and Other Pharmacy Information

➢ _Forms and Documents_: GCHP's various forms are posted for a whole host of uses.

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

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

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

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

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

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

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

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

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

CAQH. The Council for Affordable Quality Healthcare. 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.

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

Case Management Protocol. The specific written policies and procedures outlined by Plan to govern the practices of Primary Care Physicians and Specialist Physicians in their care and treatment of Plan Members. The complete document is attached to both Primary Care and Specialist Physician Service Agreements with the Plan.

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., a heart transplant case).

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

Child Health and Disability Prevention Services (CHDP). Health care preventive services for beneficiaries under 21 years of age provided in accordance with the provisions of Health and Safety Code Section 124025, et. seq., and Title 17, CCR, Sections 6842 through 6852.

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

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

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

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

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

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

Direct Referral Authorization Form (DRAF). A form evidencing a referral by PCP or Medical Director, or designee, to a contracted specialist. No authorization is required from a PCP to a specialist within Ventura County; the form is used to track referrals only. However, specialist providers outside of Ventura County may not be accessed in this way. Prior authorization is required from the Plan as noted in the Non-PCP and Specialist Physicians Provider Directory.

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 reside in the Plan Service Area and is certified as eligible for Medi-Cal by the county agency responsible for determining the initial and continuing eligibility of persons for the Plan's Medi-Cal Managed Care Program's Service Area.

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

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

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

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

Excluded Services. Those services for which the Plan is not responsible and for which it does not receive a capitation payment from DHCS (Also called "Carve-Outs").

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

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

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

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

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

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

Hospital. Any acute general care facility licensed by DHCS.

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

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

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

Long-Term Care. Facilities providing the appropriate level of nursing care, excluding Hospice services but not limited to: Skilled Nursing Facilities, Intermediate Care Facilities, Pediatric Sub Acute Care Facilities, or Sub-Acute Level Facilities, excluding Plan approved Administrative Days, in accordance with Title 22, CCR, Sections 51118, 51120, 51120.5, 51121, 51124.5, 51124.6, 51335, 51335.5, 51335.6, and 51334 and related sections of the Medi-Cal Program Manual Criteria referenced in Title 22, CCR, Section 51003.(e).

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.

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

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

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

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

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

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

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

Observation Day. A period of a minimum of 8 hours in duration during which services furnished by a Participating Hospital on the Hospital's premises, including use of a bed and at least periodic monitoring by a Hospital's nursing staff, which are reasonable and Medically Necessary and appropriate to evaluate a Member's outpatient condition or determine the need for a possible admission to the Hospital as an inpatient.

Operations Manual. The Manual of Operational Policies and Procedures for the Plan's Medi-Cal Managed Care Program also known as the Provider Manual.

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

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

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

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

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

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

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

Physician. A person who holds a degree of Doctor of Medicine [MD] or Osteopathy [DO] from an accredited university program, who is licensed to practice medicine in the State of California in accordance with the Business and Professions Code, and who is Board Certified or Eligible in a particular clinical field of medicine.

Physician's Advisory Committee. A committee of physicians appointed by the Plan that 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.

Physicians who serve on this committee must be Board Certified and practice in Ventura County.

Physician Patient Load Limitation. The maximum number of Members for whom the Primary Care Physician has contracted to serve, which has been accepted by the Plan. Plan agrees that additional Members will not ordinarily be permitted to select or be assigned to that Primary Care Physician. Such limit may be changed by mutual agreement of the parties.

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

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

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

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

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

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

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

Provider Advisory Committee. A committee composed of physicians and other non-physician representatives who are broadly representative of the provider community and who serve on this committee.

Provider Manual. The manual of operational policies and procedures for the Plan's Medi-Cal Managed Care Plan. This manual is also known as the Operations Manual.

Quality Improvement Program (QIP). Systematic activities to monitor and evaluate the clinical and non-clinical services provided to Members according to the standards set forth in statute, regulations, and Plan's Agreement with the DHCS. The QIP consists of processes, which measure the effectiveness of care, identifies problems, and implements improvement on a continuing basis towards an identified target outcome measurement. The Plan's Quality Improvement and Quality Improvement Program are overseen by the Quality Assurance/Utilization Review/Peer Review Committee that is approved by the Board of Commissioners. Subcommittees include the Credentials Committee and the Pharmacy and Therapeutics Committee.

Referral Physician. Any qualified physician, duly licensed in California who meets the general credentialilng requirements of Plan and has signed an Agreement with Plan. Any exception to this requirement must be authorized by DHCS, Plan CEO and/or Medical Director. The Provider has executed an Agreement with Plan, to whom a Primary Care Physician may refer any Member for consultation or treatment. Also referred to as Participating Provider.

Referral Services. Covered services, which are not Primary Care Services, provided by Specialist Physicians on referral from the Primary Care Physician or provided by the Primary Care Physician as a non-capitated service outside of the list of capitated services (Attachment C) to the Primary Care Physicians' signed Service Agreement with the Plan.

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

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

Specialist Physicians and other Non Primary Care Providers Directory. The list of all non primary care providers that participate in the Plan's network.

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

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

Section 3: Provider Application, Credentialing and Contracting

Initial Application Process and Recredentialing

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

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

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

Additional Requirements for CHDP, CPSP, HIV/AIDS

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

CAQH and Gemini Diversified Services

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

Facility Site Review (FSR) of Primary Care 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 (license status, wheelchair access, fire extinguishers, etc.), Providers' initial credentialing and re-credentialing files are submitted to the Credentials Committee for review and approval. If a provider's credentials are approved, the Chairperson of the Committee or his designate will formally authorize the provider Services Agreement.

Notification about Adverse Actions Taken Against You or Your Staff

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

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

Appealing Adverse Decisions by the Credentials Committee

If the 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. For more information on the GCHP credentialing policy, please see the forms section of our website dealing with Fair Hearings and Filing of Appeals. The appropriate forms may also be requested by contacting ProviderRelations@goldchp.org.

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

Debarment, Suspension, Ineligibility or Voluntary Exclusion

In accordance with 45 CFR (Code of Federal Regulations) Part 76, GCHP receives indirect Federal funding through the California Medi-Cal Program and, therefore, must certify that it has not been debarred or otherwise excluded from receiving these funds. Under this rule, because GCHP receives this indirect Federal funding, GCHP is considered a "lower tier participant." As subcontractors, our providers—who essentially receive Federal funding by nature of their Agreement with GCHP — are also considered "lower tier participants" and thus must also attest to the fact that, by signing the Provider Service Agreement, they have not

been debarred or otherwise excluded by the Federal government from receiving Federal funding. Pursuant to this certification and your agreement with GCHP, should you or any provider with whom you hold a subcontract become suspended or ineligible to receive Federal funds, you are required to notify GCHP immediately.

Fraud, Waste and Abuse Prevention

GCHP's Fraud, Waste and Abuse Prevention (FWAP) program focuses on review of standards, program evaluation, and education to ensure policies and practices are consistent with contractual, regulatory and statutory requirements. Through its FWAP program, and as a component of the Compliance program, GCHP seeks to develop, maintain, document and evaluate GCHP's business operations in compliance with these requirements.

GCHP shall:
- Prevent, detect, investigate, report and resolve suspected and/or actual FWA that may arise in GCHP's daily operations and interactions, whether internal or external;
- Communicate information about the FWAP program to GCHP stakeholders, including GCHP's Board of Directors (the Commission), employees, contractors, providers, Members and the state;
- Ensure that the scope of benefits covered by GCHP programs is appropriately delivered and billed by contractors;
- Protect Members in the delivery of health care services through timely detection, investigation and relevant prosecution of suspected FWA; and
- Identify, address and refer quality of care issues to GCHP management and oversight agencies, as needed.

GCHP's FWAP program integrates the activities of all GCHP departments in meeting our FWAP objectives. GCHP stakeholders, such as GCHP's board, employees, contractors, providers, Members, the state and local law enforcement are viewed as important partners in our FWAP efforts. The FWAP Program is one of the many ways that GCHP ensures appropriate service provision to our Members; partnerships with reputable contractors; and proper administration of our health Plan, including correct use of public funds. GCHP takes the position that fraud, waste and abuse at any level is impermissible and intolerable. When a practice is deemed not consistent with our standards and requirements, an investigation may be performed and, as needed, a corrective action plan will be developed. For more information on reporting issues of fraud, waste or abuse please call our compliance Hot Line at **866-672-2615** or send an email to **https://gchp.alertline.com**.

Continuity of Care after Contract Termination

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

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 him/her after the contract ends. Continuity of care is permitted for the following conditions:

- An acute condition.
- A serious chronic condition and/or a terminal illness.
- A pregnancy and care of a newborn child from birth to 6 months.
- 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.

Coordination of Care

Gold Coast Health Plan will continue to provide for normally covered medical services for Members receiving services from CCS, SARC/CVRC, or the Early Start Program and will coordinate with the PCP and the designated center to assist with the development of a care plan, or in complying with the care plan that has been developed.

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

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

California Children's Services (CCS)

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

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

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

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

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

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

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

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

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

Child Health and Disability Prevention (CHDP)

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

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

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

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

Complete guidelines for CHDP preventive health services are available at the State website, **www.dhcs.ca.gov/services/chdp.** Frequently Asked Questions (FAQs) about CHDP are contained in Section 18. Appendix 5 of this Manual. Information about billing GCHP for CHDP services can be found in Section 10 Claims and Billing.

Comprehensive Perinatal Services Program (CPSP)

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

Members with Developmental Disabilities or Developmental Delay

The Initial Health Assessment (IHA) is performed when enrolling new children into your practice. During the IHA you will identify those who have, or are at risk of acquiring, developmental delays or disabilities, including signs and symptoms of mental retardation, cerebral palsy, epilepsy or autism. Additionally, developmental screening is a required part of each well-baby and well-child visit; children at risk for developmental delay may also be identified during prenatal examinations when developmental history as well as physical and neurological examinations are conducted.

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

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

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

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

Medically Necessary therapies and items of durable medical equipment within the scope of your practice. For those necessary services that are beyond the scope of your practice, you should make the necessary referrals and coordinate with the appropriate funding agency.

Early Start Program for Developmentally Disabled Infants and Toddlers

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

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

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

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

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

Health Insurance Premium Payment Program (HIPP)

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

Objectives of HIPP

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

Eligibility and Documentation Requirements for HIPP

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

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

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

HIPP Responsibilities – GCHP vs. Ventura County

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

- Initiate premium payments to the insurance carrier, employer, or beneficiary	- Notify HIPP of any changes to the beneficiary's OHC - Provide and assist applicant/beneficiary with HIPP application

Vision Services

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

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

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

- Pregnant women; and only if the doctor says that not having eyeglasses will be harmful to the baby or pregnancy; or

- Children or people less than 21 years old who have full scope Medi-Cal; or

- People who live in a nursing home.

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

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

As of March 1, 2012 routine vision care services for GCHP Members will be managed by VSP. Please call VSP for information on Participating Optometrists, benefits and details of coverage. The VSP Customer Service Number is **800-877-7195**. For information on becoming a Participating Provider with VSP for Gold Coast Health Plan, please call the VSP Provider Network Department at **800-852-7600 extension 5339**.

Carved-Out Services Not Administered by GCHP

Certain medical or allied-health services are covered benefits but are not administered by GCHP. GCHP is not responsible for authorizing or providing those services; rather, they are covered directly by the State Medi-Cal program. These are referred to as "Carved-Out

Benefits." Following is a list of these benefitswhich are administered by and billed directly to the State Medi-Cal program:

- Dental services: Please call Denti-Cal at (800) 322-6384 for assistance in locating a Medi-Cal dentist or to obtain prior authorization for service.

- Mental Health: Short-Doyle/Medi-Cal mental-health services (inpatient or outpatient). Providers are required to provide assistance to Medi-Cal Members needing specialty mental-health services by referring them to the appropriate local Medi-Cal mental-health plan. Additionally, Providers should coordinate services with the Medi-Cal Member's mental-health provider, as appropriate. Please contact the Ventura County Behavioral Health Department, STAR Program, Crisis Team at 1-866-998-2243 for referral information.

- Alcohol and drug treatment program services (including outpatient heroin detoxification).

- Laboratory services provided under the State serum alpha-fetoprotein testing program administered by the Genetic Disease Branch of the Department of Health Care Services.

- Targeted Case Management Services as specified in Title 22 CCR Section 51351.

- Services rendered in a State or Federal hospital.

- Home and community-based wavered services (e.g., In Home Operations, HIV/AIDS Home and Community Based Services Waiver, Multipurpose Senior Services, Adult Day Health Care Services). [*Note*: *The Adult Day Health Care Services program is in the process of transformation by he state. Please call the Provider Relations Department at 888-301-1228 for most current information.*]

- California Children's Services (CCS). Providers must identify and refer Members with CCS- eligible medical conditions to the local CCS Program for authorization of such services. The GCHP-CCS Liaison Case Manager will guide you through the CCS referral process. Please call GCHP's CCS Liaison Case Manager at 888-301-1228. The number for CCS in Ventura County is 805-981-5281.

- Early Start Program for early intervention and Medically Necessary diagnostic and therapeutic services provided to infants and children aged 0-36 months who have disabilities.

- Members with developmental disabilities who shall be referred to the appropriate agency, such as the Local Education Agencies (LEA).

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

Categories of Medi-Cal Eligibility: Aid Codes

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

The Medi-Cal aid code is the two-digit number or combination of alpha and numeric characters that indicates the specific Medi-Cal program category under which the individual qualifies. Aid codes can be found on the State Medi-Cal Benefits ID card (BIC) or at the Medi-Cal eligibility website. The aid codes for GCHP Members can be found when checking eligibility at the GCHP Provider Web Portal. The GCHP ID card does not provide the Member aid code. The list of aid-codes is revised regularly. While this Provider Manual cannot provide all aid codes, the list of "GCHP Covered Medi-Cal Aid Codes" is available at Appendix 4.

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

Types of Medi-Cal: Levels of Benefits

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

Full-Scope Medi-Cal

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

Limited-Scope or Restricted Medi-Cal

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

Special Programs

Medi-Cal also has aid-codes that provide a limited scope of coverage. These special-program aid-codes include Tuberculosis (TB) services, pregnancy-only services, and minor-consent services. Individuals in these aid-codes are eligible under regular fee-for-service Medi-Cal and not through GCHP.

Share of Cost

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

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

Administrative vs. Regular Member

A "Regular" Member (also referred to as "case managed" or "linked" Member) of GCHP is an individual who has selected or is assigned to a PCP. An "Administrative Member" is a Member who is not assigned to a specific Provider or clinic and, therefore, may see any willing Medi-Cal provider. Administrative Members will have "Admin 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.

- Share of Cost — Some Medi-Cal Members must pay,or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This dollar amount is called Share of Cost (SOC). The SOC is similar to a private insurance plan's out-of-pocket deductible.

- Long-Term Care — A Member who is residing in a skilled or intermediate-care nursing facility (LTC or Long-Term Care facility) for more than 30 days after the month of admission.

- Out of Area — A Member who resides out of GCHP's service area but whose Medi-Cal case remains in Ventura County. These may include out-of-area foster care or adoption assistance placements and Long-Term Care placements.

- Newly Eligible — A Member in the first month of eligibility as a GCHP Member who may see any willing Medi-Cal provider within GCHP's service area until they have chosen or been assigned to a PCP.

- Other Health Coverage (OHC) — A Member who has other health insurance that is primary to their Medi-Cal; this includes Members with both Medi-Cal and Medicare Part B (also called "Dual Eligibles"), as well as Members with both Medi-Cal and commercial insurance. GCHP Members with other health coverage (Administrative Members) must access care through their primary insurance and are not required to select a GCHP Primary Care Provider. Please remember that Medi-Cal is the payer of last resort and only pays after all other avenues have been attempted. Coordination of benefits will be calculated using the Medi-Cal fee schedule as the provider's maximum reimbursement.

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

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

Eligibility, Enrollment and Member ID Cards

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

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

Selection of a Primary Care Provider

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

- Selection of a PCP upon enrollment

- New Members receive an enrollment package containing a Primary Care Provider Directory.

- Members must complete the PCP Selection Form indicating their choice of PCP, and return it to GCHP.

- If GCHP receives a Member's Selection Form by the fifteenth calendar day of the month, the Member will be enrolled with their PCP on the first calendar day of that month.

- If GCHP receives a Member's Selection Form after the fifteenth calendar day of the month, the Member will be enrolled with their PCP on the first calendar day of the immediately 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.

- Members may request to change their PCP by contacting GCHP.

- Members may choose any of the doctors or clinics listed in the GCHP Primary Provider Directory as their PCP. If the PCP is not open to new Members, GCHP will ask the Member to choose another PCP.

How to Verify Eligibility

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

The online and automated eligibility systems will provide you with the following information:
- Member PCP
- Member is an Administrative or Regular Member.
- Member's eligibility for CCS eligibility (if applicable).

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

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

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

Member Identification Card

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

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

Out of Area Medi-Cal Beneficiaries

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

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

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

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

Benefits

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

Section 6: The Role of the Primary Care Provider

The Primary Care Provider (PCP) plays the central role in structuring care for GCHP Members. The PCP is the main provider of health care services, and is responsible for the delivery of health care to their assigned Members. The PCP is responsible for supervising, coordinating, and providing Primary Care Services to Members and for maintaining the continuity of care for the Members who select or are assigned to the Primary Care Provider. Primary Care Providers include general and family practitioners, internists, and pediatricians. Obstetricians-Gynecologists are generally considered to be specialist providers; however, if they are willing to provide the list of capitated services for the monthly capitation amount specified in the Primary Care Provider Service Agreement then they may apply for PCP status and sign a Primary Care Physician Medical Service Agreement.

Responsibilities of the PCP

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.

- Assure access to care twenty-four (24) hours per day, seven (7) days per week.

- Assure or facilitate patient access to the healthcare system and appropriate treatment interventions.

- Consultation with referral specialists. Including Initiating and coordinating referrals to Specialists or other GCHP participating providers as needed.

- Follow up and monitoring of appropriate services and resources required to meet the needs of the assigned Member.

- Assuring 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.

- Assuring that no unnecessary or duplicate medical services are being provided.

- Establishing a good medical-records system for tracking, recall, efforts of follow-up for missed or cancelled appointments, and identifying any clinical problems unique to your particular patient population.

- Coordinate and direct appropriate, Medically Necessary services; risk assessment, treatment planning, including:

Initial Health Assessment (IHA)

Medi-Cal requires that each PCP complete a comprehensive Initial Health Assessment (IHA) for all assigned Members **within 120 days** after the Member's enrollment, unless the PCP has determined that the Member's medical record is sufficiently current to enable an assessment of the individual's health status. At a minimum, an IHA must include an Individual Health Education Behavioral Assessment (IHEBA), medical history, weight and height data, blood pressure, preventive health screening, discussion of appropriate preventive measures, and arranging for future follow-up appointments as indicated. Additionally, screening using the age-specific IHEBA - "Staying Healthy" Assessment (SHA) must be included in the IHA — this tool and related instructions can be found at www.dhcs.ca.gov.

Preventive Care

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

Accessibility Standards

Each PCP is required to provide Covered Services to Case Managed Members on a readily available and accessible basis in accordance with Plan policies and procedures as set forth in the Provider's signed Service Agreement and this Provider Manual; during normal business hours at Primary Care Provider's usual place of business and arranging for Emergency Services and Urgent Care Services seven days a week, twenty-four hours per day.

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 fourty-eight (48) hours (No Preauthorization required)
Urgent acute care	Within ninety-six (96) hours of Preauthorization request
Primary care	Within ten (10) business days of request for appointment
Specialty care	Within fifteen (15) business days of request for appointment
Ancillary services for diagnosis or treatment	Within fifteen (15) business days of request for appointment
Initial Health Assessments (IHA) and Individual Health Education Behavioral Assessments (IHEBA)	Within one-hundred-twenty (120) calendar days after enrollment
Waiting time in office	Not to exceed thirty (30) minutes after time of appointment
Sensitive services	Ensure confidentiality and ready access to sensitive services in a timely manner and without barriers

Medical Records

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

Access to and Copies of Records

Our Health Services Department and/or Member Services Department staff may request records from your office for one of our covered Members for several reasons, including:

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

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

Reporting Encounter Data

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

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

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

Confidentiality of Information

Providers are responsible for ensuring and maintaining the confidentiality of information about Members and their medical records, in accordance with applicable Federal and State laws. The names of any Member receiving public social services must be kept confidential and protected from unauthorized disclosure. This includes all information, records and data collected and maintained for the operation of the Agreement. Providers may not use any such information for any purpose other than carrying out the terms of their Agreement. In compliance with the HIPAA regulations and the privacy rules for Protected Health Information (PHI), Members are entitled to an accounting of any disclosure of their confidential information.

Provider Incentives

Because our Plan provides Members with easy access to care, a well-organized case-management program, and other programs that generally promote and support health, we are able to minimize waste and avoidable medical costs, thus enabling Primary Care Providers (PCPs) the opportunity to share in financial savings. GCHP does not reward financial incentives to providers or staff under any conditions for denial of services.

It is our intent to implement a quality-based incentive (QBI) program, which is a Pay for Performance (P4P) plan which offers financial rewards to Providers who provide outstanding quality of care. Updated annually, the program will provide incentive payments for meeting or exceeding performance levels for selected indicators.

Essentially, the QBI P4P program will use positive incentives to promote quality clinical practices such as appropriate preventive services and chronic disease management. As part of the QBI program we intend to monitor clinical performance measures of Provider care

based on claims and encounter data related to well-child visits, adolescent well-care, breast cancer screening, cervical cancer screening, diabetes low-density lipoprotein cholesterol (LDL-C) screening, diabetes Hemoglobin A1c (HbA1c) screening, asthma medication usage, provider emergency-department utilization rates, and Providers' submission of asthma/diabetes action plans.

Performance criteria will be based, in part, on measures from the HEDIS®. These criteria will be reviewed and approved annually by the QualityAssurance/Utilization Management/Peer Review Committee (QA/UM/PRC) and the Commission. Provider-specific studies may include but are not limited to, measures of:

- Compliance with preventive health service standards.
- Quality of care for Members with chronic conditions.
- Performance rates for specific clinical measurements.
- Changes in clinical office practice that will improve health outcomes.

We will notify Providers of changes in QBI measures by amending the Provider Services Agreement; through articles in the quarterly Provider Bulletin; and by posting articles on the website. If you have questions or would like additional information, please call our Provider Relations or Health Services Department at 888-301-1228.

PCP Request for Member Reassignment

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

A. A Provider's request to transfer the Member to another PCP requires the Plan's approval.

B. Such requests for transferring a Member to another PCP will be granted for the following reasons:

1. Significant lack of cooperation, understanding and/or communication between doctor and patient. In such cases, the PCP and Plan will use their best efforts to provide the Member with the opportunity to be served by a PCP with whom a satisfactory Provider/patient relationship can be developed. If the Plan is unable to make such arrangements and the Member is in active care, the PCP will continue to serve the Member according to the PCP's best professional judgment until the Plan is able to change the Member's PCP, a period not to exceed two months.

2. Requests to transfer a Member to another PCP due to the patient's medical condition resulting in high cost or frequent visits will not be granted.

3. The PCP must notify our Member Services and Provider Relations Department in writing regarding the PCP's desire to disenroll a Member from their practice. Complete documentation regarding the nature of the problem must be included with the request. Requests to disenroll a Member will be considered based on criteria outlined in this Provider Manual.

4. Requests will be reviewed and the PCP will be notified of the Plan's decision. Once the PCP has been notified of the disenrollment, it is expected that the PCP will notify the Member in writing regarding the PCP's decision to terminate the Member from their practice and that the PCP will no longer be responsible for the Member's medical care effective the date of the disenrollment. GCHP's Member Services Department will contact the patient to facilitate enrollment with a new PCP.

5. Exceptions to this policy will be considered on a case by case basis.

6. A Provider can cease providing care for a non-assigned Member when the Provider/patient relationship becomes unsatisfactory. In these cases, the Provider must notify the Member in writing that they will no longer provide care for the Member. The Provider should assist the Member in choosing another Provider and transfer appropriate office medical records to that Provider.

7. A Specialist Provider can cease providing care for any Member when the Provider/patient relationship becomes unsatisfactory. In these cases, the Specialist Provider must notify both the PCP and the patient that they will no longer provide care to the patient. The PCP will refer the Member to another participating Specialist for care and treatment if specialist care is still Medically Necessary.

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

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

Emergency Transportation from PCP Office to Hospital

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

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

If you have determined that cab service is more appropriate than ambulance service, please notify our Members Services after the taxicab has been called to ensure reimbursement to the cab company. The Member Services will document in the PCP's notification that a taxi was called to transport the Member to the hospital.

Non-Emergency Transportation

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

Non-emergency transportation will be authorized for the transfer of a Member from a hospital to another hospital or facility provided that the transport is Medically Necessary, has been

requested by a GCHP Provider, and has been authorized in advance by GCHP. We require advance notice of 3-4 days for all non-emergency transportation requests. Specifically, the following types of transport will be allowed:

- The Member is being moved either to a higher or lower level of care (with the exception of mental-health patients moving from a higher to a lower level of mental healthcare). Please note that the transfer from one level of care to the same level of care at another facility will not be authorized if the requesting facility is able to meet the Member's medical needs.

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

Member Procedures/Rights for Emergency Care

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

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

The GCHP Quality Improvement (QI) system identifies and pursues opportunities for improvement in the quality of care and services delivered to our Members, and helps ensure that healthcare services provided conform to professionally recognized standards of care. The Quality Improvement process is structured to develop and maintain an integrated system that continuously measures, identifies, assesses, and improves health outcomes.

Quality is overseen and approved by the GCHP Quality Assurance /Utilization Management/Peer Review Committee (QA/UM/PR) using methods that include a multidisciplinary approach to analysis and development of improvement plans. A brief summary of these activities is presented below. GCHP does not give financial incentives to providers or staff for denial of services.

The Quality Improvement (QI) System

The scope of the QI System includes the quality of clinical care and service for all Members, without regard to age group, disease category, and risk status. We monitor and evaluate patient care and service in virtually all settings in which our Members may receive healthcare services; the program encompasses all aspects of medical care.

The QI System is approved, implemented, and evaluated by the Quality Assurance /Utilization Management/Peer Review Committee in the first quarter of each calendar year. During the program year, the plan is revised and reviewed continually to reflect reprioritizing of activities. This process is interactive, repeating measurement and interventions until performance goals or benchmarks are met or exceeded — or until the Committee determines that further interventions will not be likely to result in additional improvement.

Problem Identification

The Quality Improvement process involves a variety of mechanisms to identify potential quality of service and patient safety issues through systematic review of information gathered from multiple sources, which include:

- Member satisfaction — analysis of satisfaction surveys, complaints, grievances, and potential quality issues.
- Practitioner and provider satisfaction surveys.
- Medical and pharmaceutical claim/encounter data analysis to identify sentinel events and variations in practice.
- Provider audits of facility and patient safety, infection control, and quality of medical records.
- Monitoring Provider performance to ensure compliance with guidelines for preventive, chronic and acute care, and continuity of care.
- Provider contracting and credentialing, including peer review activities.
- Concurrent, prospective and retrospective reviews.
-

- Data indicating over/under utilization of services.
- Internal QI project performance goals.
- The National Committee for Quality Assurance (NCQA) HEDIS® measures and calculates GCHP's performance in comparison against Minimum Performance Levels (MPL) established by contractual requirements and national or regional benchmarks.
- Stratified data that identifies disparities by race/ethnicity, language, sex, age, or geographic location.
- Member focused studies.
- Information from research, evidence-based studies and national literature.
- Opportunities for improvement identified through contractual or compliance audits including those special quality studies or collaboratives coordinated by and reported through the state's contracted External Quality Review Organization (EQRO).

Communicating Results of QI Activities

The activities of the Committee are communicated to GCHP staff, the Health Services Department, the Commission, oversight and advisory committees, healthcare purchasers, regulatory agencies, individual practitioners and providers, and Members.

Once performance measurement is completed, results are reported to NCQA, contractual, and regulatory agencies as required. In addition, reports are made to the QA/UM/PR Committee, Providers Advisory Committee, and the Commission.

We communicate outcomes of QI measures with providers through newsletters or special mailings for general performance reports. The content of these communications may include:

- Listings of Members who need specific services.
- Listings of Members who need intervention based on pharmacy indicators.
- Comparison of practitioner/Provider performance to average Plan-wide performance.
- Reports showing practitioner/Provider deviation from a benchmark or threshold.
- Recommended interventions to improve performance.
- Barrier analyses and intervention plans/timelines.
- Plan-sponsored training directed at improving performance.
- Incentives for improved or above average performance in quality of care or service.
- Requests for Corrective Action Plans (CAPs) to correct any identified deficiencies.

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

Section 8: Case Management Program

Case Management, as defined by the Department of Health Care Services (DHCS) is:

"Guiding the course of resolution of a personal medical problem (including the problem of the need for health education, screening or preventive services) so that the recipient is brought together with the most appropriate Provider at the most appropriate times, in the most appropriate setting."

It is, essentially, a program that enables Providers and care givers to identify Members with ongoing healthcare needs so that an effective plan may be developed that enables the efficient use of healthcare resources, with a goal of achieving the best possible health outcomes. GCHP contracted Primary Care Providers are required to provide case management to all GCHP members.

Five requirements are necessary for the case-management system to function:

1) Members in the case management program must have selected a PCP or have been assigned to a Primary Care Provider (or Clinic).
2) PCPs and Referral Providers are required to contract with GCHP for the provision of Covered Services at rates established by GCHP and approved by the California Department of Health Care Services.
3) Through Prior Authorization, PCPs will refer Members directly to all Medically Necessary services, with the exceptions of Emergency, Limited Allied Services, OB-GYN, and certain family planning or "sensitive" services that qualify for self-referral.
4) PCPs in either individual or group practice — and in private and/or public settings — will be geographically located throughout Ventura County to facilitate Members' access to healthcare services. **[NOTE: Any tertiary care provider and/or facility services for Members that are located outside the Ventura County service area will be procured through contractual arrangements with providers who are Medi-Cal approved and willing to accept such cases from GCHP providers on referral. This would include, but not be limited to, cases requiring solid organ and Bone Marrow transplants that are not available within the service area. These services require advance approval from the Plan.]**
5) Providers serving GCHP Medi-Cal Members should have a current Medi-Cal provider number and must be approved through the Plan's appropriate credentials review process.

The objectives of a good case-management plan are:

- To foster continuity of care as well good relationships between Providers and Members.
- To coordinate the care of GCHP Members so that satisfactory health outcomes are achieved.
- To contribute to a decreased use of hospital emergency department (ED) as a source for non-emergency, first contact and urgent medicine by our Members.
- To reduce the incidence of Members' unnecessary self-referral to specialty providers.

- To discourage medically inappropriate use of pharmacy and drug benefits by our Members.
- To facilitate Members' understanding and use of disease-prevention practices and early diagnostic services.
- To allow the movement of Members from one PCP to another as necessary.
- To provide a structure within which our Providers can manage Members' healthcare services in a manner that ensures a high quality of care delivered in a cost effective manner.

Targeted Case Management

(TCM) consists of case management services that assist Medi-Cal eligible individuals within a specified targeted population who reside in a community setting or are transitioning to a community setting to gain access to needed medical services and interrelated social, educational, housing, transportation, vocational, and other services. Case management services ensure that the changing needs of this Medi-Cal eligible population are addressed on an on-going basis and appropriate choices are provided among the widest array of options for meeting those needs.

Persons eligible for **Targeted Case Management** are:

- High risk, as defined in CCR Title 22, § 51185, persons who have failed to take advantage of necessary health care services or non-compliant with their medical regimen or those who have an unstable medical condition that requires coordination of multiple medical/social and/or other services, those with substance abuse issues or those who have been victims of abuse, neglect, or violence including, but not limited to:

  - Women, infants children and young adults to age 21

  - Pregnant women

  - Persons with HIV/AIDS

  - Persons with reportable communicable disease

  - Persons who are technologically dependent

  - Persons with multiple diagnoses who require services from multiple health/social services providers

  - Persons who are medically fragile

  - Persons who have language or other comprehension barriers

- Persons 18 years or older who:

  - Are on probation and have a medical and/or mental condition

  - Have exhibited an inability to handle personal, medical or other affairs

  - Are under public conservatorship of person and/or estate

  - Have a representative payee

  - Are in frail health and in need of assistance to access services in order to prevent institutionalization

Qualified providers of TCM services are limited to Local Government Agencies under contract with the Department of Healthcare Services, as identified in the California State Plan.

Gold Coast Health Plan ensures identification of Members eligible for Targeted Case Management (TCM) services and ensures access to Medically Necessary covered services for all eligible Members who are not accepted for TCM. This policy delineates the process for:

- ➢ Referring eligible Members to TCM

- ➢ Ensuring access to Medically Necessary covered services for Members not accepted for TCM

- ➢ Determining the Medical Necessity of covered diagnostic and treatment services recommended by the TCM provider

- ➢ Coordinating care with the Regional Center and/or local government agencies providing TCM

The Primary Care Provider (PCP) is responsible for the identification of Members who are eligible for TCM. The PCP is responsible for referring Members to the appropriate Regional Centers and/or local government agencies for TCM. Upon request, the Gold Coast Health Plan Case Manager (CM) assists the PCP with identifying the appropriate referral agency and may also assist the PCP in coordinating the Member's care with the Regional Center and/or local government agencies. The Utilization Management (UM)/CM nurse assures Medically Necessary covered diagnostic and treatment services recommended by the TCM provider are authorized when necessary.

For complete details on GCHP's Case Management program, including specific responsibilities of the Providers, please see the ***Case Management Protocol*** attached to each executed Provider Service Agreement, Authorization Policies and Procedures on our website **www.goldcoasthealthplan.org**.

Section 9: Services Requiring Prior Authorization

Individual Preauthorization Requests For Treatment forms (PRFTs) 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 — or GCHP's Chief Medical Officer or his designee may need to speak directly with the Provider to discuss the request.

Only licensed medical professionals employed by GCHP are able to make decisions about Preauthorization Requests. Only the Chief Medical Officer or Associate Medical Director has the authority to deny service authorization requests. Authorization decisions are based upon evidence-based GCHP policies as well as nationally recognized standards including:

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

Nationally recognized standards of practice from organizations, such as:

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

Members must obtain a referral from their PCP before scheduling an appointment with any other provider, except for the self-referral services described below under "Self-Referral." PRFTs 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 PRFT must be submitted after a service has been provided or initiated to a GCHP Member, it must be received by GCHP within 30 calendar days of initiation of the services or the request will be denied for non-timely submission. Please note that a PRFT submitted after 30 days must be accompanied by documentation explaining why the authorization was not requested earlier.

If the PRFT 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 generally require **_prior_** authorization include:

- Allergy desensitization treatment
- MRIs and CT scans
- Outpatient surgery
- Dermatology therapy
- Podiatric treatment
- Home Health services
- Physical, occupational and speech therapy
- Non-emergency hospitalizations, except for an obstetrical delivery
- Medical supplies and Durable Medical Equipment (DME)
- Requests for referral to an out-of-area provider/facility or a non-contracted provider/facility (referred to as "out-of-plan" or "non-par" to indicate a non participating or non-contracted provider)
- Drugs or treatment interventions not included in our Formulary (or if the quantity requested is more than a 90-day supply for maintenance drugs, and a 30-day supply for all other agents).

You will find a more detailed list of services that require either a request for Direct Referral referral or Prior Authorization at the end of this Provider Manual in Appendix 2.

Self-Referral: No Authorization Required

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

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

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

For emergency inpatient admissions or emergency services, the hospital must contact GCHP. Contracting facilities are obligated to notify GCHP within one business day of admission to obtain authorization, and confirm the length of stay and the level of care needed by the patient.

Emergency Services are covered in-patient and out-patient services that are necessary to enable stabilization or evaluation of an emergency medical condition and are provided by a healthcare professional qualified to furnish emergency services. An emergency medical condition is a condition that manifests itself by acute symptoms of sufficient severity (including

severe pain) that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

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

No authorization is required for emergency/urgent services and emergency hospital admissions.

For emergency hospital admissions and emergency room outpatient services, the hospital should verify the Member's status by telephoning our Eligibility Verification System or Eligibility Clerk at 888-301-1228. Contracting facilities are obligated to notify GCHP and the PCP within one business day of service and will generally forward a copy of the ER report/face sheet to the PCP within **the same timeframe.**

Additionally, the hospital must forward a copy of the ER report/face sheet to GCHP documenting the PCP authorization as well as the emergency nature of the services.

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

Administrative Members

Those Members not linked to a PCP, may self-refer to any "willing" Medi-Cal provider for covered benefits. In addition, authorization from GCHP is not required for Members with other health coverage including Medicare since GCHP is not the primary payer.

No prior authorization is required for family planning and sensitive services.

GCHP Medi-Cal Members also may self-refer to any willing Medi-Cal Provider for family planning and sensitive services. Family planning services include birth control and pregnancy testing and counseling. Sensitive services include pregnancy testing and counseling, birth control, AIDS/HIV testing, sexually transmitted disease testing and treatment, and termination of pregnancy. These services are listed alphabetically below:

- Abortion (legal, unspecified, failed)
- Candidiasis/monilia
- Condyloma acuminatum
- Contraception and contraceptive management
- Diagnosis and treatment of STDs if medically indicated
- Dysplasia
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider.
- Genital herpes

- Health education and counseling necessary to make informed choices and understand contraceptive methods

- High-risk sexual behavior

- Inflammatory disease of uterus, except cervix

- 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

- Phthirus pubis (pubic lice)

- PID — unspecified organism

- Pregnancy exam or test, pregnancy unconfirmed

- Provision of contraceptive pills/devices/supplies

- Rape examination

- Scabies

- Screening, testing and counseling of at-risk individuals for HIV and other STDs and referral for treatment Syphilis and other venereal diseases

- Termination of pregnancy

- Trichomonas

- Tubal ligation

- 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, plese first complete the registration process using your GCHP provider ID number.

- To register go to www.goldcoasthealthplan.org and visit the "Providers" section.

- At the menu, select Provider Web Portal and follow the instructions.

- The "Provider Portal User Guide" walks through the process, step by step.

Fax

- Complete the Preauthorization Request for Treatment Form

- Fax the PRFT form to GCHP at 1-888-310-3660

Telephone

Call GCHP Health Services Department at 1-888-301-1228

By Mail

Gold Coast Health Plan

<u>Attention</u>: Health Services Department

PO Box 9152

Oxnard, CA 93031

Member Requests

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

Routine Pre-Service Requests

You must complete a Preauthorization Request (PRFT) before the service is performed. For routine pre-service requests for procedures/services that can be pre-scheduled without danger of adverse outcome to the Member, GCHP will usually make a determination **within 5 business days** — **but no longer than 14 days** — from receipt of the request and appropriate documentation of Medical Necessity.

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

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

Expedited/Urgent Requests

In medically urgent situations, you may request an expedited PRFT review by calling our Customer Service Department at 888-301-1228 or faxing it to 888-310-3660. Expedited Preauthorization Requests will be reviewed within 72 hours after receipt of the request when the Provider indicates that following a standard timeframe could seriously jeopardize the Member's life or health, or ability to attain, maintain or regain maximum function.

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

The majority of the time, when a Member needs specialty care or procedures, the Member's PCP should refer the Member to a participating Provider ("par provider") within GCHP's Ventura County service area. If there is no participating Provider ("non-par provider") available within the

Ventura County service area, the PCP may refer the Member to a non-contracted provider within the service area only with Plan approval (except for Administrative Members).

The process for making these referrals to par providers is for the PCP to complete a Direct Referal Authorization Form, sending one copy to the referral provider, giving one copy to the Member and sending and one copy to GCHP. GCHP will not approve or deny these referrals. However, GCHP must review and approve referrals to out-of-area providers, regardless of contract status, before the service can be provided. This helps ensure that appropriate medical criteria are met and that the Member is being referred to an appropriate provider.

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

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

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

All services requested will be reviewed for clinical appropriateness by a GCHP nurse, with final decisions made by the Chief Medical Officer.

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

Post-Service Authorization Requests

If it was not possible for the Provider to obtain authorization before providing a Medically Necessary service, we will respond to a post-service PRFT if we receive it within 30 calendar days of initiation of the service; if received later, the retrospective PRFT will be denied for non-timely submission. Please note that a post-service PRFT must be accompanied by documentation explaining why the authorization was not requested earlier. Our response will inform the Provider of the decision to approve, modify or deny the PA, including communication to the Provider and the Member or his/her designated representative. While elective surgery requires Preauthorization, under exceptional medical circumstances we may provide authorization after the fact.

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

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

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

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

Authorization Requests for Ancillary Services

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

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

Hospital Inpatient Services

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

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

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

Discharge planning is initiated upon admission to facilitate the transition of beneficiaries to the next phase of care. The discharge planning team is multi-disciplinary and consists of the treating Provider and hospital discharge planners. Provider responsibility includes participation in coordinating Member discharge planning and referrals to appropriate post-discharge settings. GCHP staff will work with the hospital's discharge planning staff, as needed, in determining the most appropriate post-discharge setting.

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

- Please type the form — an illegible handwritten form may be returned to the Provider.
- Be sure to include your name, address, contact number and FAX number.
- Be sure to include Member's name, address, age, sex, date of birth, and identifying information such as the Member ID number.
- The Medi-Cal identification number must be correct. Refer to the Medi-Cal card if necessary.

- Enter into the appropriate box the description of the diagnosis and ICD-9 or CPT code with appropriate modifiers that most closely describe the Member's condition.
- Use the correct GCHP provider identification number. If the patient is hospitalized, the hospital name or provider number must be used.
- Attach documentation that supports the Medical Necessity of the request to the form (in addition to providing documentation required in the History/Medical Justification area).
- Be sure to sign and date the form (if required, it must be signed by the referring Provider).
- Submit a separate PRFT for each service request per Member; the PRFT will be given a unique number that is used to facilitate reimbursement.

Long-Term Care 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.

Long-Term Care Facilities Include:

Skilled Nursing Facilities (SNF)

Intermediate Care Facilities (ICF)

Intermediate Care Facilities of the Developmentally Disabled (ICF/DD), Developmentally Disabled Habilitative (ICF/DDH) or Developmentally Disabled Nursing (ICF/DDN)

Subacute Care Facilities

Referring a Member to a Long-Term Care Facility

The admitting facility is required to submit medical justification and obtain authorization from GCHP.

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
- Curreny history and physical
- Diagnosis/diagnoses
- The name of the physician who will be following the Member once he/she is admitted to the facility

For new Member/patients, the SNF or LTC must submit the following pages of the Medi-Cal Medical Data Sheet ("MDS"): 1, 2, 3, 14, 17 and 18. These must be completely filled out and not left blank. For ICF-DD providers, for new Member/patients Gold Coast Health Plan requires the HS-231 and or IPP/ISP with a copy of the original TAR if available.

Specific information about Medi-Cal coverage for Long-Term Care is available at the State Medi-Cal website at http://www.dhcs.ca.gov. For additional information please contact our Health Services Department at 888-301-1228.

Hospice

Medi-Cal covers hospice services when medically indicated for terminally ill Members. Hospice services can be provided in the home, skilled nursing facility and in an acute hospital setting.

The contracted hospice agency is responsible for submitting a request for authorization.

Specialist Referrals

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

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

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

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

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

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

Serious and Complex Medical Conditions

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

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

- Continuing care from a Specialist or specialty care center over a prolonged period of time.
- Standing referral visits to the Specialists.

- Extended access to a Specialist because of a life threatening, degenerative or disabling condition involving coordination of care by a specialty care practitioner. (For extended specialty referrals, the requesting Provider should indicate the specific healthcare services to be managed by the Specialist vs. the requesting Provider.)

Standing Referrals to an HIV/AIDS Specialist

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

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

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

Obtaining a Second Opinion

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

Second opinions may be rendered *only* by a Provider qualified to review and treat the medical condition in question. Referrals to non-contracting medical providers or facilities may be approved only when the requested services are not available within the GCHP network.

Second opinions should not be sought from providers affiliated with the same provider who rendered the first opinion.

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

Status of Authorization Requests

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

Deferrals and Denials

As discussed earlier in this section, decisions about requests for authorization may be deferred or denied. The most common reasons for such decisions are outlined in the chart below.

When a request is denied, a Notice of Action letter will be mailed to the Member no later than the third business day after the decision, with a copy sent to the Provider. If the denial is a result of insufficient information from the Provider, we will inform the Member that the case will be reopened when complete information is received. The denial letter will explain the reason for denial of the request and will provide information about the Member's right to appeal the decision. If you need clarification of the reason your PA was denied, please call Customer Service at 888-301-1228 to reach GCHP's Prior Authorization Nurse Coordinator.

Notes on the Status of Authorization Requests

Approved as requested	You may provide service as requested
Approved as Modified	Fewer visits or modified scope of services from request are authorized
Deferred	PRFT form not completely filled out
Denied	If you need further clarification of the reason your PRFT was denied please call your PRFT Nurse Coordinator at the number indicated on the denial..

Assistance with Referral Consultation Requests

To view a sample of the Direct Referral Authorizatin Form, or instructions to complete the Referral, please go to our website and access the Provider Portal. If you are unable to determine if a referral is required after reading this chapter, please call Customer Service at 888-301-1228 to reach Prior Authorization Nurse Coordinator (please have the CPT Procedure Code available to facilitate the research). You may also fax your completed Direct Referral Authorization Form to 888-310-3660.

Long-Term Care (LTC) is defined as care in a facility for longer than one full month. LTC facilities may include a Skilled Nursing Facility (SNF), sub-acute facilities (pediatric and adult), or Intermediate Care Facilities (ICF).

Determination of the most appropriate level of care for the Member, and the best facility to provide such care, is made by collaborative efforts between the PCP, the hospital Discharge

Planning/Care Management departments, and the GCHP Utilization Management (UM) and Case Management (CM) teams. Prior Authorization is required for approval of admission to a Long-Term Care facility of any kind.

The criteria for receiving skill-nursing services must meet the level-of-care standards set by Medi-Cal (Title 22, Section 51215). The patient must require the continuous availability of procedures, including but not limited to:

- Administration of IV, IM or SC injections and IV or SC infusions.
- Gastric tube or gastronomy feedings.
- Nasopharyngeal aspiration.
- Insertion or replacement of catheters.
- Application of dressings involving prescribed medications and aseptic techniques.
- Treatments that require observation by licensed healthcare staff to evaluate the patient's progress.
- Administration of medical gases under a prescribed therapeutic regimen.
- Restorative nursing procedures that require the presence of a licensed nurse.

Medically Necessary Long-Lerm Care will be authorized by GCHP at the time of admission for Members who meet the criteria.

If the Member does not meet the criteria for Long-Term 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 Medi-Cal Claims are Paid

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

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

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

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

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

Please have available the GCHP Claims Control Number (CCN) and/or the Member's 9-digit ID number. If the inquiry is regarding a newborn claim billed under the mother's ID number, indicate:

- Date of service
- Dollar amount billed
- Date claim was sent to GCHP

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.

To begin the process to submit claims electronically, please go to the Providers Portal at the GCHP website at **www.goldcoasthealthplan.org.** Visit the menu option "Electronic Claims Submission." Refer to the instructions to learn how to register to become a Trading Partner If you utilize the services of a clearinghouse to submit electronic claims on your behalf, please refer your clearinghouse to our website in order for them to register.

Paper Claim Submission

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

CHDP Claim Submission

CHPD claims for services to GCHP Members should be sent to GCHP on the PM-160 forms.

Claims by FAX

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

Claim Forms by Provider Type

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

Claim Forms Used by Different Types of Providers*

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

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

Section 11: Coordination of Benefits

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

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

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

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

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

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

Dual Coverage by Medi-Cal and Medicare

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

- Send a hardcopy copy or an original Medicare claim. Confirm that your National Provider Identifier (NPI) number is on the claim and the appropriate Medi-Cal

procedure codes and modifiers are present. You may bill us in the same manner as you billed Medicare, using the same procedure codes and modifiers. While place-of-service codes may be either Medicare or Medi-Cal codes, it is essential that a code be given to indicate the place of service.

- Attach a hardcopy of the Medicare explanation of benefits. The dates and procedures must match those on the claim submitted to GCHP. Please draw a line through all other patient names and identifying numbers.

If you are submitting crossover claims to State Medi-Cal for GCHP Members, you may receive a denial indicating "Bill Other Health Plan." These denials indicate that the Member is enrolled in GCHP. To receive any additional reimbursement, you must submit a hard-copy claim to GCHP.

The GCHP bases billing limitations on the Medicare Explanation of Benefits (EOB) date of service rather than the received date.

Exceptions to the billing limit can be made if it is one of the reasons allowed by Medi-Cal for late billing. Please refer to the Delay Reason Code section of the Medi-Cal Manual for the exceptions to the billing limits allowed by Medi-Cal. Medicare coverage is an approved reason for late billing.

Primary and Secondary Payers

To coordinate benefits for a patient who has dual coverage, you must bill the primary insurance first. GCHP Medi-Cal is always the payor of last resort. If there is any balance remaining after payment is received from the primary insurer, you should submit a claim to GCHP along with an EOB from the primary payer.

When a GCHP Member's primary insurance has co-payments and/or deductibles, the Member cannot be asked to pay, as long as he or she is obtaining benefits within the rules of the primary insurance.

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 will not require it (with the exception of pharmacy services).

How a Medicare/Medi-Cal Crossover Claim is Processed

Medi-Cal or GCHP pays a Medicare/Medi-Cal Crossover Claim according to the Welfare and Institutions Code limits, combining the payment to no more than the lesser of the amount allowed by Medicare or Medi-Cal. This limit is applied to the sum totals of the claim. In other

words, the combined Medicare/Medi-Cal payment for all services of a claim may not exceed the lesser of the amounts allowed by Medicare or Medi-Cal for all the services of the claim. Medicare-denied services billed directly to Medi-Cal will be paid at the Medi-Cal maximum allowable amount.

For example, you file a claim for $60.00. The Medi-Cal allowable amount is $32.90. Medicare paid you its allowance of $53.90. The Medi-Cal payment on this claim would be $0.00, not the difference of $6.10, because the primary insurer (Medicare) covered the maximum amount allowed by Medi-Cal ($32.90).

Share of Costs

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

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

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

Examples of Share of Cost: Medi-Cal + Medicare

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

GCHP Members with Veterans Benefits

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

Members with VA benefits may use their own discretion in choosing whether to receive

their care through the VA system or GCHP — we cannot require or request that they do so; but, if the Member wishes, we will facilitate and coordinate their care.

Emergency Services for Veterans

Payment or reimbursement for Emergency Services for non-service-connected conditions in a facility other than a VA facility may be authorized under the "Millennium Bill Act." To be eligible for this authority, the veteran must satisfy *all* of the following conditions:

- The Emergency Services must have been provided in a hospital emergency department or a similar facility that is known to provide emergency care to the public.
- The claim for payment or reimbursement for the initial evaluation and treatment must be for a condition of such a nature that a prudent layperson would have reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health.
- This standard would be met in the presence of an emergency medical condition manifesting 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 that the absence of immediate medical attention would seriously jeopardize the health of the individual, would result in serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part.

If we receive a claim for emergency services for a Member who is known to have VA benefits, the claim will be held until the facility has received payment (or formal denial) for qualified services, as described above. Once the VA has made its determination, we will make a determination based on ongoing Medical Necessity, but will accept responsibility for coverage even when the Member could have been transferred.

VA System Referrals

In certain circumstances, the VA contracts services in non-VA facilities. If we become aware of such a service resulting from a VA referral, we will determine whether the VA has accepted financial responsibility and, if so, issue a denial.

For more information on coordination of VA benefits, please see Authorization Policies and Procedures at **www.goldcoasthealthplan.org**.

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

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

New Members receive a mailing, which includes:

- A Welcome letter and an invitation to select a Primary Care Provider from our Provider Directory.
- An initial GCHP ID card when they first become Members with the name of their PCP.
- In a separate mailing, they also receive a Member Handbook that serves as the state-required Evidence of Coverage and Disclosure 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 a quarterly newsletter, which includes articles on health education topics, service and benefit reminders, and information about how to use the health plan.

Member Services Staff

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

New Members have one month to choose a PCP, during which time they are able to access care from any willing Medi-Cal provider within GCHP's Ventura County Service Area. If a Member does not choose a PCP, we will assign one automatically based on the Member's street address, language preference, past history with the Participating Providers and other factors. Members may change their PCP by calling Member Services; the change will be effective the first of the following month (if change is requested after the 15th of the month). If a Member loses eligibility for Medi-Cal but returns as a Member within 12 months, s/he will remain linked to his/her previous PCP unless that Participating Provider is closed to new patients or no longer available.

Interpreter Services – Language Access Program Services

Gold Coast Health Plan adheres to federal and state guidelines that require health plans to ensure that limited English proficient (LEP), non-English-speaking or monolingual Medi-Cal beneficiaries have access to interpreters at all key points of medical points of service. Interpreter services are available on a 24-hour basis for medical encounters. Members are NOT required to bring an interpreter. Gold Coast Health Plan provides telephonic interpreter services for Members, please call Customer Services at 888-301-1228 or Health Educator at 805-981-5320 for assistance with coordinating interpreter services.

Gold Coast Health Plan works with a language line vendor to provide telephonic interpreter services for spoken language. Please contact Customer Services for assistance with telephonic interpreter services. GHCP provides face-to-face interpretation under special circumstances, please contact the Health Educator at 805-981-5320 for assistance.

Gold Coast Health Plan complies with the American Disability Act to ensure that deaf and hearing impaired Members receive interpreter services. Gold Coast Health Plan has contracted with an agency to provide American Sign Language Interpretation (ASL) for its deaf and hearing impaired Members for medical appointments.

How to Request Interpreter Services

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

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

Cultural & Linguistic Services

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

Member Enrollment FAQ's

Do all Medi-Cal Beneficiaries Have to Join GCHP? Do They All Have to Select a PCP?

Yes, with only a few exceptions, all Ventura County eligible Medi-Cal beneficiaries will be enrolled by the State into GCHP. Some of the eligible beneficiaries with special aid codes will not have to select a PCP. These include "dual eligibles" (also called "Medi/Medi" who are covered by both Medicare and Medi-Cal), those residing outside Ventura County, those with other health insurance coverage (Medi-Cal is never primary and always pays last), those who are confined to a Long Term Care facility, some women covered with Breast, Cervical Cancer and Treatment Program services, and beneficiaries with Share of Cost requirements. See Appendix 4 of this Provider Manual for all aid codes that GCHP is contracted with the Department of Health Care Services to administer for Ventura County residents.

Will There Be Other Managed Care Plans for Medi-Cal in Ventura County?

No. GCHP will be the only available managed care Plan in Ventura County for Medi-Cal patients. However, in the federal Health Reform initiative there is much consideration being given to greatly expand Medi-Cal to allow individuals who are now too wealthy or unqualified for Medi-Cal or too young for Medicare or too poor to afford group health insurance to be allowed to join Medi-Cal Plans. Current estimates are that the size of Medi-Cal in California could easily double.

Aid Paid Pending

If Members have received a notice that GCHP has decided to reduce, suspend or terminate medical services, they may be able to keep getting the services while the decision is appealed through a State Hearing. This is called "Aid Paid Pending." Members are eligible for Aid Paid Pending if:

- The Members request a State Hearing on or before the tenth (10th) day after a written decision is sent you so that services being received on an ongoing basis will not be reduced, suspended, or terminated **OR** before the date of the proposed action, whichever is later, and the treating GCHP provider has ordered the services at the present level.

- GCHP will continue to provide services at a level equal to the level ordered by the provider until a final decision is made by the administrative law judge.

Section 13: Health Education and Disease Management Programs

Introduction

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

Health Education Contract Requirements for Plan Providers

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

Health Promotion & Disease-Prevention Programs

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

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

- **Asthma –** GCHP will work with local Providers, clinics, and hospitals to identify appropriate Asthma health education classes. The goal is to provide PCPs with information about local health education classes and workshops to control asthma related symptoms. Asthma related topics include but are not limited to self-management classes, proper use of peak flow meter, inhaler spacer, medications as needed, and how to avoid triggers.

- **Diabetes Education –** GCHP will work with providers and local agencies in identifying diabetes self-management classes and support groups.

- **Weight Management & Physical Activity –** GCHP will collaborate with local public health agencies, community clinics, hospitals, and doctors to ensure that Plan Providers have information about local support groups, exercise and nutrition classes.

- **Breastfeeding Support –** GCHP and Ventura County Women, Infants and Children Nutrition Program (WIC) have entered into a Memorandum of Understanding (MOU) for the delivery of WIC program services to Members who are served by both parties. GCHP will work with Plan Providers on the benefits of breastfeeding during the first year and breastfeeding promotion and support groups available to women.

- **Smoking Cessation –** GCHP will collaborate with various agencies to promote smoking cessation classes throughout the county. For free smoking cessation classes, support groups and nicotine patches and gum, call GCHP Health Education services for more information or the California Smoker's Helpline.

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

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

Women's Health

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

Health Promotion Materials

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

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

Materials on Other Topics or In Different Languages

GCHP acknowledges the role that language barriers can play in reducing the quality of care to monolingual and Limited English Proficient (LEP) Members. Health Education Services will work with Plan Providers to ensure that (1) health promotion materials are available for distribution and (2) that equal access is provided for services to Members of all ethnic and cultural groups, Members with LEP and Members with hearing or speech impairment. Please contact Health Education staff for assistance with cultural and linguistically appropriate materials for your Members.

Outreach to Members and Providers

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

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

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

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

Drug Formulary

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

Step Therapy Protocol

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

- Step Therapy is based upon current medical findings, FDA-approved manufacturer labeling information, and cost and manufacturer rebate arrangements.

- Alternative drugs and their corresponding Step Therapy drugs are FDA-approved and are used to treat the same conditions.

- If Medically Necessary, it is possible to obtain coverage for a Step Therapy drug without trying an alternative drug(s) first. The physician must request coverage for a Step Therapy drug as a medical exception. If approved, the drug will be covered.

Sample Step Therapy Program:

Therapeutic Class	First Therapy (Alternative Drugs)	Second Therapy
Ulcer and Reflux	Pantoprazole Omeprazole vastatin	Aciphex Dexilant
Antihyperlipidemics	Lovastatin Simvastatin	Lipitor Crestor Vytorin

Authorizations for Non-Formulary Drugs

Prior Authorization is necessary for a prescription drug that is not on the GCHP Drug Formulary or exceeds the limit of days/quantity allowed per formulary. If a patient requires a non-formulary medication, you may submit a Pre-authorization Request For Treatment by FAX (888-310-3660) or by mailing the PRFT form to:

> **Gold Coast Health Plan**
> Health Services Department - Pharmacy
> PO Box 9152
> Oxnard, CA 93031

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

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

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

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

Please see the Pharmacy listing in our Specialist Directory at our website for in-network pharmacy locations and contact information. The Directory is posted in the providers portal at www.goldcoasthealthplan.org.

Section 15: Outpatient Clinical Laboratory & Outpatient Imaging Services

Overview of Outpatient Clinical Laboratory Services & Outpatient Imaging Centers

Clinical Laboratory Services—Lab Specimens and Drawing Stations

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

Outpatient Imaging Centers

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

Lab Tests Performed in the Provider's Office

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

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

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

Section 16: Resolution of Disputes and Grievances

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

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

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

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

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

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

You also may include additional supporting clinical information if applicable. Please note that, if the dispute does not include the above information and we cannot readily obtain it, we will

return the dispute to you for more information. Providers have 30 working days to submit an amended dispute to GCHP.

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

GCHP will acknowledge the mailed dispute within five (5) days of receiving it. GCHP will acknowledge emailed dispute within two (2) working days of receiving it.

GCHP will send a written resolution to the dispute within thirty (30) calendar days of the date we receive the dispute.

For assistance in filing a dispute, please call our Customer Service at 1-888-301-1228 to reach the Provider Relations Department .

Member Complaints

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

Provider Responsibilities

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

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

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

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

➢ In person, by making an appointment to meet with a Member Services Representative at our offices:

> 2220 E. Gonzales Road, Suite 200
> Oxnard, CA 93036
> Phone: 805-981-5320

➢ By calling a Member Services Representative at: 888-301-1228 [or the TTY line for the hearing and/or speech impaired at: 888-310-7347].

➢ By filling out a complaint form or putting the complaint in writing and sending it to the Member Services Department at:

Gold Coast Health Plan
ATTN: Member Services Department
2220 E. Gonzales Road, Suite 200
Oxnard, CA 93036-8294

➢ Electronically, by visiting our website at: **www.goldcoasthealthplan.org**

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

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

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

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

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

Member Rights in the GCHP Grievance Process

- The Member may authorize a friend or family member to act on his/her behalf in the grievance process.

- If the Member does not speak English fluently, s/he has the right to interpreter services by phone via the Customer Services Call Center at 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 (888) 452-8609 and request assistance.

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

Claims

- Claim Form Sample - Image of actual claim form.

- Interested in Electronic Claims Submission? - This form begins the electronic claims submission instruction process.

Finance—Please see Appendix 6

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

Health Services

- Preauthorization Treatment Request Form - This form is used by Providers to request prior authorization from the Plan for certain specified services that require advance approval.

- Medication Agreement, English or Spanish - This form may be used by Providers participating in the Quality Based Incentive for Chronic Pain Management. FAX form to (805) 981-5314 Attn: Health Services Department.

- 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.

- Admissions Notification Form – The document that hospitals file with the Plan to notify the Plan of an emergency admission.

- Care Management Referral Form – The form used to request assistance with a Member with unique or special needs.

- General Consent To Treatment of a Minor Form – Authorizes treatment of a minor Member.

Member Services

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

- Confidentiality and Release of Information Form – To ensure compliance with HIPAA rules and regulations regarding PHI (Private Health Information).

Provider Relations

- Patient Complaint / Grievance Tracking Log - Form those Physicians/Providers can use to track patient requests for Complaint / Grievance Forms.

- Provider Information Change Form - This form is used to update provider contact and practice information. Information includes Provider address, phone number, contact information, payment address, and tax ID number.

- Provider Request for Contract - If you are interested in becoming a GCHP Provider and joining our network, please call Customer Services at 888-301-1228. [No form yet as of this date.]

- Certification Regarding Lobbying - Exhibit D(F) Att 1 and 2 - If payments to a Provider under the GCHP Services Agreement total $100,000 or more, the Provider must submit the "Certification Regarding Lobbying" to GCHP.   Download the form at: **www2.ed.gov/fund/grant/apply/appforms/sflll.doc**

- Declaration of Confidentiality - Form sent to GCHP regarding authorization procedures for release / access of DHCS computer files for the Medi-Cal program, as required by GCHP's Medi-Cal contract with the State.

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

Appendix 1: Functions of Committees and GCHP Staff

Quality Assurance /Utilization Management/Peer Review Committee (QA/UM/PR)

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

- Critically examine, evaluate and make recommendations on all quality functions of the health plan including: quality improvement over and underutilization peer review of licensed professionals and their contracted activities in service to the enrolled Members and promote educational activities for providers for best cost effective quality care.

- Review activities of the Credentials and Pharmacy & Therapeutics Committees, and monitor the functions of all of the Committees that review the quality and safety of care provided to Members.

- Approve and/or recommend changes to health plan policies, practice guidelines and reporting Committees' proposed action plans.

- Present reports on Quality Improvement activities to the Board on a bi-annual basis, and annually review and approve the QI Program Evaluation, QI Program and QI Work Plans.

- Submit annually the QI Program and the QI Work Plan to Board for approval.

- The GCHP Chief Executive Officer and Chief Medical Officer shall review and appoint the Members of the QA/UM/PR Committee on an annual basis.

Pharmacy & Therapeutics (P&T) Committee

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

Credentials Committee (CC)

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

Quality Improvement Committee (QIC)

The GCHP management team is actively involved in the development, monitoring, and implementation of GCHP Quality Improvement programs, policies and operations. Members include but are not limited to the Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Medical Officer, Health Services Director, Provider Relations Director, Member Services Director, HR and Administrative Services Director, Quality Improvement Director, Information Technology Director and others as deemed appropriate or necessary, and shall meet bi-weekly.

Cultural & Linguistics Committee (C&L Committee)

The C&L Committee is chaired by the Health Educator, and staffed by the Quality Improvement Manager, Provider Relations Director, Health Services Director, Member Services Director, Human Resources Director and others, as appropriate. The Committee shall meet no less than quarterly, and reports to the QA/UM/PR Committee.

GCHP Cultural and Linguistic Services include interpretation and translation services, Provider education and resources, and cultural competence training for GCHP staff. Committee objectives are to increase access to high quality care for all GCHP Members, reduce health disparities among different cultural groups, and to improve communication among staff, Providers and Members.

Provider Advisory Committee (PAC)

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

Chief Medical Officer (GCHP Medical Director)

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

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

Specific functions include:

1. Fulfillment of and adherence to QI Program goals and all regulatory agency and accreditation body requirements.

2. Fulfillment of and adherence to UM Program goals and all regulatory agency and accreditation body requirements.

3. Development and coordination of the peer review process.

4. Serve as Chair for the QA/UM/PR Committee and Credentials Committee.

5. Remain on-site or available via telephone for consultation with the Health Services Director, UM Director, Quality Director and other staff, as appropriate.

6. Guide and assist in the development and revision of quality improvement criteria, practice guidelines, new technology assessments and performance standards, as appropriate, and the development and implementation of quality improvement strategies.

7. Present periodic updates on quality improvement and utilization management activities to Committee Chairs and to the Commission as appropriate.

Appendix 2: Summary of Referral and Authorization Requirements

Referral Guidelines		
Service	**Linked Members assigned to a PCP**	**Un-linked or Administrative Members who do not have a PCP assignment**
Referral/Specialty Consultation (Par Providers in County)	Prior approval and authorization are not required. PCP or Specialist complete "Direct Referall Authorization Form" and submits to GCHP for filing with copy to the Member being referred.	Member may self-refer to any "willing provider." Provider must accept Medi-Cal and bill GCHP.
Physical Therapy	PCP completes the Referral Consultation form for an initial evaluation and submits the form to GCHP. Additional treatment requires a Pre-authorization Request For Treatment with approval from GCHP.	Member may self-refer to any "willing provider." Provider must accept Medi-Cal and bill GCHP.
Podiatry, Speech, Occupational Therapy	Members may self-refer for an initial evaluation. Treatment requires a Pre-authorization Request For Treatment with approval from GCHP. The number of treatments is based upon current GCHP and Medi-Cal Guidelines and benefits.	Member may self-refer to any "willing provider." Provider must accept Medi-Cal and bill GCHP.
Chiropractic and Acupuncture	No Longer a Covered Medi-Cal benefit.	No Longer a Covered Medi-Cal benefit.
Family Planning and Sensitive Services (OB Care)	Member can self-refer to any willing in area Medi-Cal obstetrical provider	Member may self-refer to any "willing provider." Provider must accept Medi-Cal and bill GCHP.
Referral/Specialty Consultation for all Providers outside Ventura County	Referral requires a Pre-authorization Request For Treatment with approval from GCHP. PCP or Specialist completes the PRFT form and submits to GCHP for review BEFORE referral.	Member may self-refer to any "willing provider." Provider must accept Medi-Cal and bill GCHP.
Optometry	Member must see VSP optometrist and may self-refer (effective Mar 1, 2012).	Member must see VSP optometrist and may self-refer (effective Mar 1, 2012).

Authorizations Required

Elective Inpatient Hospitalizations	**Acute Care and for Acute Rehabilitation:** All elective inpatient admissions must be requested minimally five (5) business days prior to planned procedure / hospital inpatient admission. Please use the Preauthorization Treatment Request Form and provide sufficient clinical information and other relevant information so that there are no delays in obtaining authorization.
Emergency Inpatient Admissions	Emergency inpatient admission requires notification (not prior authorization). Notification must be provided within 24 hours of admission but no later than the first business day following admission. Hospitals are required to notify Gold Coast Health Plan by submitting an "Inpatient Notification Authorization Request" form or faxing the Inpatient Face Sheet to the appropriate fax number.
Surgeries	**Ambulatory:** All outpatient surgical procedures at surgical-centers require prior authorization for payment. **Office:** Surgeries and procedures that require greater than $300 in Medi-Cal reimbursement rates.
Long Term Care	All planned admissions to Skilled Nursing Facilities and sub-acute care require prior authorization for payment.
Home Health Care	The first three visits following a hospital discharge do not require authorization. After 3 visits a Preauthorization Treatment Request Form is required with relevant information to justify additional visits with treatment plan.
Outpatient Diagnostic Studies	MRI, CT Scan, PET Scan, Nuclear Medicine Imaging, Transcranial Doppler, Sleep Studies / Polysomnography, Lab Testing greater than $100 in Medi-Cal reimbursement rates (see codes on following pages).
Renal, Hemodialysis & Peritoneal Dialysis	Initial authorization is limited to 90 days and extensions will be granted only after receipt of Medicare determination.
Phototherapy	For dermatological condition
DME	All equipment, hearing aids, etc. Purchases > than $500/item., Rental > $200/mo., Repair > $250/item Oxygen Compressor Rental
Supplies	Ostomy, incontinence, all other medical supplies will be authorized only upon physician justification for medical necessity > $200/item per month in Medi-Cal reimbursement rates. Diabetic Shoes and Inserts.
Others	Audiogram Testing for medical evaluaton of hearing loss Cochlear Implant Dental Anesthesia for children under 21 years of age only. No coverage for dentist Drugs / Pharmaceuticals: Contact Script Care **EPSDT:** Early/Periodic Screening, Diagnosis & Treatment Supplemental Services for children under 21 years of age only. Identify & refer to qualifying agency Home Infusion Therapy/TPN/Enteral Feeding Hospice Hyperbaric Oxygen Pressurization IVIG Non-Emergency Transportation based on setting Nutritional Services including enteral feeding Oxygen Pain Management Epidural Injections Physical, Occupational, Rehabilitation & Speech Therapies. Medi-reservation = 3 visits/month (no authorization) Plasmapheresis Podiatric Office Procedures (limit $300 plus supplies in Medi-Cal reimbursement rates) Prosthetics and Orthotics (limit $500 plus supplies in Medi-Cal reimbursement rates) Radiation Therapy

NOTE: All CCS Eligible Conditions are to be immediately referred to CCS. Any questions, please call Gold Coast Health Plan at 1-888-301-1228.

LAB TESTS GREATER THAN $100 WHICH REQUIRE PRE-AUTHORIZATION
(Sorted by Code)

Type	Code	Procedure Description	Type	Code	Procedure Description
M	87153	DNA/RNA SEQUENCING	1	P9010	BLOOD (WHOLE), FOR TRANSFUSION, PE
M	87900	PHENOTYPE, INFECT AGENT DRUG	1	P9011	BLOOD SPLIT UNIT
M	87901	GENOTYPE, DNA, HIV REVERSE T	1	P9016	RBC LEUKOCYTES REDUCED
M	87902	GENOTYPE, DNA, HEPATITIS C	1	P9020	PLATELET RICH PLASMA, EACH UNIT
M	87903	PHENOTYPE, DNA HIV W/CULTURE	1	P9021	RED BLOOD CELLS, EACH UNIT
M	88230	TISSUE CULTURE, LYMPHOCYTE	1	P9022	WASHED RED BLOOD CELLS UNIT
M	88233	TISSUE CULTURE, SKIN/BIOPSY	1	P9031	PLATELETS LEUKOCYTES REDUCED
M	88235	TISSUE CULTURE, PLACENTA	1	P9032	PLATELETS, IRRADIATED
M	88237	TISSUE CULTURE, BONE MARROW	1	P9033	PLATELETS LEUKOREDUCED IRRAD
M	88239	TISSUE CULTURE, TUMOR	1	P9034	PLATELETS, PHERESIS
M	88245	CHROMOSOME ANALYSIS, 20-25	1	P9035	PLATELET PHERES LEUKOREDUCED
M	88248	CHROMOSOME ANALYSIS, 50-100	1	P9036	PLATELET PHERESIS IRRADIATED
M	88249	CHROMOSOME ANALYSIS, 100	1	P9037	PLATE PHERES LEUKOREDU
M	88261	CHROMOSOME ANALYSIS, 5	1	P9038	RBC IRRADIATED
M	88262	CHROMOSOME ANALYSIS, 15-20	1	P9039	RBC DEGLYCEROLIZED
M	88263	CHROMOSOME ANALYSIS, 45	1	P9040	RBC LEUKOREDUCED IRRADIATED
M	88264	CHROMOSOME ANALYSIS, 20-25	1	P9048	PLASMAPROTEIN FRACT, 5%, 250ML
M	88267	CHROMOSOME ANALYS, PLACENTA	1	P9050	GRANULOCYTES, PHERESIS UNIT
M	88269	CHROMOSOME ANALYS, AMNIOTIC	1	P9051	BLOOD, L/R, CMVNEG
M	88309	TISSUE EXAM BY PATHOLOGIST	1	P9052	PLATELETS, HLAM, L/R, UNIT
M	88325	COMPREHENSIVE REVIEW OF DATA	1	P9053	PLT, PHER, L/R CMVNEG, IRR
M	88348	ELECTRON MICROSCOPY	1	P9054	BLOOD, L/R, FROZ/DEGLY/WASH
M	88349	SCANNING ELECTRON MICROSCOPY	1	P9055	PLT, APH/PHER, L/R, CMVNEG
M	88355	ANALYSIS, SKELETAL MUSCLE	1	P9056	BLOOD, L/R, IRRADIATED
M	88356	ANALYSIS, NERVE	1	P9057	RBC, FRZ/DEG/WSH, L/R, IRRAD
M	88358	ANALYSIS, TUMOR	1	P9058	RBC, L/R, CMVNEG, IRRAD
M	88361	TUMOR IMMUNOHISTOCHEM/COMPUT			
M	88362	NERVE TEASING PREPARATIONS			
M	88367	INSITU HYBRIDIZATION, AUTO			
M	88368	INSITU HYBRIDIZATION, MANUAL			

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LAB TESTS GREATER THAN $100 WHICH REQUIRE PRE-AUTHORIZATION
(Sorted by Description)

Type	Code	Procedure Description	Type	Code	Procedure Description
M	88356	ANALYSIS, NERVE	1	P9048	PLASMAPROTEIN FRACT, 5%, 250ML
M	88355	ANALYSIS, SKELETAL MUSCLE	1	P9037	PLATE PHERES LEUKOREDU
M	88358	ANALYSIS, TUMOR	1	P9035	PLATELET PHERES LEUKOREDUCED
1	P9010	BLOOD (WHOLE), FOR TRANSFUSION, PE	1	P9036	PLATELET PHERESIS IRRADIATED
1	P9011	BLOOD SPLIT UNIT	1	P9020	PLATELET RICH PLASMA, EACH UNIT
1	P9051	BLOOD, L/R, CMVNEG	1	P9031	PLATELETS LEUKOCYTES REDUCED
1	P9054	BLOOD, L/R, FROZ/DEGLY/WASH	1	P9033	PLATELETS LEUKOREDUCED IRRAD
1	P9056	BLOOD, L/R, IRRADIATED	1	P9052	PLATELETS, HLAM, L/R, UNIT
M	88269	CHROMOSOME ANALYS, AMNIOTIC	1	P9032	PLATELETS, IRRADIATED
M	88267	CHROMOSOME ANALYS, PLACENTA	1	P9034	PLATELETS, PHERESIS
M	88249	CHROMOSOME ANALYSIS, 100	1	P9055	PLT, APH/PHER, L/R, CMVNEG
M	88262	CHROMOSOME ANALYSIS, 15-20	1	P9053	PLT, PHER, L/R CMVNEG, IRR
M	88245	CHROMOSOME ANALYSIS, 20-25	1	P9039	RBC DEGLYCEROLIZED
M	88264	CHROMOSOME ANALYSIS, 20-25	1	P9038	RBC IRRADIATED
M	88263	CHROMOSOME ANALYSIS, 45	1	P9016	RBC LEUKOCYTES REDUCED
M	88261	CHROMOSOME ANALYSIS, 5	1	P9040	RBC LEUKOREDUCED IRRADIATED
M	88248	CHROMOSOME ANALYSIS, 50-100	1	P9057	RBC, FRZ/DEG/WSH, L/R, IRRAD
M	88325	COMPREHENSIVE REVIEW OF DATA	1	P9058	RBC, L/R, CMVNEG, IRRAD
M	87153	DNA/RNA SEQUENCING	1	P9021	RED BLOOD CELLS, EACH UNIT
M	88348	ELECTRON MICROSCOPY	M	88349	SCANNING ELECTRON MICROSCOPY
M	87902	GENOTYPE, DNA, HEPATITIS C	M	88237	TISSUE CULTURE, BONE MARROW
M	87901	GENOTYPE, DNA, HIV REVERSE T	M	88230	TISSUE CULTURE, LYMPHOCYTE
1	P9050	GRANULOCYTES, PHERESIS UNIT	M	88235	TISSUE CULTURE, PLACENTA
M	88367	INSITU HYBRIDIZATION, AUTO	M	88233	TISSUE CULTURE, SKIN/BIOPSY
M	88368	INSITU HYBRIDIZATION, MANUAL	M	88239	TISSUE CULTURE, TUMOR
M	88362	NERVE TEASING PREPARATIONS	M	88309	TISSUE EXAM BY PATHOLOGIST
M	87903	PHENOTYPE, DNA HIV W/CULTURE	M	88361	TUMOR IMMUNOHISTOCHEM/COMPUT
M	87900	PHENOTYPE, INFECT AGENT DRUG	1	P9022	WASHED RED BLOOD CELLS UNIT

CPT codes and descriptors are copyright 2002 American Medical Association

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

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

2. What should I do with suspended claims on my Remittance Advice (RA)?

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

PAID:　　　　　The claim detail line has been processed for payment by GCHP.

ADJUSTED:　　The claim detail line has been adjusted either positively or negatively.

DENIED:　　　　The claim detail line has been processed as a denial by GCHP.

SUSPENDED:　The claim detail line is on hold and requires additional clarification for final processing. Suspended claims will appear one time on the RA until GCHP staff has removed the hold and either denied or approved the line for payment.

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

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

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

4. What is GCHP's capitation check schedule?

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

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

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

6. Will GCHP accept electronic claims?

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

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

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

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

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

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

CHDP services are billed on the PM-160 claim form. We require that:

– The top page of the PM-160 claim (green or brown) be sent to GCHP for processing

– The second page (yellow) will be sent to the CHDP office for tracking/informational purposes

– The third copy (white) will be reserved for the Provider's file.

– The fourth copy (pink) will be given to the patient.

GCHP will return any incomplete PM-160 forms to the Provider before processing; with the exception of requiring a diagnosis, GCHP is following the CHDP guidelines provided by the State of California.

10. How should claims for newborns be submitted?

Services rendered to an infant may be billed with the mother's ID only for the first 30 days of the newborn's birth date.   After this time, the infant must have his/her own Medi-Cal ID number. During the first 30 days of life a *Care Management Referral Form* from the mother's PCP is not required; however, during Days 31-60 a CMRF from the mother's PCP

is required (if the mother is linked to a PCP) unless the infant has his/her own case and 9-digit Member ID#.

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

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

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

Share-of-Cost (SOC) collection and billing is an important function for every Provider. The Medi-Cal website at **https://www.medi-cal.ca.gov/Eligibility/Login.asp** will inform you of a Member's outstanding SOC and allow you to clear the amount collected (or the amount that the patient is obligated to pay). Once the amount collected (or obligated) is cleared, the Member will be a GCHP Member (or will be closer to Eligibility if there is a remaining SOC amount). Members with outstanding SOC amounts are not eligible for GCHP membership during that month. It is important for all Providers to collect and clear SOC each month to ensure a Member's ability to obtain services from other Providers later that month.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- The Member has an unmet monthly Medi-Cal share-of-cost amount.
- The Member does not disclose his/her GCHP/Medi-Cal coverage.
- The Member consents to receive services that are not covered by GCHP.
- The Member chooses to see a physician/provider who does not accept Medi-Cal or is not a Medi-Cal provider.
- The Member waives his/her Medi-Cal benefits.
- The Member does not obtain or access primary insurance benefits correctly.

A Member may be charged when he/she does not obtain primary insurance benefits correctly. Note also that, unless you have provided benefits to the Member according to the primary insurance authorization/benefit requirements, you may not charge the GCHP Member for the service.

Aid Code	Category	Description
0A	OTHER	Refugee Cash Assistance
0M	BCCTP	Breast & Cervical Treatment Plan
0N	BCCTP	Breast & Cervical Treatment Program
0P	BCCTP	Breast & Cervical Treatment Program
0R	BCCTP	Breast & Cervical Treatment Program
0T	BCCTP	Breast & Cervical Treatment Program
0U	BCCTP	Breast & Cervical Treatment Program
OW	BCCTP	Breast & Cervical Treatment Program
01	OTHER	Immigrants/Refugees
02	OTHER	Immigrants/Refugees
04	MI-CHILD	Medically Indigent (No SOC) Child Adoption Assistance
06	PA-FAMILY	Adoption Assistance Program
07	MI-CHILD	Medically Indigent (No SOC) Child Adoption Assistance
08	OTHER	Immigrants/Refugees
10	PA-AGED	SSI – Public Assistance Aged
13	SP-MN-A-LT	Medically Needy (LTC) Aged
14	MN-AGED	Medically Indigent (No SOC) Aid to the Aged
16	PA-AGED	Aid to the Aged-Pickle Program
17	SP-MN-AGD	Aid to the Aged-SOC
1E	MN-AGED	Continued Eligibility Prior SSI
1H	MN-AGED	Recipients Federal Poverty Level
20	PA-DISABLD	Aged SSI/SSP
23	SP-MN-D-LT	Aid to the Blind – LTC Status
24	MN-DISABLD	Aid to the Blind – Medically Needy
26	PA-DISABLD	Aid tot eh Blind – Pickle Program
27	SP-MN-DISAB	Aid to the Blind – Medically Needy-SOC
2E	MN-DISABLD	Continued Eligibility Prior SSI Recipients
2H	MN-DISABLD	Continued Eligibility Prior SSI Recipients
30	PA-FAMILY	Aid to Families w/Dependent Children
32	PA-FAMILY	Public Assistance - CalWORKS
33	PA-FAMILY	Aid to Pregnant Women
34	MN-FAMILY	Aid to Families

Aid Code	Category	Description
35	PA-FAMILY	Aid to Families
36	PA-AGED	Aid to Disabled Widow/ers
37	SP-MN-FAM	Aid to Families-SOC
38	PA-FAMILY	60 Days Continued Eligibility Post-Partum
39	PA-FAMILY	6 Mos. Continued Eligibility
3A	PA-FAMILY	Continued Eligibility for Children of Disc.
3C	PA-FAMILY	Parents Continued Eligibility for Children of
3E	PA-FAMILY	Disc. Parents Public Assistance
3G	PA-FAMILY	Aid to Families w/Dependent Children
3H	PA-FAMILY	Aid to Families w/Dependent Children
3L	PA-FAMILY	Aid to Families - CalWORKS
3M	PA-FAMILY	Aid to Families - CalWORKS
3N	PA-FAMILY	Aid to Families – Low Income
3P	PA-FAMILY	Aid to Families w/Dependent Children
3R	PA-FAMILY	Aid to Families w/Dependent Children
3U	PA-FAMILY	Aid to Families - CalWorks
3W	PA-FAMILY	TANF-Timed out, mixed case
43	PA-FAMILY	AFDC – Foster Care
45	MI-CHILD	Aid to Children – Group Homes
46	PA-FAMILY	Interstate Child Placement (Foster Kids)
47	Percent of Poverty	Aid to Infants - %of Poverty Program
49	PA-FAMILY	AFDC – Foster Care
4A	MI-CHILD	Adoption Assistance
4F	PA-FAMILY	Guardianship Program
4K	MI-CHILD	Emergency Assistance – Foster Care
4L	MI-CHILD	Foster Care Children
4M	MI-CHILD	Aid to Children – 18 thru 20 Prior Foster Care
4N	PA-FAMILY	Foster Care Children
4S	Family	Foster Care Children
4W	PA-FAMILY	Guardianship Program
53	SP-MN-D-LT	LTC Restricted – No Acute Care
54	PA-FAMILY	CalWORKS - Continued
59	PA-FAMILY	Eligibility AFDC - Continued
5K	MI-CHILD	Eligibility 6 mos. Emergency
60	PA-DISABLD	Aid to Disabled - LTC
63	SP-MN-D-LT	SSI/SSP
64	MN-DISABLD	Aid to Disabled - LTC

Aid Code	Category	Description
66	PA-DISABLD	Aid to Disabled
67	SP-MN-DISAB	Aid to Disabled – Pickle Program
6A	PA-DISABLD	Aid to Disabled – SOC
6C	PA-DISABLD	Disabled Adult Child(ren) Blindness
6E	MN-DISABLD	Disabled Adult Child(ren) Disabled
6G	MN-DISABLD	Continued Eligibility Prior SSI
6H	MN-DISABLD	Recipients Working Disabled
6J	MN-DISABLD	Fed Poverty Level – Disabled
6N	MN-DISABLD	Aid to Disabled – Pending
	XXXX	Prior SSI Appealing Cessation of Benefits
6P	MN-DISABLD	Prior SSI Children Appealing Cessation of Benefits
6R	MN-DISABLD	MN Disabled Program
6V	MN-DISABLD	Aid to Disabled
6W	SP-MN-DISAB	Aid to Disabled – SOC
6X	MI-CHILD	Medi-Cal in Home Waiver Program
6Y	SP-MN-DISAB	Medi-Cal in Home Waiver Program – SOC
72	Percent of Poverty	Aid to Children - % of Poverty Program
7A	Percent of Poverty	Aid to Children - % of Poverty Program
7J	MI-CHILD	Continued Eligibility for Children
7X	PA-FAMILY	2 Mo Bridge to Healthy Families Program
81	SP-ADULT	Aid to Adults – SOC
82	MI-CHILD	Medically Indigent
83	SP-CHILD	Medically Indigent – SOC
86	SP-ADULT	Medically Indigent – Pregnancy
87	SP-ADULT	Medically Indigent – Pregnancy – SOC
8P	Percent of Poverty	Aid to Children - % of Poverty Program
8R	Percent of Poverty	Aid to Children - % of Poverty Program

Appendix 5: FAQs about Submitting a CHDP Claim

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

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

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

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

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

   No.

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

   No, this is only required for full screenings.

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

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

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

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

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

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

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

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

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

   Yes, claims must be signed by authorized personnel.

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

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

11. **Is it mandatory to fill out WIC boxes?**

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

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

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

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

    No, only for the full screen.

14. **On the PM-160, do we need to add what series of the vaccine (e.g., hep 1, hep 2) was given?** No.

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

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

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

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

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

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

18. **Are claims returned for adding the series of the specified vaccine administered?** No.

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

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

20. **What is an ICD-9?**

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

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

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

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

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

APPENDIX 6: Financial Disclosure and Reporting

By the terms of its contract with the state of California, Gold Coast Health Plan is required to monitor the financial viability of its contracting Providers. The purpose is to establish that they are financially solvent and that their financial status is not deteriorating over time. This requirement only applies to those specific Providers who have risk bearing contracts with GCHP (such as capitation payments). GCHP will exercise discretion to only collect financial information if and when there is a clear need to do so in order to fulfill its obligations to the state. For example, PCPs who have only a small or limited number of Members on their panel will not have to comply with these provisions. Nor will tertiary care out-of-area providers that rarely treat our Members or Providers that are compensated on a straight fee-for-service rate schedule or case rate basis.

Risk-bearing contracting Providers, as described above, are required to submit audited annual financial statements to GCHP and possibly quarterly updates. The Provider's financial statements should be prepared in accordance with GAAP (Generally Accepted Accounting Principles). Financial statements may be collected more frequently if deemed appropriate.

Audited annual financial statements must be filed within 120 days of the end of each fiscal year by the Contracted Provider. Depending on the circumstances, the Provider may be required to provide copies of its quarterly financial statements within 45 days at the end of each fiscal quarter.

GCHP will perform analyses of the financial statement(s) to determine if the Provider meets minimum acceptable liquidity, profitability, efficiency, and stop-loss protection levels.

The financial viability of each Provider will be determined based on established criteria and California's Department of Managed Health Care (DMHC) required grading criteria.

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).

Leverage Ratio:

- Debt to equity ratio to be equal to or less than 1.0. Profitability:
- Profit Margin ratio (Net Income/Net Patient Service Revenue) to be positive.

Efficiency:

- Combined operating expense ratio to be equal to or less than 1.00.
- Medical care ratio (MCR) to be equal to or less than 0.85.
- Administrative expense (G&A) ratio to be equal to or less than 0.15.
- Incurred but not reported (IBNR) claims liability reserve to be within the range of 2.5 and 3.5 times average monthly claims liability. NOTE: Applies to Provider groups only (DMHC required grading criteria).
- Accounts Receivable Turnover (ART) ratio to be equal to or greater than 11.81.
- Average Days to Collect (ADC) ratio to be equal to or less than 30 days.
- Claims Timeliness must be 95% and above compliance (DMHC required criteria).

  Based on the preceding examinations of the financial statements, the Provider groups will be classified into one of the following rating categories:

  Meet Standards /Satisfactory = 1 or 2

  Observe/Acceptable = 3

  Moderately High Risk of Insolvency = 4

  High Risk of Insolvency = 5

The results of the financial analyses are confidential and will only be shared with the respective reporting Provider groups. Follow-up actions for adverse conditions or financial status may include additional reporting, financial guarantees or recapitalization, withhold of capitation payments, closure of the Provider panel to new Members, development of a Provider Corrective Action Plan or termination of the Service Agreement with GCHP.

APPENDIX 7: FAQs from Members on Complaints/Grievances

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

1. **What is the GCHP grievance process?**

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

2. **When would a Member file a complaint?**

   You could file a complaint if:

   - You are having a problem getting services you feel you need (for example, if you are having problems getting medication or medical equipment, problems getting an appointment with your doctor or problems getting treatment at the hospital).

   - You are not happy with the services you got from a healthcare provider.

   - You disagree with us when we deny a service you feel you need.

   - You are unhappy with any aspect of your health care.

   - You feel that a health care Provider or GCHP has not respected your privacy.

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

3. **How do I file a complaint?**

   You can file a complaint one of the following ways:

   - Calling our Member Services Department at 888-301-1228.

   - Writing your complaint and mailing it to:

     > Member Services Department
     > Gold Coast Health Plan
     > P.O. Box 9152
     > Oxnard, CA 93036

   - Going to our Internet Web site and filling out a complaint form:

     > **https://www.goldcoasthealthplan.org**

> ➤ Calling and making an appointment to come to our office in person,

Monday - Friday, 8am to 11am or 2pm to 4pm. Our office is in Oxnard at 2220 E. Gonzales Rd. Suite 200.

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 the Call Center at 888-301-1228.

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

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

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

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

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

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

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

7. What happens after I file my complaint?

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

8. How does my complaint get settled?

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

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

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

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

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

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

11. What can I do if I don't agree with the proposed resolution Letter?

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

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

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

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

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