



**Gold Coast
Health Plan**SM
A Public Entity

Provider Operations Bulletin

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SECTION 1:

Provider Information Update Request

In an effort to improve operations, Gold Coast Health Plan (GCHP) has entered into an agreement with BetterDoctor, a primary source verified data management service that is used by health plans across the country.

BetterDoctor, which some of you may have already worked with, will help GCHP obtain updated demographic information for the Plan's contracted provider network. As you know, having correct information in GCHP's systems ensures that communication between the Plan and providers flows as smoothly as possible. This information is critical for proper claims administration, authorization of services, and other operational functions performed by the Plan to support its provider network.

With more than 6,000 individual providers contracted with GCHP, BetterDoctor offers the Plan an opportunity to gather data quickly and efficiently.

Representatives from BetterDoctor will be reaching out to GCHP's provider network via the Provider Portal, email, fax, and telephone. Please respond to those requests as quickly as possible so that GCHP's systems can be updated expeditiously.

If you have any questions regarding this, please reach out to GCHP's Provider Relations Department at ProviderRelations@ghcp.org.

SECTION 2:

Immunization Requirements

Per All Plan Letter (APL) 18-004, the state Department of Health Care Services (DHCS) requires that all Gold Coast Health Plan (GCHP) providers:

1. Ensure the timely provision of immunizations to members in accordance with the most recent schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP), regardless of a member's age, sex, or medical condition, including pregnancy.
2. Document each member's need for ACIP-recommended immunizations as part of all regular health visits, including, but not limited to, the following types of member encounters:
 - Illness, care management, or follow-up appointments
 - Initial Health Assessments (IHA)
 - Pharmacy services
 - Prenatal and postpartum care
 - Pre-travel visits
 - Sports, school, or work physicals
 - Visits to a local health department (LHD)
 - Well patient checkups

ACIP-recommended immunizations are viewed as preventive services and are not subject to prior authorization.

This immunization information is essential to GCHP, as DHCS requires that the Plan ensure that member-specific immunization information is periodically reported to an immunization registry or registries as part of the State-wide Immunization Information System. DHCS strongly encourages providers to report immunization information within 14 days of administering an immunization.

Pharmacies

Pharmacists are required to report the administration of any vaccine, within 14 days, to the immunization registry designated by the immunization branch of the state Department of Public Health (according to APL 18-004 pursuant to Title 16, California Code of regulations (CCR) Section 1746.4§).

GCHP is required to periodically report to an immunization registry. Reports must also be made to the state following a member's Initial Health Assessment (IHA) and other health care visits that result in an immunization, in accordance to state and federal laws.

ACIP-recommended Immunization Schedules can be found [here](#).

SECTION 3:

Important Reminders when Submitting Authorization Requests via the Provider Portal

When creating an authorization through the Gold Coast Health Plan (GCHP) Provider Portal, please make sure to use the comments section to enter the name and phone number of the contact person for the request. This information helps GCHP's Health Services Department direct questions to the right person and ask for additional information, if needed. Doing this prevents delays in processing.



When you have a request that is urgent and needs to be expedited because the standard timeframe for review will seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, GCHP's Health Services Department recommends that the request be faxed to the Plan at 1-855-883-1552 instead of submitting it through the Provider Portal. Faxing an expedited or urgent request can prevent delays in processing.

Only services that meet the definition of urgent should be submitted as expedited. When non-urgent requests are submitted as expedited, processing times may be delayed for services that are truly urgent.

SECTION 4:

California Children's Services (CCS)

Gold Coast Health Plan (GCHP) and California Children's Services (CCS) work together for the benefit of children and young adults living in Ventura County.

CCS is a state-funded program that provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic

injuries, and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at six area public schools.

CCS-eligible diagnoses are carved out of GCHP. Patients that have an active case in the CCS program are required to receive treatment from a CCS-paneled specialist for their CCS-eligible condition. The primary care provider (PCP) is responsible for providing routine care, immunizations and care outside of the care associated with CCS-eligible conditions. GCHP is still responsible for

providing primary care and prevention services not related to the CCS-eligible medical condition to the member.

All requests for CCS diagnostic and treatment services must be submitted using a CCS Service Authorization Request (SAR) form:

- [CCS New Referral Client SAR](#)
- [CCS Established Client SAR](#)

Providers are required to submit documentation to substantiate medical necessity at the time the SAR is submitted. To refer a new client or to request services for

an existing CCS client, send the completed CCS SAR form to the CCS program with supporting documentation via fax at 1-805-658-4580, electronically via E-SAR (PEDI system), or by mail.

To speak with a CCS representative regarding the services offered or to become CCS paneled, call 1-805-981-5239 or 1-805-981-5281. Click [here](#) to learn more about CCS.

GCHP will begin sending clinics a list via fax or email of their members who have an active case. This list will be updated and sent monthly.

SECTION 5:

California Children's Services (CCS) Medical Therapy Program Helps Children Improve Functional Activities

California Children's Services (CCS) offers occupational or physical therapy services for children with long-term, life-threatening, and physically disabling conditions. Children with the following conditions may be eligible for the Medical Therapy Program (MTP) for treatments to improve mobility, ambulation, self-help skills or activities of daily living (ADLs):

- **Cerebral palsy**
- **Neuromuscular conditions** such as muscle diseases or myopathies, arthrogryposis
- **Chronic musculoskeletal and connective tissue disorders** including juvenile idiopathic arthritis, osteogenesis imperfecta, amputations and contractures due to burns
- **Noninfectious central or peripheral nervous system diseases** such as spina bifida, spinal cord injuries, or brachial plexus injuries

In addition, a child under the age of 3 showing signs of evolving cerebral palsy *may be eligible* for the program if the clinical presentation of the child justifies therapy services. In the case of suspected cerebral palsy, documented evidence may include:

- Rigidity or spasticity;
- Hypotonia with normal or 3+ or greater deep tendon reflexes;



- Involuntary movements (athetoid, choreoid or dystonic);
- Presence of primitive reflexes beyond normal age; or
- Ataxia with clinical description.

To refer a child for medical therapy services, send a completed CCS Service Authorization Request (SAR) form, a prescription for MTP OT evaluation and PT evaluation, and a current medical record describing the child's condition to:

Fax: **1-805-658-4580** or

Ventura County CCS
2240 E. Gonzales Road
Suite 260
Oxnard, CA 93033

The MTP holds Medical Therapy Conferences (MTC) to coordinate the therapy program, durable medical equipment (DME), and rehabilitation needs for each child at 6-12 month intervals. This is a valuable team process, which includes the child, parent, pediatrician, orthope-

dist, physical therapist (PT), occupational therapist (OT), orthotist, registered dietitian nutritionist, and social worker. The child's medical home receives reports from the conference.

To learn how to write a referral, what is included in therapy services or ask other questions, please contact Ventura County CCS at **1-805-981-5281** and ask to speak with the MTP manager or case team member. To learn more about the MTP, click [here](#).

SECTION 6:

Pediatric Patients and Audiology Testing

Questions frequently arise regarding where to send pediatric members for audiograms that will expedite treatment for chronic or sensorineural hearing loss, which may be eligible for coverage by the California Children's Services program. GCHP is responsible for the screening of these children, but CCS has requirements regarding audiology testing. Given CCS paneling status is based on a Communication Disorder Center's (CDC) experience with different age groups, here are some helpful hints to save time on your referral.

For children under 5 years of age:

An audiogram from a CDC Type C facility is required. The only locally approved facility is:

- Hearing Conservation Program, also known as the Ventura County Office of Education (VCOE).

If the member requires a sleep deprived or sedated Auditory Brain Response (ABR) due to age, services will need to be requested as an out-of-area referral to:

- Children's Hospital Los Angeles
- Friedel B. Cunningham and Associates
- House Ear Institute CARE Center
- John Tracy Clinic - Los Angeles
- Ronald Reagan UCLA Medical Center

For children 5 years of age or older:

An audiogram from a CDC Type A or Type C facility is required. Therefore, in addition to the Hearing Conservation Program (VCOE), the following local facilities are available for audiograms of children 5 years and older:

- Ascent Hearing Center – Simi Valley
- Excellence Audiology – Ventura
- Second Chance Hearing Center – Westlake Village

If you are unsure of where to refer your pediatric patient, please feel free to reach out to GCHP for further assistance at 1-888-301-1228.



SECTION 7:

Changes to Prior Authorization Requirements

Gold Coast Health Plan (GCHP) continues to evaluate and monitor the services that require prior authorization. As a result, the following change will be made effective December 1:

- Authorization will be required for all outpatient physical therapy and occupational therapy services for members under 21 years of age.

For questions regarding GCHP's prior authorization process, please contact the Plan's Customer Service Department at 1-888-301-1288.

SECTION 8:

Nursing Facilities

Gold Coast Health Plan (GCHP) is responsible for Medi-Cal covered long-term care services. GCHP pays the facility daily rate for 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. All nursing facilities admissions require an authorization from GCHP.

Nursing facilities include:

- Long-Term Care (LTC) Facilities
- Skilled Nursing Facilities (SNF)
- Intermediate-Care Facilities (ICF)
- Intermediate-Care Facilities of the Developmentally Disabled (ICG/DD), Developmentally Disabled

Habilitative (ICF/DDH), or Developmentally Disabled Nursing (ICF/DDN)

- Sub-acute Care Facilities

If a member is residing in a nursing facility and their condition requires them to be admitted to an acute care hospital, the nursing facility may ask for bed hold days.

The following rules apply to bed hold days:

- The bed hold is limited to a maximum of seven days per hospitalization.
- The nursing facility must obtain an authorization from GCHP for the bed hold days.

SECTION 9:

Non-Medical Transportation (NMT)

As of October 1, 2017, GCHP covers Non-Medical Transportation (NMT) for all medically-necessary services. NMT coverage includes transportation for a member and one attendant, such as a parent, guardian, or spouse, to accompany a member in a vehicle or on public transportation, subject to prior authorization at the time of the initial NMT request.

NMT does not include transportation of sick, injured, invalid, convalescent, infirmed or otherwise incapacitated members who need to be transported by ambulance, litter vans, or wheelchair vans. NMT does not cover trips to a non-medical location or to appointments that are not medically necessary.

NMT includes transportation to and from:

- A medical appointment for treatment or screening.
- A location to pick up prescriptions for drugs that cannot be mailed directly to the member.
- A location to pick up medical supplies, prosthetics, orthotics and other medical equipment.

GCHP's contracted vendor, Ventura Transit System (VTS), will provide transportation using sedan vehicles at no cost to members. Members must contact VTS directly at 1-855-628-7433. No authorization is required; however, members must attest to having no other means of transportation.

If you have any questions, call GCHP's Customer Service Department at 1-888-301-1228.



SECTION 10:

MyGoldCare™ Palliative Care Program Changes

Gold Coast Health Plan (GCHP) implemented the following changes to the MyGoldCare program as of January 1 in an effort to improve access and care for the Plan's adult palliative care members.

No Prior Authorization Required for Palliative Care Services:

Referring providers may refer directly to a MyGoldCare palliative care provider to assure timely access. A list of contracted outpatient and in-home palliative care providers can be found in GCHP's Provider Directory.

Expansion of Eligibility Criteria for Palliative Care:

GCHP will provide palliative care services to all members who elect and qualify under all of the following general eligibility and disease-specific criteria.

Eligibility Criteria

1. The beneficiary is likely to or has started to use the hospital or emergency department as a means to manage their advanced disease. This refers to unanticipated decompensation and does not include elective procedures.
2. The beneficiary has an advanced illness with appropriate documentation of continued decline in health status and is not eligible for or declines hospice enrollment.
3. The beneficiary's death within a year would not be unexpected based on clinical status.
4. The beneficiary has either received appropriate patient-desired medical therapy or is a beneficiary for whom patient-desired medical therapy is no longer effective. Patient is not in reversible acute decompensation.
5. The beneficiary and, if applicable, the family- / patient-designated support person, agrees to:
 - a. Attempt, as medically / clinically appropriate, in-home, residential-based, or outpatient disease management / palliative care instead of first going to the emergency department; and participates in Advance Care Planning discussions.



Disease-Specific Criteria

A member must qualify for palliative care services in accordance with APL 17-015

OR

Have a serious diagnosis (which is not defined in the APL) and death would not be unexpected within a year.

- ▶ Qualified conditions include but are not limited to the following:
 1. Congestive Heart Failure (CHF)
 2. Chronic Obstructive Pulmonary Disease (COPD)
 3. Advanced Cancer
 4. Liver Disease
 5. Other: Prognosis of death within a year would not be unexpected based on clinical status

If a beneficiary continues to meet the above eligibility criteria, they may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death.

Billing Changes for Palliative Care Providers:

The PE modifier is no longer required for billing palliative care services.

NEW for Patient Encounter Submission for Palliative Care Providers:

Effective January 1, all MyGoldCare palliative care providers will need to bill for palliative care services with a diagnosis code of Z51.5

If you need more information regarding the MyGoldCare Program, please click [here](#) or contact Provider Relations email ProviderRelations@goldchp.org.

SECTION 11:

Free Palliative Care Training for Qualified Medi-Cal Providers – Limited Time Opportunity

There is still time for providers to apply for this no-cost training program! The state Department of Health Care Services (DHCS) has contracted with the *California State University Institute for Palliative Care* to provide palliative care training to qualified Medi-Cal providers and their clinician staff members. Providers can apply for training, at no charge, through the institute's [website](#) ON or BEFORE February 28.

Funding for this effort concludes March 29, so all provider applications for the training funds should be submitted by February 28.

Providers can use the code “PAL2019” when using the institute's online enrollment system. Use of this code will indicate the provider is enrolled with the Medi-Cal managed care plan.

The institute's courses are geared toward physicians, physician assistants, nurse practitioners, registered nurses, and social workers who are interested in building their palliative care skills. Courses are developed by clinical experts in palliative care, and are engaging, interactive, and

accessible 24 hours a day, seven days a week. Each course provides continuing education credits or continuing medical education credits.

Qualified Medi-Cal clinical providers who are interested in applying for these courses may click [here](#) for additional details and use the “PAL2019” code.

Enrollment will be funded on a first-come, first-served basis. DHCS will continue to accept applications until all funding has been committed. Providers will be given priority based on geographic and clinical diversity.

DHCS will limit funding to no more than four individuals per organization to support geographic diversity for training.

Please reach out to the institute's relationship manager, Brandon McDonald, with further questions at 1-760-750-7288 or bmcDonald@csusm.edu.

To learn more about the palliative care Senate bill, SB 1004, click [here](#).

SECTION 12:

Hospice Routine Home Care Updates

Federal Rule 42 CFR Part 418, CMS-1629-F RIN 0938-AS39 Medicare Program: FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements established an updated reimbursement rate of differential payments for routine home care services.

Reimbursement rates will be based on a recipient's length of stay. The first 60 days of routine home care in a recipient's certification period will utilize revenue code 0650 (routine home care high rate). Any subsequent days of care beyond the 60-day period will utilize revenue code 0659 (routine home care low rate). In addition, revenue code 0552 (routine home care service intensity add-on [SIA] rate) payment for services provided by a registered nurse or social worker in the last seven days of a recipient's life for at least 15 minutes

and up to four hours total per day has also been added.

Hospice providers are required to bill new revenue codes for routine home care services and SIA, effective retroactively for dates of service on or after January 1, 2016.

The existing local Medi-Cal revenue code 0651 (hospice service, routine home care) will be end-dated and replaced by the following three new applicable, Health Insurance Portability and Accountability Act (HIPAA)-compliant revenue codes:

- 0552 (routine home care [SIA rate])
- 0650 (routine home care [high rate])
- 0659 (routine home care [low rate])

SECTION 13:

Grievance and Appeals Information

Provider Reconsideration Request Form

Please remember to attach the Provider Reconsideration Request Form to your provider resolution dispute, provider grievance, or appeal.

The Provider Reconsideration Request Form allows you to choose from the following:

Provider Dispute - A request for reconsideration of an original claim that has been previously denied or underpaid.

Grievance - A request for reconsideration of a previously disputed claim in which the provider is not satisfied with the outcome.

Appeal - A review by Gold Coast Health Plan (GCHP) of an Adverse Benefit Determination, which is a denial, deferral or limited authorization of a requested covered service, including determinations on the level of service; denials of medical necessity; and reduction, suspension, or termination of a previously authorized service.

Click [here](#) for the Provider Reconsideration Request Form.

Corrected Claim

A **Corrected claim** is a replacement of a previously submitted claim (e.g., changes or corrections to charges, clinical or procedure codes, dates of service, member information, etc.). A corrected claim is not an inquiry or appeal. Do not submit a Provider Reconsideration Request Form with a corrected claim.

Please note: Do not mark claim “corrected” if additional information is requested, such as medical records or primary carrier EOB, unless a change is made to the original claim submission.

Balance Billing Member

Balance billing occurs when the provider or billing company acting on behalf of the provider, bills the member the difference between the provider’s charge and the allowed amount.

Please note: A provider of health care services who obtains proof of Medi-Cal eligibility may not seek payment from the beneficiary for covered services. If the provider receives notice, the provider and any debt collector must cease debt collection and correct any reports to consumer reporting agencies (Reference: Cal. Welf. & Inst. Code § 14019.4).

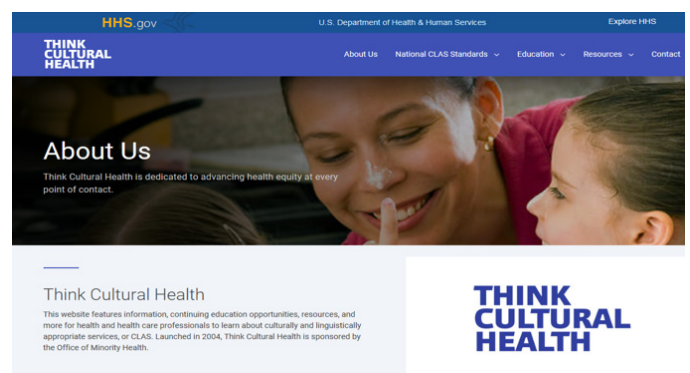
SECTION 14:

Cultural Competency Provider Training Opportunity

Gold Coast Health Plan (GCHP) would like to ensure that Plan providers and delegated entities are meeting the diverse needs of all members. As part of new federal requirements, providers that have taken cultural competency training will be designated as such in the Plan’s Provider Directory.

The U.S. Department of Health and Human Services (HHS) offers presentations, webinars and other online training programs for health care providers. The website, Think Cultural Health, features information and resources for health care professionals to learn about culturally- and linguistically-appropriate services.

To register and learn more about the free online educational program, click [here](#). Health care professionals may receive free CME credits.



For additional questions or resources, please email CulturalLinguistics@goldchp.org or call 1-805-437-5603 Monday through Friday between 8 a.m. and 5 p.m.

SECTION 15:

Non-Discrimination Notice

Gold Coast Health Plan (GCHP) complies with the applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

Under Section 1557 of the Affordable Care Act (ACA), providers are required to post notices of nondiscrimination and taglines that alert individuals with limited English proficiency (LEP) to the availability of language assistance services. Section 1557 requires posting of the taglines in English and at least the top 15 non-English languages spoken in California. However, the state Department of Health Care Services (DHCS) requires GCHP to post taglines in English and at least the top 16 non-English languages. Member informing letters, flyers and brochures developed by your clinic will also need to include the nondiscrimination notice and/or tagline requirements.

Click [here](#) to learn more about Section 1557 and to download the taglines and notices.

SECTION 16:

Quality Improvement: Spotlight on Improvement Projects (IPs) and Performance Improvement Projects (PIPs)

Gold Coast Health Plan (GCHP) engages in Improvement Projects (IP) and Performance Improvement Projects (PIP) as tools to test interventions that aim to improve quality of care outcomes. An IP typically tests a narrow, small-scale change throughout a year-long improvement cycle, while a PIP is larger in scale and has a two-year duration.

The state Department of Health Care Services (DHCS) mandates that all Medi-Cal plans implement IPs and PIPs on Healthcare Effectiveness Data and Information Set (HEDIS®) measures that are low performing or do not hit the minimum performance level (MPL*).

The current focus of GCHP improvement efforts are detailed below.

Improvement Projects (IPs)

- **Annual Monitoring for Patients on Persistent Medications (MPM):** A data-driven intervention to improve the capturing and reporting of metabolic lab screenings delivered to patients who need medication monitoring for ongoing ACE inhibitors / ARBs and/or diuretics.

- **Comprehensive Diabetes Care (CDC) – Attention to Nephropathy:** An academic detailing intervention to educate clinicians on the importance of annual nephropathy monitoring for patients diagnosed with diabetes.
- **Asthma Medication Ratio (AMR):** An outreach intervention by health plans / pharmacy benefit management providers to educate practitioners on the recommended prescribing guidelines for patients with persistent asthma.

Performance Improvement Projects (PIPs)

- **Child Immunization Status (CIS):** A health plan / telephone outreach program to increase child immunization rates.
- **HbA1c Disparity Project:** A health plan / clinic telephone outreach program aimed at decreasing the rate of HbA1c >9 in non-English speaking Hispanic / Latino members with diabetes.

If you have any questions regarding quality improvement strategies you can implement within your practices or would like to partner with GCHP's Quality Improvement Department on a performance improvement effort, please contact the department at hedis@goldchp.org.

* The MPL equates to the 25th national Medicaid percentile ranking, which is established by the National Committee for Quality Assurance (NCQA).

SECTION 17:

Administration of Urine Test for Protein or Albumin to Monitor Diabetic Nephropathy

The Healthcare Effectiveness Data and Information Set (HEDIS[®]) measure, Comprehensive Diabetes Care (CDC) Screening for Nephropathy, is developed by the National Committee of Quality Assurance (NCQA) to evaluate if a member, 18-75 years of age who is diagnosed with type 1 or type 2 diabetes, had any of the following events to validate that an annual diabetic nephropathy monitoring event occurred:

- **Evidence of nephropathy:** A diagnosis of end-stage renal disease (ESRD), chronic or acute renal failure, renal insufficiency, diabetic nephropathy, dialysis or renal transplant.
- **Lab test:** A urine test for albumin or protein.
- **Prescription:** Evidence of ACE inhibitors / ARB therapy.

In order for members who have diabetes to be compliant with the CDC measure, providers need to not only get their patients in for their annual screening, but be aware of the compliant screening methods and documentation.

Validating that there was an annual screening for nephropathy can be broken down into the following three steps. If the provider can answer YES to any of these steps, then the member is compliant.

Step 1: Is there documentation of ESRD, chronic or acute renal failure, renal insufficiency, diabetic nephropathy, dialysis or renal transplant?

If NO,

Step 2: Was a urine test for albumin or protein performed during the measurement year?

If NO,

Step 3: Is there evidence of ACE inhibitors / ARB therapy during the measurement year?

If NO, the member is not compliant.



NCQA requires that the assessment of albumin or protein be performed with a urine test in the measurement year. NCQA recommends this method over others, such as a blood test, because increased urinary protein excretion is the earliest clinical manifestation of diabetic nephropathy. This is important to detect because moderately increased albuminuria (formerly, microalbuminuria) is associated with a substantial risk of progressive renal damage.

Documentation in the electronic medical record (EMR) should consist of the date the test was completed and the results. If applicable, document and code for conditions that indicate nephropathy or whether a patient that is on ACE inhibitors / ARB therapy. Claims with screening should be submitted on time with of the following CPT codes:

- **81000 – 81003, 81005, 82042, 82044, 84156**

Lastly, GCHP recommends implementing physician orders that empower clinical staff to take leading roles in diabetic screenings, improve management of patients with chronic conditions who need annual screenings and increase patient compliance with preventive screenings.

If you have any questions, please contact GCHP's Quality Improvement Department at hedis@goldchp.org.

SECTION 18:

Guide to Alcohol Misuse Screening and Behavioral Counseling Interventions

Gold Coast Health Plan (GCHP) providers are required by the state Department of Health Care Services (DHCS) to provide all preventive services in line with the U.S. Preventive Services Task Force (USPSTF) recommendations. DHCS requires that clinicians screen adults ages 18 years and older, including pregnant women, annually for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

The term, alcohol misuse, defines a spectrum of behaviors. Risky or hazardous alcohol use means drinking more than the recommended quantity of alcohol. For men, risky use is defined as consuming more than four drinks on any day or 14 drinks per week for men; for women, it is defined as consuming more than three drinks on any day or seven drinks per week.

The USPSTF considers the following three tools as valid instruments of screening for alcohol misuse in the primary care setting:

1. The Alcohol Use Disorders Identification Test (AUDIT)
2. The abbreviated AUDIT-Consumption (AUDIT-C)
3. A single-question screening, such as asking, “How many times in the past year have you had four (for women and all adults older than 65 years) or five (for men) or more drinks in a day?”

It is important to note that these tools are available in other languages to provide culturally- and linguistically-appropriate materials to GCHP’s members.

Staying Healthy Assessment

The Staying Healthy Assessment (SHA) fulfills the AUDIT / AUDIT-C requirement. The SHA questionnaire for those ages 12 and up includes a question for patients related to their alcohol use. The SHA can be found on the GCHP website under the “Health and Wellness” tab or can be directly downloaded from the DHCS website by clicking [here](#). Table 1 below shows which question(s) fulfill the DHCS requirement on the SHA.

SHA QUESTIONNAIRE	ENGLISH & SPANISH
SHA 12-17 Years	Questions 23-24
SHA Adult	Question 19
SHA Senior	Question 23

Behavioral Counseling Assessment

Behavioral counseling interventions for alcohol misuse must occur during the screening process if a member is identified as being engaged in risky or hazardous drinking. These interventions for alcohol misuse vary in their specific components, administration, length and number of interactions, but may include cognitive behavioral strategies, such as action plans, drinking diaries, stress management, or problem solving.

GCHP has trained providers on the Five Major Steps to Intervention (5 A’s – Ask, Advise, Assess, Assist, Arrange), an evidence-based training that can be used to motivate members to implement a wide range of behaviors. Compliant interventions may be delivered via face-to-face sessions, written self-help materials, computer or web-based programs, or telephone counseling. This screening must be offered at least once a year, up to a maximum of three. When medically necessary, authorization for additional behavioral counseling is needed.

To be compliant with this requirement, it is important that providers document the alcohol misuse screening of their patients, as well as all counseling, referrals, and follow up.

If providers have questions about these requirements, trainings, or documentation, please contact GCHP's Health Education Department at HealthEducation@goldchp.org.

SECTION 19:

Check Primary Care Provider (PCP) Assignments

Before you schedule an appointment for a member, please check eligibility to ensure that the member is currently assigned to your PCP / clinic. If your PCP / clinic is not assigned, have the member contact the Gold Coast Health Plan (GCHP) Member Services Department at 1-888-301-1228 / TTY 1-888-310-7347 Monday-Friday between 8 a.m. and 5 p.m. to select your PCP / clinic. The change will go into effect on the first day of the month following the change request.

SECTION 20:

Interactive Voice Response (IVR) Portal Verification

Gold Coast Health Plan (GCHP) offers providers the ability to check eligibility and claim status through the GCHP Web Portal or the Interactive Voice Response (IVR) phone system.

The process requires authentication of your provider information. Registration is easy and available 24 hours a day, seven days a week. Once you register, you will have access to the desired eligibility or claim information at your convenience.

To register, visit GCHP's [website](#), click on the "Providers" tab, select "Provider Portal," click on "Access the Provider Web Portal" and follow the directions to register (or click [here](#)).

To check **claim status** through the **Provider Web Portal** follow these steps:

Searching For, Viewing, and Printing Claims

1. From the menu bar, click **Claims**.
2. Type the search criteria to locate a member and click **Search**.
3. From the list presented, check the **Status / EOP** column for the status of a claim. You can only view claims that have the status **Processed**.
4. To view the claim, click the applicable **Processed** link. An **Explanation of Payment** appears.

5. To print the claim, right-click anywhere in the Explanation of Payment and select **Print** from the menu presented.

To check **member eligibility** via the **Provider Web Portal**:

1. On the menu bar, click **My Members**. The **Search Member Eligibility** window opens.
2. In the appropriate boxes, type *at least one* of the search fields requested and click **Search**. **Note:** The **Effective Date** defaults to today's date and can be changed prior to clicking Search to see a member's status for other effective dates.
3. From the search results presented, click a member to view the eligibility details.
4. After a member's eligibility details are presented onscreen, additional options become available at the bottom of the window. Clicking an option will take you to the appropriate window. Information about these options are described later in this document:
 - Authorization
 - UB Claim
 - HCFA Claim
5. To return to the search results screen click the **Back** button. Your previous search results will still be available.

Claim status can also be checked by using the **IVR** system by calling Customer Service at 1-888-301-1228 and following the prompts:

1. Select Provider – press 2
2. Enter your NPI number
3. For claim status, press 1
4. To enter the GCHP ID number – press 1
5. Member identification number – eight-digit numeric ID
6. Member date of birth in a two-digit format (xx/xx/xx)
7. Enter Date of Service
8. Requested information provided

You can also check **member eligibility** by using the **IVR** system by calling Customer Service at 1-888-301-1228 and following the prompts:

1. Select Provider – press 2
2. Enter your NPI number
3. For eligibility status, press 2
4. To enter the GCHP ID number – press 1
5. Member identification number – eight-digit numeric ID
6. Member date of birth in a two-digit format (xx/xx/xx)
7. Requested information provided

SECTION 21:

Member Benefit Information Meetings

Gold Coast Health Plan (GCHP) holds member orientation meetings three times a month for all members. These meetings are held throughout the county and are presented in English and Spanish.

At the meetings, members will learn about their rights and responsibilities as GCHP members, as well as how to:

- Establish a medical home.
- Select a PCP.
- Get medical services.
- Get necessary medications.
- Locate and use resources available in the community.

Meeting times and locations vary monthly. Members can call GCHP's Member Services Department at 1-888-301-1228 for the meeting times and dates.


Click [here](#) for the current schedule.

Gold Coast Health Plan
Member Benefit Information
You and Your Medi-Cal Benefits

Join us at a Member Benefit Information meeting to learn how to:

- Select a Primary Care Provider (PCP).
- Get medical services.
- Access dental, vision and other benefits.
- Get behavioral health assistance.
- Maintain your Medi-Cal eligibility.
- Learn about Medi-Cal.
- Know your member rights and responsibilities.
- Locate community resources.
- Access the health classes that are offered by Gold Coast Health Plan (GCHP).
- Access the classes and services that are offered by other agencies.

Questions?
Contact Member Services at:
1-888-301-1228
TTY 1-888-310-7347


www.goldcoasthealthplan.org

Meeting Dates and Locations

Oxnard Library
251 South "A" Street, Oxnard, CA 93030 – Room A
January 15, 2019, Tuesday: English 5:15 pm, Spanish 6:30 pm
February 28, 2019, Thursday: English 5:15 pm, Spanish 6:30 pm
March 16, 2019, Saturday: English 10:00 am, Spanish 11:30 am

Camarillo – GCHP Office
711 E. Daily Drive, Suite 106, Camarillo, CA 93010
January 24, 2019, Thursday: English 2:00 pm, Spanish 3:30 pm
February 13, 2019, Wednesday: English 2:00 pm, Spanish 3:30 pm
February 23, 2019, Saturday: English 10:00 am, Spanish 11:30 am
March 13, 2019, Wednesday: English 2:00 pm, Spanish 3:30 pm
March 28, 2019, Thursday: English 5:30 pm, Spanish 6:45 pm

Ventura – Ventura Avenue Adult Center
550 N. Ventura Avenue, Ventura, CA 93001 – Rincón Room
January 26, 2019, Saturday: English 10:00 am, Spanish 11:30 am

Statement of Non-Discrimination and Language Assistance
Gold Coast Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Gold Coast Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.
Gold Coast Health Plan 遵守適用於聯邦民權法之規定，不以任何種族、膚色、民族、年齡、殘疾或性別為由，對會員進行歧視。
ATENCIÓN: si habla español, tiene o desea recibir servicios gratuitos de asistencia lingüística. Llame al 1-888-301-1228 (TTY: 1-888-310-7347).
注意：如果您使用繁體中文，您可以免費獲得語言協助服務。請致電 1-888-301-1228 (TTY: 1-888-310-7347)。

Gold Coast Health Plan
Información sobre Beneficios para Miembros
Usted y Sus Beneficios de Medi-Cal

Particpe con nosotros en una reunión de Información sobre Beneficios para los Miembros para que aprenda como:

- Seleccionar a un Proveedor de Atención Primaria (PCP por sus siglas en inglés).
- Obtener servicios médicos.
- Tener acceso a servicios dentales, de la vista y otros beneficios.
- Obtener asistencia de salud mental.
- Mantener su elegibilidad para Medi-Cal.
- Aprender sobre Medi-Cal.
- Conocer sus derechos y responsabilidades como miembro.
- Localizar recursos comunitarios.
- Tener acceso a las clases sobre la salud que ofrece Gold Coast Health Plan (GCHP).
- Tener acceso a las clases y servicios que ofrecen otras agencias.

Preguntas?
Servicios para Miembros:
1-888-301-1228
TTY 1-888-310-7347


www.goldcoasthealthplan.org

Fechas y Lugares de las Juntas

Biblioteca de Oxnard
251 South "A" Street, Oxnard, CA 93030 – Room A
15 de enero de 2019, martes: en inglés a las 5:15 pm, en español a las 6:30 pm
28 de febrero de 2019, jueves: en inglés a las 5:15 pm, en español a las 6:30 pm
16 de marzo de 2019, sábado: en inglés a las 10:00 am, en español a las 11:30 am

Camarillo – Oficina de GCHP
711 E. Daily Drive, Suite 106, Camarillo, CA 93010
24 de enero de 2019, jueves: en inglés a las 2:00 pm, en español a las 3:30 pm
13 de febrero de 2019, miércoles: en inglés a las 2:00 pm, en español a las 3:30 pm
23 de febrero de 2019, sábado: en inglés a las 10:00 am, en español a las 11:30 am
13 de marzo de 2019, miércoles: en inglés a las 2:00 pm, en español a las 3:30 pm
28 de marzo de 2019, jueves: en inglés a las 5:30 pm, en español a las 6:45 pm

Ventura – Ventura Avenue Adult Center
550 N. Ventura Avenue, Ventura, CA 93001 – Rincón Room
26 de enero de 2019, sábado: en inglés a las 10:00 am, en español a las 11:30 am

Declaración de No Discriminación y Asistencia Lingüística
Gold Coast Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Gold Coast Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.
Gold Coast Health Plan 遵守適用於聯邦民權法之規定，不以任何種族、膚色、民族、年齡、殘疾或性別為由，對會員進行歧視。
ATENCIÓN: si habla español, tiene o desea recibir servicios gratuitos de asistencia lingüística. Llame al 1-888-301-1228 (TTY: 1-888-310-7347).
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**Gold Coast
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A Public Entity

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Provider Operations Bulletin

JANUARY 2019

For additional information, contact
Network Operations at 888-301-1228
Gold Coast Health Plan
711 East Daily Drive, Suite 106, Camarillo, CA 93010
www.goldcoasthealthplan.org