



Santa Clara Family
Health Plan™

PROVIDER MANUAL

Medi-Cal

Provider Network Management: **1-408-874-1788**

Monday through Friday, 8:30 a.m. to 5:00 p.m.

www.scfhp.com

Updated 08/2021

Provider Manual Revision History

Date	Version	Changes
01/14/2016	V2	Section 25, Page 86: Expanded description of information available by calling the dedicated provider phone line to include submission of provider disputes.
05/03/2016	V3	<ul style="list-style-type: none"> • Section 21, beginning on page 75: Updated Medical Records Standards. • Provider Training, Education, and Resources section has been moved to Section 26. • Inserted new Section 25: Provider Directory Requirements.
12/01/2017	V4	<ul style="list-style-type: none"> • Section 4, Role of Primary Care Provider, beginning on page 13: Updated to include the role of the PCP in Case Management • Section 5 Access and Appointment Standards Non-Emergency Medical Transportation beginning on page 19: Updated NEMT and NMT requirements • Section 10 Authorizations, Page 32 & 33: Updated prior authorization review times for standard and expedited authorization requests; Page 35 Added Tracking a Prior Authorization Request; Page 36 Added Colorectal Cancer Screening; Page 38 Added Discharge Planning & Concurrent Review and Retrospective Review • Section 11 Case Management, Page 40– Moved Discharge Planning & Concurrent Review to Section 10 • Section 20 Grievances and Appeals, beginning on Page 68 – Updated information pertaining to Appeals and Grievance processes • Section 21 Quality Improvement Program: beginning on Page 75 - Removed Preventive Health Guidelines and Health Assessments from Medical Records Standards; Beginning on Page 78 Added new section and updated information regarding Preventive Health Guidelines; Beginning on Page 86 Added new section Health Assessments; Page 89 Updated SBIRT to AMSC

Provider Manual Revision History (continued)

Date	Version	Changes
4/12/2018	V5	<ul style="list-style-type: none"> • Section 20, Grievances & Appeals, beginning on page 69: <ul style="list-style-type: none"> ○ Filing a Member Grievance - Updated timeframe for filing a grievance. ○ Expedited Grievances - Updated timeframe for sending a follow up letter. ○ Filing an Appeal - Updated timeframes for submitting appeals for Medi-Cal and Healthy Kids. ○ Expedited Appeals - Updated timeframe for SCFHP to make a decision on the appeal. ○ Provider Responsibility – Added requirement to gain member’s written consent before filing an appeal. ○ Added requirement to maintain copies of the grievance form in the office.
8/1/2021	V6	<ul style="list-style-type: none"> • Addressed typographical error from 90 days to 60 days (Section 20).
8/26/2021	V7	<ul style="list-style-type: none"> • Addition of language addressing availability of assistance for members in filing an appeal and the member’s right to request continuation of benefits during an appeal or State Fair Hearing (Section 20). • Removal of Health Kids-inclusive sections and language,

Table of Contents

Section 1	Introduction.....	4
Section 2	Governing Board and Committees.....	7
Section 3	Member Enrollment and Eligibility	10
Section 4	Role of the Primary Care Provider (PCP)	13
Section 5	Access & Appointment Standards	18
Section 6	Cultural & Linguistic Services	21
Section 7	Marketing	25
Section 8	Benefits	27
Section 9	Claims & Billing Information	28
Section 10	Authorizations.....	32
Section 11	Case Management	40
Section 12	Emergency, Urgent Care & Trauma Services.....	41
Section 13	Behavioral Health	43
Section 14	Family Planning, Pregnancy & Post-Partum Services .	45
Section 15	Public Health Services.....	47
Section 16	Health Education Programs	50
Section 17	Special Programs for Children.....	52
Section 18	Additional Programs & Services	57
Section 19	Pharmacy Benefits	64
Section 20	Grievances & Appeals	68
Section 21	Quality Improvement (QI) Program.....	73
Section 22	Provider Preventable Condition	91
Section 23	Facility Site Review.....	92
Section 24	Credentialing and Re-credentialing	93
Section 25	Provider Directory Requirements	97
Section 26	Provider Training, Education, and Resources	98

Section 1 Introduction

Santa Clara Family Health Plan (SCFHP) is dedicated to improving the health and well-being of the residents of our area. Our mission is to provide high quality, comprehensive health-care coverage for those who do not have access to, or are not able to purchase, good health care at an affordable price. Working in partnership with select providers, we are a bridge between the health-care system and those who need health coverage.

Our provider network is a critical component in serving our mission. Our goals with this manual are to give you tools to reduce your administrative burden and make sure you have all the necessary contact information for reaching SCFHP staff.

This manual covers our Medi-Cal line of business. We want this manual to be a useful guide for you and your staff. If you have any questions, need assistance, or have suggestions for improving the manual, please contact the Provider Services Department at **1-408-874-1788**.

Information about SCFHP is contained in **Section 2 Governing Board and Committees**.

Quick Reference Numbers

SCFHP Provider & Member Services	
Automated Eligibility Verification 24 hrs/7 days	1-800-720-3455
Member Services 8:30 a.m. – 5:00 p.m., M-F	1-800-260-2055
Language Interpretation Services Language Line	1-888-898-1364 Access code: 8033
TDD Hearing Impaired Phone Line 8:30 a.m. – 5:00 p.m., M-F	1-800-735-2929
Nurse Advice Line 24 hrs/7 days	1-877-509-0294
Independent Physicians	
Authorizations	1-408-874-1821
Provider Services	1-408-874-1788
Claims Inquiries	1-408-874-1788
Claims Address	Santa Clara Family Health Plan PO Box 18640 San Jose, CA 95158
Valley Health Plan	
Authorizations	1-408-885-4647
Provider Services	1-408-885-2221
Claims Inquiries	1-408-885-4563
Claims Address	Valley Health Plan

Language Interpretation Services Spanish Vietnamese Other (Including Tagalog/Chinese)	PO Box 28407 San Jose, CA 95159 1-408-808-6151 1-408-808-6152 1-408-808-6150
Physicians Medical Group of San Jose	
Authorizations Provider Services Claims Inquiries Claims Address	1-408-937-3645 1-408-565-8358 1-408-937-3620 Excel MSO, Physicians Medical Group 75 E. Santa Clara Street, Suite 950 San Jose, CA 95113
Premier Care of Northern California	
Authorizations Provider Services Claims Inquiries Claims Address	1-877-216-4215 1-877-216-4215 1-877-216-4215 Conifer Health Solutions PO Box 260830 Encino, CA 91426
Kaiser Permanente	
Member Services Authorizations Claims Inquiries Claims Address	1-800-464-4000 1-800-464-4000 #1 1-800-390-3510 Kaiser Foundation Health Plan Attn. Claims Administration Dept. PO Box 12923 Oakland, CA 94604-2923
Palo Alto Medical Foundation (PAMF)	
Authorizations Provider Services Claims Inquiries Claims Address Medi-Cal	1-408-874-1821 Fax 1-408-874-1957 1-408-874-1788 1-408-874-1788 Santa Clara Family Health Plan PO Box 18640 San Jose, CA 95150-5550

Stanford Medical Center

Authorizations	1-408-874-1821
Provider Services	1-408-874-1788
Claims Inquiries	1-408-874-1788
Claims Address	Santa Clara Family Health Plan PO Box 18640 San Jose, CA 95150-5550

Section 2 Governing Board and Committees

The SCFHP Governing Board: Santa Clara County Health Authority

The SCFHP Governing Board has duties, powers, and responsibilities authorized under the Welfare and Institutions Code section 14087.38 and Ordinance No. 300.576.

Committees of SCFHP

SCFHP has Governing Board and Oversight committees; at least one member of the Governing Board participates on each oversight committee. At no time can the number of SCFHP committee members be such that the committee is composed of a quorum of SCFHP Governing Board members. All committees are subject to the provisions of the Ralph M. Brown Act. Following is a list and brief description of responsibilities of these committees:

SCFHP Governing Board Committees

- **Executive and Finance Committee:** Responsible for developing, monitoring and reviewing SCFHP fiscal policy and financial performance for the Governing Board. This Committee has the authority to take action on behalf of the Governing Board in the event of a financial, operational, legal, personnel or public relations emergency.
- **Bylaws Committee:** Proposes changes to the SCFHP Bylaws to the Governing Board.
- **Audit Committee:** The Governing Board established a two-member Audit Committee, which is responsible for: hiring, setting compensation, and overseeing the activities of independent financial auditors; approving any non-audit activities of the independent audit firm; reviewing SCFHP's financial statements; approving the annual financial audit; and reporting on SCFHP's financial status to SCFHP's Governing Board.

Advisory and Standing Committees

- **Provider Advisory Committee:** Composed of contracted providers that act as an advisory body to assist SCFHP in achieving the highest quality of care for members of the health plan. The Committee addresses clinical and administrative topics that affect interactions between physicians/providers and SCFHP, discusses regional, state, and national issues related to enhancing patient care, provides input on health care services of SCFHP, provides input on the coordination of services between networks of SCFHP, provides input to improve communications, relations, and cooperation between physicians/providers and SCFHP, and provides expertise to SCFHP relative to their area of practice.
- **Quality Improvement Committee:** Comprised of contracted providers and groups who review and advise SCFHP regarding the performance of contracting providers, quality of care provided, and members' utilization of services.
- **Credentialing Committee:** Comprised of contracted physicians who oversee the credentialing and practice patterns of all practitioners and providers.
- **Utilization Management Committee:** Consists of health-care professionals who develop criteria for determining medical necessity, delegation, and utilization activities.
- **Pharmaceutical and Therapeutics Committee:** Comprised of contracted pharmacists and physicians who advise SCFHP in developing and modifying the drug formulary.

- **Consumer Affairs Committee:** Comprised of community and SCFHP members/parents/guardians enrolled in Medi-Cal who provide community involvement and represent the interests of SCFHP members.
- **Consumer Advisory Board:** Comprised of members enrolled in SCFHP Cal MediConnect, and/or their caregivers. CAB members provide feedback on services, benefits, providers, issues and ways to improve the program, and share their experiences, helping us improve our services.

Responsibilities of Departments within SCFHP

SCFHP is organized as described below:

- **Executive Office/Administration:** Responsible for the overall administration and strategic direction of the health plan. Finance, legal and government relations activities are included.
- **Member Services:** Responsible for assisting and educating members.
- **Marketing:** Responsible for producing all SCFHP member and promotional materials, public relations, event and outreach planning and management, and other activities designed to attract and retain members.
- **Grievance and Appeals:** Responsible for managing and helping to resolve member complaints and grievances. Staffs the Grievance Review Committee.
- **Health Education:** Responsible for providing members, physicians, and other health-care providers with quality health education.
- **Cultural & Linguistic Services:** Responsible for providing members, physicians, and other health-care providers with a range of cultural and linguistic services to enhance patient-provider communications, and make possible effective delivery of health care to a diverse membership.
- **Outreach:** Responsible for assisting families with the application process.
- **Provider Services:** Responsible for conducting training, education and office visits with providers to review plan policies and procedures, assist with any identified problems or concerns, conduct ongoing education about SCFHP, and obtain feedback regarding provider satisfaction.
- **Contracting:** Responsible for developing, negotiating and executing provider contracts, and for analyzing data on the financial impact of contract proposals.
- **Credentialing:** Responsible for credentialing and re-credentialing SCFHP's contracted providers.
- **Quality Improvement:** Responsible for monitoring, evaluating and improving the quality, safety, and outcomes of patient care through the performance of quality studies such as NCQA and HEDIS.
- **Utilization Management:** Responsible for coordination of care, medical necessity, and clinical appropriateness of the health needs of your patients.
- **Pharmacy:** Responsible for managing and maintaining a formulary, overseeing the pharmacy benefit manager, monitoring medical necessity, and ensuring clinical appropriateness of pharmacy services.

- **Information Technology:** Responsible for managing the information system services and implementing data exchanges with contracting providers.
- **Claims:** Responsible for adjudicating all claims and responding to provider requests related to claims.
- **Compliance:** Responsible for promoting an ongoing culture that encourages ethical conduct and a commitment to compliance with the law in preventing fraud, waste, and abuse.

Section 3 Member Enrollment and Eligibility

Eligibility Criteria

For patients to be enrolled in one of the two programs addressed in this Manual, they must meet the criteria outlined in the chart below:

Medi-Cal
Patient's family income is within Medi-Cal guidelines
Patient is a resident of California
Patient is a U.S. citizen or legal permanent resident
Patients may be automatically eligible for Medi-Cal if they receive cash assistance under one of the following programs: <ul style="list-style-type: none">• SSI/SSP (Supplemental Security Income/State Supplemental Program)• CalWORKs (California Work Opportunity and Responsibility to Kids). Previously called Aid to Families with Dependent Children (AFDC).• Refugee Assistance• Foster Care or Adoption Assistance Program.

Enrollment Process

We provide Certified Assistors to help with the enrollment process for both lines of business; for access to a Certified Assistor, please call Member Services at **1-800-260-2055**.

For initial Medi-Cal enrollment, we suggest you ask your patient (or his/her representative) to call Santa Clara County Social Services directly at **1-408-271-5600** or the Medi-Cal Service Center at **1-800-753-0024**.

Additionally, either of the two numbers below can be used to enroll a patient in SCFHP's Medi-Cal program:

- SCFHP Member Services Department at **1-800-260-2055**.
- Children's Health Initiative (CHI) at **1-888-244-5222**.

Eligibility Verification

When an individual seeks medical care, you must attempt to determine SCFHP enrollment status and PCP assignment. You are required to do this at the time the patient presents for his/her appointment, i.e., before providing the service.

While you may use any one of the three methods listed below to verify enrollment, we recommend using one of the first two:

1. SCFHP Online Eligibility Verification

This is the easiest and most convenient method for checking eligibility. It is available 7-days a week, 24-hours a day. Please contact the Provider Services Department at **1-408-874-1788** or **providerservices@scfhp.com** to obtain a password and instructions for obtaining online verification.

2. SCFHP Automated Eligibility Verification

Using this system, which is also available 7-days a week, 24-hours a day, you may verify eligibility for the current month as well as the past three months. You must have a touch-tone phone and call **1-800-720-3455**. The system can accept up to 10 requests per call.

To use the automated eligibility system, you must enter the following information using the phone keypad:

- Member Name and SCFHP identification number.
- Member date of birth.
- Month of service.

The automated eligibility system will:

- Confirm eligibility for the month requested.
- Provide the name and phone number of the member's PCP.
- Provide the phone number of the PCP's Medical Group authorization department.
- Give you a confirmation number.

3. Member Identification (ID) Card

All SCFHP members receive a Member ID card that allows physicians and other health-care providers to identify patients as members of the plan. The identification card includes:

- Member's name, sex and date of birth.
- Member's SCFHP ID number.
- The back of the card contains SCFHP contact numbers as well as the address for submitting claims.

A new Member ID card will be issued in response to the report of a lost or stolen card. Possession of a Member ID card is not verification of eligibility to receive services—you should verify that the card is being submitted by the member him/herself, i.e., that someone else is not using the card.

Retroactive Member Additions and Deletions

Circumstances may arise in which retroactive additions and deletions may be made to your eligibility list. Examples include a member requesting a change in PCP assignment or retroactive change by DHCS or SCFHP in a member's eligibility status.

Member's Rights and Responsibilities

In partnership with our physicians and medical service suppliers SCFHP acknowledges that each patient is an individual with unique health care needs, and we respect each patient's personal dignity. Based on this premise, we have adopted a list of patient rights and responsibilities, listed in the Evidence of Coverage (EOC) booklets given to every member upon enrollment in one of our programs.

If you would like to receive printed copies of the members' EOC booklet, please visit our website www.scfhp.com or contact our Provider Services Department at **1-408-874-1788**.

Section 4 Role of the Primary Care Provider (PCP)

The PCP's role is vital in the overall coordination of health care for each member and in providing routine and preventive health care services, including:

- Assessing each individual's health status.
- Providing and documenting preventive services in accordance with established criteria including those from the American Academy of Pediatrics, the United States Preventive Services Task Force "A" and "B" recommended services, and the American College of Obstetricians and Gynecologists.
- Providing quality care.
- Coordinating referrals to specialists.
- Facilitating patients' access to treatment.
- Referring patients to health education classes.
- Educating them on the use of their health education benefits.
- Providing basic case management services in collaboration with SCFHP's case management department including, at a minimum:
 - Assisting with the identification of patients in need of case management services.
 - Completing patient's initial health assessment and reviewing responses related to potential needs for care coordination.
 - Communicating directly with the member, family and/or SCFHP case management staff.
 - Participating in initial and ongoing training and education related to SCFHP's case management and care coordination services.
- Assuring that members are not discriminated against in the delivery of services, both clinical and non-clinical, 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, disability, genetic information, or source of payment.
- Assuring that no unnecessary or redundant medical services are being provided.
- Identifying and following any member who has missed or cancelled his/her appointments.
- Establishing a system for tracking and identifying any clinical problems unique to the PCP's particular patient population. The system should focus on patients who require special attention, i.e., those for whom regular doctor visits are imperative and warrant special attention from the PCP's office to assure that the visits actually occur.

Clinical Practice Guidelines

The PCP is responsible for determining the medical needs of their assigned members. However, our Medical Department can assist providers in adapting Clinical Practice Guidelines for providing preventive care and care for acute and chronic physical/mental illnesses.

Such guidelines should be consistent with established national guidelines (where available); the scientific literature; reasonable evidence-based medicine; current standards for best-practices as established by experts; and Federal/State laws and regulations.

Below are examples of some of the national professional organization guidelines we use (listed in alphabetical order):

- Advisory Committee on Immunization Practices (ACIP)
- Agency for Healthcare Research and Quality (AHRQ)
- American Academy of Family Physicians (AAFP)
- American Academy of Pediatrics (AAP)
- American College of Obstetricians and Gynecologists (ACOG)
- American Diabetes Association (ADA)
- Centers for Disease Control and Prevention (CDC)
- Child Health and Disability Prevention Program (CHDP)
- Department of Health Services Comprehensive Perinatal Services Program (CPSP)
- Diabetes Coalition of California
- US Preventive Services Task Force Guidelines (USPSTF)

We also assist PCPs in communicating Clinical Practice Guidelines to members through our physician/provider committees, newsletters, targeted member mailings, consumer meetings and focus groups, outreach events, educational programs, and the SCFHP website (www.scfhp.com).

We ensure compliance with these guidelines through chart-review audits such as annual HEDIS abstraction, and through periodic reviews of medical records at providers' offices.

For further details on assistance with Clinical Practice Guidelines, see the SCFHP website at www.scfhp.com.

The Initial Health Assessment (IHA)

As part of our contractual agreements with the Department of Health Care Services (DHCS), the Managed Risk Medical Insurance Board (MRMIB), and various funding agencies, each new Medi-Cal member must receive an Initial Health Assessment from the PCP.

We require that a good-faith effort be made by the PCP to conduct this initial assessment within 120 days of enrollment or, for pregnant members, as soon as possible after discovery of the pregnancy; for infants, the assessments should be scheduled in accordance with AAP periodicity recommendations. To help the PCP meet these timelines, we provide a list of new or re-enrolled members each month.

The initial history and physical examination helps establish relationships with patients in a non-crisis situation, and is an important aspect of a preventive medicine program. Generally, an IHA is comprised of:

- A comprehensive history, including medical, social, psychological and family background as well as lifestyle habits, such as tobacco, alcohol, nutrition/diet, exercise, and sexual activity.

- A complete physical examination to assess the member’s present health status, including possible acute, chronic and/or preventive health needs.
- Age-specific assessments and services, including administering necessary immunizations (if this is not possible, appointments for appropriate services should be scheduled, with the date noted in the medical record).
- Screening for TB or other communicable diseases (see **Section 15 Public Health Services**).
- Recommendations for health education and mental-health services.

Please note that the services described below *do not meet the criteria* for an IHA:

- A visit for evaluation and/or management of a specific problem.
- Perinatal visits, other than the initial complete assessment of a pregnant woman according to ACOG guidelines.
- Urgent-care and/or emergency visits or services.

Assessment Tools for Performing an IHA

To help PCPs fulfill the IHA requirements, we provide copies of various professional standards, guidelines, and age-appropriate screening/assessment tools on our website, www.scfhp.com.

Initial Health Assessment for Pregnant Members

The examination of a newly enrolled pregnant member must include a comprehensive OB/GYN and medical examination as well as an assessment of nutritional, psychosocial, and health-education needs.

PCPs may wish to take advantage of the Comprehensive Perinatal Services Program—a State program that integrates nutrition, psychosocial and health-education services and related case coordination with basic obstetrical services.

SCFHP Encourages Members to Schedule an IHA

We inform members of the availability and importance of an IHA via the Evidence of Coverage (EOC) booklets, which are mailed to each member shortly after enrollment. We also mail a welcome letter to each new member on behalf of our PCPs, which mentions the value of an IHA.

We are obligated by regulatory authorities to report our members’ rates of compliance with the requirement for an Initial Health Assessment.

Scheduling IHA’s: Failed Attempts and Missed Appointments

After at least two attempts have been made to contact the member to schedule an IHA without success, further attempts are not required. Likewise, if a member has missed a scheduled appointment and an attempt to reschedule has been unsuccessful—or if the member has missed a second scheduled appointment—no further attempts to schedule an IHA are required. However, all attempts should be documented in the member’s medical record.

Exemption to the IHA Requirement

If any member—including emancipated minors, or a member’s parent or guardian—refuses an IHA, this should be documented in the member’s medical record with a statement signed by the

member. If a member refuses to sign a statement, please note this in the medical record. *All exemptions from the IHA requirement should be appropriately documented in the medical record or in another identifiable format.*

For additional details, see relevant SCFHP policies at www.scfhp.com.

Assessing Your Patient's Level of Health Education

The Individual Health Education Behavioral Assessment (IHEBA) is a valuable tool for early detection of possible risks to patients' health and well-being. Also known as the "Staying Healthy Assessment," the IHEBA will reveal health education needs by providing a quick, overall perspective on the person's living conditions, health practices, behaviors, attitudes, beliefs, lifestyle and social environment, and cultural and linguistic needs.

The IHEBA form is age-specific and available in multiple languages. It can be copied onto the reverse side of the well-visit form, thus permitting the provider to capture all the necessary information on a single sheet of paper. The IHEBA is easy for a member, parent or designated representative to complete while waiting for his/her IHA. (Please note that, since the form is age-specific, a new version may need to be completed again at future visits as younger patient's age.)

The IHEBA form should be completed for a new member within 120 days of enrollment, and updated annually for patients under 18 and every 3-5 years for patients over 18. If a member declines to complete the IHEBA assessment, please be sure to document this in the member's medical record.

After reviewing the completed form, PCPs may refer patients to health education classes through SCFHP, or provide them with copies of their own educational materials. **Section 16 Health Education Programs** contains a description of the health education classes we offer our members.

The SHA is available in multiple languages on the SCFHP website. If you have any questions about the IHEBA form or other tools for assessing health education needs, please contact our Health Education Department at **1-408-874-1847**.

Patients with Special Health-Care Needs

If the results of an IHA indicate the member has special health-care needs—either physical, mental, behavioral, or developmental problems—please document this in the patient's record and refer the person to the appropriate agencies outside the SCFHP network to facilitate continuity of care, coordination of care, and case management.

All pertinent results from an IHA must be documented in the patient's medical record, including:

- Diagnosis of and treatment for any disease or health condition identified.
- Proposed (or provided) counseling, anticipatory guidance and interventions for risk factors detected.
- Other preventive, diagnostic or treatment follow-up services as needed.
- Referrals made to specialists or other providers.
- Proposed or scheduled revisit date.
- Provisions for continuation or initiation of all services necessary to treat preexisting conditions, including initiation or continuation of specialty care.

- If the IHA was actually conducted during a previous visit, note the patient's health status in his or her medical record, as this documentation will serve as evidence of an IHA.

SCFHP employs nurses who are trained in case management, disease management, and chronic care, any of whom can answer questions and assist you or your staff in obtaining special health-care services for your patients. Please call **1-408-874-1821** if you need assistance. For further information, see **Section 11 Case Management**.

Section 5 Access & Appointment Standards

To ensure that members have timely access to medical care, SCFHP follows standards set by DHCS, a summary of which is shown in the chart below.

Appointment Availability		
Licensed Health Care Provider	Service	Access Timeframe
PCP, Specialist	Urgent Care Appointment <ul style="list-style-type: none"> • Services <u>not requiring</u> Prior Authorization • Services <u>requiring</u> Prior Authorization 	<ul style="list-style-type: none"> • Within 48 hours of request for appointment • Within 96 hours of request for appointment
PCP and Non-Physician Mental Health Provider	Non-Urgent Appointment —for the diagnosis or treatment of injury, illness or other health condition	Within ten (10) business days of request for appointment
Specialist and Ancillary Services	Non-Urgent Appointment —for the diagnosis or treatment of injury, illness or other health condition	Within fifteen (15) business days of request for appointment
All	Preventive Care Appointment <ul style="list-style-type: none"> • Periodic follow-up • Standing referrals for chronic conditions • Pregnancy • Cardiac condition • Mental Health conditions • Lab and radiology monitoring 	May be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his/her practice
PCP, Specialist	First Prenatal Visit	Within two (2) weeks of request

Telephone Triage		
Licensed Health Care Provider	Service	Access Timeframe
All Licensed SCFHP Providers	Telephone Triage or Screening Services	<ul style="list-style-type: none"> • 24 hours per day, 7 days per week • Waiting time within 30 minutes

In Office Wait Time		
Licensed Health Care Provider	Service	Requirement
PCP, Specialists and Non-Physician Mental Health Provider	In office wait time for scheduled appointments.	45 minutes or less

After Hours Accessibility		
Licensed Health Care Provider	Service	Requirement
PCP and Non-Physician Mental Health Provider	What instructions would you give a caller who is dealing with a life threatening situation?	<ul style="list-style-type: none"> Go to the nearest emergency room Hang up and dial 911
PCP and Non-Physician Mental Health Provider	If the patient expresses an urgent need to speak with a clinician, is there a way to put them in touch with the physician or an on-call provider?	Yes
PCP and Non-Physician Mental Health Provider	In what time frame can the patient expect to hear from the physician or on-call provider?	30 minutes or less

As indicated in the above chart, health care services must be available to members 7 days a week, 24 hours a day. To this end, you must arrange an on-call 24-hour service with a physician available to take the calls as appropriate. For further details on access standards, see relevant policies on our website, www.scfhp.com.

Non-Emergency Medical Transportation and Non-Medical Transportation

We cover Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) when the member has a medical condition that does not allow him/her to travel by any other form of public or private conveyance without endangerment to his/her health. Authorized transportation may include public transportation (bus, light rail, etc.), vans, taxis, or other public or private transportation, ambulance, litter car, wheelchair van medical transportation or air transport services when needed to obtain covered medically necessary services and services that are carved out (e.g. dental services).

Non-Emergency Medical Transportation (NMT):

- Prior authorization is required before arranging non-emergency transportation services, except in the cases of a transfer from an acute inpatient hospital to a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or from a SNF/ICF to an acute-care hospital. Physicians are required to complete a Physician Certification Statement (PCS)

form to request specific types of transportation requests. SCFHP needs these forms for preapproval before NEMT services can be arranged.

- Completed forms should be faxed to 1-408-874-1957 or 1-408-376-3548.
- Once UM received and processed completed PCS forms, then patients can call SCFHP Customer Service to arrange transportation.
- **SCFHP requires a 5-7 day advance notice for all non-urgent requests.**

The designation of an appropriate transportation service will take into account the following:

- Member's medical and physical condition.
- Urgency of the need for transportation.
- Availability of transportation at the time of need.

Non-Medical Transportation (NMT):

Non-Medical Transportation (NMT) Services do not require a PCS form. Patients must call SCFHP at least three (3) days prior to their scheduled appointments and provide an attestation that they do not have other transportation resources.

Section 6 Cultural & Linguistic Services

Cultural and linguistic competence is an on-going learning process, with the level of competence having a profound impact on the diverse communities within Santa Clara County. The direct relationship between culture, language, and health is complex and inextricably linked to the health status of individuals and subsequently communities. For this reason, it is essential that SCFHP and providers strive to ensure members receive culturally and linguistically competent health care services.

All health care providers are expected to ensure equal access to health care services for all members with communication disabilities and for all Limited English Proficient (LEP) members. Health care providers include but are not limited to medical, behavioral health, long-term services and supports, and pharmacy network providers.

Additionally, all health care providers shall comply with all of the provisions of linguistic and culturally sensitive services in accordance with SCFHP's policies. All health care providers shall address the special health care needs of all members, and shall ensure equal access and participation in federally funded programs to members with LEP or hearing, speech or vision impairment through the provision of bilingual or adaptive services. All providers are expected to:

- Honor the member's beliefs, traditions and customs;
- Recognize individual differences within a culture;
- Create an open, supportive, and responsive organization in which differences are valued, respected, and managed through:
 - Completing cultural diversity training;
 - Fostering attitudes and interpersonal communication styles which respect members' cultural backgrounds and are sensitive to their special needs; and
 - Referring members to linguistically and culturally sensitive programs.

Section 6.1 Interpreting Services

Guides to Using Interpreting Services

SCFHP provides foreign language and American Sign Language interpreters to members for any covered service—at no cost to members or providers.

- **Telephonic Language Interpreters**

Interpreting services are available for more than **170 languages**, and are available **24 hours a day, 7 days a week**. To access interpreting services:

1. Call Language Line Interpreter Services directly at **1-888-898-1364**
2. Press 1 for Spanish or Press 2 for other languages and speak the name of the language.
3. An agent will come on the line. Provide the agent with:
 - Access code: Network providers use operator **access code 8033**.
 - Your first name
 - Your department and/or the office's name

- Member's ID
- **California Relay Service** is available in English and Spanish for members with difficulty hearing.
 1. TTY:
 - English: **1-800-735-2929**, or dial **711**
 - Spanish: **1-800-855-3000**
 2. Voice:
 - English: **1-800-735-2922**
 - Spanish: **1-800-855-3000**
- **In-Person Language Interpreters**

In-person interpreter services are available for more than 100 languages. If possible, please schedule an in-person interpreter at least 5 business days in advance. You need the following information when scheduling in-person interpreter services:

- Member's name and date of birth
- Provider's name and address
- Language needed
- Appointment date, time, and location
- Type of assignment (doctor's check-up, surgery, consultation, etc.)
- Onsite contact (representative's name, department, phone number, etc.)
- Preference, if any, for male or female interpreter

Call SCFHP Member Services at **1-877-723-4795**, 8:30 am – 5:00 pm, Monday through Friday. Interpreters can be scheduled for any day/any time, but all in-person appointments, including in-person American Sign Language (ASL), must be set up during regular Member Services business hours.

Tips to Work with California Relay

California Relay Services is a telecommunications relay service, which provides full telephone accessibility to people who are deaf, hard of hearing or speech disabled. Specially trained Communication Assistants (CAs) complete all calls and stay on-line to relay messages electronically over a text telephone (TT), called TTY for "teletype," or to relay messages verbally to hearing parties.

- **How to make a traditional VOICE relay call using Standard Telephone:**
 3. Call California Relay Services directly at **1-800-735-2929** (English) or **1-800-855-3000** (Spanish).
 4. Give the CA the area code and telephone number you wish to call and any further instructions.
 5. Talk to the CA as though you are speaking directly to the person you called (avoid saying "Tell him" or "Tell her").
 6. Say "Go ahead," each time you have finished speaking.

7. Continue steps 3 and 4 throughout your call.
 8. When you are done, say “GA to SK” (go ahead to stop keying), then hang up.
- **How to receive a traditional relay call:**
 1. Your phone rings and you answer it. A CA says, “Hello, this is California Relay Services, Communication Assistant # XXX with a relay call for this number.”
 2. You (or the staff member who answered the call) say “Go ahead.”
 3. The CA types your message to the TTY user and reads the reply to you.
 4. Say “Go ahead,” each time you have finished speaking.
 5. Continue steps 3 and 4 throughout your call. When you are done, say “GA to SK” (go ahead to stop keying), then hang up.
 - **How to make a traditional relay call using the TTY:**
 1. Dial California Relay Services directly at 1-800-735-2929 (English) or 1-800-855-3000 (Spanish)
 2. Type the area code and telephone number you are calling.
 3. The CA places your call and informs you of the call status: “ringing” or “busy.”
 4. If the phone is answered, the CA relays the greeting s/he hears and then types “GA” for you to “Go ahead.”
 5. The CA speaks what you have typed to the person you have called.
 6. Continue with this process through the call. When you are ready to end your call, type “SK” for “stop keying” then hang up.

Section 6.2 Translation Services

SCFHP provides Limited English Proficient (LEP) members with written member informing materials in the member’s identified primary threshold language. The threshold languages are English, Spanish, Vietnamese, Chinese and Tagalog.

Section 6.3 Language of Proficiency

Clinical and non-clinical bilingual staff members who interact with LEP members are required to be assessed using the Self-Assessment Language Capabilities tool. Providers and office staff who rate themselves with speaking, reading, or writing capabilities below level 3 as defined on the Self-Assessment Language Capabilities should not use their bilingual skills or serve as interpreters and/or translators.

Qualified interpreting services are available through SCFHP. This includes telephonic and face-to-face interpreting services, including American Sign Language. Please refer to **Section 6.1 Interpreting Services**.

Section 6.4 Cultural and Linguistic Services Training

SCFHP offers cultural competency resources and trainings on a variety of topics to providers and office staff. Training methods include, but are not limited to, cultural competency training tool

kit posted on the SCFHP website, provider orientation, in-services, meetings, quarterly visits, provider newsletters, faxes, mailing and special trainings. Trainings topics include:

- Knowledge of SCFHP's policies and procedures for cultural and linguistic services
- Communicating across language barriers
- Communicating with seniors and people with disabilities
- Increasing awareness of cultural diversity
- Maintaining language proficiency and qualifications of bilingual staff
- Ensuring 24-hour access to interpreting services at all points of contact, including after-hours services
- Documenting request/refusal of interpreting services in the medical record
- Filing a grievance if a patient's language needs are not met

A complete cultural competency training tool can be viewed or downloaded from SCFHP's website at www.scfhp.com/for-providers.

Section 6.5 Monitoring

Providers are required to develop and distribute policies and procedures that address all cultural and linguistic requirements listed in this provider manual. Providers are also responsible for provider education and oversight to ensure full compliance with state and federal laws.

Section 7 Marketing

Compliance with Laws and Regulations

Marketing of the Medi-Cal plans is regulated by DHCS and DMHC. Providers must adhere to all applicable laws, regulations, DHCS guidelines, and DMHC guidelines regarding plan marketing, as specified under Title 22 California Code of Regulations (CCR) 53880 and 53881 and Welfare and Institutions Code Sections 10850(b), 14407.1, 14408, 14409, 14410, and 14411.

Under program rules, network providers may not distribute any marketing materials or make such materials or forms available to individuals eligible to enroll in a Medi-Cal plan unless the materials meet the marketing guidelines and are first submitted to SCFHP and DHCS/DMHC for review and approval.

Acceptable Marketing Methods

As a Medi-Cal health care provider, you may:

- Tell your patients the name of the health plan or plans with which you are affiliated.
- Actively encourage your patients to seek out and receive information and enrollment material that will help them select a Medi-Cal health care plan for themselves and their family.
- Provide patients with the phone number of the outreach and enrollment or member services departments of the plan(s) with which you are affiliated.
- Provide patients with the toll-free phone number of Health Care Options (HCO), the DHCS enrollment contractor (1-800-430-4263) and inform patients of locations and times when they may receive information from HCO about selecting a health plan or provider. This number is specifically for beneficiary questions. HCO provides enrollment and disenrollment information and activities, presentations, and problem resolution functions.

Prohibited Marketing Methods

As a Medi-Cal health care provider, you may NOT:

- Coerce, threaten, or intimidate patients into making a particular selection.
- Tell patients they could lose their Medi-Cal health benefits if they do not choose a particular health plan.
- Make any reference to competing plans, e.g., comparing plans in a positive or negative manner.
- Copy sample enrollment forms with your name filled in and distribute them to patients, use photocopied blank forms, or use plan-printed enrollment forms.
- Make false or misleading claims, inquiries, or representations that:
 - Office staff are employees or representatives of the State or County.

- A plan is recommended or endorsed by any State or County agency or any other organization.
- The State or County recommends that a Medi-Cal beneficiary enroll with a specific health plan.
- Offer or give any form of compensation, reward, or loan to a prospective enrollee to induce or procure Medi-Cal beneficiary enrollment in a specific health plan.
- Use any list of Medi-Cal beneficiaries obtained originally from confidential State, County, or health plan data sources or from the data sources of other contractors for enrollment purposes.
- Engage in marketing practices which discriminate against prospective members based on race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
- Sign an enrollment application for the member.
- Provide marketing presentations by a health plan or provider's staff at primary care sites.
- Engage in any Medi-Cal marketing activity on State or County premises or any other location not authorized in the health plan's marketing plan.
- Distribute unauthorized or unapproved material to Medi-Cal beneficiaries.

Engaging in prohibited practices may result in sanctions or fines imposed by DHCS.

Section 8 Benefits

Upon enrollment in any of our programs, all members receive an Evidence of Coverage (EOC) booklet, which contains a detailed summary of benefits as well as other useful information about their health plan.

The EOC is available on our website at www.scfhp.com. If you or other providers in your office would like to receive copies of the EOC to give to your Medi-Cal, please contact the Provider Services Department at **1-408-874-1788**.

Section 9 Claims & Billing Information

The primary responsibility of our Claims Department is to adjudicate medical claims submitted by physicians, hospitals and other health-care providers. The Claims Call Center welcomes telephone inquiries from providers about the status of their claims. We also provide helpful advice on how to submit claims, inquiries, and appeals.

The Claims Call Center may be reached Monday through Friday from 8:30 AM to 5:00 PM at **1-408-874-1788**. You also may call after hours and leave a message. A Call Center representative will return after-hours calls the next business day. You may fax inquiries to **1-408-874-1911**.

Approved Claim Forms

The following forms are approved for submitting claims:

- CMS 1500 - Valid for professional and ancillary services.
- UB-04 - Valid for both inpatient and outpatient hospital care and clinics.
- PM 160 - Valid for use only by Child Health & Disability Program (CHDP)-certified providers and only for Medi-Cal members.

All claim forms must be signed and dated. Medi-Cal's CHDP forms must include the treating physicians name on the PM 160.

Mailing Addresses for Submission of Claims

Santa Clara Family Health Plan
P.O. Box 18640
San Jose, CA 95158

Electronic Data Interchange (EDI)

Effective January 1, 2012, SCFHP requires that all contracted providers bill their claims electronically. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that SCFHP adopt standards for specific financial health care transactions. The HIPAA-mandated national standard format for transactions is the ANSI ASC X12N.

SCFHP only accepts the following claims-related transactions formats for health care claims:

- ASC X12N 837 (005010X222) Professional
- ASC X12N 837 (005010X223) Institutional

If your office bills CHDP claims on a PM160 claim form and you are interested in submitting these claims electronically, please contact the SCFHP Provider Services Department at **1-408-874-1788** for additional information.

No other electronic formats are valid for the billing of medical claims to SCFHP.

SCFHP contracts with both Emdeon and Office Ally for clearinghouse services. When submitting claims through Emdeon, Office Ally, or your own clearinghouse, please use Payer ID 24077. The daily cutoff time for same day claims submission is 5:00 PM Pacific time. If you need clearinghouse submission assistance, please contact:

- Emdeon Customer Service at **1-866-742-4355** or
- Office Ally at **1-866-575-4120** option 1.

Billing Time Limits

California Welfare and Institutions Code Section 14115 mandates a 12-month timely filing limit for Medi-Cal claims. Therefore, the timely filing limits for all Medi-Cal claims are 12 months from the date of service. These billing time limits are applicable to both contracted and non-contracted providers.

Original or initial claims must be received by the delegated group or health plan within six months from the date of service. Claims that are not received within the six-month billing time limit and do not meet any of Medi-Cal's delay reasons as delineated in the Medi-Cal Provider Manual, CMS 1500 Submission and Timeliness Instructions, are reimbursed at a reduced rate or are denied as follows:

- Claims received during the seventh through ninth month are reimbursed at 75% of the payable amount.
- Claims received during the tenth through twelfth month are reimbursed at 50% of the payable amount.
- Claims received after the twelfth month are denied.

Coordination of Benefits & Share of Cost

The member's Medi-Cal coverage through SCFHP is the payer of last resort. If a member has coverage through both SCFHP and another health insurance program, the other insurance program is the primary payer. You should attempt to be reimbursed for services from any other health insurance program for which the patient is eligible (including Medicare) before submitting a claim to SCFHP.

For members with other health insurance, if you receive payment from that carrier, you may bill SCFHP to allow for coordination of benefits. Our reimbursement will be the difference between the SCFHP allowable and the other health insurance carrier's payment.

Member Financial Responsibility

Medi-Cal Members

A member shall never be held liable for any sums owed to a contracted provider, nor shall the provider bill, charge, collect a deposit or other sum—or seek reimbursement from—an SCFHP member for covered services. However, members may be held financially liable for any non-covered and/or excluded services or for coordination of benefits from other carriers by which the member is covered. SCFHP Medi-Cal members do not have co-payments for any covered benefits.

Misdirected Claims

Claims received by us but are the financial responsibility of a capitated sub-contractor are forwarded to that sub-contractor within 10 working days. Our current capitated sub-contractors

are: Kaiser, Premier Care, Physicians Medical Group of San Jose, Valley Health Plan, and Palo Alto Medical Foundation.

Pharmacy Claims

All claims from participating pharmacies for members participating in the Medi-Cal program should be processed through the online transaction processing system maintained by SCFHP's Pharmacy Benefit Manager (PBM), MedImpact.

To inquire about the status of a pharmacy claim, the provider may call MedImpact at **1-800-788-2949**.

- **Exception:** Pharmacy prescriptions and pharmacy claims for members participating in SCFHP's Kaiser network should always be filled and processed through Kaiser pharmacies.

See **Section 19 Pharmacy Benefits** for more detailed information.

Claims Inquiries

Providers may inquire about the status of their claims by calling the Member Services Department at **1-408-874-1788**. Providers with 3 or more claims inquiries should fax their lists to the Member Services Department at **1-408-874-1911**. The Member Services Department responds to the fax within ten working days.

Corrected Claims

If you are submitting a "corrected claim," it must be submitted within the timeframes outlined in your contract. The appropriate claim form is a CMS 1500 or UB-04 claim form with the words "CORRECTED BILLING or RESUBMISSION" stamped on the front of the claim. Attach a copy of the explanation of benefits indicating the original request for the corrected claims and submit to SCFHP:

- By fax to **1-408-874-1925**
- By mail to
Attn: Claims Department
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

Billing/Claim Disputes (Appeals)

All claims appeals should be submitted within one year from the date of SCFHP's remittance advice. Submissions after one year may result in the claims appeal being denied. To file a claims appeal, you may either submit a claims dispute on our website or mail/fax a formal letter. Please identify the disputed claim number, with a clear explanation of the basis upon which you believe the amount of payment and or denial is incorrect and applicable supporting documentation.

All claims appeals should be submitted to SCFHP:

- Via our website, **www.scfhp.com**

- By fax to **1-408-874-1925**
- By mail to
Attn: Claims Department
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

Claims Appeals are resolved and responded to within 45 working days of from the day of receipt of the appeal.

Contracted providers who receive a first level denial letter or that receive an outcome that they regard as unfavorable, may avail themselves of SCFHP's second level appeal process. Providers must submit their second level appeal within 30 working days of receiving their first level claims appeal decision from the Claims Director. Second level claims appeals are resolved and responded to in writing within 30 working days from the day of receipt of the appeal by SCFHP. Providers may submit these appeals:

- By fax to **1-408-874-1925**
- By mail to
Attn: Claims Department
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

Section 10 Authorizations

The information in this chapter is relevant for Independent Providers and not our delegated Provider Networks, which uses their own authorization process. Delegated provider networks include Kaiser, Palo Alto Medical Foundation, Physicians Medical Group of San Jose, Premier Care and Valley Health Plan.

SCFHP Review and Decision Process

Individual authorization requests are reviewed by the UM Department according to predetermined criteria, protocols, and the medical information from the physician or other provider. In some cases, the UM Department may need to contact the provider directly to request additional information—or the SCFHP CMO/Medical Director may need to speak directly with the provider to discuss the request.

We use the following standard guidelines for evaluating authorization requests and determining medical necessity and effectiveness of care:

- Milliman Care Guidelines
- American College of Obstetricians and Gynecologists (ACOG) Guidelines
- US Preventive Services Task Force (USPSTF): Guide to Clinical Preventive Services
- Manual of Criteria of Medi-Cal Authorizations
- InterQual Guidelines
- Apollo Medical Review Criteria Guidelines
- Published guidelines of other national specialty boards
- Results of clinical studies contained in the National Library of Medicine (NLM) database (MedLine)
- Recommendations from actively participating board-certified specialists
- Clinical judgment.

Since nationally developed guidelines are often designed to be appropriate for the uncomplicated patient, the following factors also may be considered when applying criteria to an individual patient's situation:

- Age
- Comorbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment
- Member's desires

- Other relevant factors, per the physician's discretion.

Developing New Guidelines or Protocols

The UM Department maintains a list of expert specialists in the community who have agreed to assist with reviewing cases for which adequate criteria or protocols are not available. When these situations occur, the UM Department consults with a physician in the network who is considered an expert in his/her field.

The CMO/Medical Director also initiates the development of new service criteria for adoption by SCFHP.

Medical Services & Procedures Requiring Prior Authorization

Medical services that require prior authorization from SCFHP are identified in the Prior Authorization Reference Guide on our website, www.scfhp.com.

Prescribing physicians may request authorization by completing the Prior Authorization Request (PAR) form, attaching clinical documentation to support the request, and submitting it:

- Online at www.scfhp.com.
- By fax to **1-408-874-1957**
- By mail

Attn: UM Department
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

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.
- Even if the member does not accept the suggested alternative, DHCS requires that you submit his/her request to SCFHP's Utilization Management Department for determination. Be sure to include a statement that the request has been submitted at the member's request and that you do not concur that the requested service is medically necessary. (Providers in networks with their own authorization process should submit the request to the applicable UM Department.)
- Contact SCFHP's Utilization Management Department at utilization@scfhp.com or **1-408-874-1821** with questions.

Routine Pre-Service Requests

For routine pre-service requests for procedures/services that can be pre-scheduled without danger of adverse outcome to the member, SCFHP usually makes a determination within 5 business days of receipt of the request and appropriate documentation of medical necessity. In exceptional

circumstances, a decision may be deferred for an additional 14 days when the member or provider requests an extension.

Emergency Care

For emergency inpatient admissions or emergency services, the hospital should contact SCFHP for verification of the member's eligibility. You may contact the UM Department by phone at **1-408-874-1821** or by fax at **1-408-874-1957**.

- Emergency/urgent services and emergency hospital admissions do not require prior authorization.

Contracting facilities are **obligated to notify** SCFHP of all inpatient admissions within one (1) business day following the admission to obtain authorization, and confirm the length of stay and level of care needed by the patient.

SCFHP conducts concurrent and retrospective medical case reviews.

Out-of-Network/Area Authorizations

In the event of an urgent/emergent medical situation outside of the SCFHP service area, it is the responsibility of the facility to contact us to confirm eligibility and service authorization.

Out-of-area medical services and admissions are concurrently reviewed by telephone, or are reviewed on a retrospective basis by review of the medical record as provided by the facility within 30 days of discharge. Arrangements for transfer back to the SCFHP network are initiated as soon as the member is stable for transfer.

Expedited Requests

In medically urgent situations, you may request an expedited PAR review by contacting our UM Department at **1-408-874-1821** or by faxing it to **1-408-874-1957**. Urgent authorization requests are reviewed within 24 hours of receipt. You will be notified of the decision by return phone call with a fax confirmation provided within 72 hours of the determination.

If the faxed PAR is not urgent, it is processed within 5 business days.

Prior Authorizations for Ancillary Services

When ancillary services such as home health care, medical supplies, rehabilitation services, and DME are required, the UM Department works with the physician to select an appropriate provider based on the member's medical needs and assists the provider and member with care management. Prior authorization is required for these services including documentation of medical necessity and prescription signed by ordering physician.

As part of the prior authorization process, the PCP or prescribing physician should fax the request to the selected contracted ancillary provider to arrange for service.

Ancillary services requiring a PAR may include, but are not limited to, the following:

- Durable Medical Equipment (purchase or rental).
- Dialysis.

- Eye appliance services.
- Hearing devices.
- Audiologic services.
- Home Health Agency services.
- Medical supplies.

Please see the Prior Authorization Reference Guide to determine whether a PAR is needed for a specific service.

Hospital Inpatient Services

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

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

An admission that is pre-planned, with a date of expected admission, is valid for only 30 days after the expected date of admission, with the exception of obstetric deliveries.

Emergency and urgent admissions do not require prior authorization. SCFHP should be notified by the facility of emergency admissions within one business day.

Tracking a Prior Authorization Request

Providers can monitor the status of a Prior Authorization Request by calling SCFHP's Utilization Management Department at 408-874-1821. They may also send an email to the UM Help Desk at UMHELPDESK@scfhp.com.

Direct Access Services: No Authorization Required

Women's Health Services

A female member may elect to choose a participating OB/GYN as her PCP for all medical services as long as that OB/GYN is contracted with SCFHP as a PCP. If the member's PCP is not an OB/GYN, she may self-refer directly to a participating OB/GYN, or directly to a participating family practice physician and surgeon who has been designated as an OB/GYN service provider as long as the provider is within the same network as the PCP. The following services may be provided:

- Annual OB/GYN examination, including Pap smear.
- Diagnosis and treatment of an acute gynecologic problem, including appropriate follow-up care.

- Prenatal care, delivery and post-partum care.
- Family planning services and/or abortion services.

Annual Screening Mammography

SCFHP members may self-refer, within the provider group network, for an annual screening mammography. You are required to provide members with a list of contracted mammography facilities each year.

Flu Vaccine

SCFHP members have direct access to an in-network physician for an annual flu vaccine. Please inform your members about the availability of flu vaccines through your office.

If your office runs out of flu vaccine, SCFHP members may also receive their flu vaccine through one of the pharmacy chains.

Colorectal Cancer Screening

SCFHP members have direct access to in-network physicians for colorectal cancer screening provided within the guidelines established by the US Preventive Services Task Force (USPSTF). This includes access to the following services for adults age 50-75:

- Annual screening with high-sensitivity fecal occult testing **OR**
- Sigmoidoscopy every 5 years with high sensitive fecal occult blood testing every 3 years **OR**
- Screening colonoscopy every 10 years.

If requested by a member, you are required to provide members with a list of contracted providers who provide this service. Contracted providers can be found on our website at www.scfhp.com.

Obtaining Authorization for a Second Opinion

Members may request a second opinion about a recommended procedure or service. The request must go through the PCP for authorization, and SCFHP's UM Department must review the request for medical necessity. All decisions about second opinions must be rendered within the following time limits:

- Expedited Initial Determination: Within 3 calendar days
- Standard Pre-Service: Within 5 business days

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

If the provider giving the second opinion recommends a treatment, diagnostic test, or service that is medically necessary and covered by SCFHP PCP must provide or arrange for the service.

Continuity of Care from a Terminating Physician or a Non-Contracted Provider

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-contracted provider.

When a provider'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 for the following conditions:

- An acute condition
- A serious chronic condition and/or a terminal illness
- A pregnancy and care of a newborn child
- Surgery or other procedure that has been authorized
- Any other covered service dictated by good professional practice

Continued care for a newly enrolled member may not exceed 12 months from the initial effective date of coverage. For current members, the following contingencies apply:

- The provider must continue to treat the member and must accept the payment and/or other terms.
- Continued care with a terminated provider may be provided for up to 12 months for a serious chronic condition.
- For an acute or terminal condition, the services shall be covered for the duration of the illness.
- If a member is in the second or third trimester of pregnancy, treatment may extend through the post-partum period. Coverage for care of the newborn child may extend through 36 months.

We send a written notice to members at least 30 calendar days before the effective termination date, and we offer assistance in selecting a new provider. For members receiving active treatment for an existing medical condition, continued access to the terminating provider is allowed for up to 90 calendar days. The member should request continuity of care through SCFHP Member Services.

Members' Role in Authorization

SCFHP members (or their representatives) are part of the authorization process and should be aware of the approved services and the authorization turnaround times. Members must consult with their PCP before scheduling an appointment with any other physician, except for the self-referral services mentioned earlier under Direct Access Services.

Members may request a second medical opinion and have the right to appeal to SCFHP if their PCP denies their request for referral to obtain a second medical opinion. See **Section 20 Grievances & Appeals**.

Discharge Planning & Concurrent Review

Discharge planning is the coordination of a patient's anticipated continuing care needs after his/her discharge from a hospital or other institution. Initial evaluation for discharge planning begins at the time of notification of inpatient admission. A comprehensive discharge plan includes, but is not limited to, the following:

- Documented assessment, upon admission, of the patient's needs, which should include written notation of functional status as well as anticipated discharge disposition.
- Development of a written discharge plan, including evaluation of financial, psychosocial and potential post-hospital service needs, e.g., home health care, DME, and/or placement in a SNF or custodial-care facility.
- Timely referral to SCFHP's Case Management and Disease Management Programs as indicated.

Concurrent review is an assessment of medical necessity and appropriateness of health services being rendered for a patient's ongoing care.

Retrospective Review

Retrospective review is the review of medical treatments, documentation, and billing after the service has been provided. In performing these reviews, our UM Department evaluates the following:

- Eligibility verification.
- Determination of medical necessity.
- Appropriateness of admission.
- Length of stay.
- Level of care.
- Initiation of appropriate follow up for issues related to utilization, quality, and risk.
- Appropriateness of billing.
- Identification and resolution of claims-related issues as they involve medical necessity and SCFHP's claims payment criteria and guidelines.

Retrospective Review of Emergency Services

Health Plans, Medical Groups and IPAs that are delegated for utilization management are responsible for retrospective review of emergency department claims, criteria for which include:

- Coverage of emergency services to screen and stabilize the member without prior approval, in a situation where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.
- Coverage of emergency services if an authorized representative, acting for the Medical Group/IPA, had authorized the provision of emergency service.
- Appropriate physician review of presenting symptoms.

- The patient's discharge diagnosis.

For additional information about emergency services, see **Section 12 Emergency, Urgent Care & Trauma Services**.

Section 11 Case Management

Case management is a collaborative process of evaluation, planning, facilitation and advocacy for members whose health conditions warrant particular attention. SCFHP's Case Management depends on close communication between our case managers, the PCP, and his/her office staff.

After collecting and processing information on members whose condition warrants formal case coordination, our case manager communicates this to the PCP. Additionally, the case manager contacts the PCP's office periodically to ensure that the member's treatment plan, referrals, and educational plans are carried out.

Section 12 Emergency, Urgent Care & Trauma Services

Emergency Services

Emergency services are covered services required by a member as the result of a medical condition that manifests as the onset of symptoms (including pain) so severe that a prudent layperson would expect the absence of immediate medical attention to:

- Place the health of the member in serious jeopardy.
- Cause serious impairment to bodily functions.
- Cause serious dysfunction of any bodily organ or part.
- Induce an “active labor” in a pregnant woman requiring emergency delivery to avoid threat to the health and safety of either mother or child.

For emergency inpatient admissions or emergency services, the hospital should contact SCFHP for verification of the member’s eligibility.

- Emergency services do not require prior authorization.

The hospital must, however, contact SCFHP’s UM Department within 24 hours (or next business day) of a member’s admission through the emergency room. Our UM Department then communicates with the admitting hospital and follows the member’s care until the member is discharged or sufficiently stabilized for transfer to a network hospital.

If the hospital does not receive authorization from SCFHP’s UM Department, emergent and/or urgent services necessitating admission are assumed to be authorized and shall be documented as such. However, once SCFHP becomes involved in the case, all subsequent services must be authorized in advance.

Post Stabilization Care

When the treating physician believes additional health care services are needed before a member can be safely discharged or transferred after stabilization of an emergency condition, the treating physician should contact our UM Department as soon as possible to request prior authorization. We respond within 30 minutes of receiving the request for a pre-approval for post-stabilization/maintenance medical care; if no response is received, the physician may deem the request to be pre-approved/authorized.

SCFHP covers all medically necessary, approved health care services to maintain the member’s stabilized condition until the member is discharged or transferred.

Urgent Care Services

Urgently needed services are covered services provided when the member is temporarily absent from a service area or when, as a result of an unforeseen illness or injury, medical services are required without delay and the services could not be obtained reasonably through a normal

appointment with a contracted provider. Contracted providers can be found using the provider search on our website, www.scfhp.com.

Trauma Services

Trauma services are medically necessary covered services that are rendered at a state-licensed, designated trauma hospital—or a hospital specifically designated to receive trauma cases.

Trauma services must meet identified county or state trauma criteria.

The provider reviews and authorizes such services; however, SCFHP may review related claims and medical records retrospectively to verify that trauma services were indeed delivered and that the services met trauma criteria.

The following provision criteria should be considered when authorizing trauma services:

- Trauma team activation.
- The trauma surgeon is the primary treating physician.
- The member's clinical status meets current Emergency Medical Services (EMS) protocols for identifying a trauma patient.

Once the treating physician has indicated that the patient is hemodynamically stable, or ready to be transferred out of the critical care area, trauma service status no longer applies.

Unless there is documented evidence of medical necessity indicating that trauma-level services must be continued, trauma services apply to only the first 48 hours after admission to hospital. Clinical management by members of the trauma team shall be the sole criteria used to determine and authorize continued trauma services care.

Section 13 Behavioral Health

Mental Health

As part of the Initial Health Assessment of new SCFHP members, the PCP should assess the member's mental health status. As part of the Early Start Program for Developmentally Disabled Infants and Toddlers, pediatricians and other PCPs are responsible for assessing the mental health needs of all children who are under 21 years of age.

During all patient encounters and throughout the course of a member's care, please watch for any signs of mental illness or a mental-health crisis such as severe depression, psychosis, mania, etc. Refer any mental health care needs identified through this process to an appropriate mental health provider to ensure that the patient receives timely access to appropriate levels of medical care for mental illness, substance abuse, and the management of psychiatric medications.

For assistance with referring members to mental health services, contact our Member Services Department at 1-800-260-2055.

How to Access Mental Health Services – Medi-Cal

All inpatient and specialty outpatient mental health services for Medi-Cal beneficiaries have been “carved out” of SCFHP. They remain either in the county-operated Short-Doyle/Medical system or in the traditional Fee-for-Services (FFS) Medi-Cal. An exception is the outpatient service PCPs provide within the scope of their practice, and the psychotherapeutic drugs prescribed by him/her or the contracted psychiatrist.

Drug & Alcohol Treatment Services

PCPs are responsible for arranging and coordinating the provision of drug or alcohol rehabilitation services when medically necessary. If you have identified a member with potential need for alcohol/drug treatment, contact SCFHP's UM Department at **1-408-874-1821**. Or, you may call Santa Clara County Department of Alcohol and Drug Services Gateway Program at **1-408-272-6518** or **1-800-488-9919**.

For Medi-Cal patients, detoxification and drug dependency are “carve-out” benefits covered by Medi-Cal FFS.

Once a member is referred and accepted for treatment or detoxification, the PCP continues to be responsible for medical care not related to the drug or alcohol treatment. Medical detoxification generally is provided in an inpatient setting and is administered under the member's medical benefit.

Substance abuse or chemical dependence may involve any of the following 10 classes of substances:

1. Alcohol
2. Amphetamines, including “crystal meth,” “some medications used in the treatment of attention deficit disorder (ADD), and amphetamine-like substances found in appetite suppressants
3. Cannabis, including marijuana and hashish
4. Cocaine, including “crack”

5. Hallucinogens, including LSD, mescaline, and “ecstasy” (MDMA)
6. Inhalants, including compounds found in gasoline, glue, and paint thinners
7. Nicotine (considered a substance dependence rather than abuse per se)
8. Opioids, including morphine, heroin, codeine, methadone, and synthetic pain medications such as oxycodone, hydrocodone, etc.
9. Phencyclidine, including PCP, angel dust, ketamine
10. Sedatives, hypnotics, and anxiolytic (anti-anxiety) agents, including benzodiazepines, barbiturates, prescription sleeping medications, and most prescription anti-anxiety medications

For an emergency or crisis, providers may contact the Valley Medical Center Emergency Psychiatric Services Office at **1-408-885-6100**. Members should be advised to contact the Santa Clara County Department of Alcohol and Drug Services Gateway Program intake line at **1-800-488-9919** (Mon-Fri, 8:00 AM to 5:00 PM).

Section 14 Family Planning, Pregnancy & Post-Partum Services

Family Planning Services

Family planning services are provided to determine pregnancy, temporarily delay pregnancy, or permanently prevent pregnancy. Family Planning Services for Medi-Cal members do not require prior authorization and may be obtained from any family planning provider. However, we encourage PCPs and OB/GYN specialists to promote in-plan services by providing education, ensuring easy access to services, and establishing an environment in which the member feels free to talk to her physician.

As discussed earlier in **Section 10 Authorizations**, most women's health services may be accessed directly, without referral or prior authorization.

The following family planning services are covered for Medi-Cal members. Services may be provided by contracted or out-of-plan providers who accept Medi-Cal.

- Health education and counseling necessary for a member to understand contraceptive methods and/or procedures proposed, and to make an informed choice
- Limited history and physical examination consistent with ACOG standards
- Services listed in Medi-Cal CPT Codes for Family Planning Services published by DHCS
- Laboratory tests, when medically indicated, as part of the decision-making process in choosing contraceptive methods
- Diagnosis and initial treatment of sexually-transmitted diseases, if medically indicated
- Screening of at-risk individuals for HIV, when indicated
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider
- Provision of contraceptive pills, devices, supplies
- Tubal ligation and vasectomy
- Pregnancy testing and counseling
- Therapeutic abortions and related services

Excluded Services

The following services are excluded and if deemed necessary would require prior authorization.

- Infertility studies or procedures
- Reversal of voluntary sterilization
- Hysterectomy for sterilization purposes only

Pregnancy and Post-Partum Services

SCFHP covers comprehensive prenatal services provided by qualified providers, including PCPs, family practitioners, OB/GYN specialists, and organized outpatient clinics holding a valid Medi-Cal provider number and approved to provide comprehensive prenatal services.

Any provider offering prenatal services to our members should provide an organized, comprehensive prenatal service, including but not limited to supervision of all aspects of patient care including antepartum, intrapartum, and postpartum care.

Providers also are required to create and implement an Individual Care Plan (ICP) for each pregnant SCFHP member. The ICP facilitates the coordination of care and should be developed by the provider in consultation with the patient, and placed in the medical record.

Scope of Services

The scope of prenatal services and guidelines for providing them should conform to the following published standards:

- Guidelines for Perinatal Care (most current edition); The American Academy of Pediatrics (AAP) and the American Congress of Obstetricians and Gynecologists (ACOG)
- Standards for Obstetric Services (most current edition); The American Congress of Obstetricians and Gynecologists (ACOG)
- Newborn Screening regulations as set forth in Title 17, California Code of Regulations, Section 6500 et seq
- Comprehensive Prenatal Service Program (CPSP) regulations as set forth in Title 22, Code of Federal Regulations (CFR)

As described in the guidelines above, medical records for pregnant members should include, at a minimum:

- Medical and pregnancy history
- Physical examination, including pelvic
- Initial and periodic laboratory tests
- Medical risk assessment
- Proposed interventions or treatment plan, methods, timeframes, outcomes and objectives
- Proposed referrals, if applicable
- Obstetric re-assessment flow sheet
- A list of all staff involved in the patient's care

Section 15 Public Health Services

Immunizations

Immunizations are a covered benefit for Medi-Cal and Healthy Kids members. To ensure that immunizations occur on schedule and are not inadvertently duplicated, we work closely with several agencies/organizations, e.g., the Public Health Department, Bay Area Regional Registry (BARR), Child Health and Disability Prevention Program (CHDP) providers in school-funded programs, and other county service centers contracted to administer vaccinations. The State-funded program, Vaccines for Children (VFC), also provides vaccines for Medi-Cal and low-income Medi-Cal children. PCPs who have children assigned to their panel must participate in the VFC program.

In accordance with DHCS requirements, we ask that providers follow the immunization schedules described in the most recent version of CDC Recommended Pediatric and Adolescent Immunization Schedule. See also SCFHP's Preventive Health Guidelines for Healthy Adults and Preventive Health Guidelines for Children. Both are available on our website, www.scfhp.com. We also encourage you to participate in the Bay Area Regional Registry.

- When administering vaccines, it is important to document the date(s) of immunizations and the lot number of the vaccine in the patient's medical record.

SCFHP monitors the provision of immunizations through Quality Improvement (QI) studies and facility audits. We also conduct studies to determine the aggregate provision of immunizations by our entire provider network.

Infectious or Communicable Diseases

HIV/AIDS

All SCFHP members may receive confidential HIV testing and counseling services through our provider network or through the Public Health Department and family planning providers. Pursuant to Health and Safety Code Section 26, "HIV test" refers to any clinical test, laboratory or otherwise, used to identify the presence of HIV, a component of HIV, or antibodies or antigens to the HIV virus.

Members must sign a consent form before being tested for HIV. Out-of-network providers must make all reasonable efforts, consistent with current laws and regulations, to obtain the necessary signatures to report confidential test results to the member's PCP.

All HIV test results are kept confidential and strictly limited to the disclosure of test results as required by California law. DHCS requires that all positive HIV results be reported to the Public Health Department (if testing was not performed by Public Health Department).

If a member tests positive for HIV, his/her PCP is responsible for ongoing case management; moreover, the PCP must promptly refer the member to an SCFHP specialist who has been qualified as an HIV physician.

While an SCFHP member may self-refer to any provider for confidential HIV testing, he/she must always be referred back to the PCP for follow up, case management, and referral to the appropriate treatment specialist.

Case management of Medi-Cal members with HIV/AIDS is required to follow protocols recommended by CDC and NIH.

Sexually Transmitted Diseases (STDs) Other than HIV

All sexually transmitted diseases (STDs) encountered in an SCFHP patient must be reported on the correct form (DHS 8352) to the Department of Public Health within 24 hours of positive test result, in order to facilitate the initiation of contact tracing.

As in the case of a positive HIV test, if a member tests positive for any other STD, the PCP is responsible for ongoing case management and for referring the patient to the appropriate specialist for follow-up care.

The confidentiality of the member's STD service records must be scrupulously preserved unless the member has consented in writing to disclosure. Written authorization must be obtained for every disclosure of STD service records.

Reportable STDs

The following diseases must be reported to DPH, in conformance with Federal and/or State law:

- Acute pelvic inflammatory disease (PID)
- Chancroid
- Chlamydia
- Gonorrhea
- Granuloma inguinale
- Herpes simplex
- Human papilloma virus
- Lympho granuloma venereum
- Non-gonococcal urethritis
- Syphilis
- Trichomoniasis

Tuberculosis (TB) Diagnosis and Treatment

SCFHP participates in the identification, treatment, and eradication of tuberculosis (TB) in our members. SCFHP guidelines and protocols for TB control have been developed according to requirements from the Public Health Department requirements and guidelines from both the American Thoracic Society and the Centers for Disease Control (CDC).

We also work in close collaboration with the Public Health Department to educate our members—particularly who have tested positive, have active TB, or who live in close proximity to a TB patient—about the importance of treating TB as early as possible to help obviate the spread of the disease.

Screening for TB Infection

As described in **Section 4 Role of the Primary Care Provider (PCP)**, each new member should be given a tuberculin screening during his/her IHA. Depending on the member's risk factors, PCPs should determine the frequency with which further skin testing must be done for individuals in high-risk groups.

SCFHP requires that the Mantoux tuberculin skin test be used as the standard method of identifying persons infected with *M. tuberculosis*. A trained healthcare worker must read the reaction to the Mantoux test within 48-72 hours after the injection and determine the treatment and future assessment of the member.

Management of Persons with Suspected or Confirmed TB

For any member who has a positive skin test and is suspected of having TB, the PCP is required to order appropriate diagnostic studies as a means of determining the presence of active TB. Any patient with active TB must be referred to the TB clinic of the Santa Clara County Public Health Department.

The PCP is also required to assist in developing a treatment plan, the aim of which is to provide the most effective therapy in accordance with public health guidelines.

Our UM case manager follows the member's treatment to assure continuity and to support the goal of achieving 100% compliance with treatment.

Members who are not compliant with the treatment regimen are referred to the Santa County Public Health Department's TB Control Officer for Direct Observation Therapy (DOT).

Direct Observation Therapy (DOT) for TB Patients

A member who has been referred for DOT must be seen monthly by their PCP or by the TB Clinic of the Santa Clara County Public Health Department for evaluation of medical status and to ensure consistent treatment.

Section 16 Health Education Programs

SCFHP offers health education classes and programs to all of our members at no charge. To obtain a Health Education Referral Form, please visit our website www.scfhp.com or call Member Services at **1-800-260-2055**. Member Services can also provide detailed information about any of the classes described below. For classes that do not require a physician referral, members may enroll by calling **1-800-260-2055**.

Programs

- Chronic Disease Self-Management
- Exercise & Fitness
- Nutrition & Weight Management
- Parent Education
- Prenatal Education
- Safety Programs
- Smoking Cessation - Group classes and individual counseling

Classes

The following classes are open to adult members and the parents/guardians of members who are children, without the need for referral by a physician.

Nutrition Programs

In these classes, members learn how to read food labels with nutritional composition in mind, plan a healthy meal, make healthier choices at the grocery store, and understand portion sizes. Information about vitamins, minerals, and herbs is also provided. Members do not need to be referred by a physician to participate.

Babysitter Training (Teens)

This class provides important information on child safety, focusing on rescue breathing, first aid for choking and bleeding, and basic care (e.g., diapering, holding, feeding, and dressing) for infants and small children. Each participant will receive a certificate with no end date.

CPR and First Aid

Participants learn rescue breathing, bleeding control, and treatment of burns, choking, fractures, sprains, seizures, poisoning, and heat/cold injuries. A certificate is awarded upon completion of the class (valid for up to 3 years).

Domestic Violence Prevention for Adults

This class provides information and statistics on domestic violence. Participants receive reference materials for locating support groups, obtaining protection orders, and using local agencies and shelters. (Individual counseling services are available if referred by a physician.)

Counseling & Support Groups

Several support groups are open to our members without the need for a referral by a physician, including but not limited to:

- Anger/Stress Management
- Drug & Alcohol Abuse Prevention
- Family Counseling
- Individual and Couple's Counseling
- Parenting Classes
- Weight Management: WeightWatchers® (NOTE: Physician referral is required for this program).

Fitness & Recreational Program

Many social, recreational and fitness activities are also available to our members without referral by a health care provider.

Section 17 Special Programs for Children

SCFHP helps coordinate referrals to special government-funded health programs that provide extra benefits for children who qualify. The member may be eligible for benefits from the Early and Periodic Screening, Diagnostic and Treatment program (EPSDT), the California Child Health and Disability Prevention Program (CHDP), Early Intervention Services Program (EIS), services from San Andreas Regional Centers (SARC) for children with developmental disabilities, or the California Children's Services (CCS) program for children with handicapping conditions. Each of these programs is described briefly below.

The child's PCP is responsible for referring them to these programs, as appropriate, and for providing normal primary care services separate from those covered by these programs. The PCP's fees are paid directly by the particular agency rather than by SCFHP. However, our UM nurse or case manager continues to work with the PCP and the outside agency to ensure that the patients' health care is coordinated and documented.

Early and Periodic Screening, Diagnostic & Treatment (EPSDT)

EPSDT is a federally funded program for providing medically necessary services to correct or ameliorate a physical defect, mental illness or other medical condition in children under 21 years of age. These services are federally mandated to ensure that eligible members receive appropriate screening, preventive, diagnostic and treatment services.

The EPSDT benefit includes the following screening services:

- Comprehensive health and developmental history (both physical and mental health development)
- Comprehensive unclothed physical exam
- Immunizations as appropriate
- Laboratory tests as appropriate
- Lead toxicity screening (All children must receive a screening blood lead test at 12 and 24 months of age; children between the ages of 36 months and 72 months of age should receive a screening blood lead test if they have not been previously screened for lead poisoning)
- Health education, as appropriate, to provide information about the benefits of healthy lifestyles and practices as well as prevention of diseases and accidents
- Vision services (at minimum, diagnosis and treatment for defects in vision, including eyeglasses)
- Dental services (at minimum, relief of pain and infections, restoration of teeth and maintenance of dental health)
- Hearing services (at minimum, diagnosis and treatment for defects in hearing, including hearing aids)
- Other necessary health care services as needed to correct or ameliorate defects, and physical/mental illnesses and conditions discovered through the screening services

For additional information on EPSDT services, go to <http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/>.

California Child Health & Disability Prevention Program (CHDP) Services

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.

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 so that case managers from the Public Health Department Lead Program may follow up and investigate the child's home setting, as indicated
- Nutritional assessment
- Periodic health examination
- Psychosocial screening
- Speech screening
- Vision screening

Complete guidelines for CHDP preventive health services are included in the CHDP Periodicity Schedule for Health Assessment and Dental Referral and the Department of Health Services CHDP Health Assessment Guidelines, which are available through the Santa Clara County CHDP office or website, www.sccgov.org.

Developmental Disabilities: San Andreas Regional Centers (SARC)

We make every effort to assure that members with developmental disabilities receive all medically necessary screening, preventive, and therapeutic services as early as possible. If any of your child members fall 4-6 months below age-appropriate parameters or exhibit symptoms or conditions that indicate risk factors such as autism, cerebral palsy, mental retardation or seizures, you are required by law to refer them to a San Andreas Regional Center (SARC).

SARC is part of a statewide system of 21 locally based regional centers that offer supportive services and 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.

Contact information for the local SARC office is:

San Andreas Regional Center
300 Orchard City Drive, Suite 170
Campbell, CA 95008

Phone: **1-408-374-9960**

Intake Coordinator: **1-408-341-3475**

Fax: **1-408-376-0586**

Hours: 8:00 a.m. – 5:00 p.m.

Early Start Program for Developmentally Disabled Infants and Toddlers

The Early Start Program is a collaboration between the San Andreas Regional Centers and the Santa Clara County Office of Education to provide medically necessary diagnostic and therapeutic services for infants and children aged 0-2.9 years of age who have developmental disabilities.

During the IHA, PCPs 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. California State legislation requires that PCPs refer children to Early Start Program for evaluation who are exhibiting a significant developmental delay, have multiple risk factors, or have an established risk factor; moreover, the law requires that this referral take place within 48 hours of your assessment.

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, 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.

Services are provided by SARC's Early Start Program and coordinated with assistance from SCFHP.

SCFHP is a resource for providers and members (or their parents/guardians) who have questions about services for disabled children and the Early Start Program. Parents may contact the Member Services Department at **1-800-260-2055** for assistance with referrals.

Identifying Members with Suspected and/or Diagnosed Developmental Disabilities

Infants and children with the following conditions have a potential for being at risk for developmental disabilities, thus requiring Early Start services:

- Autism, or similar conditions
- Blindness or limited vision
- Spinal bifida
- Cancer
- Cerebral palsy

- Cleft palate
- Downs syndrome
- Epilepsy
- Hearing impairment
- Heart conditions
- HIV/AIDS
- Juvenile diabetes
- Lung disorders, including asthma and cystic fibrosis
- Mental retardation
- Neurologically impaired, spinal cord injuries
- Physical handicaps due to extensive orthopedic problems
- Seizures
- Sickle cell anemia

Referral Procedure for the Early Start Program & Regional Center Services

To make a referral to the Early Start Program, write, fax or call:

Santa Clara County Early Start Program
780 Thornton Way
San Jose, CA 95128

Fax: **1-408-295-6104**

Referral Hotline: **1-800-404-5900**

Hours: 9:00 a.m. – 4:00 p.m.

Parents of children over 2.9 years of age with developmental disabilities should contact directly the school district of residence and local the San Andreas Regional Center for assistance.

Coordination of Care with Regional Centers and Early Start Program

SCFHP continues to provide for the medical needs of members receiving services from SARC/Early Start and coordinates with the Center to assist with the development of a care plan, or in meeting the care plan that has been developed.

The PCP is part of the interdisciplinary team supporting the member's medical as well as psychosocial and environmental needs. Screening, preventive and medically necessary and therapeutic services that are a normally covered benefit are continued to be covered by SCFHP.

California Children's Services (CCS) Program

California Children's Services (CCS) Program is a state-funded program that pays for the medical care of children (aged 0-21 years) who have physically handicapping conditions. Conditions that qualify for CCS are those that limit or interfere with physical function but can be cured, improved or stabilized, e.g., birth defects, handicaps present at birth or developed later, and injuries from accidents or violence. These conditions may require treatment with medicine, surgery or rehabilitation. CCS manages the eligible health condition which includes referrals to the appropriate specialists and facilities for care.

Providers should refer SCFHP members with CCS medically-eligible conditions to CCS for case management and treatment of the particular condition. Notify our Utilization Management Department at **1-408-874-1821** about any potential CCS-eligible condition.

Please note that members under the care of CCS continue to remain enrolled in SCFHP for primary-care services and referrals unrelated to the CCS conditions. The PCP relationship remains intact for providing all primary care, medically necessary screening, diagnostic, preventative and treatment services unrelated to the member's CCS eligible condition, as well as forwarding any requested medical information the program(s) may request.

SCFHP UM staff 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 work with providers, admitting physicians, hospital discharge planners, neonatologists, or hospital pediatricians, as appropriate, to ensure that potential candidates are referred to CCS.

SCFHP ensures that children in foster care and other out of home placement situations receive comprehensive, medically necessary services and preventative healthcare, especially when a child is placed outside the SCFHP service area. Additional questions can be directed to Utilization Management at **1-408-874-1821**.

Section 18 Additional Programs & Services

Managed Long-Term Services and Supports

Historically, Medi-Cal managed care plans covered acute, primary, and rehabilitative care services, but not Long-Term Services and Supports (LTSS). Under the Coordinated Care Initiative (CCI), SCFHP is responsible for administering and coordinating expanded LTSS benefits. Beginning July 1, 2014, the first component of CCI took effect—Managed Long-Term Services and Supports (MLTSS). Expanded Medi-Cal benefits under the health plan now include the following LTSS programs:

- In-Home Supportive Services (IHSS)
- Community-Based Adult Services (CBAS)
- Multipurpose Senior Services Program (MSSP)
- Long-term care in a nursing facility, including skilled, subacute and long-term custodial care

What is Long-Term Care (LTC)?

Long-term care (LTC) is the provision of medical, social, and personal care services that are not available in the community and are needed regularly due to a mental or physical condition. Services are provided in a skilled nursing facility (SNF).

A skilled nursing facility (SNF) is a licensed facility with the staff and equipment to provide nursing care and/or rehabilitative services at different levels as needed. The levels of care can vary, but usually include subacute care, skilled care and long-term care.

- Subacute care: Needed by a patient who does not require hospital acute care, but who requires more intensive skilled care than is provided to the majority of patients in a skilled nursing facility. Example: A patient on a ventilator or receiving IV antibiotics. Note that subacute care can also be provided in a dedicated subacute care facility.
- Skilled care: For people who are physically disabled and/or require a high level of care. Skilled care services are prescribed by a physician or certified nurse practitioner. Example: A person discharged from the hospital to a SNF for rehab from a broken hip.
- Long-term care (LTC): Provides what is called “custodial care,” a level of care that is the least intensive care and is not skilled care.

LTC Referrals and Prior Authorization

The SCFHP Medical Management Department processes authorization requests in a timely manner and in accordance with state and federal requirements. SCFHP Authorizations Department is available by telephone every business day from 8:30 a.m. – 5 p.m. at **1-408-874-1808**. Please leave a message including your phone number and you receive a call back from a department member within one (1) business day.

To submit a prior authorization request, please complete the **Authorization Request form**, attach supporting clinical documentation, and fax it to the SCFHP Medical Management

Department at **1-408-874-1957**. This fax number can be used to send authorization and utilization inquiries and requests to SCFHP during and outside of business hours.

Prior authorization requests should be accompanied by medical records to assist SCFHP's clinical reviewers with determining whether the requests meet SCFHP's criteria for coverage.

What is Community-Based Adult Services (CBAS)?

CBAS is an outpatient, facility-based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals and transportation to eligible Medi-Cal beneficiaries enrolled in a managed care plan. CBAS targets at-risk patients who need extra supervision and support in order to remain living in their homes or communities and to prevent emergency room visits, hospitalizations, and other institutionalization.

CBAS Referrals and Prior Authorization

Upon receipt of a new member inquiry, CBAS providers must fax the following documents to **1-408-874-1975**.

- CBAS referral form
- Medical necessity form completed by the member's primary care provider

SCFHP Medical Management staff review all documentation and schedule a face-to-face interview with the member at a location convenient for the member. The face-to-face interview must be scheduled within 14 days of submitting a CBAS referral; otherwise a new referral is required. The face-to-face interview must be completed within 30 days of submitting a CBAS referral.

Face-to-face CBAS Eligibility Determination

The member and CBAS provider are informed of the decision as soon as the face-to-face interview is completed and an eligibility determination is made. Should SCFHP Medical Management staff determine the member does not meet eligibility criteria for CBAS services, a denial letter is sent along with grievance and appeal rights. Should the member meet eligibility criteria for CBAS services, SCFHP Medical Management staff authorize the CBAS provider to perform a 3-day multidisciplinary team assessment. CBAS providers receive a prior authorization form with a designated authorization number for billing for assessment days.

Prior Authorization Requests for CBAS Level of Service

In order for CBAS services to be considered for 6-month intervals, CBAS providers must submit an Individual Care Plan (ICP) for all new members who complete a multidisciplinary team assessment, along with a prior authorization request form specifying the level of service recommended by the multidisciplinary team. Please fax all documents to **1-408-874-1975** or mail to:

Attn: LTSS Authorizations
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

SCFHP Medical Management staff informs CBAS providers within five (5) business days of the decision to approve, modify, or deny prior authorization requests.

1. If SCFHP cannot make a decision within five (5) business days, a 14 day delay letter is sent to the member and CBAS provider, during which time, SCFHP Medical Management staff may:
 - Send a **Request for Further Documentation form** to the requesting CBAS provider if additional supporting documentation is needed.
 - Refer the case to a Medical Director or the Chief Medical Officer for consultation and review.
 - Refer the case to case management for assessment and participation in recommendations.
2. If the prior authorization request is denied or modified, the member is sent a **Notice of Action letter**, along with grievance and appeal rights, within 48 hours of the decision. CBAS providers are notified of the decision within 24 hours.

CBAS Reassessment

In order for a member to continue receiving CBAS services, CBAS providers must submit a new prior authorization request form specifying the recommended level of service, along with an updated Individualized Care Plan. Reauthorization is an administrative process and may be accomplished without a face-to-face interview. If a change in level of service is indicated on the request for reauthorization of CBAS services, SCFHP Medical Management staff may conduct another face-to-face interview with the member to verify appropriateness of service.

Please fax all documents to **1-408-874-1975** or mail to:

Attn: LTSS Authorizations
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

Fax or mail **prior to the expiration of the previously authorized 6-month period.**

If a member no longer requires CBAS services, CBAS providers complete a **CBAS Discharge Plan of Care.**

Expedited Referrals

An expedited referral process is available to members who are in a hospital or nursing facility and whose discharge plan includes CBAS, or for members who are at immediate risk of admission to a nursing facility. Upon receipt of such referral, SCFHP Medical Management staff immediately schedule a face-to-face interview at the hospital or skilled nursing facility and complete the face-to-face interview within five (5) business days. Written documentation of medical necessity is obtained from the attending physician.

For more information, please refer to SCFHP's relevant policies on **www.scfhp.com**.

What is Multipurpose Senior Services Program (MSSP)?

MSSP provides social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community. The goal of the program is to arrange for and monitor the use of community services to prevent or delay premature institutional placement. The services must be provided at a cost lower than that for nursing facility care.

To be eligible, members must be:

- An active member of SCFHP Cal MediConnect
- 65 years of age or older
- Living within a site's catchment area
- Receiving Medi-Cal under an appropriate aid code
- Able to be served within MSSP's cost limitations
- Appropriate for care management services
- Certifiable for placement in a nursing facility

MSSP services include:

- Case management
- Personal care services
- Respite care (in-home and out-of-home)
- Environmental accessibility adaptations
- Housing assistance, minor home repair, etc.
- Transportation
- Chore services
- Personal emergency response system (PERS)/communication device
- Adult day care/support center
- Protective supervision
- Meal services - congregate/home-delivered
- Social reassurance/therapeutic counseling
- Money management
- Communication services: translation/interpretation

MSSP Referral Process

Please fax referrals to Sourcewise MSSP program at **1-408-289-1880**.

What is In-Home Supportive Services (IHSS)?

The IHSS program provides payment for non-medical in-home care for qualified individuals who are unable to remain safely in their homes without this assistance. Members must be evaluated by a social worker to be determined financially and functionally eligible. Eligible members must be:

- Citizen of the United States or a qualified alien, and a California resident.
- Over 65 years of age, or disabled, or blind (disabled children also eligible).
- One of the following:
 - Current recipient of Supplemental Security Income/State Supplementary Payment (SSI/SSP); or
 - Meet all the eligibility criteria for SSI/SSP except that your income is in excess of the SSI/SSP income levels; or
 - Meet all the eligibility criteria for SSI/SSP, including income, but do not receive SSI/SSP; or
 - Medi-Cal recipient who meets SSI/SSP disability criteria.
- Live in a residence, not an institution.
- Determined at risk for institutionalization based on initial IHSS screen.

The Public Authority Services by Sourcewise maintain responsibility for processing, approving/authorizing, and monitoring IHSS requests. Call **1-408-792-1600**.

Home Health Care Services

SCFHP covers medically necessary health care services in the member's permanent or temporary place of residence, when requested by the primary care/attending physician. Covered services include hospice care, home health care, and home infusion therapy.

Hospice

Hospice is specialized interdisciplinary health care designed to provide palliative care, services, equipment and supplies to alleviate the physical, emotional, social and spiritual discomforts of a terminal illness. This care is provided to members who are diagnosed with a terminal illness and are only expected to live six months or less. The member may elect to receive hospice care at home or in a Medi-Cal licensed facility. The facility and the hospice provider must have a contract with SCFHP and the care must be approved by SCFHP through the authorization process. The member may elect to revoke or discontinue hospice services at any time.

Home Health

Home health services include visits by registered nurses (RNs), licensed vocational nurses (LVNs), social workers, and home health aides and may include short-term intravenous infusion therapy, physical therapy, occupational therapy, speech therapy and respiratory therapy when prescribed by a licensed plan provider. The member must be confined to his/her home ("homebound") and need intermittent skilled nursing or related therapies. Prior authorization and

concurrent review are required for home health services. Written treatment plans are requested and reviewed to assist with case management of members. Durable medical equipment (DME) be covered under a separate authorization when requested by a physician and provided in accordance with the treatment plan.

Home Infusion Therapy

Medically necessary home infusion therapy is a covered benefit through SCFHP. Treatment must be prescribed by a physician and be provided in accordance with a written treatment plan. Medical and prescription prior authorizations are required. The home health agency providing the care teaches the member and the supporting care providers how to administer products and maintain the infusion site. When the member's conditions makes outpatient infusion therapy possible, the member's care may be transferred to a contracted outpatient infusion therapy center.

Major Organ Transplants (excluding Kidney and Corneas)

Under age 21

SCFHP provides coverage for medically necessary organ transplants for members under age 21, excluding experimental or investigational procedures. Such members are referred to the CCS Program for determination of admission to the CCS Program for services.

If the member is deemed eligible for CCS services, SCFHP assists with coordination of care with CCS for the covered condition, and with the PCP for other, non-CCS health care issues.

Medi-Cal: Ages 21+

Major organ transplant procedures are carved-out benefits for members of SCFHP and are covered as a Medi-Cal fee-for service (FFS) benefit. Transplant procedures include:

- Bone marrow transplants
- Heart transplants
- Heart/lung transplants
- Liver transplants
- Lung transplant
- Combined liver and kidney transplants
- Combined liver and small bowel transplant

Case Management of Transplant Patients

Please inform our Case Management Department as early as possible about any SCFHP member who is a potential candidate for major organ transplant (except kidney-only or cornea transplants). Our nurse case manager facilitates the disenrollment process from Managed Care Medi-Cal to the FFS Medi-Cal, under the State's Transplant Waiver Program.

If the transplant group does not have the appropriate Medical Exemption form, SCFHP will fax or mail a copy of the document to them, with the instructions for completion attached. The

completed document is to be mailed or faxed to the Health Care Options address located on the bottom of the Medical Exemption form, with a copy faxed to the SCFHP Case Manager (**1-408-874-1957**).

If the member is evaluated and determined not to be a candidate for a major organ transplant, the cost of the evaluation and responsibility for the continuing treatment of the member remains with SCFHP. The member and his/her PCP is informed of the Medi-Cal decision and assisted through the grievance and appeal process, if necessary.

Section 19 Pharmacy Benefits

SCFHP contracts with a Pharmacy Benefits Management (PBM) company to provide an extensive network of pharmacies throughout Santa Clara County. Our members may go to any contracted pharmacy to obtain their prescriptions. For a list of contracted pharmacies, please refer to the pharmacy directory available on our website, www.scfhp.com.

Please feel free to call, fax or email the SCFHP Pharmacy Services Department any time you have questions, comments, or suggestions about our pharmacy benefits:

By phone: **1-408-874-1796**
By fax: **1-408-874-1444**
By email: **pharmacy@scfhp.com**

Pharmacy & Therapeutics Committee

In conformance with DHCS requirements, the SCFHP Pharmacy and Therapeutics (P&T) Committee meets once per quarter to develop and maintain the Formulary Drug List to ensure that the formulary remains responsive to the needs of our members and providers. The committee is composed of physicians from various medical specialties and pharmacists, whose role is to evaluate clinical drug reviews concerning safety, effectiveness, costs, and decide on the most cost-effective drugs in each class.

Drug Formulary

The SCFHP drug formulary is a list of preferred generic and brand-name medications in various therapeutic classes that are covered under the SCFHP pharmacy benefit. The Drug Formulary exists to allow our providers and clinicians to determine the safest, most effective, and least costly drug therapy possible. The formulary is available on our website, www.scfhp.com.

The Drug Formulary is reviewed by the P&T Committee and updated based on comprehensive data on efficacy and safety that is available from evidence-based clinical studies, and for which evidence of performance in overall use in a variety of therapeutic settings has been established. The decisions are also based on the Department of Health Care Services (DHCS) contract requirement stating that the Formulary Drug List shall be comparable to the Medi-Cal Fee for Service list of contract drugs, except for drugs that are carved out through specific contract agreements.

Medications listed on the Drug Formulary may be subject to certain restrictions such as quantity limits, step therapy, age limit, or PA requirements. We also cover FDA-approved contraceptive drugs and devices, including emergency contraceptive drug therapy. Additionally, members may receive up to a 90-day maintenance supply of certain drugs specified in the Drug Formulary. (Note: injectable medications are not eligible for maintenance supply.)

Upon request, we cover up to a 60 day vacation supply of prescription medications. This is available once every 365 days for members who are traveling out of the SCFHP service area for a short period of time.

Certain over-the-counter (OTC) drugs are covered for Medi-Cal members unless otherwise specified; processing for OTC drugs should be handled in the same manner as that used for prescription drugs.

Formulary Exclusions

The following drugs are not covered under the Medi-Cal pharmacy benefits:

- Investigational drugs (these are not approved by the FDA)
- Infertility drugs
- Products for cosmetic indications
- Treatment of sexual dysfunction
- Agents “carved out” to the State’s regular FFS program (applies to Medi-Cal members only and includes medications that must be billed to the Medi-Cal Electronic Data System (EDS): i.e., HIV/AIDS-related antiretroviral drugs and antipsychotic drugs.)
- Most vitamin/dietary supplements other than prenatal vitamins for pregnant women and pediatric vitamins for children ages 0-6
- Any other stated as such in the EOC

Continuation of Drug Therapy

We allow new members to receive coverage for up to 30 days for drugs that are part of a provider-prescribed treatment regimen at the time of enrollment, regardless of whether the drug is on the formulary. Future coverage of the drug may require prior authorization.

Likewise, in the event of a change to our formulary, a current member may remain on a non-formulary drug or one that requires Step Therapy if the drug had been previously approved for an existing medical condition and the formulary alternatives would not be medically appropriate as determined through prior authorization.

Out-of-Pocket Payments

Medi-Cal

SCFHP’s Medi-Cal members are not required to pay out of pocket for medically necessary prescription drugs.

Drugs Requiring a Coverage Determination or Formulary Exception (Drug Prior Authorization)

A drug prior authorization (PA) is necessary for the following:

- Non-formulary drugs
- Compound prescriptions over \$50
- Formulary drugs for which the limitations and/or restrictions listed have not been met or are exceeded such as step therapy or quantity limit restrictions
- Any prescription over \$500 (Pharmacies may contact MedImpact at 1-800-788-2949 to request a high-dollar override)

- Rejected claims for which SCFHP plan limitations have been exceeded, including but not limited to those described below:
 - Excessive daily doses of acetaminophen
 - Excessive daily doses of narcotics

Procedures for Filing a Drug PA

Rather than waiting until contacted by a pharmacist, you may obtain prior authorization for a drug by:

- Downloading a Drug Prior Authorization Form directly from our website, www.scfhp.com. Complete the form to the best of your ability and fax it to SCFHP Pharmacy Department at **1-408-874-1444**.
- Calling SCFHP at **1-408-874-1796** and asking to initiate a prior authorization for an SCFHP Medi-Cal member.

You may submit a prior authorization request directly to SCFHP Pharmacy Department for review using the Drug Prior Authorization Form. Once a determination has been made, SCFHP faxes the pharmacy and physician with the decision as noted on the PA form. In the event of a negative decision, we also mail the appropriate Notice of Action to the member, with a copy to the prescribing provider.

For additional information on the Drug PA process, please see our drug formulary, available on our website, www.scfhp.com.

3-Day Emergency Supply Override

When the contracted pharmacy cannot fill a prescription promptly and the patient's clinical situation demands immediate treatment as determined by the physician or pharmacist, the pharmacy may utilize the Emergency Supply Override, which guarantees reimbursement for up to a 3-day supply of a medication.

To process an emergency supply, the pharmacy or physician may call the MedImpact Customer Service line at **1-800-788-2949** for an override.

Submitting a Pharmacy Claim

Pharmacies should bill MedImpact for all covered drugs. Claims may be sent electronically or by mail.

- **Electronic Claim Submission**

Electronic claims are sent to MedImpact for processing through a Point of Service environment in the National Council for Prescription Drug Programs (NCPDP) standardized format. The PBM issues payment to providers two times a month. Questions should be directed to the MedImpact Pharmacy Help Desk at **1-800-788-2949**.

- **Paper Claim Submission**

Pharmacies without electronic billing capabilities may submit paper claims:

By Mail: MedImpact
ATTN: Pharmacy Claims
10680 Treena Street, Stop 5
San Diego, CA 92131

Pharmacy Appeals

For detailed information about pharmacy appeals, see **Section 20 Grievances & Appeals**.

Section 20 Grievances & Appeals

SCFHP responds promptly to complaints from either a provider or a member. Two types of formal complaints may be submitted by or on behalf of member: a grievance and an appeal.

Grievance means any written or oral expression of dissatisfaction, regarding the plan and/or provider, including quality of care concerns and shall include a complaint, dispute, and request for reconsideration or appeal made by a member or the member's representative to the plan or to any entity with delegated authority to resolve grievances on behalf of the plan. A complaint is the same as a grievance. A grievance can be filed at any time regardless of the date of the occurrence or issue.

Appeal is a formal request for SCFHP to reconsider a determination (e.g., denial, deferral or modification of a decision about health care coverage) that a member believes he or she is entitled to receive as part of Medi-Cal. An appeal may also be filed to request reconsideration of a proposed resolution of a reported grievance.

Filing a Member Grievance

A member or his/her appointed representative may file a grievance at any time. Grievances and appeals may be submitted to SCFHP in one of the following ways:

- Submit an online form via SCFHP website: <https://www.scfhp.com/for-members/grievance-and-appeal-process>.
- Call Member Services at **1-800-260-2055**, or TTY **1-800-735-2929**.
- Fill out the Grievance and Appeal Form or submit a letter by mail:
Attn: Grievance and Appeals Department
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158
- By fax at **1-408-874-1962**

All member grievances regarding a specific provider are reported monthly to the Credentialing Department. The information is included in the physician's credentialing file and reviewed as part of the re-credentialing process.

Standard Grievances

Once a standard grievance is filed, the Grievance and Appeals Department mails an acknowledgement letter within 5 calendar days of receipt of the grievance. Grievances are investigated by identifying and requesting relevant information, including medical records necessary to make a determination.

SCFHP issues a resolution letter within 30 calendar days of receipt of the grievance.

Expedited Grievances

An expedited grievance may be requested in writing, by telephone, or through our website. SCFHP is required to respond by telephone within 24 hours of receipt of a request for an expedited grievance. We follow up with a letter within 72 hours thereafter.

Grievances Related to Quality of Care

Members have the right to file a complaint with SCFHP about quality of care. All such complaints are thoroughly investigated by identifying and requesting relevant information (e.g., medical records) necessary to evaluate the complaint. Our CMO/Medical Director and Quality Improvement Department review all issues related to quality of care. Screening criteria for identifying medically related grievances, as established by our CMO/Medical Director, include the following circumstances:

- Patient disagrees with the provider's treatment (e.g., medication prescribed, technique of examination).
- Patient disagrees with the provider's diagnosis.
- Patient reports that the provider failed or refused to refer him/her to a specialist or other appropriate health care provider.
- Lack of availability of the provider (during or after office hours) resulting in an adverse outcome.
- Provider did not provide covered and medically necessary service.
- Patient reports adverse results of treatment.
- Patient reports that the provider refused to provide treatment or services.
- Requested health care services were deferred, modified or denied.
- Patient reports concern regarding alleged inappropriate behavior on the part of the provider.

Members may submit a complaint about quality of care orally or in writing. Participating providers or members who have questions about the member grievance process should contact the Customer Service at **1(800) 260-2055**.

Filing an Appeal

A member, his/her appointed representative or a provider may file an appeal. Appeals should be submitted to SCFHP within 60 calendar days after receipt of a Notice of Action.

Appeals Review Process

If a member, member's representative or provider is dissatisfied with determination decision made by SCFHP, the member, member's representative or provider may initiate an appeal. The request for an appeal must be made within 60 calendar days of the date of the adverse Notice of Action.

Services or benefits that were previously authorized, but terminated through a Notice of Action will continue to through the appeal process if the request for continuation is filed

- Within 10 calendar days of the Notice of Action, or
- Before the date SCFHP intends to terminate services, explained through the Notice of Action

Standard Appeals

A provider, member or his/her appointed representative may file an appeal. Appeals may be submitted to SCFHP in one of the following ways:

- Submit an online form via SCFHP website: <https://www.scfhp.com/for-members/grievance-and-appeal-process/>.
- Call Customer Service at **1-800-260-2055**, or TTY **1-800-735-2929**.
- Fill out the Grievance and Appeal Form or submit a letter by mail:

Attn: Grievance and Appeals Department
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

- By fax at **1-408-874-1962**
- In person at Santa Clara Family Health Plan

Upon receipt of the appeal from the member, SCFHP may notify the PCP (or the appropriate provider) and will request relevant information and medical records to make a determination.

Within 5 calendar days of receipt of a request for appeal, our Grievance and Appeals Department sends an acknowledgment letter to the member or provider, as appropriate. Appeals are resolved within 30 calendar days. The member and the appropriate provider are notified in writing of the appeal resolution.

If SCFHP decides in favor of the member, we authorize, pay for or provide the requested service within 30 calendar days of receipt of the request for appeal. A written notice will be mailed to the member, member's representative and/or provider. Unfavorable determinations are submitted to the member, member's representative and/or provider in writing with further rights, including the right to request a State Fair Hearing. Medi-Cal members are also advised of their right to seek assistance from the Ombudsman Program.

Expedited Appeals

Expedited appeals are available in time-sensitive situations in which waiting for 30 days for SCFHP to process a standard appeal would seriously jeopardize the member's life, health, or ability to regain maximum function. Expedited appeals may be initiated:

- Submitting an online form via SCFHP website: <https://www.scfhp.com/for-members/grievance-and-appeal-process/>.
- Calling Customer Service at **1-800-260-2055**, or TTY **1-800-735-2929**.

- Filling out the Grievance and Appeal Form or submit a letter by mail:
 Attn: Grievance and Appeals Department
 Santa Clara Family Health Plan
 PO Box 18880
 San Jose, CA 95158
- By fax at **1-408-874-1962**
- In person at Santa Clara Family Health Plan

The appellant will be notified within 24 hours as to whether or not the appeal will be expedited. If the request for expedited appeal is granted, SCFHP makes a decision on the appeal within 72 hours. A request for payment for a service already provided to a member is not eligible to be reviewed as an expedited appeal. The member, member's representative and/or appropriate provider are notified in writing of the appeal resolution.

When a member requests an expedited appeal, our CMO/Medical Director evaluates the request and the person's medical condition to determine if the request meets the criteria.

SCFHP may extend the timeframe for resolution of an expedited appeal if the member requests the extension, or if SCFHP justifies a need for additional information before making a decision.

For decisions in the member's favor, the disputed service is authorized, paid for or provided as soon as possible, but no later than 3 calendar days after our receipt of request. A written notice will be mailed to the member, member's representative and/or provider. Unfavorable determinations are submitted to the member, member's representative and/or provider in writing with further rights, including the right to request a State Fair Hearing. This is sent within 3 calendar days. Medi-Cal members are also advised of their right to seek assistance from the Ombudsman Program.

Provider Responsibility

SCFHP does not delegate authority or responsibility to providers for processing member grievances and appeals; however, we do require that you help resolve member grievances and appeals by:

- When requesting an appeal on behalf of a member, gain the member's written consent before filing the appeal.
- Immediately forwarding all member grievances or appeals to SCFHP for processing.
- Responding within designated timeframes to SCFHP's request for information relevant to the member's grievance or appeal.
- Complying with all final determinations made by SCFHP about the grievance and/or appeal.
- Cooperating with SCFHP by promptly forwarding copies of all medical records and information pertinent to the disputed health care service, including any newly discovered relevant medical records or other information requested by our Medical Director or review committees.

- Maintain copies of the SCFHP grievance form in your office to provide to member's upon request. Grievance forms can be found at <https://www.scfhp.com/grievance-form>.

State Hearings

The Medi-Cal members have the right to request a State Hearing when an appeal is denied or when an initial authorization or appeal is not acted upon with reasonable promptness. A State Hearing may be requested by calling the State Department of Social Services toll free at 1-800-952-5253. TTY/TDD users may call 1-800-952-8349. A State Hearing is an administrative procedure at which you can present your concern directly to the State of California. If you decide to request a State Hearing, you may represent yourself at the hearing, or another person (such as an attorney, friend, relative, or any person you choose) may represent you.

Dispute Resolution

A disputed health care service refers to any service which, although eligible for coverage/payment under the Medi-Cal plan, has been denied, delayed, or modified based on a finding by SCFHP that the service was not medically necessary. Thus, a decision about disputed health care services relates to the practice of medicine and not to coverage decisions. Your rights and responsibilities relative to dispute resolution are described in detail in your contract.

Section 21 Quality Improvement (QI) Program

QI Program Goals

The goal of the QI program is to support, foster, and promote continuous quality improvement for the safety and satisfaction of care for all of our members and in organization-wide performance. Quality improvement activities are developed and maintained within the limits of the resources available to SCFHP and our participating providers.

Improvement processes are also developed to meet the requirements of state and federal agencies such as the California Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and standards, such as the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS), and the Quality Improvement System for Managed Care (QISMC). These goals are accomplished through the systematic monitoring and evaluation of the quality, safety appropriateness, outcomes, and satisfaction of the services provided to members and through the active pursuit of opportunities for improvement to the health care delivery system.

We strive to ensure that members:

- Have a choice of practitioners and providers.
- Are served with cultural sensitivity and linguistic competency.
- Receive necessary health education.
- Are assisted with and informed about using the health care system appropriately and effectively.

We also require that all services from our staff and providers be made available to all members, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability—and that such services are provided in a culturally and linguistically appropriate manner.

For more information about our QI Program, see SCFHP's relevant policies at www.scfhp.com.

Structure of the QI Program

The QI Program operates under the direction of the Manager of Quality Improvement who works in close collaboration with the CMO/Medical Director, sub-committees reporting to the Chief Medical Officer, and other SCFHP staff as indicated. The SCFHP Governing Board and the Chief Executive Officer support all QI activities.

QI Committees and Sub-Committees

SCFHP's QI Committee is charged with overseeing the development, implementation, and effectiveness of the QI Program. The Committee is accountable to the SCFHP Governing Board.

Several sub-committees also assist with various aspects of improving the quality of our services and those of our network providers, including:

- Credentialing Committee

- Compliance Committee
- Delegation Oversight Committee
- Grievance Review Committee
- Pharmacy & Therapeutics Committee
- Utilization Management Committee

In addition to the QI Committee and sub-committees, the Provider Advisory Committee and the Consumer Affairs Committee convene regularly to review and discuss QI activities.

Recommendations related to QI activities are discussed with the CMO, and/or the CEO as applicable for appropriate follow up on specific activities. These committees ultimately report to the Governing Board.

Sub-committees of the QI Committee are convened ad hoc at the request of SCFHP's CMO/Medical Director, CEO, COO, or the QI Committee Chair. The sub-committees review specifically identified areas for continuous quality improvement, e.g., emergency care, primary care, and public health.

Implementation and Coordination of the QI Program

Because quality is a critical company-wide goal, the resources and efforts of senior and other management staff— including the CEO, COO, Chief Medicare Officer, Chief Medical Officer/Medical Director—are essential for optimal implementation of the QI Program. The staff members who participate in the Quality Improvement Program include:

- Quality Management
- Utilization Management
- Pharmacy Management
- Provider Services
- Member Services
- Claims
- Grievance and Appeals
- Health Education
- Culture and Linguistic Services
- Information Services

Evaluation of the QI Program

To evaluate the effectiveness of our QI process, the QI Committee conducts an annual evaluation of all aspects of the program. The Committee reports its findings and recommendations for improvement to the Chief Medical Officer and CEO. The final report is sent to the Governing Board for ratification. A work plan is also developed each year and ratified by the Governing

Board, after which the QI Department sends quarterly reports to both the Committee and the Governing Board.

Finally, the QI Director, in collaboration with the Chief Medical Officer/Medical Director, prepares an annual report of the entire QI Program for approval by the QI Committee and ratification by the Governing Board. The annual report summarizes all QI activities and identifies areas where improvement in quality and outcomes have been measured and documented. If any deficiencies are noted, they are reported to the QI Committee and the Governing Board, with suggestions for specific actions to improve the process in the subsequent year.

State and federal legal regulations, as well as our own internal Confidentiality Policy, require that all records and proceedings of the QI Committee be kept confidential and protected from discovery. Thus, confidentiality of any information that identifies a practitioner, a provider, or a member is ensured.

Quality Improvement Program Design (QIP)

The QIP is designed to include operational planning, internal and external quality control in the provider network, and quality improvement activities. QI activities related to provider performance are conducted in compliance with state and federal regulations. This medical QI process addresses the following components:

- Aspects of care and service
- Delegated review
- Focus studies
- Development of an action plan
- Establishment of thresholds
- Internal QI Program
- Credentialing/re-credentialing or peer review of contracted provider performance
- Potential quality of care issues
- Quality indicators
- Risk management
- Review of providers sites and medical records

We are obligated by both federal and state regulations to review all participating PCP sites and medical records to verify that sites have the capacity to provide clinical services effectively and safely.

Our Chief Medical Officer/Medical Director is ultimately responsible for all site review activities, and we do not delegate to any other entities the task of conducting reviews of facilities or medical records.

For further details on site and record reviews, refer to SCFHP's QI policies available at www.scfhp.com.

Medical Records Standards for the Provider’s Office/Clinic

The medical record is an important source of patient data. It documents the health care provided to the patient by the providers. Therefore, it is important that the medical record be current, detailed and organized to promote effective continuity of patient care, promote efficient and effective treatment and facilitate quality review.

The following guidelines/standards for patient medical records are based on guidance from the Department of Health Care Services Facility Site and Medical Record Review Criteria and the National Committee for Quality Assurance (NCQA) Managed Care Organizations Standards for Medical Records.

1. All active medical records must be stored in a secured area that is accessible only to office staff who have direct patient care responsibilities.
2. Inactive records are stored for a minimum of 7 years and may be kept in a location off-site. Children’s records must be saved until the child reaches 21 plus the statute of limitations or 24 years of age.
3. All records must be protected from loss, tampering, destruction, alteration, and unauthorized or inadvertent disclosure of information.

Clinical information cannot be released without prior written approval of the patient or parent/guardian. Exceptions to written approval and signed release of medical records information may be made if regulatory criteria for disclosure of information without authorization are met.

1. Format Criteria
A. An individual medical record is established for each member. <ul style="list-style-type: none"> • “Family charts” are not acceptable.
B. Member’s Identification is on each page. <ul style="list-style-type: none"> • Identification includes first and last name and/or a unique member number.
C. Individual personal biographical information documented. <ul style="list-style-type: none"> • If member refuses, “Refusal” is noted in the medical record. • Includes date of birth, current address, home/work phone numbers, and name of parent(s) /legal guardian if member is a minor
D. Emergency Contact is identified. <ul style="list-style-type: none"> • If a patient refuses, “Refusal” is noted in the medical record. • If an adult member has no contact, “None” is documented. • If the member is a minor, the primary (first) emergency contact person must be a parent or legal guardian and then other persons may be listed as additional emergency contacts.
E. Medical records are consistently organized.
F. Chart contents are securely fastened.
G. Printed chart contents are securely fastened, attached or bound to prevent medical

record loss.
H. Electronic medical record information is readily available.
I. Member's assigned primary care physician (PCP) identified <ul style="list-style-type: none"> Assigned PCP is <i>always</i> identified.
J. Primary language and linguistic service needs of non- or limited-English proficient (LEP) or hearing-impaired persons are prominently noted. <ul style="list-style-type: none"> Member refusal of interpreter services documented Family or friends should not be used as interpreters, unless specifically requested by the member.
2. Documentation Criteria
A. Allergies are prominently noted. <ul style="list-style-type: none"> In a consistent location in the medical record If no known allergies or adverse reactions, "No Known Allergies" (NKA, NKDA), or Ø is documented.
B. Chronic problems and/or significant conditions are listed. <ul style="list-style-type: none"> Encouraged to be on a separate "problem list" page
C. Current continuous medications listed <ul style="list-style-type: none"> Encouraged to be on a separate "medication list" page and includes medication name, strength, dosage, route (if other than oral), and frequency Discontinued medications are noted on the medication list or in progress notes.
D. Signed <i>Informed Consents</i> are present when any invasive procedure is performed <ul style="list-style-type: none"> For medical treatment, operative, and invasive procedures, and for release of medical information Human sterilization requires DHCS Consent Form PM 330.
E. Advanced Health Care Directive information offered (Adults, 18 years/older Emancipated Minors) <ul style="list-style-type: none"> Document: Offered information and/or executed
F. Entries are made in accordance with acceptable legal medical documentation standards <ul style="list-style-type: none"> All entries are signed, dated, and legible. Signature includes the first initial, last name and title. Initials may be used only if signatures are specifically identified elsewhere in the medical record (e.g. signature page). Stamped signatures are acceptable, but must be authenticated, meaning the stamped signature can be verified, validated, confirmed, and is countersigned or initialed. Electronic signatures are documented and protected.

<p>G. Errors are corrected according to legal medical documentation standards.</p> <ul style="list-style-type: none"> • There are no unexplained cross-outs, erased entries or use of correction fluid. Both the original entry and corrected entry are clearly preserved. • The S.L.I.D. rule is one method used to correct documentation errors: Single Line, Initial, Date. (Omit the written word “error”). • Error corrections for EMR should include the log-in process and whether the EMR allows for corrections to be made after entries are made.
<p>3. Coordination/Continuity of Care Guidelines Criteria</p>
<p>A. History of present illness documented at each visit.</p>
<p>B. Working diagnoses are consistent with findings at each visit.</p>
<p>C. There is evidence of Health Plan and/or other agency Individual Care Plan for high risk members.</p>
<p>D. A plan of treatment, care and/or education related to the stated diagnosis is documented for each diagnosis.</p>
<p>E. Instructions for follow-up care documented</p>
<p>F. Return visits or other follow-up care is definitively stated in number of days, weeks, months, or PRN (as needed).</p>
<p>G. Unresolved and/or continuing problems addressed in subsequent visit(s)</p> <ul style="list-style-type: none"> • Until problems are resolved or a diagnosis is made. • Each problem need not be addressed at every visit.
<p>H. There is evidence of practitioner review of consult/referral reports and diagnostic test results.</p> <ul style="list-style-type: none"> • Consultation reports and diagnostic test results are documented for ordered requests. • Evidence of review may include the physician’s initials or signature on the report, notation in the progress notes, or other EMR- or site-specific method of documenting physician review. • Abnormal test results/diagnostic reports have explicit notation in the medical record. • Documentation includes member contact or contact attempts, follow-up treatment, instructions, return office visits, referrals, and/or other pertinent information.
<p>I. There is evidence of follow up of specialty referrals made and results/reports of diagnostic tests, when appropriate.</p> <ul style="list-style-type: none"> • Consultation reports and diagnostic test results documented for ordered requests • Abnormal test results have explicit notation in the medical records, including attempts to contact the member/guardian for follow-up treatment, etc.

<ul style="list-style-type: none"> • Missed or broken appointments for diagnostic procedures, lab tests specialty appointments and/or other referrals are noted and include attempts to contact the member/parent and results to follow up actions.
<p>J. Missed primary care appointments and outreach efforts/follow-up contacts are documented.</p> <ul style="list-style-type: none"> • Documentation includes incidents of missed/broken appointments (cancellations or “No Shows” with the PCP office). Attempts to contact the member and/or parent/guardian (if minor) and the results of follow-up actions are also documented.

Preventive Health Guidelines

The following section outlines SCFHP’s Preventive Health Guidelines for pediatric, adult and perinatal patients. These guidelines are adopted from the American Academy of Pediatrics (AAP), the United States Preventive Services Task Force (USPSTF) and the American College of Obstetricians and Gynecologists (ACOG).

<p>1. Pediatric Preventive Guidelines Criteria 0-21</p>
<p>A. Childhood Immunizations</p> <ul style="list-style-type: none"> • Immunization status is assessed at each health assessment visit. Practitioners are required to ensure the provision of immunizations according to CDC’s most recent Advisory Committee on Immunization Practices (ACIP) guidelines, unless medically contraindicated or refused by the parent. • The name, manufacturer, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries.
<p>B. Blood Lead Screening</p> <ul style="list-style-type: none"> • Blood lead level (BLL) testing done at 12 months and 24 months of age • Children with elevated BLLs are referred to the local Childhood Lead Poisoning Prevention Branch – 408-992-4900. • Children with confirmed BLL’s >20µg/dl must be referred to CCS.
<p>C. Dental Assessment</p> <ul style="list-style-type: none"> • Inspection of the mouth, teeth, and gums are performed at every health assessment visit. • A child is referred to a dentist at any age if a problem is detected or suspected. • Beginning at age 3 years, all children are referred annually to a dentist.
<p>D. Dental Caries Prevention</p> <ul style="list-style-type: none"> • For infants and children up to age 5 years: <ul style="list-style-type: none"> ○ Application of fluoride varnish to the primary teeth of all infants and

children starting at the age of primary tooth eruption in primary care practices

- Primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.

E. Depression Screening

- Screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years.
- Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up.

F. Gonorrhea Prophylactic Medication

- Prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.

G. Hearing Screening

- Non-audiometric screening for infants/children (2 months - 3 years) includes family and medical history, physical exam, and age-appropriate screening.
- Audiometric screening for children and young adults (3-21 years) is done at each health assessment visit.
- A failed audiometric screening is followed up with a repeat screening at least two weeks and no later than 6 weeks after the initial screening. If the second screening also fails, there is a referral to a specialist.

H. Hemoglobinopathies Screening

- Screening for sickle cell disease in newborns.

I. Hepatitis B Screening

- Screening for hepatitis B virus infection in persons at high risk for infection.

J. HIV Screening

- Screening for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.

K. Hypothyroidism

- Screening for congenital hypothyroidism in newborns.

L. Nutrition Assessment

- Screening includes 1) height and weight, 2) hematocrit or hemoglobin to screen for anemia starting at 9-12 months, and 3) breastfeeding and infant feeding status, food/nutrient intake and eating habits (including evaluation of problems/conditions/needs of the breastfeeding mother).
- At-risk children under 5 years of age referred to the Women, Infants and Children (WIC) Supplemental Nutrition Program

M. Obesity Screening

- Screening for obesity in children and adolescents 6 years and older and offer

or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.

N. Phenylketonuria Screening

- Screening for phenylketonuria in newborns.

O. Sexually Transmitted Infections Counseling

- Intensive behavioral counseling for all sexually active adolescents and adults who are at increased risk for sexually transmitted infections.

P. Skin Cancer Behavioral Counseling

- Counseling children, adolescents and young adults ages 10 to 24 years who have fair skin, about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.

Q. Tobacco Use Interventions

- Interventions including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

R. Tuberculosis Screening

- All children screened for risk of exposure to tuberculosis (TB) at each health assessment visit.
- The Mantoux skin test, or other approved TB infection screening test, is administered to children identified at risk, if there has not been a test in the previous year. The Mantoux is not given if a previously positive Mantoux is documented.
- For all positive skin tests, there is documentation of follow-up care.

S. Vision Screening

- Vision screening at least once in all children 3 to 5 years to detect amblyopia or its risk factors.

2. Adult Preventive Guidelines Criteria (18 yrs and older)

A. Abdominal Aortic Aneurysm

- One-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.

B. Adult Immunizations

- Immunization status is assessed at periodic health evaluations. Practitioners are required to ensure the provision of immunizations according to CDC's most recent Advisory Committee on Immunization Practices (ACIP) guidelines, unless medically contraindicated or refused by the member.
- Name, manufacturer, and lot number of each vaccine given is recorded in the medical/electronic record or on medication logs, including immunization registries.
- The date Vaccine Information Statement (VIS) given (or presented and offered) and the VIS publication date are documented in the medical record.

C. Alcohol Misuse Screening and Treatment

- Adults 18 years or older screened for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

D. Aspirin Preventive Medication

- Initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years with a >10% 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy or at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.

E. Blood Pressure (BP) Screening

- BP measurement documented in adults aged 18 years or older, including those without known hypertension, at least once every 2 years if BP <120/80, annually if BP 120-139/80-89
- Obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.

F. BRCA Risk Assessment and Genetic Counseling/Testing

- Screening women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of the several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2).
- Women with positive results should receive genetic counseling and, if indicated after counseling BRCA testing.

G. Breast Cancer Preventive Medications

- Engaging in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk
- For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.

H. Breast Cancer Screening

- A routine screening mammography with or without clinical breast examination completed every 1 to 2 years for women age 40 years and older.

I. Cervical Cancer Screening

- Cervical cancer screening in women ages 21 to 65 years with cytology (Pap Smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.

J. Chlamydia Screening

- Screening for chlamydia in sexually active women age 24 years or younger

- Screening for women older than 25 years of age if the practitioner determines that the patient is at increased risk for infection.

K. Colorectal Cancer Screening

- All adults are screened from age 50-75 years to include:
 - Annual screening with high-sensitivity fecal occult testing **OR**
 - Sigmoidoscopy every 5 years with high sensitive fecal occult blood testing every 3 years **OR**
 - Screening colonoscopy every 10 years.

L. Depression Screening

- Screening for depression in the general adult population, including pregnant and postpartum women.
- Implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

M. Diabetes Screening

- Screening for abnormal blood glucose as part of cardiovascular risk assessments in adults aged 40 to 70 years who are overweight or obese.
- Offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.

N. Falls Prevention in Older Adults

- For community-dwelling adults age 65 years and older who are at increased risk for falls:
 - Exercise or physical therapy
 - Vitamin D supplementation

O. Folic Acid Supplementation

- All women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg of folic acid.

P. Gonorrhea Screening

- Screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.

Q. Healthy Diet and Physical Activity Counseling to Prevent Cardiovascular Disease

- Offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.

R. Hepatitis B Screening

- Screening for hepatitis B virus infection in non-pregnant adolescents and adults in persons at high risk for infection.

S. Hepatitis C Screening

- Screening for hepatitis C virus (HCV) infection in persons at high risk for

<p>infection.</p> <ul style="list-style-type: none"> • One-time screening for HCV infection to adults born between 1945 and 1965
<p>T. HIV Screening</p> <ul style="list-style-type: none"> • Screening for HIV infection in adolescents and adults ages 15 to 65 years. • Screening for younger adolescents and older adults who are at increased risk for infection.
<p>U. Intimate Partner Violence Screening</p> <ul style="list-style-type: none"> • For women who do not have signs or symptoms of abuse: <ul style="list-style-type: none"> ○ Screening for women of childbearing age for intimate partner violence, such as domestic violence. ○ Provider or refer women who screen positive to intervention services
<p>V. Lung Cancer Screening</p> <ul style="list-style-type: none"> • Annual screening for lung cancer with low-dose tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. • Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
<p>W. Obesity Screening and Counseling</p> <ul style="list-style-type: none"> • Screening for all adults for obesity • Clinicians should offer or refer patients with a body mass index of 30 kg/m² or higher to intensive, multicomponent behavioral interventions.
<p>X. Osteoporosis Screening</p> <ul style="list-style-type: none"> • Screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 54-year-old white woman who has no additional risk factors.
<p>Y. Sexually Transmitted Infections Counseling</p> <ul style="list-style-type: none"> • Intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections. <p>Z. Skin Cancer Behavioral Counseling</p> <ul style="list-style-type: none"> • Counseling children, adolescents and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer. <p>AA. Statin Preventive Medication</p> <ul style="list-style-type: none"> • Adults with no history of cardiovascular disease (CVD) (i.e. symptomatic coronary artery disease or ischemic stroke) use a low-to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: <ol style="list-style-type: none"> i. Ages 40 to 75 years

- ii. Have 1 or more CVD risk factors
- iii. Have a calculated 10-year risk of a cardiovascular event of 10% or greater
- Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.
-
- BB. Tobacco Use Counseling and Interventions
 - Ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to adults who use tobacco.
- CC. Syphilis Screening
 - Screening for syphilis infection in persons who are at increased risk for infection.

- DD. Tuberculosis Screening
 - Screening for latent tuberculosis infection in populations at increased risk.

3. Perinatal Preventive Guidelines Criteria

- A. AFP/Genetic Screening offered (*Member participation is voluntary*)
 - The offering of blood screening tests prior to 20 weeks gestation counting from the first day of the last normal menstrual period documented
 - Testing only through CDPH designated labs through CDPH Expanded AFP Program
 - Genetic Screening documentation includes:
 - Family history
 - Triple marker screening tests
 - Member’s consent or refusal to participate
- B. Bacteriuria Screening
 - Screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks’ gestation or at the first prenatal visit, if later.

- C. Breastfeeding Interventions
 - Interventions during pregnancy and after birth to support breastfeeding.
- D. Depression Screening
 - Screening for depression in pregnant and postpartum women.
 - Implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
- E. Family Planning Evaluation
 - Family Planning counseling, referral, or provision of services documented

<p>F. Folic Acid Supplementation</p> <ul style="list-style-type: none"> All women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg of folic acid.
<p>G. Gestational Diabetes Mellitus Screening</p> <ul style="list-style-type: none"> Screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.
<p>H. Hepatitis B Screening</p> <ul style="list-style-type: none"> Screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
<p>I. HIV Screening</p> <ul style="list-style-type: none"> Screening all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.
<p>J. HIV-related services offered (<i>Member participation is voluntary</i>)</p> <ul style="list-style-type: none"> The offering of prenatal HIV information, counseling, and HIV antibody testing documented unless a positive HIV test already documented or AIDS diagnosed by a physician Providers are not required to document that the HIV test was given or disclose (except to the member) the results (positive or negative) of an HIV test. If documented, must be in accordance with confidentiality and informed consent regulations.
<p>K. Referral to WIC and assessment of Infant Feeding status</p> <ul style="list-style-type: none"> All plan members referred to WIC and documented in the medical record. Infant feeding plans are documented during the prenatal period, and infant feeding/breastfeeding status is documented during the postpartum period.
<p>L. Intimate Partner Violence Screening</p> <ul style="list-style-type: none"> For women who do not have signs or symptoms of abuse: <ul style="list-style-type: none"> Screening for women of childbearing age for intimate partner violence, such as domestic violence. Provide or refer women who screen positive to intervention services.
<p>M. Preeclampsia Prevention</p> <ul style="list-style-type: none"> Use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.
<p>N. Preeclampsia Screening</p> <ul style="list-style-type: none"> Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.
<p>O. Postpartum Comprehensive Assessment</p> <ul style="list-style-type: none"> Postpartum reassessment includes: <ul style="list-style-type: none"> Medical exams

<ul style="list-style-type: none"> ▪ Nutrition (mother and infant) ▪ Psychosocial ▪ Health education within 4-8 weeks postpartum <ul style="list-style-type: none"> • Document missed appointments; attempts to contact patient and/or outreach activities
<p>P. Rh Incompatibility Screening</p> <ul style="list-style-type: none"> • Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care. • Repeated Rh (D) antibody testing for all unsensitized Rh(d)-negative women at 24 to 28 weeks' gestation unless the biological father is known to be Rh (D)-negative. <p>Q. Syphilis Screening</p> <ul style="list-style-type: none"> • Screening all pregnant women for syphilis infection.
<p>R. Tobacco Use Counseling</p> <ul style="list-style-type: none"> • Asking all pregnant women about tobacco use. • Advising them to stop using tobacco • Providing behavioral interventions for cessation to pregnant women who use tobacco.

Health Assessments

Health assessments are a core requirement of the Medi-Cal program. This includes an Initial Health Assessment, Staying Healthy Assessments and Periodic Assessments. The following information outlines the expectations regarding completion of the assessments for Pediatric, Adult and Perinatal members. Primary Care Providers, Perinatal Care Providers and Non-Physician, Mid-Level Practitioners can provide these assessments. Completion of the assessments are to be contained in the member's primary medical record and completed in an accurate and comprehensive manner. Initial Health Assessments are to be completed within 120 calendar days of enrollment.

1. Pediatric Health Assessments

A. Initial Health Assessment (IHA) includes H&P

- Completed within 120 days of the effective date of enrollment into the Plan, or documented within the 12 months prior to Plan enrollment. H&P is sufficiently comprehensive to assess and diagnose acute and chronic conditions, which may include: history of present illness, past medical and social history, and review of organ systems.
- If IHA is not present, the member refusal, missed appointments and contact attempts to reschedule are documented in the medical record

B. Staying Healthy Assessment (SHA) (Initial and Subsequent)

- If the member refuses to complete SHA, the refusal is documented on the SHA form.
- An age-appropriate SHA is re-administered when the member has reached the next specific age interval designated by MMCD. Documentation requirements are the same as the initial SHA.
- Age-appropriate physical exams according to most recent AAP schedule. Assessments and identified problems recorded on the PM160 form are documented in the progress notes. AAP scheduled assessment must include all components required by the Child Health and Disability Program (CHDP) for the lower age nearest to the current age of the child including:
 - Height and weight are documented at each well child exam, including head circumference for infants up to 24 months.
 - BMI percentile is plotted on an appropriate CDC growth chart for each well exam ages 2-20 years.
 - Developmental surveillance at each visit and screening for developmental disorders at the 9th, 18th and 30th month visits. Children identified with potential delays require further assessment and/or referral.
 - Anticipatory guidance includes age appropriate counseling/health education provided to parent or pediatric member.
 - Tobacco and Drug/Alcohol Habit assessment
 - Evidence of referrals to the Early Start programs
 - Evidence of communication and acknowledgement of HP and SARC on Early Start referrals/follow-up
 - STI screening on all sexually active adolescents including chlamydia for females

2. Adult Health Assessments

A. Initial Health Assessment (IHA) and Staying Healthy Assessment (SHA)

- New members: The IHA consists of an H&P and a SHA completed within 120 days of the effective date of enrollment into the Plan, or documented within the 12 months prior to Plan enrollment.
- The H&P is sufficiently comprehensive to assess and diagnose acute and chronic conditions, which may include: history of present illness, past medical and social history, and review of organ systems.
- If an H&P and/or initial SHA is not present, member's refusal, missed appointments or other reason must be documented.

B. Subsequent Staying Healthy Assessment (SHA)

- An age-appropriate SHA is re-administered when the member has reached the next specific age interval designated by MMCD. Documentation requirements are the same as the initial SHA.

C. Periodic Health Evaluation

- In accordance with current USPSTF Adult Preventive Health recommendations
- Additional periodic health evaluations are scheduled as indicated by the member's needs and according to the clinical judgment of the practitioner.

3. Perinatal Health Assessments

A. Initial Comprehensive Assessment (ICA)

- The ICA, completed within 4 weeks of entry to prenatal care, includes the following obstetric/medical assessments:
 - Health and obstetrical history (past/current)
 - Physical exam: includes breast and pelvic exam
 - Lab Tests: hemoglobin/hematocrit, urinalysis, urine culture, ABO blood group, Rh type, rubella antibody titer, STI screen
 - Nutrition Counseling Anthropometric (height/weight), dietary evaluation, prenatal vitamin/mineral supplementation
 - Psychosocial: Social and mental health history (past/current), substance use/abuse, support systems/resources
 - Health Education: Language and education needs
 - Screening for Hepatitis B Virus during their first trimester or prenatal visit, whichever comes first.
 - Screening for Chlamydial Infection: All pregnant women ages 25 and younger and older pregnant women who are at increased risk are screen for Chlamydia during their first prenatal visit

B. Second Trimester Comprehensive Re-Assessments

- Obstetric/Medical, Nutrition, Psychosocial and Health Education assessments are completed during the 2nd trimester.
- Conduct screening for asymptomatic bacteriuria with urine culture at 12 to 16 weeks' gestation or at the first prenatal visit, if later.

C. Third Trimester Comprehensive Re-assessment

- Obstetric/Medical, Nutritional, Psychosocial and Health education reassessments are completed during the 3rd trimester.
- Screening for Strep B between 35th and 37th week of pregnancy

D. Prenatal care visit periodicity according to most recent ACOG standards

- For a 40-week uncomplicated pregnancy: Document missed appointments, attempts to contact patient, and/or outreach activities

E. Individualized Care Plan (ICP)

- ICP documentation includes specific obstetric, nutrition, psychosocial and health education, risk problems/conditions, interventions, and referrals.

Alcohol Misuse Screening and Counseling (AMSC)

As part of the comprehensive preventive care program, effective with dates of service on or after January 1, 2014, SCFHP reimburses PCPs for annual alcohol misuse screening of adults over 18 years of age and provides persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or provide appropriate referrals to mental health and/or alcohol use disorder services, as medically necessary.

- The requirements for AMSC are outlined in **DHCS MMCD All Plan Letter 17-016**. Members who meet criteria for an alcohol use disorder must receive referrals to treatment by either the County or a DHCS-certified treatment program.

The DHCS AMSC website has background information and multiple resources such as training, screening tools, and other helpful links pertaining to AMSC

Section 22 Provider Preventable Condition

The Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS) require providers to report provider-preventable conditions (PPCs). Federal law prohibits Santa Clara Family Health Plan (SCFHP) from paying for the treatment of PPCs, and payment adjustments may be applied to involved claims. Furthermore, SCFHP must review all claim and encounter data to identify submitted PPCs and report them to the Audits and Investigation Division of DHCS.

There are two categories of PPCs: other provider preventable conditions (OPPCs) occurring in all health care settings and health care acquired conditions (HCACs) in inpatient acute care hospital settings only.

For any SCFHP member, providers must report the occurrence of PPCs that did not exist prior to the provider initiating treatment. Additional DHCS reporting information can be found here: http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx.

All contracted providers are required to report directly to SCFHP the occurrence of OPPCs and HCACs for any SCFHP member. Providers must complete **DHCS form 7107, PPC Reporting Form** and send it to SCFHP, Attn: Quality Improvement Manager via secure fax at **1-408-874-1461**. The form must be completed within 5 days of discovering the event and confirming the patient is a Medi-Cal beneficiary through SCFHP. The form is to be completed only for a PPC that occurred during the course of treatment, not for those PPCs that were already present when treatment began. The PPC form includes detailed instructions and is located at: http://files.medi-cal.ca.gov/pubsdoco/Forms/dhcs_7107.pdf.

All claims/encounters submitted to SCFHP for treatment of PPCs should also be identified on the claim/encounter form or file. Submitting PPCs on a claim or encounter form or file does not waive the requirement to submit **PPC Reporting Form 7107** to SCFHP. HCACs must utilize diagnosis codes and in some cases, procedure codes, to indicate any corresponding complication (CC) or major complication or co-morbidity (MCC) related to the PPC.

For OPPCs, one of the following modifiers is required:

PA: Surgery wrong body part

PB: Surgery wrong patient

PC: Wrong surgery on patient

Please refer any questions on this mandated reporting to SCFHP Provider Services Department at **1-408-874-1788**.

Section 23 Facility Site Review

SCFHP conducts facility site reviews (FSRs) for new PCPs at the time of initial credentialing, and every three years thereafter as part of the re-credentialing process, regardless of the status of other accreditation and/or certifications. There are three components to the FSR process:

- The site review survey
- The medical record review survey
- The physical accessibility review survey

The site review survey and medical record review survey are scored reviews. The site review survey reviews the physical aspects of the site for basic requirements in areas such as: safety, regulatory compliance, and infection control. The medical record review survey is conducted three to six months after initial member linkage and as part of re-credentialing along with the site review survey, and focuses entirely on medical record review. The physical accessibility review survey is not a scored review, and focuses entirely on physical accessibility of the healthcare site for seniors and persons with disabilities (SPDs). This review is not scored and is used for informational purpose only.

For more information on facility site reviews, please see SCFHP's site review policies available at www.scfhp.com.

Section 24 Credentialing and Re-credentialing

Participation Requirements

Provider must complete, sign, and return a credentialing application along with a copy of their Tax Payer Identification Form (W-9) and current copies of all the information below, as applicable:

- Copy of current medical license or business license
- Copy of current DEA license
- Copy of professional liability insurance (malpractice) face sheet (required limits are \$1,000,000 per occurrence/\$3,000,000 annual aggregate)
- Copy of Property Comprehensive General Liability Insurance (Premises) face sheet (required limits are \$100,000 per occurrence/\$300,000 annual aggregate)
- Completed and signed attestation questionnaire
- Signed Release of Information/Acknowledgments Form
- Curriculum Vitae
- Copy of current Clinical Laboratory Improvement Amendments (CLIA) or Waiver (if applicable)
- Copy of current Child Health and Disability Prevention (CHDP) Certificate (if applicable)
- Copy of current Comprehensive Perinatal Services Program (CPSP) Certificate (if applicable)
- Copy of Educational Council of Foreign Medical Graduates (ECFMG) Certificate (if applicable)
- Copy of current board certification from the American Board of Medical Specialties or American Board of Podiatric Surgery (if applicable)

Once SCFHP receives the required information, the credentialing process proceeds as follows:

1. The plan verifies the information provided (National Provider Identifier, license status, etc.).
2. The application and supporting documentation are reviewed by SCFHP's Credentialing Verification Organization (CVO), Contracting and Credentialing Analyst, Contracting and Credentialing Manager, Chief Medical Officer, Medical Director and Credentialing Committee.
3. Upon approval of the above-mentioned parties, the Contracting Department generates a contract. The contract and welcome letter are sent to the provider within sixty days of the committee's decision.
4. The contract effective date shall be the first of the month following countersignature by SCFHP's Chief Executive Officer, if signed between the 1st and the 20th of the month. If the contract is signed after the 20th then the effective date shall be the first of the next month.

5. A copy of the completed contract is then returned to the provider. A new provider orientation and training must be scheduled within 10 days of the effective date of the contract.
6. Primary care providers must also have a facility site review, conducted by a certified SCFHP Quality Improvement Nurse, before the credentialing process is finalized.
7. Provider is re-credentialed every three years, based on the date of the initial Credentialing Committee approval date.

Contractual Requirements for Credentialing and Regulatory Compliance

By signing your contract you agree that you, and any providers working for you, are and will continue to be properly licensed by the State of California. Additionally, you represent that you are qualified and in good standing in terms of all applicable legal, professional, and regulatory standards. Providers who are excluded from participation in Medi-Cal or Medicare programs by the U.S. Department of Health and Human Services may not contract with SCFHP to provide any services.

If you fail to meet the credentialing standards or, if your license, certification, or privileges are revoked, suspended, expired, or not renewed, SCFHP must ensure that you do not provide any services to our enrollees. Any conduct that could adversely affect the health or welfare of an enrollee will result in written notification that you are not to provide services to our enrollees until the matter is resolved to our satisfaction.

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion

Your contract references this certification in Section 7 of the Agreement. SCFHP qualifies as a contractor receiving funding from the federal government. Any such contractor is required to represent to the government that they and their subcontractors have not been debarred, suspended, or made ineligible. By completing and signing the attestation questionnaire and the Release of Information/Acknowledgements Form of the California Participating Physician Application, you certify that you are eligible to participate in our program and receive funds provided by the government. This form must be signed and returned with your agreement. Pursuant to this certification and your agreement with SCFHP, should you or any provider with whom you hold a sub-contract become suspended or ineligible, you shall notify SCFHP immediately.

General Rights and Responsibilities

Providers must:

- Render medically necessary services in accordance with the provider's scope of practice, the SCFHP contract, the applicable benefit plan, SCFHP's policies and procedures, and other requirements set forth in the Provider Manual. Provider shall also openly discuss treatment options, risks and benefits with enrollees without regard to coverage issues.
- Participate in all programs in which the provider is qualified and has been requested to participate.

- Not unfairly differentiate or discriminate in the treatment of enrollees or in the quality of services delivered to enrollees on the basis of membership in SCFHP, age, national origin, sex, sexual preference, race, color, creed, marital status, religion, health status, source of payment, economic status, or disability.
- Cooperate with SCFHP's enrollee grievance and appeals procedures. Provider will provide grievance, dispute, and appeal information as required by the Centers for Medicare and Medicaid Services, the California Department of Health Care Services and other appropriate regulatory agencies.
- Maintain standards for documentation of medical records and confidentiality for medical records. Medical information shall be provided to SCFHP, as appropriate, and without violation of pertinent state and federal laws regarding the confidentiality of medical records. Such information shall be provided without cost to SCFHP.
- Actively participate in and comply with all aspects of SCFHP's quality improvement programs and protocols.
- Understand and acknowledge that various governmental agencies with appropriate jurisdictions have the right to monitor, audit, and inspect reports, quality, appropriateness and timeliness of services provided under your contract with SCFHP.
- Comply fully and abide by all rules, policies, and procedures that SCFHP has established regarding credentialing of network providers.
- Remain responsible for ensuring that services provided to enrollees by provider and its personnel comply with all applicable federal, state and local laws, rules and regulations, including requirements for continuation of medical care and treatment of enrollees after any termination or other expiration of provider's SCFHP agreement. Nothing contained herein shall be construed to place any limitations upon the responsibilities of the provider and its personnel under applicable laws with respect to the medical care and treatment of patients or as modifying the traditional physician/patient relationship.
- Not advise or counsel any subscriber group or enrollee to disenroll from SCFHP and will not directly or indirectly solicit any enrollee to enroll in any other health plan, PPO, or other health care or insurance plan.
- Permit representatives of SCFHP, including utilization review, quality improvement, and provider services staff, upon reasonable notice, to inspect provider's premises and equipment during regular working hours.
- Immediately notify SCFHP of any malpractice claims involving any current or former enrollees to whom provider is a party as well as provide information specifying settlement of adjudication within fourteen (14) calendar days of the provider being notified of such action.
- Comply with all applicable local, state, and federal laws governing the provision of medical services to enrollees.
- Uphold all applicable enrollee rights and responsibilities as outlined in the Evidence of Coverage and the Provider Manual.

- Provide for timely transfer of enrollee clinical records if an enrollee selects a new primary care physician, or if the provider's participation in the SCFHP network terminates.
- Respond to surveys to assess provider satisfaction with SCFHP and identify opportunities for improvement.
- Participate on a Quality Improvement Committee, or act as a consultant in peer review processes, as requested.
- Notify SCFHP in advance of any change in office address, telephone number, or office hours.
- Notify SCFHP at least ninety (90) calendar days in advance, in writing, of any decision to terminate their relationship with SCFHP or with the participating provider group. SCFHP will assist in notifying affected enrollees of termination and will assist in arranging coordination of care needs.
- Retain all medical records for a minimum of ten (10) years from the last contracting period or last audit, whichever is latest.
- Maintain appointment availability in accordance with SCFHP standards.
- Agrees that in no event including, but not limited to, nonpayment by SCFHP, insolvency of SCFHP, or breach of provider's agreement, shall provider or its personnel bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from or have recourse against a enrollee or persons (other than SCFHP) acting on the enrollee's behalf. This provision shall not prohibit provider from collecting from enrollees for co-payments, or coinsurance or fees for non-covered services delivered on a fee-for-service basis to enrollees, provided that enrollee has agreed prospectively in writing to assume financial responsibility for the non-covered services.

General Considerations

Provider selection is based on the availability of providers meeting minimum criteria for credentialing, geographic standards for accessibility, compliance with the Americans with Disability Act, and availability of culturally and linguistically competent staff to meet the needs of the enrollee population. In the event that a participating physician is not available with the skills required to meet an enrollee's needs, the plan authorizes a non-participating provider at no additional out of pocket expense to the enrollee.

Section 25 Provider Directory Requirements

Santa Clara Family Health Plan (SCFHP) is required to provide accurate information to its members and prospective members regarding its contracted providers, hospitals, ancillary services and pharmacies. As a contracted provider, it is your responsibility to ensure SCFHP has accurate directory information for you and your office. SCFHP collects this information through the credentialing process and verifies this information every three years during the re-credentialing process. In addition, SCFHP asks all contracted providers to attest to the accuracy of their reported provider directory information in accordance with the frequency and time frames defined in Health and Safety Code section 1367.27.

To update your provider directory information you may:

- Contact SCFHP's Call Center at **1-408-874-1788**
- Fax an updated Provider Change Notification form, located at **www.scfhp.com**, to **1-408-376-3537**
- Email an updated Provider Change Notification form to **providerservices@scfhp.com**

Upon receipt of this information SCFHP verifies the information for accuracy and updates its provider database in a timely manner. This ensures that both the printed directory and the online provider search function located at www.scfhp.com are as accurate as possible.

If a member or a prospective member contacts you due to a potential directory inaccuracy, you may re-direct that member or potential member to SCFHP Member Services for assistance at **1-800-260-2055**.

Members, potential members, other providers, and the public may also report provider directory inaccuracies by completing the directory update form located on our website at **www.scfhp.com**.

In addition to contacting SCFHP, you may also direct the member or a prospective member to the California Department of Managed Health Care at **1-888-466-2219** to report any inaccuracy with SCFHP's directories.

Section 26 Provider Training, Education, and Resources

Providers are required to participate in Santa Clara Family Health Plan (SCFHP)'s provider education and training efforts.

The following training courses are offered on SCFHP's website.

- Long-Term Supportive Services (LTSS)
- Stay Healthy Assessment (SHA)
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Cultural Competency which includes:
 - Communication across Language Barriers
 - Communication with Seniors and with People with Disabilities
 - Increasing Awareness of Cultural Diversity

We also offer a variety of services to help providers effectively coordinate and manage each member's care, including the following:

- **Continuing Medical Education (CME) courses:** SCFHP notifies providers of accredited continuing medical education classes applicable to our population, including CME courses in cultural and linguistic competency.
- **Interpreter services:** We contract with an interpreter services company to provide telephone interpreting services at no charge to providers or members. We also help to arrange on-site, face-to-face interpreter services.
- **Orientation field calls for new providers:** Our Provider Services staff conducts orientation and training with all newly contracted providers. In addition, providers may request orientation field calls for newly hired staff.
- **Telephone network support services:** You may call us at **1-408-874-1788**—a dedicated provider telephone line—for assistance with policies, procedures, clarification of covered benefits, obtaining information regarding submissions of disputes and other inquiries concerning provider disputes, or to schedule a training session at your office. If our staff is not able to address a specific issue, we will forward your call to the correct staff member, or we will research your question and call you back.
- **Training for PCPs and specialists:** The Provider Services Department schedules visits to your office to integrate plan policies and procedures, assist with any problems or concerns you or your staff have, and listen to feedback about your satisfaction with participation in SCFHP health plans.

Information available on SCFHP website: The policies, procedures, forms and documents referenced in this handbook can be found at www.scfhp.com/for-providers. This page is the hub of information for providers, including the latest memos, regulatory updates, and training opportunities.



Santa Clara Family
Health Plan™

Updated 08/2021

40604

© 2012 Santa Clara Family Health Plan. All rights reserved.