

CHOC HEALTH ALLIANCE PROVIDER MANUAL



Revised January 2006

Dear CHOC Health Alliance Healthcare Professional,

Welcome to CHOC Health Alliance (CHA) and thank you for your participation in our managed care Physician Hospital Consortium (PHC). CHA covers medical services for Orange County's Medi-Cal / CalOptima and Healthy Families Program / CalOptima Kids recipients. As a leading care professional in Orange County, you are essential to the provision of quality, cost effective medical care to our Members.

The CHA Provider Manual will assist you in providing care to CHA Members and discusses essential policies and procedures that are important for you to understand and comply with while treating CHA Members. In this manual you will also find a CD, which includes useful resources and forms for you and your staff. This manual and CD are updated on a regular basis as policies and procedures change. These changes will be formally communicated to you in Provider Manual Updates.

Your review and understanding of the Provider Manual is essential. Questions, issues, or suggestions concerning the manual are encouraged and should be directed to your CHA Provider Relations Representative.

Again, thank you for your participation in CHOC Health Alliance. Together we can make a difference in the health of our Members.

Sincerely,

A handwritten signature in cursive script, appearing to read "Richard Kammerman".

Richard Kammerman, M.D.
President, CHOC Physicians Network

CHOC HEALTH ALLIANCE (CHA) PROVIDER MANUAL

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CHOC HEALTH ALLIANCE PROVIDER MANUAL RESOURCES

RESOURCE CD TABLE OF CONTENTS

- Copy of Member Benefits Identification Card (BIC)
- Copy of CalOptima Kids / Healthy Families Program Member Card
- Prior Authorization Form
- Procedures / Services Requiring Prior Authorization
- Specialist Adult Referral Matrix
- PCP Adult Referral Matrix
- CCS Conditions
- Fraud and Abuse
- CalOptima Pediatric Preventive Services Schedule
- Recommended Childhood and Adolescent Immunization Schedule
- Clinical Preventive Services for Normal-Risk Adults
- Pediatric and Adult Health Screening Guidelines
- Screening-Cervical Cancer
- Screening-Breast Cancer
- Screening-Lipid Disorders in Adults
- Screening Tuberculosis Infection
- Staying Healthy Assessment Tools (English and Spanish)
- Consent for Minors
- Informed Consent
- Family Planning (Medi-Cal) / Sterilization Consent
- Sterilization Consent Form
- Hysterectomy-Informed Consent
- CHA Pregnancy Notification Report
- Poor Outcome Notification Report
- Exposure to Blood-What Healthcare Personnel Need to Know
- Universal Precautions in the Provider Office Setting
- Cold Sterilization and Glutaraldehyde
- Immunizations and Chemoprophylaxis
- Vital Sign Guidelines
- Guidelines for Tuberculosis Treatment
- Treatment of Tuberculosis
- Treatment of Tuberculosis and Tuberculosis Infection in Adults and Children
- CalOptima Provider Toolkit Sample Forms
 - SOAP Instructions
 - Body Mass Index: BMI for Children and Teens
 - CDC Growth Charts
 - Child Immunization Flow Charts
 - Childhood Lead Poisoning Prevention Program
 - Recommended Routine Health Visits

I. INTRODUCTION

A) OVERVIEW

CHOC Health Alliance (CHA) is a managed care Physician Hospital Consortium (PHC) that offers its Members access to quality, cost-effective health care. CHA is headquartered in Orange and is sponsored by the Children's Hospital of Orange County (CHOC). The Physician component of the PHC is represented by the CHOC Physicians Network, Inc. (CPN), an independent physician organization of primary care, ancillary and specialist providers.

CHA develops its Membership through contracts with CalOptima's, Medi-Cal and Healthy Families Programs, and is responsible for arranging covered medical services for thousands of eligible Members in Orange County. Members are eligible through the CalOptima program, which is Orange County's State of California Medi-Cal and Federal Medicaid Program.

B) CHA AS AN ORGANIZATION

Within CHA, the Provider Relations Department is designated as the primary point of contact for providers who may require assistance. The Provider Relations Department is staffed with Provider Relations Representatives who have the primary responsibility of assisting providers and serving as a liaison with other departments within CHA. Your Provider Relations Representative will assist you with your questions or requests. If you do not know the Provider Relations Representative assigned to your office, please call (800) 387-1103 or (714) 541-2462 and **Choose Option #3**.

C) CHA MANAGED CARE PHILOSOPHY

CHA's managed care philosophy includes the administration of efficient, effective, and quality health care to its Members through a network of independent, credentialed health professionals contracted with CHA. The program is centered on a Primary Care Physician who manages the complete health care needs of the Member and arranges for necessary covered medical services through a network of contracted health care professionals, hospitals and ancillary providers.

Additionally, CHA utilizes industry accepted standards of prior authorization, concurrent and retrospective review, coordination of discharge planning, case management and quality management evaluation to promote the effective provision of covered services to its Members. The Prior Authorization Policy and the Referral Procedures are basic tenets of the CHA managed care program. Your understanding of and adherence to these policies and procedures, is essential for successful participation as a CHA provider.

D) CHOC HEALTH ALLIANCE CONTACT INFORMATION

CHA ADMINISTRATIVE OFFICES (714) 565-5100
CHOC Health Alliance
1120 W. La Veta Avenue, Suite #450
Orange, CA 92868

CHA MEMBER SOLUTIONS DEPARTMENT (800) 424-2462
24 Hours A Day/ Seven Days A Week (714) 835-9627

CHA PROVIDER RELATIONS DEPARTMENT **Monday-Friday**
8:00 A.M. to 5:00 P.M. (800) 387-1103
(714) 541-2462
Option #3

CHA PRIOR AUTHORIZATION DEPARTMENT **Monday-Friday**
8:00 A.M. to 5:00 P.M. (800) 387-1103
(714) 541-2462
Option #2

CHA PRIOR AUTHORIZATION FAX (714) 565-5167
(800) 387-3363

CHA PRIOR AUTHORIZATION FAX (714) 565-5170
(urgent and emergent only)

CHA CLAIMS DEPARTMENT (800) 387-1103
CHOC Health Alliance – Claims Department **Option #1**
P. O. Box 62108
Phoenix, AZ 85082-2108

CHA WEBSITE www.CHOCHealthAlliance.com

CALOPTIMA WEBSITE www.caloptima.org

CHOC HEALTH ALLIANCE CONTACT INFORMATION (cont'd)

CALOPTIMA GENERAL INFORMATION PO BOX 11033 ORANGE, CA 92856	(714) 246-8400
CALOPTIMA CUSTOMER SERVICE DEPARTMENT Monday – Friday 8:00 A.M. to 5:00 P.M.	(714) 246-8500 (888) 587-8088
CALOPTIMA PROVIDER RESOURCE LINE	(714) 246-8600
CALOPTIMA KIDS/HEALTHY FAMILIES PROGRAM CUSTOMER SERVICE DEPARTMENT	(800) 530-2899
CALOPTIMA KIDS/HEALTHY FAMILIES PROGRAM APPLICATION ASSISTANCE	(714) 246-8607
CALOPTIMA DIRECT PRIOR AUTHORIZATION	(714) 246-8686 (888) 587-7277
CALOPTIMA FRAUD HOTLINE	(877) 837-4417
MEDI-CAL AUTOMATED VERIFICATION SYSTEM (AVES) 24 Hours A Day/ Seven Days A Week	(800) 456-2387
CALOPTIMA IVR SYSTEM	(800) 463-0935
MEDI-CAL BENEFITS (Department of Health Services)	(916) 552-9797
CALIFORNIA CHILDREN SERVICES (CCS)	(714) 347-0467
DENTI-CAL	(800) 322-6384
PACIFICARE BEHAVIORAL HEALTH	(800) 723-8641
REGIONAL CENTER OF ORANGE COUNTY	(714) 796-5257
VISION SERVICES PLAN (VSP)	(800) 615-1883 (for providers) (800) 852-7600 (for members)

II. MEMBER ELIGIBILITY AND ENROLLMENT

A) CALOPTIMA MEDI-CAL ELIGIBILITY

CHA serves Members of CalOptima, Orange County's Medi-Cal and Federal Medicaid program. Eligibility for the CalOptima program is determined by county, state, and federal eligibility workers and not by CHA.

After an individual has become eligible for the CalOptima program, he/she will choose a PHC or is assigned to one of the CalOptima contracted PHC's. CHA is a CalOptima contracted PHC. Members are assigned to CHA on a daily basis.

The following is a list of categories of eligibility types that a CalOptima eligible Member can have. Each Member is determined eligible for an aid code that indicates his/her eligibility type. The aid codes are important to primary care providers in that they determine the capitation payment amount paid for the Member. Effective March 1, 2005, the Adult, Aged, Blind and Disabled aid codes below, pay fee for service (FFS) for Medi-Cal Members twenty-one (21) years of age and older.

Aid Category Grouping	Aid Code
Adult	81, 86, 87
Aged	10, 14, 16, 17, 18, 36
Blind & Disabled	20, 24, 26, 27, 28, 60, 64, 65, 66, 67, 68, 6A, 6C, 6N, 6P, 6R, 6V, 6W
Child	03, 04, 45, 4A, 4C, 4K, 5K, 6X, 6Y, 82, 83
Family	01, 02, 08, 0A, 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 40, 42, 4F, 4G, 54, 59, 5X, 7X
Federal Poverty Level	47, 72, 7A, 8P, 8R
Long Term Care	13, 23, 53, 63

1) MEMBER ASSIGNMENT TO CHA

CalOptima eligible Members are assigned to CHA on a daily basis. CHA is responsible for managing the Member's care on the date that the Member is enrolled with CHA until the Member is disenrolled from CHA. Eligibility decisions are not the responsibility of CHA. It is important to understand the difference between eligibility and enrollment as Members may be eligible for CalOptima benefits but may or may not be enrolled with CHA. If a Member is eligible for CalOptima benefits and not enrolled in CHA, he/she may be enrolled in another CalOptima Health Network or may be the direct responsibility of CalOptima through the CalOptima Direct Program.

If the Member requires health care services during the time prior to plan enrollment, CHA is not the financially responsible party. CalOptima is usually financially responsible for the period prior to program enrollment through the CalOptima Direct Program. Eligibility through the CalOptima Direct Plan should be verified by a Benefits Identification Card (BIC) or by calling the Automated Eligibility Verification System (AEVS) at 800-456-2387 or CalOptima directly at 714-246-8500.

2) CHOOSING A PRIMARY CARE PHYSICIAN (PCP)

Members are given a choice of a PCP by CalOptima prior to enrollment with CHA. Enrollment information is sent by CalOptima to each Member, and must be returned to CalOptima. CalOptima communicates the PCP choice to CHA. If the Member does not make a PCP choice, CHA will automatically assign a PCP to the Member according to CalOptima's automatic assignment policy. The assignment takes into consideration the PCP's Member capacity and if he/she is accepting new Members. Depending upon the age, medical condition and geographic location of the Member, the choice of PCP may include those practicing in a variety of areas, such as family practice, general practice, internal medicine, and pediatrics. Members will receive a welcome packet and a letter notifying them of the name and telephone number of their PCP. CHA allows Members to change initial PCP assignments. If the Member elects to change the initial PCP assignment, the effective date will be the same as the Member's enrollment date. If the Member has seen the PCP after the initial assignment, the request for re-assignment will be treated as a change of PCP and will be effective on the first of the following month.

3) MEMBER ASSIGNMENT TO A PCPs ROSTER

CalOptima assigns Members to CHA on a daily basis and CHA attempts to assign Members to PCP's accordingly. If a Member requests to change his/her PCP during the month, the change will be made effective as follows:

- Changes requested prior to the 20th of the month, will be made effective on the 1st of the following month.
- Changes requested on or after the 20th of the month, will be made effective on the 1st of the second month following the request or approximately forty-five (45) days from the date of the request. However, there are instances a change must be made effective the same day and CHA appreciates the providers' cooperation in coordinating the change.

When a Member has been assigned to a PCP, the assignment is recorded in the CHA computer system. From that system, each PCP receives a roster indicating the Members that have been assigned to him/her. PCPs will receive two (2) rosters per month. The first roster will be sent at the beginning of the current month and will

include enrollment based on information provided to CHA at the end of the previous month. The second roster will be provided some time in the middle of the month and will include enrollment information provided to CHA based on the first of the month. Providers should always verify eligibility and enrollment prior to providing any services due to the lag time in accurate eligibility transfers from Medi-Cal to CalOptima. Any questions regarding enrollment/eligibility rosters should be directed to your Provider Relations Representative. PCPs should utilize these rosters and/or call CHA to determine if they are responsible for providing primary care to a particular Member on the specific date of service.

4) REMOVING MEMBERS FROM A PCP'S ROSTER

Should a PCP want an assigned Member removed from his/her roster due to the Member's non-compliance or disruptive behavior in the office, the PCP can request the Member's removal. The usual and customary professional procedures should be followed which includes mailing a certified letter to the Member. The written request must also be sent to the Member Solutions Department. CHA will review the request and if deemed appropriate, the Member will be removed from the PCP's roster. Member Solutions will attempt to make all changes effective on the first of the month. In certain circumstances, the change may be made effective after the first or prior to the first of the month. Until the change is complete, the provider will be responsible for urgent or emergent medical treatment the Member requires.

5) MEMBER BENEFITS IDENTIFICATION CARD (BIC)

Each Medi-Cal / CalOptima eligible Member receives an identification card from the California Department of Health Services (DHS) commonly known as a Benefits Identification Card (BIC). The BIC has a magnetic tape readable through a Medi-Cal point-of-service device. CalOptima also sends a card to each Member, which indicates the Member's name, date of birth, CalOptima ID number, and assigned PHC. One or both cards should be presented to the provider's office each time the Member presents for services, but services should not be denied if no card is presented. The BIC does not guarantee that the Member is eligible for the CalOptima program. Providers who have questions about a Member's eligibility should call the CHA Member Solutions Department or CalOptima Customer Service Department. Providers may also verify eligibility by using either the BIC point-of-service system or by calling the Medi-Cal AEVS at 800-456-2387.

Providers are also encouraged to take the precaution of verifying the identity of the person presenting the BIC against some other form of identification, such as a driver's license or other photo identification. This type of verification not only deters fraudulent use of the Medi-Cal / CalOptima program, but also protects the provider against performing a service for which payment may be denied. Copies of the BIC and CalOptima ID cards are included on the Resources CD included with this manual.

6) VERIFYING CHA MEMBER ENROLLMENT

Providers should always verify the Member's Medi-Cal eligibility by using the BIC point-of-service device, if available, which will verify CalOptima eligibility and plan enrollment. The use of the point-of-service device is recommended by CHA, as it will provide the most accurate eligibility and enrollment information. Contact your Provider Relations Representative for information on how to acquire a BIC point-of-service device. If the point-of-service device is not available, providers should contact AEVS at 800-456-2387. AEVS is a service for Medi-Cal eligibility verification and is available to all registered Medi-Cal providers. Providers should also contact the CHA Member Solutions Department which is available 24 hours a day, 7 days a week, to

assist in determining if a Member is enrolled with CHA and the current PCP assignment. If the PCP has a CHA roster, the roster should be consulted to determine if the Member is assigned to the PCP. If a Member is not on a roster, but indicates that he/she has been assigned to the PCP, the PCP should call the CHA Member Solutions Department to verify enrollment. Providers who do not have current CHA rosters should call CHA to verify enrollment prior to providing service.

If the Member is not enrolled with CHA, the provider should call the CalOptima Customer Service Department at 714-246-8500, to verify eligibility and current plan enrollment.

B) CALOPTIMA KIDS, HEALTHY FAMILIES PROGRAM ELIGIBILITY

CHA serves Members of CalOptima Kids which is one of Orange County's Healthy Families Programs. This program is targeted to children in families that are low-income, but where the income is too great for no-cost Medi-Cal. Eligibility for the CalOptima Kids program is determined by the California Managed Risk Medical Insurance Board (MRMIB) and not by CHA.

When an individual is eligible for the CalOptima Kids program, he/she will choose a PHC or he/she will be assigned to one of the CalOptima Kids contracted PHC's. CHA is one of the contracted PHC's. Members are assigned to CHA on a daily basis.

1) ASSIGNMENT OF HEALTHY FAMILIES PROGRAM MEMBERS TO CHA

CHA is assigned CalOptima Kids/Healthy Families Program eligible Members on a daily basis. CHA is responsible for managing the Member's care from the date that the Member is enrolled with CHA until the Member is disenrolled from CHA. Eligibility decisions are not the responsibility of CHA. It is important to understand the difference between eligibility and enrollment, as Members may be eligible for CalOptima Kids benefits but not enrolled with CHA. If a Member is eligible for CalOptima Kids benefits and is not enrolled in CHA he/she may be enrolled in a CalOptima Kids Health Network, other than CHA.

2) CHOOSING A PRIMARY CARE PHYSICIAN (PCP)

Members are given a choice of a PCP by CalOptima Kids prior to enrollment with CHA. Enrollment information is sent by CalOptima Kids to each Member and should be returned to CalOptima Kids. CalOptima Kids will communicate the PCP choice to CHA. If the Member does not make a PCP choice, CHA will automatically assign a PCP to the Member according to the CalOptima Kids' Program automatic assignment policy. The assignment takes into consideration the PCP's Member capacity and if he/she is accepting new Members. The Member Solutions Department will assign the Member to the most appropriate PCP, closest to the Member's geographic location. Depending upon the age, medical condition and geographic location of the Member, the choice of PCP may include those practicing in a variety of areas, such as family practice, general practice, internal medicine, and pediatrics. Members will receive a welcome packet and a letter notifying him/her of the name and telephone number of his/her PCP. CHA allows Members to change initial PCP assignments. If the Member elects to change the initial PCP assignment, the effective date will be equal to the Member's enrollment date. If the Member has seen the PCP after the initial assignment, the request for re-assignment will be treated as a change of PCP and will be effective on the first of the following month.

3) ASSIGNMENT TO A PCP'S ROSTER

The CalOptima Kids program assigns Members to CHA on a daily basis and attempts to assign Members to PCP's accordingly. If a Member requests that his/her PCP be changed during the month, the change will be made effective as follows:

- Changes requested prior to the 20th of the month, will be made effective on the 1st of the following month.
- Changes requested on or after the 20th of the month, will be made effective on the 1st of the second month following the request or approximately 45 days from the date of the request. However, there are times when a change must be made effective the same day and CHA appreciates the providers, cooperation in coordinating the change.

When a Member has been assigned to a PCP, the assignment is recorded in CHA's computer system. From that system, each PCP receives a roster indicating the Members that have been assigned to him/her. PCPs will receive two (2) rosters per month. The first roster will be sent at the beginning of the current month and will include enrollment based on information provided to CHA at the end of the previous month. The second roster will be provided some time during the middle of the month and will include enrollment information provided to CHA based on the first of the month. Providers should always verify eligibility and enrollment prior to providing any services due to the lag in accurate eligibility transfers from Medi-Cal to CalOptima Kids. Any questions about enrollment/eligibility rosters should be referred to your Provider Relations Representative. PCPs should use these rosters and/or call CHA to determine if they are responsible for providing primary care to a particular Member on the specific date of service.

4) REMOVING MEMBERS FROM A PCP'S ROSTER

Should a PCP want an assigned Member removed from his/her roster due to the Member's non-compliance or disruptive behavior in the office, the PCP can request the Member's removal. The usual and customary professional procedures should be followed which includes mailing a certified letter to the patient. The written request must also be directed to the Member Solutions Department. CHA will review the request and if deemed appropriate, the Member will be removed from the PCP's roster. Member Solutions will attempt to make all changes effective on the first of the month. In certain circumstances, the change may be made effective after the first or prior to the first of the month. Until the change is complete, the provider will be responsible for any urgent or emergent medical treatment the Member requires.

5) MEMBER IDENTIFICATION CARDS

Each Member of the CalOptima Kids program shall receive an ID card at the time the Member first enrolls with the program, and after each health network change. This card should be presented at the time of the Member's appointment, however services should not be denied if the card is not available. The ID card does not guarantee that the Member is eligible for the CalOptima Kids program. Providers who have questions about a Member's eligibility should call the CHA Member Solutions Department or the CalOptima Kids Member Services Department. Providers may also verify eligibility by calling Medi-Cal AEVS at 800-456-2387.

6) VERIFYING CHA MEMBER ENROLLMENT

To verify member enrollment, providers should contact AEVS at 800-456-2387. AEVS is a service for Healthy Families Program eligibility verification and it is available to all registered Medi-Cal providers. Providers should also contact the CHA Member Solutions Department which is available twenty-four (24) hours a day, seven (7) days a week, to assist in determining if a Member is enrolled with CHA and the current PCP assignment.

If the PCP has a CHA roster, the roster should be consulted to determine if the Member is assigned to the PCP. If a Member is not on a roster, but indicates that he/she has been assigned to the PCP, the provider should call the CHA Member Solutions Department to verify enrollment. Providers who do not have current CHA rosters should call CHA to verify enrollment prior to providing service.

C) MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights

All CHA Members shall have the right to:

- Receive dignified, courteous and considerate treatment by all staff
- Receive information and communications in a language that he/she understands
- Receive preventive healthcare services
- Be informed of all healthcare services available to him/her
- Know and understand his/her medical problem and treatment plan
- Receive a response to a request for service, including evaluations and referrals, within thirty (30) days. Urgent conditions shall receive a response within twenty-four (24) hours
- Question his/her medical treatment and participate in decisions regarding the treatment plan
- Obtain a second opinion
- Be fully informed of all procedures, including complaints
- Have the confidentiality of his/her medical records protected
- Have a medical complaint referred directly to CHA's Quality Management Department, in order to protect the information in his/her medical record.

Member Responsibilities

CHA Members shall have the responsibility to:

- Present his/her BIC and CalOptima identification cards to a provider before receiving service. Members are encouraged to carry a second form of identification
- Obtain approval or authorization when required, from the Primary Care Physician (PCP) before obtaining treatment
- Notify his/her PCP before obtaining treatment in an emergency room except in life-threatening situations
- Schedule and cancel appointments for CHA services, including transportation. If the Member cannot keep a scheduled appointment, he/she must call the provider twenty-four (24) hours in advance to cancel the appointment
- Learn about his/her medical condition and what keeps him/her healthy
- Actively participate in health care programs that keep him/her well
- Inform his/her PCP of his/her medical condition
- Follow the treatment plan prescribed by his/her PCP
- Schedule periodic checkups for infants and children in the CHDP Program and keep the appointments. Prenatal Members must schedule and keep obstetrical checkups at the recommended intervals. Members are encouraged to participate in other available prevention and wellness programs
- Notify CalOptima of address changes or changes in family size that affect eligibility or enrollment (e.g., marriage, birth, adoption, divorce, death or guardianship)
- Follow the procedures outlined in the CHA Member Handbook to obtain services for present questions or concerns
- Inform CHA and the provider if he/she is also covered by other insurance, including Medicare
- Be cooperative and courteous to those who are partners in his/her health care

III. COVERED SERVICES

CalOptima / Medi-Cal

As a PHC contracted with the CalOptima program, CHA is required to make available a specific list of covered services to its enrolled Members. The services are covered when medically necessary and must be provided by or arranged by the Member's PCP. Some services require prior authorization by CHA. A list of outpatient covered services and a matrix of the carved-out covered services, which denotes the financially responsible party for each type of service is located in this manual.

The following list is not exhaustive. The specific services to be delivered to CHA Members are described in detail in the CalOptima Regulations. If a provider has questions as to whether a service is covered, he/she should contact the CHA Prior Authorization Unit or his/her Provider Relations Representative.

A) ALL CALOPTIMA MEMBERS

- Allergy Testing and Treatment
- Birth Control
- Chemical Dependency-Detoxification
- Chiropractic Services
- Corrective Appliances
- Dental Services (Repair of Accident/Injury Only)
- Durable Medical Equipment (DME)
- Emergency Room
- Family Planning Services
- Genetic Testing/Counseling
- Home Health Care (Including IV/ Injectables)
- Hospice Services
- Hospitalization, Inpatient Services, Supplies and Testing
- Injections and Injected Substances
- Laboratory Services
- Maternity Care/Perinatal Support Services Program
- Medical Supplies/Dressings
- Nutritional Dietetic Counseling
- Pain Management Services
- Physician Visits
- Podiatry Services
- Preventive Services
- Prosthetic Devices
- Radiology Services
- Reconstructive Surgery
- Rehabilitation-Short Term (e.g., PT/OT/Speech)
- Skilled Nursing Facility (Short Term Rehab/Sub-Acute-Non-Custodial)
- Transfusions From Blood Bank
- Transportation-Ambulance (medically necessary)

**B) COVERED SERVICES THAT ARE NOT THE RESPONSIBILITY OF CHA
(ALSO REFERRED TO AS CARVE-OUT SERVICES)**

The following services are not covered by contract with CHA and CalOptima. Members should be directed to call CalOptima’s Customer Service Department at 714-246-8500 for questions regarding accessing these services.

- Alcohol and drug treatment services
- Adult Day Health Program
- Home and community-based waived services
- Laboratory services provided under the State alpha feto protein testing program administered by the Genetic Disease Branch of the Department of Health Services.
- Local Education Authority (LEA) and LEA assessment services.
- Long term care services rendered by skilled nursing facility and intermediate care facilities. Facility daily charges shall be paid through the existing Medi-Cal fee-for-service program. Hospital service as defined in Title 22,CCR, Section 511180 rendered in a skilled nursing facility or intermediate care facility are not long term care services.
- Mental health services, which includes psychiatric inpatient services and outpatient mental health services provided by mental health professionals.
- Multipurpose Senior Services Program (MSSP)
- Pharmacy services
- Vision services
- Dental services
- CCS eligible conditions
- Services not rendered in accordance with CalOptima policies or contractual requirements

Carve-out services are not the direct financial responsibility of CHA. The matrix of financial responsibility below outlines the responsible party for these covered services.

Service	Responsible Party
California Children’s Services (CCS)	The State (CCS Program)
Child Health & Disability Prevention (CHDP)	The State (CHDP Program)
Dental Care	The State for CalOptima Medi-Cal & Healthy Families Dental
Mental Health	The State/Orange County Health Care Agency
Pharmacy Services	CalOptima
Perinatal Support Services	CalOptima / CHA
Services received pending eligibility	CalOptima
Substance Abuse	The State
Vision Services	CalOptima

IV. PROVIDER NETWORK DEVELOPMENT AND COORDINATION

CHA is responsible for coordinating covered services for thousands of Members, and accomplishes this through a comprehensive provider network of independent practitioners and facilities. This network is comprised of participating health care professionals such as primary care physicians, specialist physicians, medical facilities, allied health professionals and ancillary service providers contracted with CHA. Through its' various contract agreements, the network provides an integrated and coordinated health care delivery system.

The network is carefully developed to include those participating health care professionals who meet certain criteria such as availability, geographic location, specialty, acceptance of financial considerations, hospital privileges, quality of care and acceptance of CHA managed care principles.

Contracted participating health care professionals are required by contract to coordinate Member care within the CHA provider network. All referrals for CHA Members, with the exception of family planning services, should be made to CHA contracted providers. CHA Members may obtain Family Planning Services including sterilizations from out-of-network providers. Referrals for non-family planning services outside of the network are permitted, however must have Prior Authorization from CHA.

A current list of the CHA provider network is available from the website at www.CHOCHHealthAlliance.com. If a provider does not have access to the Internet, he/she may request a copy from his/her Provider Relations Representative. Questions regarding the CHA network should be directed to the attention of the providers CHA Provider Relations Representative.

V. 120-DAY INITIAL HEALTH ASSESSMENT (IHA)

All CalOptima Medi-Cal and CalOptima Kids/Healthy Families Program Members must receive an Initial Health Assessment within 120 calendar days of enrollment.

A. The Initial Health Assessment shall included the following elements:

- 1) For Members under twenty-one (21) years of age:
 - a) All elements of the periodic health assessment as delineated by the American Academy of Pediatrics, California's Child Health and Disability Prevention Program and the Advisory Committee on Immunization Practices.
 - b) Documentation of the next required periodic health assessment and any follow-up necessary, prior to the next periodic assessment.
- 2) For Members twenty-one (21) years of age and older:
 - a) A comprehensive history and physical examination, including an initial preventive medicine evaluation, that provides a core set of preventive services to all asymptomatic adult Members. The minimum for these services is delineated in the Guide to Clinical Preventive Services, a Report of the U.S. Preventive Services Task Force.

- b) Documentation of any follow-up necessary as a result of the IHA, including the diagnosis and plans for treatment of any diseases.
- 3) For Members who have been receiving services for chronic and/or complex conditions prior to enrollment in CalOptima:
 - a) A plan for continuation of all services necessary to treat those pre-existing conditions, including Member needs for continuation of specialty care.
 - b) Identification of services being provided to Members by local education agencies, regional centers, early intervention programs, California Children's Services, and other special programs outside the network.
- 4) For Members who are pregnant upon enrollment or who are discovered to be pregnant before an IHA has been performed, the initial prenatal care visit with the provider who will oversee the Member's care during her pregnancy may be considered the IHA if it meets contractual requirements for a first comprehensive prenatal visit.

B. Timelines for the provision of an Initial Health Assessment begins on a Member's effective date of enrollment and:

- 1) For infants and children under the age of eighteen (18) months, the next AAP recommended periodic IHA is due less than 120 days following enrollment.
- 2) For children eighteen (18) months of age and older, the IHA is due no later than 120 days following the Member's effective date of enrollment.
- 3) For Members who are pregnant upon enrollment or who are discovered to be pregnant prior to performance of an IHA, the IHA shall be performed as soon as possible after enrollment or discovery that the Member is pregnant. Prior authorization shall not be required for basic obstetrical, nutritional, health education and psychosocial services.
- 4) Members two (2) years of age or older upon enrollment who have a change of PCP or other provider of primary care services before an IHA is accomplished, shall receive an IHA within the initial 120 day period following enrollment or no later than sixty (60) days after the date of the PCP change.

C. Types of Initial Health Assessments:

- 1) A single visit of sufficient length to perform:
 - a. A comprehensive history and physical for Members who are new to the provider, including an appropriate preventive medicine evaluation.

- b. A detailed review of history and physical for Members who have elected to continue an established relationship with a PCP, including a history and physical examination of a newborn infant.
- 2) A combination of visits within the required timeframe, which, when taken together, meet the minimum requirements for an IHA.

D. Types of examinations that do NOT meet the criteria for an Initial Health Assessment:

- 1) A single brief visit for example, a ten (10) minute visit for limited well child care services.
- 2) An office or other outpatient consultation visit requested by the Member's PCP or another network provider regarding evaluation and/or management of a specific problem.
- 3) Perinatal visits, other than the initial complete assessment of a pregnant woman required in the health network's contract.
- 4) Urgent care and/or emergency visits or services.
- 5) Follow-up visits to any of the above types of services for further diagnosis, consultation and/or treatment purposes should be documented as necessary but do not constitute an IHA unless IHA requirements are met.

E. Documentation and Reporting of an Initial Health Assessment

- 1) The performance of an IHA shall be documented in the Member's medical record, or the equivalent information (e.g., PM160 claim form) shall be included in the Member's medical record and labeled as an IHA.
- 2) The information covered during the IHA shall be documented, including counseling, anticipatory guidance, risk factor reduction interventions and other follow-up treatment and/or referrals for problems noted.
- 3) All pertinent information shall be documented and submitted to the health network in accordance with the encounter data capture and reporting process requirements or to CalOptima utilizing the PM160 claim form.

F. Exemptions from Initial Health Assessment requirements

- 1) Adequate documentation of an IHA within a qualifying period prior to enrollment:
 - a) For Members twenty-one (21) years of age or older, the visit to their PCP or other provider of primary care services shall be within 120 days of enrollment, and the documentation deemed to satisfy the IHA requirement must have been recorded within the twelve (12) month period prior to the Member's visit to the PCP.
 - b) For Members under the age of twenty-one (21) years, the medical records must contain information sufficient to determine that the Member is up-to-date relative to the timely provision of required periodic health assessments, in accordance with the most recent AAP recommendations.
 - Documentation shall meet all IHA standards and include an immunization history sufficient to determine up-to-date status.
 - In all cases, the Member shall be brought up-to-date regarding immunizations during the visit.
- 2) Discontinuous enrollment:

Members who are not continuously enrolled in a plan for 120 days, or the period of time necessary to achieve the AAP periodicity standards for infants and children may be exempt from IHA requirements.

G. Documentation

- 1) The PCP or other provider of primary care services shall document where information can be found in the medical record, and that he/she has reviewed the Member's health history and physical examination(s) and has accomplished a targeted history and physical as needed.

VI. THE PRIMARY CARE PHYSICIAN (PCP)

A. RESPONSIBILITIES OF THE CHA PCP

1) Primary Care Physician responsibilities shall include, but are not limited to:

- Providing care for the majority of health care issues presented by a CHA Member, including preventive, acute, and chronic health care.
- Providing risk assessment, treatment planning, coordination of medically necessary services, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs. These services include coordinating care and referral for Medi-Cal covered benefits not the direct responsibility of CHA (e.g., mental health services, dental services, etc.).
- Providing medical case management to assigned Members.
- Assuring the provision of the required scope of services to the assigned Members.
- Verifying eligibility of the Member at the time that services are provided.
- Assuring the provision of twenty-four (24) hour, seven (7) days per week access to care, including accommodations for urgent care, performance of procedures, inpatient rounds, and arrangements for emergency back-up coverage in the PCP's absence.
- Maintaining staff Membership and admission privileges in good standing at a hospital.
- Utilizing participating medical facilities for the admission of Members unless prior authorization has been obtained from CHA or in the case of an emergency. PCP will provide or arrange for the provision of covered services to Members while in a hospital, nursing home or other health care facility as determined medically necessary by PCP or CHA's Chief Medical Officer.
- Minimizing office wait times to a maximum of forty-five (45) minutes.
- Coordinating and directing appropriate care for Members.
- Coordinating the referral/authorization of specialist and non-emergent hospital services for each Member. Services generated from referrals shall be initiated within thirty (30) days of the visit at which the referral was made.
- Assuring the provision of basic clinical services including primary evaluation and treatment of acute and chronic medical and surgical problems in all systems.
- Abiding by the CHA Referral and Prior Authorization policies discussed in this manual.
- Utilizing contracted hospital(s), specialists, and ancillary providers.
- Initiating referrals to specialists on the same day for emergency care, within two (2) days for urgent care and within thirty (30) days for routine care.
- Complying with CHA Quality Management and Medical Management policies and procedures.

- Obtaining prior authorization for all elective hospital admissions.
- Obtaining prior authorization on all outpatient surgeries and related medical procedures.
- Notifying CHA's Prior Authorization Department of emergency admissions within twelve (12) hours, if aware of the admission.
- **Within seven (7) days of the time a pregnancy is identified, the physician must fax a copy of the Pregnancy Notification Report to CHA's Perinatal Support Services Coordinator at 714-565-5171 or 714-565-5167.** (A copy of the form is included on the Resources CD included with this manual.) A copy of the form and the date of CalOptima notification should be maintained in the medical record.
- Requesting an authorization from the CHA Prior Authorization Unit to transfer care to an Obstetrician immediately upon the identification of pregnancy.
- Recording the appropriate information in the Member's medical record according to CHA's medical record requirements contained in this section.
- Facilitating and ensuring Member quality of care by establishing procedures to contact Members when he/she misses an appointment which requires rescheduling for additional visits, and following up on referrals to a specialist for care.
- Making all reasonable attempts to communicate with Members in their native language.
- Preserving the dignity of the Member.
- Reporting all services provided to CHA Members in an accurate and timely manner.
- Prescribing or authorize the substitution of generic pharmaceuticals when appropriate and agree to abide by the CalOptima Formulary.
- Rendering services to Members who are diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or are HIV positive who meet the CDC definition in the same manner and to the same extent as other Members and under the compensation terms set forth in the contract.
- Providers of Members meeting the CDC guidelines for the diagnosis of AIDS are eligible for additional reimbursement. Notify the CHA Chief Medical Officer when such Members are identified, (maintaining patient confidentiality) for assistance in reporting to CalOptima or for assistance in referral if the management of such Members exceeds the PCP's scope of practice.
- Implementing the California Health and Development Program (CHDP). This Applies to CalOptima Medi-Cal Program only. CalOptima Kids/Healthy Families Program Members are not eligible for CHDP services.

2) CHA Primary Care Physicians are required to:

- Assume responsibility for the provision and documentation of CHDP screening services for all assigned Members under the age of twenty-one (21) years in accordance with AAP guidelines periodicity schedule. A copy of this schedule is included on the Resources CD included with this manual.
- Submit CHDP Billing Tracking Forms to CalOptima.
- Refer Members under age twenty-one (21) years as necessary for follow-up, diagnosis and treatment, ensuring that treatment is initiated within sixty (60) days of screening services.
- Refer Members under age twenty-one (21) years with medically eligible and confirmed diagnosis to the California Children's Services (CCS) for follow-up and treatment services.
- Maintain an office adequately designed with equipment and supplies necessary to provide CHDP services.
- Utilize each clinical encounter to assess the child's immunization status and the need for any CHDP screening services thus avoiding missed opportunities to update immunizations and meet periodicity standards.
- Report all CHDP encounters on the required claim form using correct CPT Preventive Medicine Codes.
- Abide by CHDP Health Assessment Standards, Minimum Medical Record Standards and strive to adapt the Standards for Pediatric Immunization Practices.
- Maintain CHDP certification for providing quality care to all CHA Members less than twenty-one (21) years of age.
- Participate in an annual review to assure compliance with CHA Medical Record Standards, Pediatric Standards and CHDP, which includes chart reviews.

A) PCP CHECKLIST

1) When providing services to CHA Members, the following steps should be taken:

- Telephone CHA's Member Solutions Department to verify enrollment
- Verify Member identity with photo identification, if possible
- Secure Prior Authorization from CHA if appropriate
- Refer to CHA contracted specialists unless otherwise authorized by CHA
- Identify and bill appropriate third party payer

C) MEMBER ROSTERS

Member rosters are alphabetical listings, which provide Member names, PCP and enrollment information. Rosters sent to the providers are produced twice a month.

Any issues in receiving these rosters should be directed to the attention of the providers CHA Provider Relations Representative. The Member rosters do not guarantee eligibility and should not be used in lieu of verifying eligibility with the Member Solutions Department.

D) CAPITATION PAYMENTS

CHA will pay the PCP a monthly capitation payment for the delivery of covered services during the term of his/her agreement based on the number of Members assigned to the PCP on the first day of the month. Payments will be mailed by the 15th day of the month following receipt of capitation payment from CalOptima and will reflect any appropriate adjustments for enrollment increases or decreases during the previous month.

Capitation payments will be based upon specific CalOptima rate codes and contracted amounts found in Attachment A.1 of the providers' CPN contract. Questions concerning monthly capitation payments should be directed to the attention of your CHA Provider Relations Representative.

E) MEDICAL RECORDS

The following standards for medical records are based on CalOptima's Medical Records Maintenance Policy.

1) ORGANIZATION

- Each provider office/clinic shall designate an individual responsible for the medical record system by which clinical information is collected, processed, maintained, stored, retrieved and distributed.
- All active records shall be labeled and filed in a defined system (alphabetically by last name, first, middle; or numerical using a terminal digit, serial, social security or other unique assigned numbering system) to facilitate the retrieval of the record.
- Active records are to be stored in a secured area, which may include a centralized record room or decentralized areas within the office/clinic, that protects records from loss, tampering, alteration or destruction. The records must be organized in a systematic filing method that allows active records to be retrieved upon demand.
- Inactive records for adults shall be retained for five (5) years. For minors, the record shall be retained five (5) years beyond the minor's 21st birthday.
 - Storage may be electronic or hard copy.
 - Storage must be in a secured location with restricted access that meets the same security requirements listed for active records.
 - Inactive records shall be retrievable within five (5) working days if necessary.

2) FILING OF INFORMATION

- All documents shall be filed chronologically within the record with the Member's name and the name of the primary care provider (PCP) on each document. Serial reports (Laboratory/x-rays) may be filed in a segregated manner in chronological order. The documents must be secured in the folder to prevent loss.
- All reports shall be filed in the medical record within forty-eight (48) hours of receipt including, but not limited to, the following:
 - Laboratory reports
 - X-ray reports
 - Electroencephalograms (EEG)
 - Echocardiograms (ECG)
 - Consultation reports
 - Hospital reports
 - Emergency department reports

3) FORMAT AND CONTENT

- An individual record shall be established for each Member and shall be updated during each visit or encounter.
- The record shall be in a legibly hand-written or a printed format.
- The record shall reflect the findings of each visit or encounter including, but not limited to:
 - Date of service
 - Chief complaint
 - Follow-up from previous visits
 - Test/therapies ordered
 - Diagnosis or medical impression
 - Any physical, psychosocial and/or educational needs identified during the encounter
- The following data sets shall be included in each chart:
 - **Demographic information including, but not limited to:**
 - Name and address
 - Age and birth date
 - Sex
 - Telephone number
 - Emergency contact person and nearest relative (phone number(s) for each)
 - Social Security Number
 - Plan Identification
 - Medi-Cal Number, if applicable

- **Clinical data**
 - Record of diagnosis and treatment
 - Prescription orders
 - Vital signs and signature/title of person performing these functions, including:
 - a) Height
 - b) Weight
 - c) Temperature
 - d) Pulse and respiration
 - e) Blood pressure (if over three (3) years of age)
 - Allergies (recorded on front of chart or on standardized location within the record)
 - Problem list, maintained with current updates
 - List of medications, maintained with current updates, including:
 - a) Name
 - b) Dosage
 - c) Frequency
 - Ancillary services
 - Medical and surgical histories including relevant family history for:
 - a) Significant health problems
 - b) Reactions to drugs
 - c) Personal habits (alcohol/drugs/diet)
 - Physical examination by body systems with findings and treatment plan when medically indicated. The subjective, objective, assessment, plan (SOAP) format may be used;
 - Records related to all hospitalizations, such as:
 - a) History and Physical (H&P)
 - b) Discharge Summary
 - c) Operative Reports
 - d) Pathology Reports
 - Office laboratory and/or surgical/invasive procedures including anesthetics used, and specimens collected for pathological examination
 - Emergency room encounter visit record reflecting:
 - a) Assessment
 - b) Treatment
 - c) Discharge instructions
 - d) Recommended follow-up
 - e) Signed consent form or statement for any invasive procedure
 - f) Referral / Treatment Authorization Request (TAR)
 - g) Significant telephone advice, documented with date, time and signature
 - h) Consultation reports

- **Preventive Care**

- Patient education should be documented, including information on periodic exams, Prostate Specific Antigen (PSA) testing, stool guaiac, sigmoidoscopy, pelvic/Pap smear, mammogram, instructions on breast self-exam, nutrition and accident prevention
- Immunizations should be recorded with lot number and expiration date

4) AUTHENTICATION OF MEDICAL RECORD ENTRIES

- Medical record entries shall be dated and signed by each staff person or health care provider at each encounter.
- A signature shall consist of the first initial, last name, and title of the person making the entry.

5) RECALL SYSTEM FOR NO-SHOW MEMBERS

The PCP shall have a system in place to identify, monitor and follow up on any Member who does not keep his/her appointment. The following guidelines shall be used, at a minimum, in managing no-show Members and shall be documented by the PCP in the Members record:

- All attempts to reach the Member
- Instructions given to the Member when contact is made advising the Member of the need to obtain medically necessary care and the risks of not keeping an appointment

6) CONFIDENTIALITY OF RECORDS

- All Member records and Member-related information shall be handled with strict confidentiality.
- The Medical Records Department Manager or Office Manager shall be responsible for maintaining, monitoring and enforcing staff compliance in keeping Member information confidential. The release of Member information when requested by the Member or under other conditions of release as identified below, is also the responsibility of the Medical Records Department Manager or Office Manager.
- Each employee shall be advised of the importance of strict confidentiality and receive a written copy of the confidentiality requirements. Employees shall also be responsible for reading and providing his/her signature to the statement indicating his/her understanding and willingness to abide by the requirements.
- Release of any part of the medical record must be authorized in writing by the Member (or the Member's legal guardian/parent if the Member is a minor), except under the following conditions:
 - a. Mandatory Disclosure
 - By a court order

- By a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority
- By subpoena, subpoena duces tecum, notices to appear served related to the Code of Civil Procedure, Section 1987, or any provision authorizing discovery in a proceeding before a court or administrative agency
- By a board, commission, or administrative agency pursuant to an investigative subpoena issued under the California Code of Regulations, Title 2, Division 2, Par 1, Chapter 2, Article 2 (Section 1180)
- By an arbitrator or arbitration panel, when arbitration is lawfully requested by either party, pursuant to a subpoena duces tecum issued under the Code of Civil Procedure, Sections 1282.6, or any other provision authorizing discovery in a proceeding before an arbitrator or arbitration panel
- By search warrant lawfully issued to a governmental law enforcement agency

b. Discretionary Disclosure

- In an emergency situation, information may be disclosed between emergency medical personnel at the scene of an emergency or in an emergency medical transport vehicle, and emergency medical personnel at a licensed hospital who are communicating by radio with the personnel who are at the scene;
- A provider of health care may disclose medical information as follows:
 1. To other health care providers, provided the information is disclosed:
 - a. For purposes of diagnosis or treatment of the patient, or
 - b. To assist another provider in obtaining payment for health care services rendered by that provider to the Member; however, such disclosure is limited to that information which is necessary to accomplish this purpose.
 2. To an insurer, employer, health care service plan, hospital service plan, employee benefit plan, governmental authority, or any other person or entity that is or may be responsible for paying for health care services rendered to the Member, provided that information is disclosed only to the extent necessary to determine responsibility for payment and to secure payment;
 3. To organized committees and agents of professional societies; or of medical staffs of licensed hospitals; or to licensed health care service plans; or to professional standards review organizations; or to utilization and quality control peer review organizations as established by Congress in 42 U.S.C. Section 1320q *et seq.*; or to persons ensuring,

responsibility for, or defending professional liability a provider may incur, provided such entities or persona are engaged in reviewing the competence or qualifications of health care professionals or reviewing health care services with respect to medical necessity, level of care, quality of care, or justification of charges;

4. To the county coroner in the course of an investigation by the coroner's office;
5. To specified researchers for bona fide research purposes. Researchers who may receive information are limited to clinical investigators, or researchers affiliated with public agencies, health care institutions, or health care research organizations accredited to perform public or private non-profit education. Researchers may not further disclose information in any way which would permit identification of the Member unless it is necessary for continuing medical care and is being released to another physician participating in the Member's care, or is required by third party insurers or state/federal representatives as part of payment and/or quality review processes.

F) MONITORING AND EVALUATION

CHA shall evaluate the provider's compliance with these guidelines through the use of a standardized medical record audit tool as part of the Quality Improvement Program.

G) ADVANCE DIRECTIVES (PATIENT SELF DETERMINATION ACT)

The Patient Self-Determination Act of 1990, which became effective December 1, 1991, requires health professionals and facilities serving those covered by Medicare and Medicaid to give adult Members written information about the Member's right to have an Advance Directive.

Advance Directives are verbal or written statements outlining a Member's choices for medical treatment or naming a person who should make choices if the Member no longer has the ability to make decisions. Information about Advance Directives is included in the Member handbook.

Providers may be asked questions related to the printed information. If you would like a copy of the Advance Directives, please contact your assigned Provider Relations Representative.

VII OBSTETRIC PROVIDERS

A) RESPONSIBILITIES OF THE CHA OBSTETRICIAN

- Verify the enrollment of Member through the Member Solutions Department. Failure to verify Member enrollment and assignment may result in claim denial.
- Provide or arrange for the provision of Covered Services to Members as defined in the OB contract,
- Ensure that a Member's waiting time at the OB's office shall not exceed forty-five (45) minutes, unless the OB is unavailable due to an emergency.
- Provide to Members (a) office visits during regular office hours; and (b) office visits, home visits or other appropriate visits during non-office hours as determined Medically Necessary.
- Report the referral to the CHA Perinatal Unit within two (2) working days by submitting a Pregnancy Notification Report (PNR) and authorization request for services upon the receipt of a Primary Care Physician's referral (Pass-Through) for continued obstetrical care,
- Make provisions and schedule time-specific Medically Necessary appointments for enrolled pregnant Members to obtain initial and ongoing prenatal care that are within the following timeframes:
 - a) First trimester-within seven (7) days of a request for an appointment
 - b) Second trimester-within seven (7) days of a request for an appointment
 - c) Third trimester-within three (3) days of a request for an appointment
- Initiating high-risk prenatal care within three (3) working days of identification or immediately, if an emergency exists.
- Notify CHA immediately of every pregnant woman at the time the pregnancy is identified. **A copy of the Pregnancy Notification Report MUST be forwarded to the CHA Prior Authorization Unit.**
- Complete a risk assessment profile on each pregnant woman at the initiation of pregnancy related services. A CalOptima and DHS approved risk assessment tool must be utilized.
- Encourage Members to participate in the Comprehensive Perinatal Support Services Program.
- **Complete the Poor Outcome Notification Report within seven (7) days and fax to CHA at (714) 565-5167 if any of the following criteria are present at delivery: <36 weeks gestation; <2500 grams; admitted to NICU; Maternal death; Fetal death >20 weeks and/or 500 grams.**
- Cooperate with Perinatal case management and/or other Perinatal support programs that may be authorized by CHA and/or CalOptima.

- Refer the Member back to the Member's PCP or to the appropriate specialist for medical services that are outside the scope of the OB's practice.
- Scheduling time-specific office visits during an uncomplicated pregnancy based upon the following recommended standards promulgated by the American College of Obstetrics and Gynecology (ACOG):

Every four (4) weeks for the first twenty-eight (28) weeks of pregnancy; every two (2) - three (3) weeks until thirty-six (36) weeks of gestation; and weekly thereafter.
- Maintain responsibility for care until the first day of the first month following the 60th day after delivery with a minimum of one (1) postpartum visit at approximately six (6) weeks postpartum. Members at high risk shall have a return visit scheduled appropriate to their individual needs.
- Adhere to practice guidelines contained within CHA Reproductive Health and Wellness Policies.
- Schedule time-specific appointments for routine Medically Necessary care within twenty-one (21) days of a Member's request, within twenty-four (24) hours for urgent care and on the same day for emergency care.
- Comply with Federal Regulations of the Occupational Safety and Health Administration including, with limitation, the regulations concerning Blood borne Pathogens Standards at 29 C.F.R. Part 1910.1030, which became effective January 1, 1992.
- Refer Members to CHA Participating Health Providers in accordance with the CHA Referral Policy. OB's may refer a Member to a non-participating provider only if the Member requires medical services that are not available through a Participating Health Provider and if CHA approves the referral in advance. Members can obtain Family Planning services including sterilization, without a referral from in and out-of-network providers. OB's may be financially responsible for any expenses resulting from a referral to a non-participating provider that CHA did not approve in advance or any other referral that CHA determines was not Medically Necessary or appropriate.
- Initiate referrals to specialists on the same day for emergency care, within two (2) days for urgent care and within thirty (30) days for routine care.
- Notify CHA within five (5) working days if an OB determines that a Member is carrying multiple fetuses.
- Refer Members when appropriate to a CHA Participating Perinatologist for consultation and/or continued obstetrical care upon approval by CHA Prior Authorization Unit.
- Coordinate the provisions of Covered Services to Members by (a) counseling Members and their families regarding the Member's medical care needs including family practice and advance directives; (b) initiating referrals of Member for specific Covered Services to Participating Health Professionals, Hospitals and Providers; (c) monitoring progress of the Member's care and coordinating utilization of services to facilitate the coordination of Member's care with Member's PCP.

- Maintain staff Membership and admission privileges in good standing at one of the hospitals with which CHA has contracted as a Participating Hospital unless specifically authorized by CHA.
- Admit Members in need of hospitalization only to Participating Hospitals unless (1) prior authorization for admission to some other facility has been obtained from CHA or (2) the Member's condition is emergent and use of a Participating Hospital is not feasible for medical reasons. OB agrees to provide Covered Services to Members while in a hospital as determined medically necessary by the OB or CHA's Chief Medical Officer.
- Obtain prior authorization for all elective hospital admissions.
- Obtain prior authorization on all outpatient surgeries except sterilization and related medical procedures.
- Notify CHA Prior Authorization Department of emergency admissions and/or deliveries within twelve (12) hours.
- Maintain a current DEA number throughout the term of this Agreement. CHA encourages OB's to record the DEA number on all prescriptions.
- Prescribe and authorize the substitution of generic pharmaceuticals and agrees to abide with the CalOptima drug formulary.
- Render services to Members who are diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or HIV positive according to the CDC definition in the same manner and to the same extent as other Members and under the compensation terms set forth herein.
- Notify the CHA Chief Medical Officer when Members meeting the CDC guidelines for the diagnosis of AIDS are identified, (maintaining patient confidentiality) or for assistance in referral if the management of such Members exceeds the of the OB's scope of practice. Such Members are eligible for an increased high risk OB rate.
- Make a concerted effort to educate and instruct Members about the proper utilization of the OB's office in lieu of hospital emergency rooms. OB shall not refer or direct Members to hospital emergency rooms for non-emergent medical services at any time during the term of this Agreement. If hospital emergency room utilization exceeds CHA determined standards of acceptance, CHA may deduct or recoup payments from the OB.
- Providing financial reimbursement to any physician who upon request of the OB provides Covered Services. This shall be a matter decided between the two (2) physicians involved. CHA shall not be responsible for payment to the covering physician.
- Initiate and follow through on appropriate referrals to California Children's Services (CCS) for all Members up to the age of twenty-one (21) years who have been diagnosed with medically eligible CCS diagnoses.

B) OBSTETRICIAN CHECKLIST

- Telephone the CHA Member Solutions Department to verify Member eligibility prior to providing services.
- Check the Member's ID card each time the Member presents for service and verify against photo identification.
- Secure Prior Authorization from CHA if appropriate.
- Refer to CHA contracted specialists unless otherwise authorized by CHA.
- Identify and bill appropriate third party payer.
- Notify CHA immediately of every pregnant woman at the time the pregnancy is identified. **A copy of the Pregnancy Notification Form and the referral authorization for services should be forwarded to the CHA Prior Authorization Unit.**
- Notify CHA and PCP of Members who self refer for Family Planning Services.

C) DOCUMENTATION OF PRENATAL CARE

The following CalOptima guidelines for the provision of prenatal care should be followed and documented in the medical record.

First Prenatal Visit

- Medication allergies and adverse reactions must be listed if present. List no known allergies (NKA) if applicable.
- History: Genetic and Obstetric; Dietary intake; tobacco/alcohol/drug use; Risk factors for intrauterine growth retardation and low birth weight; prior genital herpetic lesions
- Laboratory/diagnostic procedures: blood pressure; hemoglobin and hematocrit; ABO/Rh typing; Rh (D) and other antibody screen; VDRL/RPR; hepatitis b surface antigen; urinalysis microscopic or culture; GC culture; rubella antibody titer; TB testing and chlamydia testing.
- Counseling: Nutrition; Tobacco/alcohol/drug use; Safety belts.
- High Risk Group Factors defined by ACOG including but not limited to:
 - Insulin dependent Diabetes
 - Chronic renal disease or renal insufficiency
 - Epilepsy requiring medication
 - Chronic hypertension requiring medication
 - A history of delivering two or more infants at 32 weeks or less
 - A malignancy
 - A current diagnosis of highly probable Intrauterine Growth Retardation (IUGR)
 - Premature rupture of membranes (before 32 weeks)
 - Pregnant with triplets or more

- Potential need for cerclage procedure
- Diagnosis of Lupus Erythematosus
- Twin pregnancy with diagnosis of discordant growth
- HIV positive mother
- Polyhydramnios
- Oligohydramnios

Follow-up Prenatal Visits

The following information should be documented in the medical record at each prenatal visit: Patient complaint, interval history, signs and symptoms, weight, blood pressure, fundal height, edema, fetal size and position, fetal heart tones, check urine for glucose and proteins and nutrition. Specific screening tests and counseling are recommended at the following gestational ages.

Gestational Age	Recommended Screening	High Risk Code
14-18 Weeks	Maternal serum AFP	-
	Tobacco use	6
	Alcohol and other drug use	7
	Ultrasound and cephalometry	8
24-28 Weeks	Oral GTT	-
	Rh (d) antibody	9
	GC culture	10
	VDRL/RPR	11
	HbSAg	12
	Counseling and testing for HIV	13
36 Weeks	Ultrasound exam	14

Other Office Visits

The following information should be documented in the medical record for each office visit and as appropriate.

- The Member's chief complaint or subjective patient information for the presenting complaints is obtained and noted at each visit.
- Documentation of an exam and/or objective physical findings and information appropriate for the condition is obtained and noted at each visit.
- Assessment/Working Diagnosis-Working diagnosis is consistent with findings (physician's medical impression).
- Plan/Treatment-Documentation of plan of action and treatment are consistent with diagnoses.
- Documentation for appropriate patient education concerning the diagnosis, follow up care, and when/if a Member needs to return to the physician's office.
- All medications prescribed must list name, dosage, frequency, and duration. Medications given on site must be dispensed with instructions and in original packaging.

- All health screening procedures, pap smears, mammograms, etc. must be documented. All screenings performed by other physician, it should be documented in the medical record.
- Member Education/Instructions-Documentation present as applicable for problems and current diagnosis. In addition, lifestyle management and preventive health information is documented to include, but not limited to:
 - (a) Family planning and sexually transmitted diseases education
 - (b) Cancer prevention/detection (i.e., sun exposure, breast self-exam)
 - (c) Injury prevention -- at least one of the following; Vehicle safety belts, or occupational hazards, or home safety such as smoke alarms
- Consults/X-ray/Lab/Imaging Reports/Referrals/Records-Reports are filed in the medical record and initialed by the primary care physician thereby signifying review. Consultation and abnormal lab imaging study results should have an explicit notation in the medical record of follow-up plans. Referrals, past medical records, hospital records, operative and pathology reports, admission and discharge summaries, consultations and ER reports should be filed in the medical record.
- Follow-up/Return Visits-Encounter forms or notes have a notation concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or as necessary. Unresolved problems from previous visits are addressed in subsequent visits.
- Medical Care/Services/Consults-A general overview of the medical care/services and consults ordered will be reviewed. If any potential quality issues are identified, the reviewer will refer to CHA's Chief Medical Officer for further direction.
- For all Members age twenty-one (21) years and older, records must indicate Member's immunization status for Tetanus diphtheria (Td). For all female Members of child-bearing age, record must indicate blood titer and/or immunization status for rubella.
- Advance Directives (for Members age twenty-one (21) years and older only). There should be evidence that the Member has been asked if they have an Advance Directive (written directions about their health care decisions, such as a "living will" or a medical power of attorney). Yes/No response should be documented. If response is "yes", it is recommended that a copy be requested for the medical record.

D) PERINATAL SUPPORT SERVICES PROGRAM

CHA offers a comprehensive Perinatal Support Services (PSS) Program for eligible enrolled Members. The maternity services range from pre-conception counseling to postpartum care and include perinatal case management for high-risk Members, outreach and family planning services whenever appropriate. CHA's program facilitates the delivery of services through a multi-disciplinary approach, involving Member Services (Customer Services), Provider Relations, Medical Management, Prevention and Wellness departments as well as Chief Medical Officers (CMO's). Services are provided by a diverse network of participating primary care physicians, obstetricians, perinatologists, neonatologists, pediatricians and ancillary service providers dedicated to maternity services.

The purpose of the Perinatal Support Services Program is to improve fetal and maternal care during pregnancy. Basic to the program is the belief that pregnancy and birth outcomes will improve when routine obstetrical care is enhanced with specific nutritional, maternity-related education, outreach activities, case management, and associated interventions and family planning services. For the pregnant Member with health complications or complex social issues, the program has a comprehensive set of case management interventions that support the mother in the delivery of a healthy newborn.

CHA's Perinatal Support Services Program is designed to provide enhanced obstetrical services to all enrolled pregnant and postpartum women. The services are client centered based on the results of a screening and/or risk assessment. CHA coordinates and directs the care of pregnant Members through the Medical Management Department, under the leadership of the plan's Chief Medical Officer. Available to the primary care obstetrician are perinatologists, hospitals equipped to care for pregnant women, home health, nutritional education and postpartum family planning.

CHA's services go beyond the successful delivery of a healthy baby. CHA utilizes Case Management to assist pregnant Members with complex clinical and social issues such as substance abuse, spousal/partner abuse and emotional or mental health concerns, family planning issues, and referrals to appropriate community resources. Case Managers assist in resolving these issues and work to ensure delivery of a well newborn without any adverse maternal outcomes.

The primary goals of the Perinatal Support Services Program are to:

- Improve early entry into perinatal care
- Reduce infant mortality and low birth weight
- Increase the number of term infants and healthy pregnancy outcomes
- Increase interconceptual spacing
- Decrease the incidence of maternal complications
- Increase the rate of healthy deliveries
- Increase the proportion of full-term infants weighing 2500 grams or more

Outcome goals related to pregnancy, which are to be monitored and reported:

- HEDIS indicators
- Low-birth weight rate (percentage of babies born weighing between 1500 and 2500 grams)
- Cesarean Section rate (percentage of births delivered by Cesarean section)
- Incidence of newborns born before 37 weeks gestation
- Additional indicators required by each respective health plan or state

Target areas for improvement include:

- Screen and perform risk/health assessment on all identified pregnant Members to determine appropriate interventions (i.e. high-risk, smoking, substance abuse, social issues)
- Reduce complications related to maternal substance abuse
- Coordinate and provide case management services to Members identified as complex high-risk
- Increase Member's compliance with prenatal visits
- Increase the availability of family planning education for Members, but particularly for adolescents

A referral for a Member's initial comprehensive prenatal visit with a Primary Care Obstetrician (PCO), is made by the Member's Primary Care Physician. Upon completion of this initial prenatal visit, the PCO need only submit a completed copy of the Member's pregnancy notification report (PNR) to the CHA Perinatal Department to have the Member enrolled in the Perinatal Support Services Program. Upon receipt of this document, CHA Perinatal Staff will open the Member's case immediately so that the Member can begin to receive Perinatal services. PCO's can also direct their Member to phone the CHA Members Solutions department at (800) 424-2462, for further information about the Perinatal Support Services Program.

E) ADVANCE DIRECTIVES (PATIENT SELF DETERMINATION ACT)

The Patient Self-Determination Act of 1990, which became effective December 1, 1991, requires health professionals and facilities serving those covered by Medicare and Medicaid to give adult Members written information about the Member's right to have an Advance Directive.

Advance Directives are oral or written statements either outlining a Member's choices for medical treatment or naming a person who should make choices if the Member is incapable to make decisions. Information about Advance Directives is included in the Member handbook. Providers may be asked questions related to the printed information. To obtain a copy of Advance Directives, please contact your Provider Relations Representative.

VIII. SPECIALIST PHYSICIANS

A) RESPONSIBILITIES OF THE CHA SPECIALIST

- Verify eligibility of the Member at the time the authorized services are provided.
- Provide authorized services within his/her scope of practice.
- Refer all patients under the age of twenty-one (21) years with CCS eligible conditions to the local CCS office and obtain prior authorization from CCS when appropriate. Failure to obtain prior authorization from CCS may result in the denial of the claim.
- Notify CCS within twenty-four (24) hours (or first working day) of all inpatient admissions for CCS eligible conditions.
- Provide specialty care services to Members only upon receipt of a written referral form from the Member's PCP or at the request of CHA per CHA referral and prior authorization policies.
- Assure the referral form from the PCP contains a valid CHA Prior Authorization Number and verifying the eligibility of the Member prior to the provision of specialty care services. Failure to comply with the CHA prior authorization and referral policies will result in claim denial.
- Provide only those specialty care services authorized by the referral form.
- Assure the Member's waiting time at the physician's office shall not exceed forty-five (45) minutes, unless the physician is unavailable due to an emergency.
- Prescribe or authorize the substitution of generic pharmaceuticals when appropriate and agreeing to abide by the CalOptima formulary.
- Agree to render services to Members who are diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or HIV positive in the same manner and to the same extent as other Members and under the compensation terms set forth in his/her contract.
- After examination and/or provision of authorized treatment:
 - Advise the PCP of the findings and recommended treatment plan or follow-up care.
 - Provide a written report of findings and recommendations to the PCP within ten (10) working days of service being rendered to the Member.
 - Coordinate authorization with the PCP and/or CHA for additional tests or diagnostic studies necessary to complete his/her evaluation of the Member.
 - Coordinate authorization with the PCP and/or CHA for any additional treatment or follow-up care that may be required.

- Refrain from directing Members to hospital emergency rooms for non-emergent medical services at any time during the term of their Agreement with CHA.
- Educate and instruct Members about the proper utilization of the physician's office in lieu of hospital emergency rooms.
- Share each Member's relevant medical information with the Member's assigned Primary Care Provider (PCP).
- Utilize contracted hospital(s), specialists, and ancillary providers.
- Obtain prior authorization for all elective hospital admissions (Inpatient and Outpatient).
- Comply with CHA Quality Management and Medical Management Policies and Procedures.
- Comply with CalOptima guidelines for scheduling a consultation or other services.

Emergent Care - on the same day as the referral

Urgent Care - within two (2) days of the referral

Routine Care - within thirty (30) days of the referral

B) SPECIALIST'S CHECKLIST

Verify the Member's enrollment prior to initiating services and on the day subsequent services are rendered, by using the BIC Card point-of-service device. This will provide the most accurate eligibility and enrollment information. If BIC is not available in the office, contact AEVS at (800) 456-2387, or call the CHA Member Solutions Department at 714-835-9627.

- Check the Member's ID card each time the Member presents for services and verify against photo identification.
- Verify that prior authorization and/or a properly completed referral form is available prior to providing services.
- Attach a copy of the referral form to all claims submitted to the CHA Claims Department.
- Bill all services provided to a CHA Member on a HCFA-1500.
- Refer all Members with diagnosed CCS conditions to Orange County CCS.
- Obtain prior authorization from CCS when appropriate.

IX. ANCILLARY PROVIDERS

Ancillary Providers includes pharmacy, home health, durable medical equipment, infusion care, vision, dental, transportation, therapy, home and community based service providers and other non-physician providers. CHA has developed a comprehensive ancillary provider network that PCPs and specialist physicians are required to utilize.

A) RESPONSIBILITIES OF THE CHA ANCILLARY PROVIDER

- Rendering covered services to CHA Members in accordance with the specific contract.
- Obtaining prior authorization from CCS when rendering services to a CCS eligible Member for a CCS eligible condition.
- Maintaining sufficient facilities, equipment and personnel to provide timely access to medically necessary covered services.
- Maintaining all licenses, certifications, permits or other prerequisites required by law to provide covered services and submitting evidence that they are in good standing upon the request of CHA.
- Rendering services to Members who are diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or HIV Positive in the same manner and to the same extent as other Members and under the compensation terms set forth in his/her contract.
- Rendering covered services to all CHA Members in an appropriate, timely, and cost effective manner. The provider will cooperate and participate in CHA quality management, utilization review, and complaint procedures.

B) ANCILLARY PROVIDER'S CHECKLIST

- Verify the Member's enrollment prior to initiating services and before rendering subsequent services by calling CHA.
- Check the Member's ID card each time the Member presents for service. The ID card does not guarantee that the Member is still enrolled with CHA.
- Verify the identity of the person presenting the ID card with some other form of identification i.e., driver's license or other photo identification.
- Verify whether a CHA Member has some other type of third party insurance. Providers are responsible for identifying any other insurance and billing the other insurance company before billing CHA.
- Ancillary providers shall indicate prior authorization number on claim form at time of submission. Provider will attach a copy of the referral form if appropriate.
- Bill all services provided to a CHA Member on a HCFA-1500 or a UB 92.

X. REFERRAL PROCEDURES

PCPs are responsible for initiating and coordinating referrals of Members for medically necessary services beyond the scope of their contract or practice. PCPs are also responsible for assisting CHA in identifying and referring Members with CCS eligible conditions to the local CCS office for case management and treatment authorizations. PCPs are to monitor the progress of referred Members' care and see that Members are returned to the PCP's care as soon as medically appropriate.

If a specialist provides services to a CHA Member and recommends further treatment, the CHA specialist should request the authorization from CHA.

Routine referrals are submitted through the CHA Web site at www.CHOCHHealthAlliance.com. If you do not have a password and username to access the CHA Web site, please contact your Provider Relations Representative. Urgent and Emergent referrals are submitted utilizing the CHA Referral Form, and are sent to a CHA contracted health professional. If a contracted health professional is not available, CHA may authorize services to a non-contracted provider.

A) TYPES OF REFERRALS

There are two types of referrals: those that require PA and those that do not require PA (pass-through referrals). The following are services that never require an authorization. The Member may self refer for these services.

- Emergencies do not require authorization; a health professional will perform emergency services and immediately refer the Member to the nearest and most appropriate facility without regard to prior authorization. However, the health plan should be notified of all emergency admissions within twenty-four (24) hours.
- Family Planning services do not require an authorization.

Please refer to the back of the CHA Referral Authorization form for a list of services that require prior authorization. **Most referrals for Members under age twenty-one (21) require prior authorization. This enables CHA to identify possible diagnoses of CCS eligible conditions. Please refer to the Procedures / Services Requiring Prior Authorization attachment on the CD included with this manual for exceptions.**

B) REFERRALS TO OBSTETRICIANS

1. The PCP will refer a pregnant Member to an OB immediately after the pregnancy is confirmed and send a copy of the referral to CHA's Prior Authorization Unit.
2. OBs are responsible for the Member's obstetrical care.
3. An OB may refer a Member back to a PCP for medical services that are outside the scope of the OB's practice. PA is not required.
4. When a Member notifies CHA of the birth of her child, the Member Solutions staff is responsible for assigning the newborn to a PCP.

5. OBs are to schedule an initial appointment with pregnant Members within the applicable time frame after the request for the appointment:
 - **First trimester: within fourteen (14) days**
 - **Second trimester: within seven (7) days**
 - **Third trimester: within three (3) days**
6. Members with high-risk conditions must be seen within three (3) days of identification of the condition or immediately, if an emergency exists.
7. Return visits for Members with uncomplicated pregnancies are to be scheduled per American College of Obstetrics and Gynecology (ACOG) standards as follows:
 - From first prenatal visit through twenty-eight (28) weeks of gestation: every four (4) weeks
 - Between twenty-nine (29) and thirty-six (36) weeks of gestation: every two (2) to three (3) weeks
 - Once a week, after the 36th week of gestation
8. Return visits for Members with high-risk pregnancies are to be scheduled according to the needs of the Member.
9. An OB shall notify CHA within five (5) business days if the OB determines that a Member is carrying multiple fetuses.

C) REFERRAL FORM

The PCP is to complete, date, and sign (signature stamp is acceptable) the CHA Referral Form. If obtaining written PA, the PCP is to mail or fax the Referral Form to CHA's PA Unit. If obtaining PA by telephone, the PCP is to write the PA number in the space provided on the form. Routine referrals are submitted through the CHA Web site at www.CHOCHHealthAlliance.com.

If you do not have a password and username to access the CHA Web site, please contact your Provider Relations Representative. Urgent and Emergent referrals are submitted utilizing the CHA Referral Form, and are sent to a CHA contracted health professional. If a contracted health professional is not available, CHA may authorize services to a non-contracted provider.

If the referral does not require prior authorization, the PCP may send a copy of the Referral Form directly to the specialist.

D) PERIOD OF AUTHORIZATION

Pass-through Referrals are valid for one hundred twenty (120) calendar days beginning with the date the referral is dated and signed by the referring physician, with the following exceptions:

- Referrals for obstetrical services are valid until the first day of the first month following the 60th day after delivery or termination of the pregnancy.
- Orthopedic referrals are limited to an initial consultation and up to two (2) follow-up visits. Follow-up visits must be completed within forty-five (45) calendar days of the date the referral is signed and dated. The specialist must check for continuing CHA and CalOptima eligibility at each visit.
- All other referrals are limited to an initial consultation only.
- To obtain access to the criteria used by CHA when making determinations on Authorization Requests, please contact the Prior Authorization Department at (714) 541-2462 or (800) 387-1103. CHA will send you a copy of the specific section that was used in making the determination.

E) CALIFORNIA CHILDREN'S SERVICES (CCS)

California Children's Services (CCS) provides treatment services and case management to children with special health care needs. These services are available to all medically and financially eligible children, including those who are Medi-Cal / CalOptima eligible. CHA contracted PCPs who encounter children with certain CCS-covered conditions must refer the children to the appropriate CCS regional office.

Assistance in identifying CCS-covered conditions or referring Members to the appropriate CCS regional site can be obtained from the CHA Prior Authorization Unit.

F) ANCILLARY REFERRALS

Contracted physicians may make referrals to ancillary service providers as follows:

1. Laboratory Referrals

Members are to be referred to a contracted laboratory provider unless a PCP's/PCO's/PSP's contract allows on-site laboratory testing. Referrals to contracted providers for medically necessary testing do not require PA. Referrals to non-contracted or hospital laboratories require PA.

2. Dental or Vision Referrals

Vision and Dental services are not the direct financial responsibility of CHA. You may contact your Provider Relations Representative for information on referral procedures and to obtain the necessary forms. Using applicable referral forms, any CHA contracted PCP may send medically necessary referrals directly to CalOptima contracted dental or vision providers without the need for prior authorization. Enrolled Members under the age of twenty-one (21) years may self-refer to dental providers or be referred by the PCP.

3. Radiology

Members are to be referred to a contracted radiology provider unless the PCP's/PCO's/PSP's contract allows radiology services to be performed on-site. Plain films and other services not specifically listed on the Request for Prior Authorization Form do not require a PA.

4. Member Transportation

Requests for medically necessary transportation are to be directed to the CHA PA Department.

G) BILLING/REIMBURSEMENT

1. Billing

Referrals will be considered for reimbursement only if they are appropriately authorized by CHA and are a covered benefit for the enrolled Member. If PA was required, the PA number must be entered on the appropriate billing form.

2. Reimbursement

A referral does not guarantee reimbursement. Reimbursement for services depends on the Member's enrollment on the date(s) of service, medical necessity, plan limitations and exclusions as stated in rules and regulations governing the plan, plan policies and procedures. Plan exclusions include occupational illnesses and injuries, and excessive, inappropriate or unallowable charges.

XI. SERVICES REQUIRING PRIOR AUTHORIZATION (PA)

Prior authorization (PA) is the chief medical management tool by which CHA ensures that Members receive medically necessary, cost-effective health care. Contracted and non-contracted health professionals, hospitals, and other providers are required to comply with CHA's prior authorization policies and procedures. Noncompliance may result in delay or denial of reimbursement.

Prior authorization review includes:

- Verification that the Member is enrolled with CHA at the time of the request and on each date of service
- Verification that the requested service is a covered benefit for the CHA Member
- Assessment of the requested service's medical necessity and appropriateness based on CHA medical review criteria.
- Verification that the service is being provided by a contracted provider

A) REQUESTING PRIOR AUTHORIZATION

1. Requests for PA are to be directed to CHA's PA Unit. Routine referrals are submitted through the CHA Web site at www.CHOHealthAlliance.com. If you do not have a password and username to access the CHA Web site, please contact your Provider Relations Representative. Urgent and Emergent referrals are submitted utilizing the CHA Referral Form, and are sent to a CHA

contracted health professional. If a contracted health professional is not available, CHA may authorize services to a non-contracted provider. Providers are not required to obtain PA before rendering emergency services; however, hospitals are to notify the PA Unit within twenty-four (24) hours of rendering emergency room treatment.

2. If a Member receiving emergency room treatment requires emergent inpatient care, the provider facility will notify the CHA PA Unit immediately of the inpatient admission, whether or not notification of ER treatment has already been given. The PA Unit or triage nurse will document the notification.
3. For non-emergent admission after emergency room treatment, the hospital must notify the PA Unit before the admission.
4. Non-contracted providers must obtain PA before rendering any service outside a hospital setting. Contracted providers must obtain PA before rendering any service that is listed on the Request for Prior Authorization Form.
5. The PCP initiates and coordinates requests for PA, however, CHA recognizes that specialists and other providers may need to contact the PA Unit directly to verify the PA or request authorization for additional services in their specialty areas.
6. Requests for PA may be directed to CHA's PA Unit by mail, telephone, CHA's Web site, or fax as follows:

Address: CHOC Health Alliance
Attention: Prior Authorization Unit
1120 W. La Veta, Suite 450
Orange, CA 92868

Telephone: 714-541-2462, Fax 714-565-5167

Web site: www.CHOCHHealthAlliance.com

7. If a request is approved, the PA Unit will send the provider a prior authorization number in the same manner the request was received.
8. Emergency authorizations will be processed the same day.
9. Urgent authorizations will be processed within twenty-four (24) hours
10. Routine authorizations will be processed within five (5) days
11. Providers must obtain a PA number and include the number on claims submitted to CHA's Claims Department. Failure to do so may result in denial or delay of reimbursement.

Please note that only MEDICALLY Emergent or Urgent Referrals should be marked as such.

B) COMPLETING THE CHA REFERRAL FORM (CRF)

1. Check one (1) of the boxes at the top of the form to indicate whether the referral is routine, urgent, emergent or a pass-through.

*****Please use emergent and urgent only for true urgent and emergent conditions.**

2. The referring Provider should complete the form. All information should be provided on the form. Missing information may delay the processing of the request.
3. The Diagnosis section must be completed indicating presumptive or known diagnosis, including the **ICD-9 code and procedure code/CPT code if requesting a procedure.**

C) REIMBURSEMENT

1. Authorization does not ensure payment if the Member is not enrolled on each date of service or if documentation submitted by the provider does not support the medical necessity of the requested procedure. The provider must verify Member enrollment prior to rendering service.
2. Reimbursement depends on medical necessity, the Member's enrollment on the date(s) of service, plan policies and procedures, and plan limitations and exclusions as stated in the rules and regulations governing the plan. Plan exclusions include services related to occupational illnesses and injuries, and excessive, inappropriate or unallowable charges.

D) RECONSIDERATION OF A DENIAL

1. Chief Medical Officer Reconsideration

Providers who have immediate questions or disputes regarding a denial of a request for Prior Authorization may request reconsideration by the Chief Medical Officer.

2. Complaints

A participating or non-participating health professional or provider may submit a formal written complaint to CHA.

XII. BILLING PROCEDURES

A) MEDI-CAL/CALOPTIMA PROVIDER IDENTIFICATION NUMBER

All health care professionals who participate in the CalOptima program must register and receive a provider number from Medi-Cal. The provider Medi-Cal number is issued by the Medi-Cal Administration, and is obtained through a formal registration process. Providers are responsible for getting a Medi-Cal ID number. If you are notified by Medi-Cal that your provider number has been changed, please notify your CHA Provider Relations Representative as soon as possible. Failure to notify CHA of a Medi-Cal provider number change may result in claims payment errors. If you need assistance in acquiring the Medi-Cal ID number, please contact Medi-Cal directly. To receive a Medi-Cal ID number providers may contact the California Department of Health Services (DHS) at:

**California Department of Health Services
Provider Enrollment
714 P Street, Room 950
P.O. Box 942732
Sacramento, CA 94234-7320
916-323-1945**

Your CHA provider number is your Medi-Cal ID number. **Your claims must indicate your correct provider ID number, or they may be improperly paid or denied.** If you do not know your Medi-Cal ID number, please refer to your contract, or contact your Provider Relations Representative.

B) ACCEPTABLE CLAIM FORMS

CHA requires all providers to use one (1) of two (2) forms when billing for claims.

- A HCFA 1500 is used when submitting claims for **all** professional services, including ancillary services and professional services billed by a hospital.
- Hospital inpatient and outpatient services, dialysis services, nursing home room and board, and inpatient hospice services must be billed on the UB-92 billing form.
- **CHA will not process claims received on any other type of claim form.**

C) COMPLETING A HCFA 1500

When filing a claim on a HCFA 1500, some fields on the form are required to be completed. Listed below are the required field numbers, along with explanations. The number of the field corresponds with the field number on the HCFA 1500 claim form.

The HCFA 1500 form is used to bill professional services provided to our Membership. The following is a description of the current form. The items listed below are used by claims processing.

ITEM 1 PROGRAM

This field shows all type(s) of health insurance coverage applicable to this claim.

ITEM 1a INSURED'S ID NUMBER

The Member's Medi-Cal ID

ITEM 2 PATIENT'S NAME

Where the CHA Member's name is displayed.

ITEM 3 PATIENT'S BIRTH DATE

The birth date and sex of the Member. This data is used to verify that this is in fact a CHA enrolled Member.

ITEM 4 INSURED'S NAME

If the contract for services is under another person's name (e.g. child covered under a parent's contract), the insured's name is listed here.

ITEM 5 PATIENT'S ADDRESS

Another possible verification for Member name and ID number.

ITEM 6 PATIENT RELATIONSHIP TO INSURED

Indicates the relationship of the Member to the insured (e.g. spouse, child or other relation).

ITEM 7 INSURED'S ADDRESS

Another possible verification for Member name and ID number. Required only when items 4, 9 or 11 are completed.

ITEM 8 PATIENT STATUS

Indicates the Member's marital status and whether employed or a student.

ITEM 9 OTHER INSURED'S NAME

If the contract for services is under another persons name (e.g. child covered under a parent's contract) in addition to the one listed in item 4, the insured's name is listed here.

ITEM 9a OTHER INSURED'S POLICY OR GROUP NUMBER

Indicate the other insured's group policy number.

ITEM 9b OTHER INSURED'S DOB & SEX

Lists the other insured's date of birth and sex for verification.

ITEM 9c OTHER INSURED'S EMPLOYER NAME OR SCHOOL NAME

Lists the name of the employer or school that this coverage is provided under.

ITEM 9d OTHER INSURED'S PLAN NAME OR PROGRAM NAME

Identifies the other carrier.

ITEM 10 IS PATIENT'S CONDITION RELATED TO...

Identifies if the claim is work related, due to an auto accident or other type of accident.

ITEM 10d RESERVED FOR LOCAL USE

ITEM 11 INSURED'S POLICY GROUP OR FECA NUMBER

Indicates the group policy number. For most CalOptima Members state either CalOptima or CHA.

ITEM 11a INSURED'S DOB & SEX

Lists the other insured's date of birth and sex for verification.

ITEM 11b INSURED'S EMPLOYER NAME OR SCHOOL NAME

Lists the name of the employer or school that this coverage is provided under.

ITEM 11c INSURED'S PLAN NAME OR PROGRAM NAME

Identifies the other carrier.

ITEM 11d IS THERE ANOTHER HEALTH BENEFIT PLAN?

Used to identify additional coverage which will be listed in item 9.

ITEM 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

Authorizes the provider to release any medical information necessary to process the claim.

ITEM 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

Authorizes the insurance carrier to release payment directly to the provider.

ITEM 14 DATE OF CURRENT ISSUE

The date of current illness, injury, or pregnancy for use in determining pre-existing conditions.

ITEM 15 DATE OF PREVIOUS..

The date of same or similar illness, injury, or pregnancy for use in determining pre-existing conditions.

ITEM 16 DATES UNABLE TO WORK

Dates the Member was unable to work.

ITEM 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

The name of the referring physician.

ITEM 17a ID NUMBER OF REFERRING PHYSICIAN

The ID number of the referring physician.

ITEM 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

Indicates any related inpatient stays.

ITEM 19 RESERVED FOR LOCAL USE

ITEM 20 OUTSIDE LAB

Indicates if laboratory services were provided outside of the office but are included in this billing.

ITEM 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

Where the provider lists the general diagnosis(s) of the Member using current ICD-9 codes.

ITEM 22 MEDICAID RE-SUBMISSION

Where the provider will indicate the original remit code and claim number if this is a re-submission of a previously processed claim.

ITEM 23 PRIOR AUTHORIZATION NUMBER

Where our prior authorization number is indicated for processing.

ITEM 24a DATE(S) OF SERVICE

Indicates the date(s) that services were provided. Date spans are not acceptable. Each individual date needs to be billed on a separate line.

ITEM 24b PLACE OF SERVICE

Indicates where the service took place (e.g. doctor's office, inpatient hospital, outpatient hospital etc.).

ITEM 24c TYPE OF SERVICE

Indicates the type of service provided (e.g. surgery, anesthesia etc.).

ITEM 24d PROCEDURES, SERVICES, OR SUPPLIES

Indicates the service provided using current HCPCS or CPT codes with modifiers as appropriate.

ITEM 24e DIAGNOSIS CODE

Indicates the specific diagnosis the procedure was to treat. Should also be listed in item 21.

ITEM 24f CHARGES

The amount the provider is billing for the service provided. If a provider is contracted for capitated services, all encounters **must be submitted** with a dollar amount. Please do not enter zero or no charge for amount billed.

ITEM 24g DAYS OR UNITS

If the service was provided over a number of days or in excess of a single unit, the quantity will be listed here.

ITEM 24h CHDP/FAMILY PLANNING

Indicates if the services provided were related to the CHDP or Family Planning programs.

ITEM 24i EMG

Used to identify if the service was rendered in a hospital emergency room. If this item is checked, the place of service code in item 24b should match.

ITEM 24j COB

Used to indicate that coordination of benefits procedures apply.

ITEM 24k RESERVED FOR LOCAL USE

Used by Medicare to identify the different providers of service that are billed on the claim. CHA can only process one (1) provider per claim so this is not used.

ITEM 25 FEDERAL TAX IDENTIFICATION NUMBER

The servicing provider's tax ID or Social Security # must be entered here.

ITEM 26 PATIENT'S ACCOUNT NUMBER.

The provider's office uses this to reference Member's account files.

ITEM 27 ACCEPT ASSIGNMENT

This field is completed if the physician/supplier accepts assignment of Medicare benefits.

ITEM 28 TOTAL CHARGE

The total amount the provider is billing for the services provided.

ITEM 29 AMOUNT PAID

The amount paid by any other payer. This amount is documented on the

Explanation of Benefits which must be attached to the claim.

ITEM 30 BALANCE DUE (IF DIFFERENT THAN ITEM 28)

Indicates the amount due after any deductions for other payers.

ITEM 31 SIGNATURE OF PHYSICIAN OR SUPPLIER

This must be indicated. The acceptable signatures are as follows:

A) Provider's signature or that of any authorized office personnel except for hospital, must be the name of the servicing provider or

B) Provider's signature rubber stamped or

C) Computer generated claim form with the provider's name in BLOCK LETTERS.

ITEM 32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED

The location the actual services were provided. This may match the billing address listed in item 33.

ITEM 33 PHYSICIAN'S, SUPPLIER'S BILLING ADDRESS

The information required for billing. The Medi-Cal ID number is usually found here.

1) HCFA 1500 DOCUMENTATION

- All claims that involve Medicare or other insurance must be accompanied by an explanation of benefits (EOB) or remittance advice.
- All claims that involve a sterilization procedure, must be accompanied by a copy of the Consent for Sterilization form.

D) HOSPITAL AND CLINIC BILLING

Professional services performed at a hospital or clinic must be billed on a HCFA 1500 with the servicing provider's name listed in box 31 and the servicing provider's Medi-Cal number listed in box 33. The "pay to" name in box 33 may be the hospital or clinic name but the Medi-Cal number must be that of the individual servicing provider.

Therefore, any provider rendering services to a CHA Member must have an individual Medi-Cal ID number. This number must be used on the HCFA 1500. For example:

Dr. USA is a contracted physician with Good Care Hospital. The hospital does the billing for Dr. USA for any services performed at the hospital. Dr. USA's provider number would be entered in box 33, but the address could be Good Care Hospital. Once the claim is received at CHA the payment would be made directly to the hospital. If Dr. USA bills for services rendered at his/her private office, the address in box 33 would be the private address and reimbursement would be made to that address. If you have any questions on this billing change, please contact your Provider Relations Representative.

E) COMPLETING THE UB-92

The UB-92 form will be used to bill facility services provided. The following is a field by field description of the form:

ITEM 1 PROVIDER NAME, ADDRESS & TELEPHONE NUMBER

The name of the provider submitting the bill and the complete mailing address to which the provider wishes payment sent.

ITEM 2 UNLABELED FIELD

This field is reserved for State use.

ITEM 3 PATIENT CONTROL NUMBER

Member's unique alphanumeric number assigned by the provider to facilitate retrieval of individual financial records and posting of payment.

ITEM 4 TYPE OF BILL

A code indicating the specific type of bill (inpatient, outpatient, etc.)

ITEM 5 FEDERAL TAX NUMBER

The number assigned to the provider by the federal government for tax reporting purposes.

ITEM 6 STATEMENT COVERS PERIOD

The beginning and ending service dates of the period that is included on this bill. Providers should not submit to CHA claims with dates of service that span two (2) contract years. That is, do not submit UB-92 forms that include December and January dates of service. All UB-92 claim forms need to be split so that contract years are not over-lapping on the claim form. Claims not split properly will cause delays in claim payment.

ITEM 7 COVERED DAYS

The number of days covered by the primary payer, as qualified by the payer organization.

ITEM 8 NON-COVERED DAYS

Days of care not covered by the primary payer.

ITEM 9 COINSURANCE DAYS

The inpatient Medicare days occurring after the 60th day and before the 91st day in a single episode of illness.

ITEM 10 LIFE TIME RESERVE DAYS

Under Medicare, each beneficiary has a lifetime reserve of sixty (60) additional days of inpatient hospital services after using ninety (90) days of inpatient hospital services during an illness.

ITEM 11 UNLABELED FIELD

This field is reserved for State use.

ITEM 12 PATIENT NAME

Last name, first name and middle initial of the Member.

ITEM 13 PATIENT ADDRESS

The address of the Member, as defined by the payer organization.

ITEM 14 PATIENT BIRTH DATE

The date of birth of the Member.

ITEM 15 PATIENT SEX

The sex of the Member as recorded at date of admission, outpatient service, or start of care.

ITEM 16 PATIENT MARITAL STATUS

The marital status of the Member at date of admission, outpatient service, or start of care.

ITEM 17 ADMISSION/START OF CARE DATE

The date the Member was admitted to the provider for inpatient care, outpatient service, or start of care.

ITEM 18 ADMISSION HOUR

The hour during which the Member was admitted for inpatient or outpatient care.

ITEM 19 TYPE OF ADMISSION

The code indicating the priority of this admission.

ITEM 20 SOURCE OF ADMISSION

A code indicating the source of this admission.

ITEM 21 DISCHARGE HOUR

The hour that the Member was discharged from inpatient care.

ITEM 22 PATIENT STATUS

A code indicating Member status as of the ending service date of the period covered on this bill, as reported in ITEM 6.

ITEM 23 MEDICAL/HEALTH RECORD NUMBER

The number assigned to the Member's medical/health record by the provider.

ITEM 24-30 CONDITION CODES

A code(s) used to identify conditions relating to this bill that may affect payer processing.

ITEM 31 UNLABELED FIELD

This field is reserved for National use.

ITEM 32-35 OCCURRENCE CODES AND DATES

The code and associated date defining a significant event relating to this bill that may affect payer processing.

ITEM 36 OCCURRENCE SPAN CODE AND DATES

A code and the related dates that identify an event that relates to the payment of the claim.

ITEM 37 INTERNAL CONTROL NUMBER (ICN)/DOCUMENT CONTROL NUMBER (DCN)

The control number assigned to the original bill by the payer or the payer's intermediary.

ITEM 38 RESPONSIBLE PARTY NAME AND ADDRESS

The name and address of the party responsible for the bill.

ITEM 39-41 VALUE CODES AND AMOUNTS

A code structure to relate amounts or values to identified elements necessary to process this claim as qualified by the payer organization.

ITEM 42 REVENUE CODE

A code which identified a specific accommodation, ancillary service or billing calculation.

ITEM 43 REVENUE DESCRIPTION

A narrative description of the related revenue categories included in this bill.

ITEM 44 HCPCS/RATES

The accommodation rate for inpatient bills and the HCFA Common Procedure Coding System (HCPCS) applicable to ancillary service and outpatient bills.

ITEM 45 SERVICE DATE

The date the indicated service was provided.

ITEM 46 UNITS OF SERVICE

A quantitative measure of services rendered by revenue category to or for the

Member to include such items as number of accommodation days, miles, pints of blood, treatments, etc.

ITEM 47 TOTAL CHARGES (BY REVENUE CODE CATEGORY)

Total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period.

ITEM 48 NON-COVERED CHARGES

To reflect non-covered charges for the primary payer pertaining to the related revenue code.

ITEM 49 UNLABELED FIELD

This field is reserved for National use.

ITEM 50 PAYER IDENTIFICATION

Names and, if required, number identifying each payer organization from which the provider might expect some payment for the bill.

ITEM 51 PROVIDER NUMBER

The number assigned to the provider by the payer indicated in ITEM 50.

ITEM 52 RELEASE OF INFORMATION CERTIFICATION INDICATOR

A code indicating whether the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.

ITEM 53 ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR

A code showing whether the provider has a signed form authorizing the third party payer to pay the provider.

ITEM 54 PRIOR PAYMENTS - PAYERS AND PATIENT

The amount the hospital has received toward payment of this bill prior to the billing date by the indicated payer.

ITEM 55 ESTIMATED AMOUNT DUE

The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).

ITEM 56 UNLABELED FIELD

This field is reserved for State use.

ITEM 57 UNLABELED FIELD

This field is reserved for National use.

ITEM 58 INSURED'S NAME

The name of the individual in whose name the insurance is carried.

ITEM 59 PATIENT'S RELATIONSHIP TO INSURED

A code indicating the relationship of the Member to the identified insured.

ITEM 60 CERTIFICATE/SOCIAL SECURITY NUMBER/HEALTH
INSURANCE CLAIM/IDENTIFICATION NUMBER.

Insured's unique identification number assigned by the payer organization.

ITEM 61 INSURED GROUP NAME

Name of the group or plan through which the insurance is provided.

ITEM 62 INSURANCE GROUP NUMBER

The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.

ITEM 63 TREATMENT AUTHORIZATION CODE

A number or other indicators that designates that the treatment covered by this bill has been authorized by the payer.

ITEM 64 EMPLOYMENT STATUS CODE

A code used to define the employment status of the individual identified in ITEM 58.

ITEM 65 EMPLOYER NAME

The name of the employer that might or does provide health care coverage for the insured individual identified in ITEM 58.

ITEM 66 EMPLOYER LOCATION

The specific location of the employer of the insured individual identified in ITEM 58.

ITEM 67 PRINCIPAL DIAGNOSIS CODE

The ICD-9-CM codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).

ITEM 68-75 OTHER DIAGNOSES CODES

The ICD-9-CM diagnoses codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.

ITEM 76 ADMITTING DIAGNOSIS

The ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

ITEM 77 EXTERNAL CAUSE OF INJURY CODE (E-CODE)

The ICD-9-CM code for the external cause of an injury, poisoning, or adverse effect.

ITEM 78 UNLABELED FIELD

This field is reserved for State use.

ITEM 79 PROCEDURE CODING METHOD USED

An indicator that identifies the coding method used for procedure coding on the bill.

ITEM 80 PRINCIPAL PROCEDURE CODE AND DATE

The code that identifies the principal procedure performed during the period covered by this bill and the date on which the principal procedure described on the bill was performed.

ITEM 81 OTHER PROCEDURE CODES AND DATES

The codes identifying all significant procedures other than the principal procedure and the dates (identified by code) on which the procedures were performed.

ITEM 82 ATTENDING PHYSICIAN ID

The name and/or number of the licensed physician who would normally be expected to certify and rectify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.

ITEM 83 OTHER PHYSICIAN ID

The name and/or number of the licensed physician other than the attending physician as defined by the payer organization.

ITEM 84 REMARKS

Notations relating specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements.

ITEM 85 PROVIDER RELATIONS REPRESENTATIVE SIGNATURE

An authorized signature indicating that the information entered on the face of this bill is in conformance with the certifications on the back of this bill.

ITEM 86 DATE BILL SUBMITTED

The date on which the bill is submitted to the payer.

F) TIMELY CLAIM SUBMISSION REQUIREMENTS

CHA requires that providers initially submit claims within the contracted deadline and should consult the contract to determine the initial filing requirement. Providers have one (1) year from the date of service to correct and resubmit claims, if the initial submission time period has been met. A "clean claim" is defined in California Revised Statute as one that can be processed without obtaining additional information from the provider of service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim selected for medical review by CHA Medical Review staff. Failure to adhere to this requirement will result in the denial of claims.

Providers are required to submit claims for all services rendered, whether the services are capitated or fee-for-service. **Claims should be electronically filed through a CHA vendor. If you are not currently set up to file claims electronically, please contact your Provider Relations Representative. For claims with attachments and resubmissions, please mail to:**

**CHOC Health Alliance
Attention: Claims Department
P.O. Box 62108
Phoenix, AZ 85082-2108**

G) CLAIMS RESUBMISSION

If a provider believes his/her claim has not been properly processed, CHA has a procedure to help the provider resolve those issues and to re-submit the claim. If a provider has met the initial submission requirements as stated in his/her contract, the provider has up to twelve (12) months from the date of service to re-submit the clean claim.

To re-submit a claim, the following is required:

1. A copy of the claim, marked re-submission
2. A copy of the remittance advice
3. Make a notation on the claim or the remit as to the reason for re-submitting the claim, and any corrections made. The provider must sign and date his/her notation and provide CHA with a telephone number should CHA need to contact the provider
4. The provider must mail the claim and all attachments to:

**CHOC Health Alliance
Attention: Claims Resubmissions Department
P.O. Box 62108
Phoenix, AZ 85082-2108**

H) CLAIM INQUIRIES

Providers may call the Claims Unit at 800-387-1103 and select option 1.

I) THIRD PARTY RESOURCES

CHA is, by law, the payer of last resort for CalOptima Members. Therefore, providers must bill and obtain an Explanation Of Benefits (EOB) from any other insurance company or source of health care coverage prior to billing CHA, as required by his/her contract.

Providers should refer to his/her contract for submission deadlines concerning third party claims. Once the other carrier has been billed and an Explanation Of Benefits (EOB) has been received, the provider may then submit the claim to CHA. Please attach a copy of the EOB to the submitted claim. The EOB must be complete in order to understand the paid amount or the denial reason.

Providers have six (6) months from the date of service to submit the claim to CHA. Any claim received over twelve (12) months from the date of service will be denied. Other insurance carriers' requirements must be met or claim may be denied.

J) TECHNICAL ASSISTANCE

For technical assistance related to billing, please contact your Provider Relations Representative. Orientation sessions can be scheduled to discuss areas of difficulty.

XIII. THE COMPLAINT PROCESS

All providers of services to CHA Members may appeal any adverse action by CHA. However, CHA encourages providers to file claims correctly or, if time allows, resubmit the claim through CHA to resolve the issue.

A) CHA CLAIMS COMPLAINTS

A provider is encouraged to contact a CHA Provider Relations Representative to help clarify any denials or other actions relevant to the claim and to help with a possible re-submission of a claim with modifications. **Once a claim is initially submitted in a timely manner, a provider has one (1) year from the date of service to correct the initial claim submission and to resubmit the claim for reprocessing.**

B) FILING A FORMAL COMPLAINT

If the issue is not resolved after CHA assistance, the provider may challenge the claim denial or adjudication by filing a formal complaint with CHA. The provider must institute any complaint challenging a claim denial or adjudication within twelve (12) months from the date of service, or, for a hospital inpatient stay, twelve (12) months from the date of discharge. Complaints on issues other than claim denials, such as challenges of authorization denials or recoupments, must be filed no later than thirty-five (35) days from the date of the adverse action.

A complaint must be submitted in writing and state with particularity the factual and legal basis therefore and the relief requested, along with any supporting documents (i.e. claim, remit, medical review sheet, medical records, correspondence, etc.). Particularity usually means a chronology of pertinent events and a statement as to why the provider disagrees with the decision by CHA. **Please submit complaints to:**

**CHOC Health Alliance
Attn: Provider Grievance Coordinator
1120 W. La Veta Avenue #450
Orange, CA 92868**

XIV. MEDICAL MANAGEMENT

The CHA Medical Management Department monitors and evaluates the utilization, quality, and continuity of the medical services provided to Members through the network of providers. The Chief Medical Officer, prior authorization and case management staff, and consultants contribute strong, effective support services to assist providers in the utilization of medical resources.

A) PRIOR AUTHORIZATION (PA)

CHA requires providers to obtain prior authorization before making referrals to certain specialists or providing certain procedures or services. PA offers CHA the opportunity to evaluate services for continuity of care, medical necessity, cost, and efficiency before services are rendered and is a chief means by which CHA manages utilization.

Because the Primary Care Physician (PCP) coordinates most services provided to a Member, it is typically the PCP who initiates requests for prior authorization; however, specialists and ancillary providers also request prior authorization for services within their specialty areas.

Unless another department has been specially designated to authorize a service, requests for PA are routed through the Medical Management Department's PA Unit, where nurses are available twenty-four (24) hours a day, seven (7) days a week. Routine referrals should be submitted through the CHA Web site at www.CHOCHHealthAlliance.com. If you do not have a password and username to access the CHA Web site, please contact your Provider Relations Representative. Urgent and Emergent referrals are submitted utilizing the CHA Referral Form and sent to a CHA contracted health professional. If a contracted health professional is not available, CHA may authorize services to a non-contracted provider.

The PA Unit includes licensed nurses with clinical expertise in specialties such as labor and delivery, home health, long-term care, surgery, orthopedics, pediatrics, and emergency room services.

The primary responsibility of the PA Unit is to evaluate providers' requests for PA. The evaluation includes:

- Verification that the Member is enrolled in CHA and that the requested service is a covered benefit for the Member
- Verification that the requestor is a participating provider
- Assessment of medical necessity based on CHA's medical review criteria
- Assessment of the appropriateness of the service location

Prior Authorization is also responsible for receiving and documenting notifications from facilities of inpatient admissions and emergency room treatment. Additionally, the unit coordinates requests to arrange prompt PCP follow-up services for Members who have received emergency room treatment.

In order to process requests for authorization more efficiently, a medical review nurse is designated to coordinate requests for elective services that require the review of the Chief Medical Officer. (These may be requests for which additional documentation is necessary or requests for services that do not clearly meet California Physician's medical review criteria).

Denial Reconsideration

Providers may request an informal reconsideration of a denial by contacting the Prior Authorization Unit by telephone or fax. With the request, the provider should submit additional information or documentation for review by the Chief Medical Officer. A provider may also file a formal complaint.

B) CARE MANAGEMENT DEPARTMENT (CASE MANAGEMENT)

The Care Management Department provides case management services to enhance the care that participating physicians give to Members with multiple or complex medical or social needs. Care Management's skilled nurses are available to coordinate resources to meet Members' medical needs at any point in the continuum of care.

For Members who are referred to case management, the Care Management Department assigns a case manager. The case manager prepares a care plan, coordinates multidisciplinary medical management resources, coordinates requested ancillary services, provides telephone contact with the Member, and conducts home visits when necessary. The PCP receives periodic reports of the Member's progress.

Providers may refer Members to the Care Management by submitting a referral on the CHA Web site. Referrals may be submitted by fax at 714-516-4286, or by telephone at 714-541-2462.

Inpatient Case Management (Concurrent Review)

Nurse case managers evaluate Members' admissions to inpatient and extended care settings and other clinical facilities. The services provided in facilities are reviewed for medical necessity and appropriateness of the level of care using nationally recognized concurrent review criteria, Milliman Optimal Recovery Guidelines. (InterQual criteria are used for conditions that do not fall within Milliman guidelines.)

Nurse case managers are also responsible for monitoring emergency room usage, screening for quality and/or risk management issues, and coordinating Members' case management and/or ancillary service needs upon discharge. Inpatient case management is performed by registered nurses and the CHA CMO and is available seven (7) days a week.

Initial reviews of inpatient services are conducted within twenty-four (24) hours after a Member's admission to a facility. Inpatient case managers' responsibilities include:

- Evaluation of medical necessity and appropriateness of the level of care (based on Milliman Optimal Recovery Guidelines or, if necessary, InterQual criteria).
- Assessment to identify quality, risk, and utilization issues (with referrals to appropriate CHA medical committees)
- Evaluation of Members' needs for post-discharge services (such as home health, durable medical equipment, etc.) and coordination of the services with the hospital and physician

The number of inpatient stay days that may be authorized varies depending on the Member's diagnosis and condition. The number of days initially authorized will be modified if a concurrent review indicates that the Member's condition has improved or deteriorated. If a Member's condition does not meet continued stay criteria, the CMO will attempt to contact the attending physician(s). The CMO reviews potential denials and is responsible for issuing denials related to a Member's inpatient stay.

Denial Reconsideration

A provider may request the reconsideration of a denial by providing further information or documentation for review. Reconsideration requests will be reviewed By the Chief Medical Officer who issued the denial, if he/she is available.

CHA's Chief Medical Officer (CMO)

CHA's CMO participates in the inpatient case management review process and are responsible for final authorization decisions. The CMO is available for consultation between 8 a.m. and 5 p.m., Monday through Friday. During evenings, weekends, and holidays, the CMO is available for telephone consultation through the CHA PA Unit.

C) MEDICAL CLAIMS REVIEW

Nurses in the Medical Management Department's Medical Claims Review (MCR) Unit review claims submitted by health professionals and providers before the claims are paid. The MCR nurses use medical review criteria to make certain the billed services are covered benefits for the Member and were medically necessary. Medical Claims Review evaluates claims for emergency room, transportation, and inpatient and outpatient medical services (including outliers).

D) COMMITTEES

The committees discussed below support the CHA medical management program. A physician who wishes to participate on a committee should contact the Chief Medical Officer at 714-565-5100.

Utilization Management Committee

The Utilization Management Committee includes the CMD or a designee, the Director of Medical Management, a Quality Management representative, and four (4) or more participating physicians who represent varied specialties. (The physicians may serve two (2) or more years.) The committee meets at a minimum of ten (10) times a year. Utilization Management Committee activities are directed toward improving medical outcomes for Members.

The activities include:

- Reviewing and recommending criteria to use in the concurrent review process
- Recommending studies to evaluate medical care provided to Members
- Reviewing the results and outcomes of the studies
- Assisting in the development of practice parameters
- Reviewing and approving medical review criteria
- Evaluating and recommending actions on peer review issues
- Reviewing and making recommendations based on physicians' requests to remove prior authorization requirements from tests or procedures

XV. CALIFORNIA CHILDREN'S SERVICES (CCS) MEDICAL ELIGIBILITY OVERVIEW

California Children's Services, a state program for physically disabled recipients under the age of twenty-one (21) years. Under CCS regulations Children under the age of twenty-one (21) years who meet medical, residential and financial criteria are eligible for specialty diagnostic, treatment, case management, and physical/occupational therapy services. The following is an overview of conditions eligible for CCS. The address and telephone number for the local CCS is included on page 7 of this manual.

Infective and Parasitic Diseases ICD-9, 000-136.9

In general, these conditions are eligible when they:

- involve the CNS and produce disabilities requiring surgical and/or rehabilitation services
- involve bone
- involve eyes and may lead to blindness
- are congenitally acquired infections which may result in disability (ie: Herpes, Rubella, etc.)

Neoplasms ICD-9, 140-208.91, 210-228.1

- all malignant neoplasms, including leukemia
- benign neoplasms are eligible when they constitute a significant disability or significantly interfere with function

Endocrine, Nutritional and Metabolic Diseases ICD-9, 240-279.9

In general, the following conditions are eligible:

- diseases of pituitary, thyroid, parathyroid, adrenal, pancreas, ovaries, testes; varied disorders of metabolism such as cystic fibrosis phenylketonuria, diabetes mellitus
- avitaminosis and other dietary deficiencies causing FFT, exogenous obesity are not eligible

Diseases of Blood and Blood-Forming Organs ICD-9, 280-289.9

In general, all these conditions are eligible:

- sickle cell anemia, hemophilia, aplastic anemia
- iron or vitamin deficiency anemias are not eligible

Mental Disorders ICD-9, 290-315.9

- conditions of this nature are not eligible except when the disorder is associated with or complicates an existing CCS-eligible condition
- diagnosis and treatment under these conditions is limited

Diseases of the Nervous System ICD-9, 320-359.9

- Diseases of the nervous system are, in general, eligible when they produce physical disability (e.g. paresis, paralysis, ataxia)

- Specific conditions not eligible are self-limiting conditions such as acute neuritis and neuralgia, meningitis that does not produce sequelae or physical disability, and learning disabilities
- Previously diagnosed convulsive disorders when they constitute severe management problems are eligible

Sensory Organs ICD-9, 360-389.9

- **Eyes:** Strabismus is eligible except when periodic refraction and glasses **or** patching is the **only** recommended treatment
- Chronic infections of the eye. Infections with a benign course and ordinary refractive errors are not eligible
- **Ears:** Chronic Otis Media is eligible (defined a perforation of the eardrum and pus is visible in the ear canal)
- Serious Otis Media is not eligible. However, if CCS eligible conductive hearing loss due to the fluid persists after treatment with antibiotics and/or PE tubes, this condition becomes eligible. Serious Otis Media is also eligible when it is part of another CCS eligible conditions (i e: Cleft Palate) or when it complicated the management of another CCS eligible condition such as sensorineural hearing loss

Diseases of the Circulatory System ICD-9,390-458.9

- Conditions involving the heart, vascular and lymphatic system are, in general, eligible

Diseases of the Respiratory System ICD-9, 460-519.9

- Upper respiratory tract: these conditions are eligible if they cause severe disability; interfere with functions, are part of a CCS-eligible condition, or complicate the management of a CCS-eligible condition
- Lungs: chronic pulmonary disease is eligible

Diseases of the Digestive System ICD-9, 520-577.9

- Malocclusion is eligible subject to CCS screening and acceptance for care
- Dental caries are eligible for Members who are under orthodontic care. Dental caries are also eligible in children with certain diseases when the nature or severity of the disease makes dental care a necessary part of the management (examples: rheumatic fever, congenital heart disease, cystic fibrosis, cerebral palsy, leukemia, etc.)
- Congenital abnormalities of the GI system, chronic infections or other chronic diseases are eligible

Diseases of the Genito-Urinary System ICD-9, 580-629.9

- Acute conditions are eligible when severe. Chronic conditions are eligible

Complications of Pregnancy, Childbirth, and Puerperium ICD-9, 630-677

- These conditions are eligible when they occur in the presence of certain CCS-eligible chronic diseases (e.g., C.F., diabetes, chronic renal or cardiac disease)
- Prenatal care, therapeutic abortion, or delivery may be provided if the pregnancy compromises the co-existing chronic disease

Diseases of the Skin and Subcutaneous Tissue ICD-9, 680-709.9

- These conditions are eligible if they are disabling. Minor orthopedic conditions such as toeing-in, knock-knees, flat feet are not eligible. They may be eligible if expensive bracing, multiple casting, and/or surgery are required

Congenital Anomalies ICD-9, 740-759.9

- Congenital anomalies of the various systems are eligible if the condition is amenable to correction
- Relatively minor conditions are not eligible

Accidents, Poisonings, Violence, and Immunization Reactions ICD, 800-999.9 AND E800-999.1

- These conditions are, in general, eligible when: they are of a serious nature, lead to significant deformity or disability, and/or require surgery
- Acute, self-limiting poisoning due to drugs/alcohol are not eligible. Similarly, simple fractures requiring casting are not eligible

Certain Causes of Perinatal Morbidity and Mortality ICD-9, 760-779.9

- A neonate with an identified CCS condition is eligible irrespective of acuity care required (examples: congenital heart disease or other congenital abnormalities, chronic lung disease such as BPD, etc.)
- Acuity criteria for NICU cases. Infants, 0-28 days, who require NICU care but do not have an identified CCS condition, are eligible for care in a CCS approved NICU unit if they meet one or more of the following CCS acuity care criteria:
 1. Ventilator assistance
 2. CPAP (includes nasal CPAP)
 3. FiO2 greater than 30%
 4. UA, UV, PAC, or Broviac lines
 5. Apneic and/or bradycardiac spells requiring stimulation 10/day or more often
 6. Chest tube in place
 7. Multiple and frequent procedures, defined as two or more of the following:
 - frequent vital signs (every two hours or more often)
 - frequent PVS, PPDS, CPT
 - maintenance of I.V. line for medication
 - hyper alimентация
 - frequent suction (every hour or more frequently)
 - frequent and/or lengthy feedings

******CCS coverage ceases when criteria listed is no longer applicable.**

XVI. QUALITY MANAGEMENT (QM) PROGRAM

CHA has a systematic and ongoing Quality Management (QM) Program that operates under the leadership of the CMO. The purpose of the program is to assure a strong monitoring and evaluation process designed to focus on quality of care issues. The program pertains to contracted and non-contracted health care professionals who provide services to CHA Members. Health care delivery methods are monitored and evaluated to continuously improve and to resolve identified QM issues.

Major components of the Program include:

- Adverse outcomes/quality issues
- Special medical practice studies
- Pharmacy/Drug Utilization
- Ancillary Provider Review
- Review of Member/provider internal CHA and CalOptima complaints related to delivery of care or service
- Physician Office on site medical record reviews and office evaluations
- Physician Profiling
- Peer Review
- Credentialing/Re-credentialing Program
- Risk Management
- CHDP/Maternal Child Health
- QM Committee
- Member & Provider Surveys

Quality Management is a cooperative effort involving CHA staff, CHA CMO and health care professionals and providers.

A) CREDENTIALING

All contracted health professionals are required to be credentialed by CHA. The physician and certain other health professionals are responsible for the completion of the CHA Credentialing application and for providing all supplemental documentation requested. CHA Provider Relations Representatives will provide the Credentialing application to new physicians prior to a contract being signed.

Completed initial credentialing applications are forwarded by the Provider Relations Representative to CHA Quality Management Department for internal processing. Provisional approval may be given prior to review by Credentialing Committee, but final approval will be given only after review by the Credentialing Committee. Completed, verified credentials are reviewed by the CMO, the Credentialing Committee, and may be reviewed by the Quality Management Committee.

Every three (3) years thereafter, a re-credentialing packet will be sent to the provider, which will be completed and returned directly to the attention of the CHA Quality Management Department. These files along with the profile data are then reviewed by the Credentialing Committee.

B) PHYSICIAN PROFILES

CHA evaluates the practice patterns of certain contracted physicians through a review of claims and encounter data, financial data, pharmacy data, complaints, surveys, quality issues/adverse outcomes, medical record reviews, and complaint activity. Data is used to create a profile of the physician's practice patterns as compared to other physicians in the same specialty with industry norms and Plan experience. The physician then receives feedback on a regular basis as to how they compare to other physicians within their specialty and geographic area, and how well they adhere to CHA managed care philosophy.

C) PEER REVIEW

Peer Review activities are evaluated by the CHA QM Committee under the direction of the CMO. Health professionals who are reviewed and not satisfied with the results are provided an opportunity to appeal the QM Committee's recommendation. Complaints may be submitted to the QM Committee via a written request stating the reasons the provider does not agree. Alternatively, the provider may request to present his/her case in person at a QM Committee meeting.

D) QUALITY MANAGEMENT COMMITTEE

The Quality Management Committee in an advisory role assists the CMO in overseeing CHA Statewide Quality Management Program.

Major functions of the committee include:

- Medical Record Standard Review Outliers
- Review patient services, identify problems, make recommendations to the CMO
- Review quality issues/adverse outcomes
- Review credentials referred by Credentialing Committee
- Peer Review
- Review Member/provider and CalOptima complaints related to delivery of care and service
- Review standards/guidelines

The Quality Management Committee meets monthly and physicians who have an interest in participating in this committee are encouraged to contact the CMO's office.

E) CREDENTIALING COMMITTEE

The Credentialing Committee is responsible for review of the professional credentials for potential participating healthcare professionals, certain allied health professionals and currently contracted health professionals. For current PHP's, profile data is reviewed along with credentials during the re-credentialing process. The Committee also assists in the development of certain credentialing policies and procedures. The Credentialing Committee meets as needed and physicians who have an interest in participating in this committee are encouraged to contact the CHA CMO.

XVII. GLOSSARY OF TERMS

Access-A Member's ability to obtain medical care. The ease of access is determined by several components, including the availability of medical services and their acceptability to the Members, the location of facilities, transportation, hours of operation and cost.

Aid Codes-The two-digit number which indicates the aid category under which a person is eligible to receive Medi-Cal benefits.

AFDC-Aid to Families with Dependent Children under Title IV-A of the Social Security Act, as amended.

Ancillary Provider Services-Supplemental health care services such as: pharmacy, medical supplies, equipment, transportation, laboratory, etc., either prescribed or referred by a physician.

Appeal-A formal mechanism that allows a provider the right to appeal a complaint decision.

Authorization-An administrative procedure whereby CHA gives approval of medical services rendered to Members, such as outpatient procedures, hospitalization, referrals to a physician specialist, etc.

Auto Assignment-An automated method of enrolling CalOptima eligible persons with a health plan and a PCP according to CalOptima policy.

Billed Charges-Charges billed by a provider rendering service to a CHA Member.

Board Certified-A physician who has successfully completed a required residency in an approved training facility and meets, or is in the process of meeting, the experience requirements for examination of the respective board.

CalOptima-Orange County's Medi-Cal managed care program.

CalOptima Benefits-CalOptima covered medical services.

CalOptima Direct-CalOptima's Fee-For-Service Health Plan which handles CalOptima Members who have not been enrolled in a capitated health plan.

Capitation Payment-A predetermined periodic payment, based upon the number of assigned Members, that is made to provider by CHA for providing Covered Services for a specific period. Also the mode of payment by which CalOptima reimburses CHA based on the contractual arrangement through which CHA agrees to arrange for the provision of specified services to Members enrolled in CHA.

Capitated Service-Any Medi-Cal covered service for which a contracted capitated health plan receives capitation payment.

CHA-CHOC Health Alliance-The Physician Hospital Consortium (PHC) composed of the Children's Hospital of Orange County (CHOC) and the CHOC Physicians' Network (CPN).

Categorically Eligible-Individuals who are mandatory eligible under federal law because they receive AFDC or SSI benefits. These individuals are not required to complete a separate CalOptima eligibility determination.

CHDP-Child Health and Disability Prevention (CHDP) program covers screening and diagnostic services to determine physical or mental defects in children under age twenty-one (21); and to ascertain health care treatment and other measures to correct or ameliorate any defects or chronic conditions discovered. (Title 22, California Code of Regulations, Section 51340)

Chief Medical Officer-A physician who is designated by CHA to have overall administrative responsibility for the direction of the CHA medical delivery system.

Chiropractic Services-Treatment, provided by a licensed chiropractor who meets uniform minimum Medicare standards, by means of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

Clean Claim-A claim with all requirements for adjudication as defined by CalOptima policy.

Complaint-a written formal complaint of dissatisfaction arising from an adverse action, discussion, or policy. Inquiries and requests for information are not complaints, therefore the complaint procedures are not applicable.

Concurrent Review-A type of Member/medical care evaluation study performed while a Member is still hospitalized, that may involve process or intermediate outcome criteria and regular data collection.

Contract-The present and future Agreement between CHOC Health Alliance (CHA) and CalOptima for the purpose of providing health care services under the Medi-Cal program.

Contractor-CHOC Health Alliance.

Covered Services-Those specific services delineated in Attachment A.1 of the provider contract or mentioned in Medi-Cal / CalOptima Rules and Regulations.

CQI-Continuous Quality Improvement

CCS-California Children's Services, a state program for physically disabled recipients under the age of twenty-one (21) years. Under CCS regulations Children under the age of twenty-one (21) who meet medical, residential and financial criteria are eligible for specialty diagnostic, treatment, case management, and physical/occupational therapy services.

DHS-California Department of Health Services is the State agency responsible for administering the Medi-Cal program.

Discharge Planning-Identification of the need and provision for a Member's health care requirements after he/she is discharged from the hospital.

Disenrollment-The discontinuance of a Member's entitlement to receive covered services from a Contractor. The Member's name is deleted from the approved list of Members furnished by CalOptima to the Contractor.

DME-Durable Medical Equipment-includes wheelchairs, oxygen equipment, hospital beds, walkers, etc.

Elective-Usually refers to medical procedures, particularly surgery, not immediately necessary to maintain life or health, procedures which can often be scheduled weeks or months in advance.

Emergency Medical Services-Those services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could be expected to result in:

- a) placing the Member's health in serious jeopardy.
- b) serious impairment of bodily functions; or
- c) serious disjunction of any bodily organ or part.

Encounter-A record of medical services provided to a Member.

Enrollment-The process by which a person who has been determined eligible becomes a Member in a contractor's plan under CalOptima.

Fee-For-Service Payment-A payment to a provider by CHA for certain covered services that is the lower of the provider billed and usual charge or CHA fee schedule.

Full-Risk Sub-capitated Provider-CHA sub-contracted provider groups who receive full capitation payments and assume all responsibility for providing either hospital or physician covered services to assigned Members according to the CalOptima Matrix of Financial Responsibility. Full-risk sub-capitated providers are responsible for all Utilization Management and claims payment.

HCFA-Health Care Financing Administration, an organization within the Department of Health and Human Service, a Federal agency. This agency is responsible for administering Medicare and overseeing the states' administration of Medicaid.

Home Health Care (Home Health Services)-Medical care services provided in the home, often by a visiting nurse, usually for Members with chronic disease or disability, or recovering Members, or aged homebound Members.

Hospital-A health care institution licensed by the Department of Health Services and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined to meet the requirements of such certification.

Inpatient-A Member admitted to an overnight medical facility such as a hospital.

Length Of Stay-The number of days a Member is an inpatient, per episode. The length of time a Member is hospitalized. Total number of days for which a Member is hospitalized, either in total or in a particular unit or level of care; abbreviated as LOS.

MCP-Managed Care Program

Medicaid-A federal/state program under Title XIX of the Social Security Act providing federal matching grants, at state's option, for a medical assistance program for recipients of federally aided public assistance and SSI benefits and medically indigent. Certain minimal programs and services must be included to receive federal matching funds, however, states may optionally include any additional services at state expense.

Medically Necessary-Those covered services required to preserve and maintain of the CHA CMO.

Medicare-A federal program under Title XVIII of the Social Security Act which provides health insurance for persons aged sixty-five (65) and older and for other specified groups. Part A of Medicare covers hospitalization and is compulsory and Part B of the program covers outpatient services and is voluntary.

Member-Medi-Cal eligible individual who is enrolled in the CalOptima program. Used interchangeably with enrollee and beneficiary. Also refers to an individual who has been determined CalOptima eligible and enrolled with CHA to receive services pursuant to the Agreement.

NCQA-National Committee for Quality Assurance-an independent external review association for health care quality management.

Occupational Therapy-Medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning.

Out-Of-Area-Care-Care received by a CHA enrollee when they are outside of their geographic territory.

Outpatient-A person who goes to a licensed health care institution or a facility for care and services, but who does not occupy an inpatient bed.

Participating Health Professionals-Those Primary Care Physicians, Physician Specialist, Medical Facilities, Allied Health Professionals and Ancillary Service Providers under contract with CHA to provide specific covered services to Members, and represent those individuals and entities to be utilized through the CHA Prior Authorization and Referral Policies and Procedures.

PCO-Primary Care Obstetrician-an obstetrician who provides obstetrical and primary care to assigned pregnant Members.

Pharmaceutical Services-Medically necessary drugs prescribed by a primary care physician, a practitioner, or other physician or dentist upon referral by a primary care physician and dispensed in accordance with California Law. Pharmaceutical services are not the direct financial responsibility of CHA.

Physician Hospital Consortium (PHC)-A physician group(s) contractually aligned with at least one (1) hospital.

Physician Services-Services provided within the scope of practice of medicine or osteopathy as defined by State law or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

Preventive Health Care-Those health care activities aimed at protection against, and early detection and minimization of disease or disability.

Primary Care Physician (PCP)-A physician such as a family practitioner, pediatrician, internist, general practitioner or obstetrician.

Prior Authorization-a unit under the direction of the Utilization Management Department which is an essential component of any managed care organization. Prior Authorization is the process where health care providers seek approval prior to rendering services as required by CHA policy.

Provider-Physicians, hospitals, etc., who provide medical services to CHA Members.

Quality Management (QM)-Methodology used by professional health personnel that reviews the degree of conformance to desired medical standards and practices; and activities designed to improve and maintain quality service and care, performed through a formal program with involvement of multiple organizational components and committees.

Retrospective Review-After the fact, used often with respect to utilization management - as with retrospective review and approval or denial of emergency room use.

Specialist-A physician duly licensed in the State of California and has completed a residency or fellowship in his or her specialty and has been approved to sit for the board examination for the specialty.

Third Party Recoveries-A general term applied to health care benefit payments. It derives from the fact that under normal market transactions, there are only two (2) parties, the consumer and the supplier, but under a benefit plan, a third party (e.g., government, an insurance company, an employer etc.) is ultimately responsible to pay the costs of services provided to covered person.

Title XIX-Section of Social Security Act, which describes the Medicaid program's coverage for eligible persons.

Utilization Management (Utilization Review, Utilization Control)-Systematic means for reviewing and controlling Members' use of medical care services, and providers' use of medical care resources. Usually involves data collection, review and/or authorization, especially for services such as specialist referrals and emergency room use and particularly costly services such as hospitalization.

Utilization Review-System of review conducted by professional health personnel, of the appropriateness, quality of and need for health care services rendered to Members covered by Medicare or other third party payers, including CalOptima.

XVIII. PROVIDER UPDATES

Please utilize this section of the manual to insert Provider Newsletters and Bulletins that are periodically mailed to your provider offices and contain important information about policy and procedure changes, medical news, and other items to help the provider effectively and efficiently provide care to CHA Members.