COVID-19 Updates

Contra Costa Health Plan continues to update our community providers on Coronavirus changes. If you visit our website [https://cchealth.org/healthplan/](https://cchealth.org/healthplan/) you will find a link for **CCHP COVID-19 Information**. Here you will find plan-specific resources such as CCHP Pharmacy Benefit Coronavirus FAQs and DHCS Recommendations for Well Visits and Immunizations during COVID-19. We have included guidance from DHCS regarding Non-Emergency Medical Transportation and Non-Medical Transportation, which includes strategies for transportation providers on preventing infections, and reporting suspected cases. There is information on new HCPCS codes for COVID-19 Diagnosis. Please also see our section on Telehealth, especially during this time of Coronavirus.

We also recommend that you reference Contra Costa County’s Health Services website: [https://www.coronavirus.cchealth.org/](https://www.coronavirus.cchealth.org/). On the Health Services Coronavirus site, you will find the newest press releases, reopening timelines, and current statistics on cases, testing, hospitalizations, and deaths. You will also find information on reporting and clinical criteria, as well as suggestions on many topics such as how to wear a mask effectively during very warm weather. This website is searchable and includes a “virtual assistant” feature. There is information that providers can share with their patients, in both English and Spanish, including videos. An extensive FAQs section is broken down into categories such as homelessness and contact tracing.

Under Quick Links, click on **Information for Providers**. This link will direct you to Forms and Info for Providers, where you can access reporting forms, lab requisitions and case discharge forms. The Clinical Management section includes Hand-outs for patients in English and Spanish on Home Isolation Instructions and a health alert on Multisystem Inflammatory Syndrome in Children.

If you have any questions, contact Provider Relations at [ProviderRelations@cchealth.org](mailto:ProviderRelations@cchealth.org).

### Highlights Inside This Issue

<table>
<thead>
<tr>
<th>COVID-19 Updates</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>CalHOPE Crisis Resources Related to COVID-19</td>
<td>2</td>
</tr>
<tr>
<td>Prop 56 News</td>
<td>3-5</td>
</tr>
<tr>
<td>cclink Provider Portal</td>
<td>6</td>
</tr>
<tr>
<td>Contact Information for Status Checks</td>
<td>6</td>
</tr>
<tr>
<td>Utilization Management (UM) - New Provider Call Center</td>
<td>7</td>
</tr>
<tr>
<td>Interactive No Authorization Required List</td>
<td>7</td>
</tr>
<tr>
<td>CORRECTED CLAIM SUBMISSION GUIDELINES</td>
<td>8</td>
</tr>
<tr>
<td>High Dollar Claims</td>
<td>8</td>
</tr>
<tr>
<td>Attention Physical Therapy and Occupational Therapy Providers!</td>
<td>9</td>
</tr>
<tr>
<td>New Member ID Cards</td>
<td>9</td>
</tr>
<tr>
<td>Pharmacy and Therapeutics Committee News</td>
<td>10-12</td>
</tr>
<tr>
<td>Updates from United States Preventive Services Task Force (USPSTF) on A and B Recommendations</td>
<td>13</td>
</tr>
<tr>
<td>Contra Costa County Children's Medi-Cal Performance and Compliance Stats</td>
<td>14</td>
</tr>
<tr>
<td>Member Rights and Responsibilities Annual Notice</td>
<td>15-16</td>
</tr>
<tr>
<td>Welcome Community Provider Network (CPN) Providers</td>
<td>17-18</td>
</tr>
<tr>
<td>The Bulletin Board</td>
<td>19</td>
</tr>
<tr>
<td>Contra Costa Health Plan Department Directory</td>
<td>20</td>
</tr>
</tbody>
</table>
Does COVID-19 have you feeling stressed, anxious, and lonely? We’re here for you.

Hope will persevere.

California HOPE Provides:

» FREE resources, including a “playbook” with tips for managing stress.

» A call line to talk about your struggles and get emotional support from someone who has persevered through tough situations.

» Call (833) 317-HOPE (4673)

Tips to Manage Stress:

» Take a break from the news if it’s causing you to feel overwhelmed.

» Maintain social contact by phone, text, or email with those who support you.

» Treat your body kindly—eat healthy foods, avoid excessive alcohol, and exercise as you are able.

calhope.dhcs.ca.gov | calhope@dhcs.ca.gov
Value-based directed payments (VBP) are incentive payments to qualified CCHP Network Providers, that are funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56). The payments are made for qualifying services tied to performance on designated health care quality measures, for dates of service on or after July 1, 2019. These measures, aimed at improving health care, fall under the domains of prenatal and postpartum care, early childhood prevention, chronic disease management, and behavioral health care.

On June 21, 2019, the California Department of Health Care services (DHCS) released the VBP program specifications outlining the measures and payment triggers for each domain on the “Value Based Payment Program” webpage on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/VBP_Measures_19.aspx

The specifications provide an explanation for each VBP program measure, the source for each measure, and the appropriate procedure codes. DHCS selected the measures in each domain in coordination with various professional and medical organizations and considered several factors, including but not limited to, stakeholder and advocate feedback, whether or not a measure aligns with DHCS’ quality efforts, the number of impacted Members, and whether or not sufficient administrative support is available for the measure.

A qualifying service is defined as a specific service, as set forth in the VBP program specifications, that is provided by an eligible Network Provider (see below) on or after July 1, 2019, to a Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D). Network Providers must meet the following criteria to be eligible for the payments outlined above:

- Possess an individual (Type 1) National Provider Identifier (NPI); and
- Be practicing within their practice scope.

Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Service Programs, and Cost-Based Reimbursement Clinics are not eligible Network Providers for the purposes of the VBP program.

The payments required by the VBP program are made within 90 calendar days of receiving a clean claim for a qualifying VBP program service, if the clean claim is received by CCHP no later than one year after the date of service. CCHP has a formal procedure for the acceptance, acknowledgment, and resolution of Network Provider grievances related to the processing or non-payment of a directed payment. If the payment amounts were not what you expected, you can file a Provider Dispute. Provider Dispute form is located on our website at www.cchealth.org/healthplan/providers

Please contact Provider Relations by e-mail at ProviderRelations@cchealth.org with any questions.
Prop 56 – FAQs

Adverse Childhood Experiences Screening (ACES) Services
Trauma Screening for Children and Adults

What is the Proposition 56 – Adverse Childhood Experiences Screening (ACES) Services?
- Assembly Bill (AB) 74, Section 2, Item 4620-101-3305 appropriates Proposition 56 funding to support clinically appropriate trauma screenings for children and adults with full-scope Medi-Cal coverage, as well as provider trainings. An ACES service evaluates children and adults for trauma that occurred in the first 18 years of life.

What Provider types are eligible for this supplemental payment?
- Any professional “Network Provider” that is eligible to bill for the applicable directed payment. The definition of “Network Provider” can be found in DHCS APL’s 19-001.

Who are the eligible Members?
- The Physician must have rendered qualified services to Medi-Cal Members who are not:
  o Full dual Members (eligible for both Medicare Part A & Part B coverage); or
  o Partial dual Members that are eligible for Medicare Part B coverage only.
  o Age 65 years old or older.

What is the effective period for this directed payment?
- Services rendered on or after January 1st, 2020.

What are the eligible (qualified) procedure codes, directed payment amount, and Provider responsibilities to earn this Prop 56 directed payment?
- The network Provider must meet all the following criteria to receive the directed payment:
  o The Provider must utilize either the Pediatric ACES Screening and Related Life- events Screener (PEARLS) tool or a qualifying ACES questionnaire for this screening service.

If an alternative version of the ACES questionnaire for adults is used, it must contain questions on the 10 original categories of ACES to qualify. The 10 original ACE categories are: abuse—physical, emotional, and sexual; neglect—parental incarceration, mental illness, substance dependence, separation or divorce, and intimate partner violence.

  o The Provider must submit a claim or encounter with one of the qualifying HCPCS codes below based on the screening score from the PEARLS tool or ACES questionnaire used.

<table>
<thead>
<tr>
<th>HCPCS Code:</th>
<th>Description:</th>
<th>Directed Payment:</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>G9919</td>
<td>Screening performed - results positive and provision of recommendations provided</td>
<td>$29</td>
<td>Bill with this HCPCS code when the patient's ACE score is 4 or greater (high risk)</td>
</tr>
<tr>
<td>G9920</td>
<td>Screening performed - results negative</td>
<td>$29</td>
<td>Bill with this HCPCS code when the patient's ACE score is between 0-3 (low risk)</td>
</tr>
</tbody>
</table>

(continued on page 5)
Prop 56 – FAQs Continued

- The Provider must maintain all documentation in the Member’s medical record of screening. This documentation must be available upon request from CCHP and/or DHCS.

- Commencing on July 1st, 2020 and forward, contracted Providers must have taken certified training, self-attested to completing the training, and be on the DHCS’ list of Providers that have completed the state-sponsored trauma-informed care training to continue to receive the directed payment for ACEs screenings. DHCS will provide and/or authorize ACEs-oriented trauma informed care training for Providers and their ancillary office staff. DHCS must approve or authorize any other trauma-informed care training that is not provided by DHCS.

   Information about the attestation process can be found at: https://www.medi-cal.ca.gov/TSTA/TSTAattest.aspx

   Information about the DHCS sponsored Provider training is now available here: https://training.acesaware.org/

How often can providers bill for this screening?

- CCHP will make one directed payment of $29 per contracted Provider per Member per year for child screenings (less than 18 years of age on date of service) using the PEARLS tool or ACEs questionnaire (based on age appropriateness).

- CCHP will make one directed payment of $29 per Provider per Member per lifetime for an adult screening (less than age 65 on date of service) using a qualified ACEs questionnaire.

How will payments be disbursed?

- The payments are made within 90 calendar days of receiving a clean claim for a qualifying ACEs program service, if the clean claim is received by CCHP no later than one year after the date of service.

What is the Provider Dispute process related to Prop 56 payments?

- CCHP has a formal procedure for the acceptance, acknowledgment, and resolution of Network Provider grievances related to the processing or non-payment of a directed payment. If the payment amounts were not what you expected, you can file a Provider Dispute. Provider Dispute form is located on our website at www.cchealth.org/healthplan/providers.

How long does a Provider have to file a dispute regarding Prop 56 payments?

- A Provider has 365 calendar days from the Prop 56 payment date to file a dispute regarding Prop 56 payments.

Please contact Provider Relations by e-mail at ProviderRelations@cchealth.org with any questions.
ccLink Provider Portal

Contra Costa Health Plan (CCHP) strongly encourage providers to sign up for the ccLink Provider Portal. There are major advantages:

- Submit your referrals electronically which enters them directly in our Epic System
- Saves time by eliminating faxing and saves paper
- Assists in the turn-around-time for approvals (3 days for urgent referrals/5-14 days for standard referrals)
- Check on the status of Claims submission
- Check on membership eligibility

If you don’t already have access to the ccLink Provider Portal, complete the ccLink Provider Portal Agreement at https://cchealth.org/healthplan/providers/ and submit the request to CCHPPortalSupport@cchealth.org.

Contact Information for Status Checks

We are here to help! Below is the contact information of the various CCHP departments who can help answer your questions. Email and usage of our ccLink Provider Portal is the preferred method of communicating with CCHP staff. It is our goal as a health plan to embrace and leverage technology. We are requesting that providers send us a quick email when you have a question. We will respond in the timeframe listed below, as opposed to having your staff call and wait on the lines. By sending us written questions it can also help us develop educational tools such as Frequently Asked Questions.

*Please note that our response time may be delayed if we experience a high number of requests or inquiries.*

<table>
<thead>
<tr>
<th>Team</th>
<th>Email</th>
<th>Purpose</th>
<th>Standard Response Time*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilization Management</td>
<td><a href="mailto:CCHPauthorizations@cchealth.org">CCHPauthorizations@cchealth.org</a></td>
<td>To check status of authorization request. You may also use the provider portal to check status (You can sign up for an account in <a href="https://cchealth.org/healthplan/providers/">https://cchealth.org/healthplan/providers/</a>)</td>
<td>24-48 Hours</td>
</tr>
<tr>
<td>Claims</td>
<td><a href="mailto:ClaimStatus@cchealth.org">ClaimStatus@cchealth.org</a></td>
<td>To check status of a claim submission. Please provide contact information and the claim number in your email</td>
<td>3 Business Days</td>
</tr>
<tr>
<td>Contracts</td>
<td><a href="mailto:CCHPcontracts@cchealth.org">CCHPcontracts@cchealth.org</a></td>
<td>For Providers to submit initial and renewal contract documents, contract related questions from providers or other HP units, rate negotiation questions, requests to terminate a contract, and update contract details (Tax ID, NPI, Legal Address etc.), copy of contract, questions regarding contract contents, Vendor or Case Management Invoice questions, Input sheet questions</td>
<td>1 Business Day</td>
</tr>
<tr>
<td>Credentialing</td>
<td><a href="mailto:CCHPcredentialing@cchealth.org">CCHPcredentialing@cchealth.org</a></td>
<td>To submit initial and recredentialing applications, and for delegated entities to submit rosters, questions regarding credentialing status and process, questions regarding the PRCC (Peer Review Credentialing Committee), requests for providers to be removed from a group, and Hot Sheet questions/concerns</td>
<td>1 Business Day</td>
</tr>
<tr>
<td>EDI Enrollment</td>
<td><a href="mailto:EDIsupport@cchealth.org">EDIsupport@cchealth.org</a></td>
<td>For Providers who are interested in enrolling in the EDI Program</td>
<td>3 Business Days</td>
</tr>
<tr>
<td>Provider Appeal</td>
<td><a href="mailto:Appeals@cchealth.org">Appeals@cchealth.org</a></td>
<td>To check status of appeals. Please provide the CRM # on the acknowledgement letter. <em>(If you are appealing for medical necessity and the DOS is within 180 days, we redistribute them to the UM team for retro auth review)</em></td>
<td>3 Business Days</td>
</tr>
<tr>
<td>Provider Portal</td>
<td><a href="mailto:CCHPPortalsupport@cchealth.org">CCHPPortalsupport@cchealth.org</a></td>
<td>For providers who are interested in getting access to the provider portal and to send referrals via the portal</td>
<td>1 Business Day</td>
</tr>
<tr>
<td>Provider Relations</td>
<td><a href="mailto:ProviderRelations@cchealth.org">ProviderRelations@cchealth.org</a></td>
<td>For Providers to submit provider complaints, request to join the network, confirm a Provider is in network, assistance with the Provider Network Updates, changes to a providers practice, and new Provider Orientation questions.</td>
<td>1 Business Day</td>
</tr>
</tbody>
</table>
Interactive No Authorization Required List

Annually we review and update the No Authorization Required List during Q1. Last year we expanded the list which is located on our website (https://cchealth.org/healthplan/providers/). The goal was to streamline our processes and most importantly to speed up the process of getting you reimbursed after you delivered services to our members. Initially it seemed providers didn’t trust that their claim would be paid if the service was listed on the Interactive No Authorization Required List. With any new process we had a few hiccups. However, we want you to trust our new process and when the service is on the Interactive No Authorization Required List we will honor that a Prior Auth request is not required. During the last update of the list our vetting process was different, this time with a more methodical approach. Therefore, please accept the results of the Interactive No Authorization Required List. There is no need to send a Prior Auth request if the service is on the list. Any issues or problems you encounter, please reach out directly to Norma.Butler@cchealth.org or the Authorization Department at CCHPauthorizations@cchealth.org. Please ensure any Protected Health Information (PHI) is encrypted.

Utilization Management (UM) - New Provider Call Center

In the last month we have revised our workflows in the UM Department and decided to start a Provider Call Center where our front line staff can answer simple questions. Starting on July 28, 2020, we will have 3 staff members answering the phones and your email request. This staffing change is critical so that our Health Plan Authorizations Representatives (HPARs) can spend time researching your referrals versus answering simple questions. When we get our HPARs off the call center phones, they can focus on turning your referrals back to you in a timely manner. We also now have escalation points, so if there are issues that the Provider Call Center cannot resolve it will go to the Clerical Supervisor for resolution. Please support our new changes so that we can better serve you as you offer quality services to our membership.

To reach the UM Provider Call Center, please call (877) 800-7423, option 3 or email CCHPauthorizations@cchealth.org.
CORRECTED CLAIM SUBMISSION GUIDELINES

What is a corrected claim?

Providers should submit a corrected claim when the claim submitted previously was incorrect or incomplete. The previous claim must be in Paid or Denied status.

For example, the initial claim submission was accepted and contained a single service line. The provider later realized a service line was missing from the original claim. The provider should submit a corrected claim that contains the original billed services plus the new service line.

How to Submit Electronic Corrected Claims

Please complete the following indicators when submitting a corrected claim electronically to CCHP in the ANSI-837 professional or institutional format.

▪ 837P (Professional) and 837I (Institutional) Claims: In Loop 2300 (Claim Information), segment CLM05-3, use Claim Frequency Type Code “7” for “Replacement.” The corrected claim will process as a replacement claim and reverse the original claim on file.

▪ The REF*F8 segment must include the original claim number ID, exactly as it appeared in the original claim being corrected—no additional characters.

How to Submit Paper Corrected Claims

Please complete the following indicators when submitting a corrected paper claim to CCHP.

▪ CMS 1500 (Professional Claim Form): Submit code 7 in box 22.

▪ UB-04 (Facility Claim Form): Submit Type of Bill ending in 7 in field 4 (Type of Bill).

▪ Please also complete the Corrected Claim Cover Sheet when submitting a paper corrected claim (https://cchealth.org/healthplan/pdf/provider/Appendix-D-Corrected-Claim-Submission-Guideline.pdf). Mail your corrected claim form, cover sheet, and any supporting documentation to:

Contra Costa Health Plan
Attn: Claims Unit
595 Center Ave, Suite 100
Martinez, CA 94553

Guidelines:

▪ The corrected claim must be submitted according to the timely filing guideline (within 180 days from Date of Service)

▪ The corrected claim is used to replace the entire claim submitted previously

▪ The corrected claim should include all line items previously processed correctly. Reimbursement for line items no longer included on the corrected claim may be subject to recoupment by the plan

▪ A corrected claim does not constitute an appeal

▪ If a claim was previously processed and is not submitted as a corrected claim, it will be denied as a duplicate claim

▪ In some cases, medical records or other documentations may be required to justify corrections to diagnosis codes, DRGs, procedure codes, medication units, modifiers, or other modifications.

High Dollar Claims

Contra Costa Health Plan (CCHP) has implemented a new policy to expedite the claim reimbursement process. Please include a Detail Bill with any claim that exceeds $300,000 to help with the expediting process.

If you have any questions regarding claim issues e-mail claimstatus@cchealth.org
Attention Physical Therapy and Occupational Therapy Providers!

Physical Therapists will no longer use the same evaluation code for every patient, as CPT code 97001 will no longer be billable. Instead, they will choose from a set of three different evaluative codes that are tiered according to complexity. Those codes are:

97161 Physical therapy evaluation: low complexity
97162 Physical therapy evaluation: moderate complexity
97163 Physical therapy evaluation: high complexity

Occupational Therapists also must select from a new set of three tiered codes when billing for patient evaluations, as CPT code 97003 will no longer be billable. And, like the new PT codes, these codes are organized by complexity:

97165 Occupational therapy evaluation: low complexity
97166 Occupational therapy evaluation: moderate complexity
97167 Occupational therapy evaluation: high complexity

New Member ID Cards

Effective July 1, 2020, new CCHP members will have the newest version of CCHP’s Member ID care. It will be printed in black and white. A sample is below.
The CCHP P&T committee met on 6/4/2020. Updates from the meeting are outlined below:

**Changes to the PDL will be effective by mid-July 2020**

**Updates/Announcements:**

1. **Fee-For-Service Medi-Cal Carve-Out:**
   a. An excerpt from CA governor’s Executive Order N-019-01 (dated 1/1/2019) states the following:
      
      “IT IS HEREBY ORDERED THAT:
      …The Department of Health Care Services shall take all necessary steps to transition all pharmacy services for Medi-Cal managed care to a fee-for-service benefit by January 2021 in order to create significant negotiating leverage on behalf of over 13 million Californians and generate substantial annual savings…”
   
   b. What does this mean? **Effective 1/1/2021, CCHP will no longer manage the pharmacy benefit for Medi-Cal members.**

   c. CCHP will still manage the medical benefit for Medi-Cal members after 1/1/2021, and will also retain responsibility for care-coordination, inpatient drugs, long-term care drugs, physician administered drugs, etc. after the carve-out occurs. CCHP will also maintain responsibility for the entirety of the Commercial pharmacy & medical benefit.

   d. DHCS is planning on educating/notifying providers and members of the change, and CCHP is tentatively planning some provider education and member outreach over the next few months as well. Please direct all questions to the CCHP pharmacy department at 925-957-7260 x1 or cchp_pharmacy_director@cchealth.org.

2. **CCHP Operational Modifications Due To COVID-19:**
   a. The CCHP pharmacy department continues to make every attempt to comply with all COVID-19 related regulatory requirements. To that end, the department has ensured that:
      
      ▪ 90 day supplies of maintenance medications are available to all CCHP members.
      ▪ Members have access to pharmacy delivery services.
      ▪ Refill-too-soon (RTS) logic was modified to allow early fills of chronic medications.
      ▪ Addition of certain drugs and items to the formulary as required by regulation such as gloves, sanitizing solutions, subcutaneous Depo Provera, etc.

   b. CCHP pharmacy staff have been working from home for the past 12+ weeks and will continue to work remotely until definitive guidance is received from county leadership regarding a transition back into the office.

   c. The day to day operations of the department remain unchanged due to the pandemic, and the department continues to meet all regulatory, clinical, and operational goals. Please direct all questions to the CCHP pharmacy unit at 925-957-7260 x1.

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**Quick reference table for all changes to the Preferred Drug List (PDL) and/or Prior Authorization (PA) criteria (for full details of each change, please see individual drugs listed below this table):**

<table>
<thead>
<tr>
<th>Changes Made</th>
<th>Drug Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Created new PA criteria:</td>
<td>Rectiv (nitroglycerin)</td>
</tr>
<tr>
<td></td>
<td>Nurtec ODT (rimegepant)</td>
</tr>
<tr>
<td></td>
<td>Reyvow (lasmiditan)</td>
</tr>
<tr>
<td></td>
<td>Ubrelvy (urbogepant)</td>
</tr>
<tr>
<td>Modified PA criteria:</td>
<td>Entresto (sacubitril/valsartan)</td>
</tr>
<tr>
<td>ADDED to the CCHP formulary:</td>
<td>Ozempic (semaglutide injection)</td>
</tr>
<tr>
<td></td>
<td>Rybelsus (semaglutide oral)</td>
</tr>
<tr>
<td></td>
<td>Färxiga (dapagliflozin)</td>
</tr>
<tr>
<td></td>
<td>Lidocaine 5% ointment</td>
</tr>
<tr>
<td></td>
<td>EMLA (lidocaine/prilocaine) cream</td>
</tr>
<tr>
<td></td>
<td>Durolane (hyaluronic acid)</td>
</tr>
</tbody>
</table>

(continued on page 11)
Creation of new criteria for Rectiv (nitroglycerin):
- Prior authorization requests for Rectiv must meet the following criteria for approval:
  - Diagnosis of moderate to severe chronic anal fissure pain for at least 6 weeks
  - The member is not taking a PDE-5 inhibitor (e.g. sildenafil, vardenafil, tadalafil).
  - Prescriber attestation that the member has tried and failed, or has a reason not to use (within past 60 days) at least two conservative treatments for the underlying cause of the anal fissure:
    - High-fiber diet or fiber supplements
    - Sitz baths
    - Topical analgesia/medicated creams (e.g. Anusol HC, zinc oxide)
    - Laxative or stool softeners (e.g. psyllium, docusate)
  - Pramosone (hydrocortisone/pramoxine) cream or ointment
  - If all conditions are met, the request will be approved for a one-time coverage duration of up to 3 weeks.

Creation of new criteria for Nurtec ODT (rimegepant), Reyvow (lasmiditan), & Ubrelvy (ubrogepant):
- Prior authorization requests for the above agents must meet the following criteria for approval:

Criteria for Initial Authorization:
- Prescribed by a neurologist with a diagnosis of migraine headache
- Requested dose is within FDA approved dosing guidelines
- Documented trial and failure of (or medical justification for not using) an analgesic medication and two triptan products
  - One preferred 1st line triptan and one preferred 2nd line triptan
- Attestation the patient was counseled regarding not driving or operating machinery until at least 8 hours after taking each dose (Reyvow only)

Criteria for Re-authorization:
- Documentation of improvement in pain and symptom(s) (e.g., photophobia, nausea, phonophobia)

Modification of criteria for Entresto (sacubitril/valsartan):
- Requirement to use spironolactone (or justify why it cannot be used) has been removed from the criteria.
- Prior authorization requests for Entresto must meet the following updated criteria for approval:
  - Must be clinically diagnosed with chronic heart failure (NYHA Class II-IV) and reduced ejection fraction (≤ 40%)
  - Must have tried and found to be tolerant to an ACE Inhibitor or an ARB (tolerability defined as a 4 week trial at any dose)
  - Must have tried or currently taking maximum tolerated dose of beta blocker

Addition of Ozempic (semaglutide injection) to the CCHP formulary:
- Ozempic 0.25mg, 0.5mg, and 1mg/injection have been added to the CCHP formulary as tier 2 products with metformin step therapy and a quantity limit of 4 injections per 28 days for all members.

Addition of Rybelsus (semaglutide oral) to the CCHP formulary:
- Rybelsus 3mg, 7mg, and 14mg tablets have been added to the CCHP formulary as tier 2 products with metformin step therapy and a quantity limit of 30 tablets per 30 days for all members.

Addition of Farxiga (dapagliflozin) to the CCHP formulary:
- Farxiga 5mg and 10mg tablets have been added to the CCHP formulary as tier 2 medications with a quantity limit of 30 tablets per 30 days for all members.
Addition of lidocaine 5% ointment to the CCHP formulary:
- Lidocaine 5% ointment has been added to the CCHP formulary as a tier 2 medication with a quantity limit of 60gm per 30 days for all members.

Addition of Emla (lidocaine/prilocaine) 2.5%/2.5% cream to the CCHP formulary:
- Lidocaine/prilocaine 2.5%/2.5% cream has been added to the CCHP formulary as a tier 2 medication with a quantity limit of 60gm per 30 days for all members.

Addition of Durolane (hyaluronic acid) to the CCHP no-authorization-required list:
- Durolane (intra-articular hyaluronic acid) has been added to the CCHP no-auth list with equivalent status to Hyalgan/Supartz. Contracted providers may use these products as the preferred hyaluronic acid agents without obtaining prior authorization. Note: these products MUST be billed through the medical benefit using the appropriate J code (Hyalgan/Supartz = J7321, Durolane = J7318).
- To see a full list of procedures and codes that can be billed to CCHP by network/contracted providers without prior authorization, please visit the provider section of the CCHP website at: https://cchealth.org/healthplan/providers/.

There are numerous ways to view the CCHP Preferred Drug List:
CCHP updates the Preferred Drug List (PDL) after each quarterly Pharmacy & Therapeutics Committee meeting. CCHP invites and encourages practitioners to access each update through the following means:

- An interactive searchable formulary is available within Epic (contact the Epic team with any questions related to functionality).
- A printable copy of the CCHP PDL can be found here: http://cchealth.org/healthplan/pdf/pdl.pdf
- A searchable copy of the CCHP PDL can be found here: http://formularynavigator.com/Search.aspx?siteID=MMRREQ3QBC

EPOCRATES – free mobile & online formulary resource
- CCHP providers may add the CCHP formulary to their mobile devices using the following steps:
  - Open the Epocrates application on your mobile device.
  - Click on the “formulary” button on the home screen.
  - Click “add new formulary” button on the bottom of the screen.
  - Use the search box to locate “Contra Costa Health Plan” Medi-Cal or Commercial formulary. Click on each formulary that you would like to add, and then click the “add formulary” button.

Epocrates mobile is supported on the iOS (iPhone, iTouch, iPad), Android, & BlackBerry platforms.

If you have any questions about the installation or use of Epocrates, please contact Epocrates Customer Support at goldsupport@epocrates.com or at (800)230-2150.

Providers may request a copy of CCHP pharmacy management procedures or specific drug PA criteria by contacting the pharmacy unit directly at 925-957-7260 x1, or via the email listed below:

P&T updates and DUR educational bulletins can be viewed online at http://cchealth.org/healthplan/provider-pharmacy-therapeutics.php

Questions and comments may be directed to CCHP Pharmacy by emailing cchp_pharmacy_director@cchealth.org
Hepatitis C Screening Expansion of Ages to 18-79

This recommendation incorporates new evidence and replaces the 2013 USPSTF recommendation, which recommended screening for HCV infection in persons at high risk for infection and 1-time screening in adults born between 1945 and 1965 (B recommendation). The new USPSTF recommendation expands the ages for screening to all adults from 18 to 79 years. The treatment of HCV continues to evolve, resulting in greater benefits and fewer harms than when the USPSTF last considered the evidence.

Extend Tobacco Counseling to Children and Adolescents and Addition of e-Cigarettes

This recommendation replaces the 2013 USPSTF recommendation on primary care interventions to prevent tobacco use in children and adolescents. It is consistent with the 2013 recommendation, which similarly issued a B recommendation for primary care clinicians to provide interventions to prevent initiation of tobacco use among children and adolescents. New to the current recommendation is the inclusion of e-cigarettes as a tobacco product. Also new to the current recommendation is the I statement on insufficient evidence on interventions for cessation of tobacco use among this population. The USPSTF is calling for more research to identify interventions (behavioral counseling or pharmacotherapy) to help children and adolescents who use tobacco to quit.

Screening for Drug Use Disorders in Adults

This recommendation statement replaces the 2008 USPSTF recommendation, which concluded that the evidence at that time was insufficient to assess the balance of benefits and harms of screening for illicit drug use in adolescents and adults, including those who were pregnant or postpartum. This updated statement incorporates new evidence since 2008 about the accuracy of screening tools and the benefits and harms of treatment of unhealthy drug use or drug use disorders. This new evidence supports the current recommendation that primary care clinicians offer screening to adults 18 years or older, including those who are pregnant or postpartum, when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. The USPSTF continues to conclude that the evidence is insufficient to assess the balance of benefits and harms of screening for drug use in adolescents.
### Contra Costa County

**25% of kids in this county are enrolled in Medi-Cal**

In this county’s Medi-Cal program

- **49%** of kids received an annual check-up
- **20%** of kids received a vision screening
- **66%** of blood lead screenings for kids were missed

### Medi-Cal Managed Care in this County

Contra Costa County Medi-Cal has a “Two Plan” model of managed care, with nearly all children enrolled in one of two plans.

### Anthem Blue Cross Partnership Plan

Anthem contracts with the state to deliver care to approximately 15% of Medi-Cal children in the County or 12,982 kids each month.

### Contra Costa Health Plan

Contra Costa Health Plan contracts with the state to deliver care to approximately 85% of Medi-Cal children in the County or 73,500 kids each month.

### Health Plan Performance on Care for Children

<table>
<thead>
<tr>
<th>Two-year old children receiving all immunizations</th>
<th>Medi-Cal</th>
<th>Anthem</th>
<th>Contra Costa Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>74%</td>
<td>78%</td>
<td>18%</td>
<td>16%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infants and toddlers under age 3 receiving a developmental screening</th>
<th>18%</th>
<th>16%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kids ages 3-6 receiving a well-child check-up</td>
<td>80%</td>
<td>75%</td>
</tr>
<tr>
<td>Thirteen-year olds receiving all immunizations</td>
<td>37%</td>
<td>38%</td>
</tr>
<tr>
<td>Enrollees ages 5-64 with asthma who were dispensed appropriate asthma-control medications</td>
<td>60%</td>
<td>53%</td>
</tr>
<tr>
<td>Percent of families who said they could get needed care for children</td>
<td>83%</td>
<td>83%</td>
</tr>
</tbody>
</table>

### Health Plan Compliance with Access Standards

| Health plan network has adequate pediatric primary care providers | ✓ | - |
| Health plan demonstrates reasonable wait times for a child’s appointment | ✓ | ✓ |
| Health plan submits complete data reports to the state on doctor visits | - | ✓ |
| Health plan was not fined in 2019 by regulators for systematically limiting access to care for Med-Cal beneficiaries | - | ✓ |

(*) = Data suppressed due to small sample size or large margin of error
(--) = No data available

Sources available at [go.childrennow.org/me-sources/](go.childrennow.org/me-sources/) [www.childrennow.org/](www.childrennow.org/)
Member Rights and Responsibilities Annual Notice

The following section details information provided to members regarding their rights as members of CCHP. Providers are encouraged to assist members with their grievances and no punitive action will be taken against a provider who supports a member through the appeals process. Also, providers may not take any negative action against a member who files a complaint or grievance against the provider. You may also refer to Appendix J and our website at www.cchealth.org/healthplan.

**Member rights and responsibilities include, but are not limited to, the following:**

- The right to receive care with respect regardless of race, religion, education, sex, cultural background, physical or mental handicaps, or financial status.
- The right to receive appropriate accessible culturally sensitive medical services.
- The right to choose a Primary Care Physician in CCHP’s network, who has the responsibility to provide, coordinate and supervise care.
- The right to be seen for appointments within a reasonable period of time.
- The right to participate with practitioners in making health care decisions including the right to refuse treatment, to the extent permitted by law.
- The right to receive courteous response to all questions from Contra Costa Health Plan and its Health Partners.
- The right to voice complaints or appeals about Contra Costa Health Plan or the care it provides orally or in writing; and to disenroll.
- The right to health plan information which includes, but is not limited to; benefits and exclusions, after hours and emergency care, referrals to specialty providers and services, procedures regarding choosing and changing providers; and types of changes in services.
- Medi-Cal recipients have the right to seek family planning services from a Medi-Cal provider outside the network without a referral or authorization if the member elects to do so.
- The right to formulate advanced directives.
- The right to confidentiality concerning medical care.
- The right to be advised as to the reason for the presence of any individual while care is being provided.
- The right to access personal medical record.
- The right to have access to emergency services outside of the Plan’s provider network.
- Medi-Cal recipients have the right to request a fair hearing.
- The right to interpreter services.
- The right to access Federally Qualified Health Centers and Indian Health Services Facilities.
- The right to access minor consent services.
Member Rights and Responsibilities Annual Notice

- The right to receive written Member informing materials in alternative formats, including Braille, large size print and audio format upon request.
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member’s condition and ability to understand.
- The right to freely exercise these rights without adversely affecting how the Member is treated by the health plan, providers or the state.
- The right to candid discussion of appropriate or medically necessary treatment options, regardless of cost or benefit coverage.
- A right to be treated with respect and recognition of their dignity and their right to privacy.
- The right to make recommendations regarding the Contra Costa Health Plan’s Member’s Rights and Responsibility policy.
- The right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.

Member responsibilities include, but are not limited to:
- The responsibility to provide complete and accurate information about past and present medical illnesses including medications and other related matters.
- The responsibility to follow the treatment plan and instructions agreed upon with your health care providers.
- The responsibility to ask questions regarding condition and treatment plans until clearly understood.
- The responsibility to keep scheduled appointments or to call at least 24 hours in advance to cancel.
- The responsibility to call in advance for prescription refills.
- The responsibility to be courteous and cooperative to people who provide health care services.
- The responsibility to actively participate in their health and the health of the member’s family. This means taking care of problems before they become serious, following provider’s instructions, taking all medications as prescribed, and participating in health programs that keep one well.
- The responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.
- The responsibility to supply information (to the extent possible) that the organization and its practitioners and providers
### Specialty Care Providers

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Specialty</th>
<th>Facility Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peter Chase, DDS</td>
<td>Dental Specialist, Sleep Appliances</td>
<td>Peter Chase, DDS, Inc. - Walnut Creek</td>
</tr>
<tr>
<td>Rafik Zarifa, MD</td>
<td>Diagnostic Radiology</td>
<td>Epic Care - Emeryville</td>
</tr>
<tr>
<td>Premjit Chahal, MD</td>
<td>Gastroenterology</td>
<td>Diablo Digestive Care, Inc.- Pleasant Hill, Brentwood</td>
</tr>
<tr>
<td>Jeffrey Ritterman, MD</td>
<td>Internal Medicine</td>
<td>LifeLong Medical Care- San Pablo</td>
</tr>
<tr>
<td>Molly Neal, NP</td>
<td>Mid-level - Family Planning</td>
<td>Planned Parenthood- Concord</td>
</tr>
<tr>
<td>Allison Waggoner, NP</td>
<td>Mid-level - Family Planning</td>
<td>Planned Parenthood- San Francisco</td>
</tr>
<tr>
<td>Abigail Cheitlin, NP</td>
<td>Mid-level - Family Planning</td>
<td>Planned Parenthood- Walnut Creek</td>
</tr>
<tr>
<td>Gwendolyn Cashman, NP</td>
<td>Mid-level - Pulmonary Disease</td>
<td>BASS - Respiratory Medical Group- Walnut Creek</td>
</tr>
<tr>
<td>Clayton Laderer, PA</td>
<td>Mid-level - Urgent Care</td>
<td>BASS Medical Group, Inc.- Walnut Creek</td>
</tr>
<tr>
<td>Karen Weiss, NP</td>
<td>Mid-level - Urgent Care</td>
<td>STAT MED Urgent Care- Concord, Dublin, Lafayette, Livermore</td>
</tr>
<tr>
<td>Kate Berry-Millett, CNM</td>
<td>Midwife</td>
<td>Planned Parenthood- Antioch</td>
</tr>
<tr>
<td>Nilka Dulan, CNM</td>
<td>Midwife</td>
<td>Planned Parenthood- Concord</td>
</tr>
<tr>
<td>Michaela Lambert, CNM</td>
<td>Midwife</td>
<td>Planned Parenthood- Walnut Creek</td>
</tr>
<tr>
<td>Michael Ajuria, MD</td>
<td>Nephrology</td>
<td>East Bay Nephrology Medical Group, Inc.- Berkeley, Vallejo</td>
</tr>
<tr>
<td>Nancy Everett, MD</td>
<td>Obstetrics And Gynecology</td>
<td>Axis Community Health- Pleasanton</td>
</tr>
<tr>
<td>Dhiren Nanavati, MD</td>
<td>Orthopaedics</td>
<td>Axis Community Health- Pleasanton</td>
</tr>
<tr>
<td>Daniel Ochalek, MD</td>
<td>Surgery - General</td>
<td>East Bay Cardiovascular and Thoracic Associates- Danville</td>
</tr>
<tr>
<td>Jana Tomsky, MD</td>
<td>Urgent Care</td>
<td>STAT MED Urgent Care- Concord</td>
</tr>
</tbody>
</table>

### Mental Health

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Specialty</th>
<th>Facility Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pamela Alafara, MD</td>
<td>Psychiatry</td>
<td>Comprehensive Psychiatric Services- Walnut Creek</td>
</tr>
<tr>
<td>Amarpreet Singh, MD</td>
<td>Psychiatry</td>
<td>Comprehensive Psychiatric Services- Walnut Creek</td>
</tr>
<tr>
<td>Hayley Schmidt, MFTI</td>
<td>Mental Health Therapist/Counselor, Substance Abuse Professional</td>
<td>Planned Parenthood- Richmond</td>
</tr>
</tbody>
</table>

### Facilities

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Type</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>DaVita - Curtola Home Training</td>
<td>Dialysis</td>
<td>Vallejo</td>
</tr>
<tr>
<td>DaVita - Fairfield Downtown Dialysis</td>
<td>Dialysis</td>
<td>Fairfield</td>
</tr>
<tr>
<td>DaVita - Fremont Dialysis</td>
<td>Dialysis</td>
<td>Fremont</td>
</tr>
<tr>
<td>DaVita - San Leandro Marina Dialysis</td>
<td>Dialysis</td>
<td>San Leandro</td>
</tr>
<tr>
<td>Fresenius Kidney Care San Miguel</td>
<td>Dialysis</td>
<td>Concord</td>
</tr>
<tr>
<td>Harmony Healthcare, LLC</td>
<td>Home Health</td>
<td>Pleasant Hill</td>
</tr>
<tr>
<td>dba Harmony Home Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creekside Healthcare Center</td>
<td>Skilled Nursing Facility</td>
<td>San Pablo</td>
</tr>
</tbody>
</table>

(continued on page 18)
## Welcome Community Provider Network (CPN) Providers

<table>
<thead>
<tr>
<th>Name</th>
<th>Qualification</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amy Zora, RBT</td>
<td>Qualified Autism Provider</td>
<td>Adapt A Behavioral Collective, Inc. - San Francisco, Stockton</td>
</tr>
<tr>
<td>Madisen Smith, RBT</td>
<td>Qualified Autism Paraprofessional</td>
<td>Bay Area Behavior Consultants, LLC - Richmond</td>
</tr>
<tr>
<td>Tiahna Green, RBT</td>
<td>Qualified Autism Paraprofessional</td>
<td>Bay Area Behavior Consultants, LLC - Richmond</td>
</tr>
<tr>
<td>Candy Reyes, RBT</td>
<td>Qualified Autism Paraprofessional</td>
<td>Bay Area Behavior Consultants, LLC - Richmond</td>
</tr>
<tr>
<td>Bahama Lynch, BA</td>
<td>Qualified Autism Professional</td>
<td>Bay Area Behavior Consultants, LLC - Richmond</td>
</tr>
<tr>
<td>Kellie Coffman, BCBA</td>
<td>Qualified Autism Provider</td>
<td>Bay Area Behavior Consultants, LLC - Richmond</td>
</tr>
<tr>
<td>Vivian Huynh, BCBA</td>
<td>Qualified Autism Provider</td>
<td>Behavior Treatment and Analysis, Inc - Walnut Creek</td>
</tr>
<tr>
<td>Devin Boas, BCBA</td>
<td>Qualified Autism Provider</td>
<td>Center for Autism and Related Disorders, LLC - Antioch</td>
</tr>
<tr>
<td>Katherine Kalsow, BCBA</td>
<td>Qualified Autism Provider</td>
<td>Center for Autism and Related Disorders, LLC - Brentwood</td>
</tr>
<tr>
<td>Amrit Kaur, BCBA</td>
<td>Qualified Autism Provider</td>
<td>Center for Autism and Related Disorders, LLC - Richmond</td>
</tr>
<tr>
<td>Jessica Pipitone, BCBA</td>
<td>Qualified Autism Provider</td>
<td>Center for Behavioral Solutions - Vallejo</td>
</tr>
<tr>
<td>Daniel Sanchez, BCBA</td>
<td>Qualified Autism Provider</td>
<td>Center for Social Dynamics - Alameda</td>
</tr>
<tr>
<td>Besaida Cardoza-Fraire, BCBA</td>
<td>Qualified Autism Provider</td>
<td>Center for Social Dynamics - Alameda, Martinez</td>
</tr>
<tr>
<td>Angelina Barajas, BA</td>
<td>Qualified Autism Professional</td>
<td>Goals for Autism, Inc. - Walnut Creek</td>
</tr>
<tr>
<td>Adriana Arias, BA</td>
<td>Qualified Autism Professional</td>
<td>Goals for Autism, Inc. - Walnut Creek</td>
</tr>
<tr>
<td>Melinda Deeds, BA</td>
<td>Qualified Autism Professional</td>
<td>Goals for Autism, Inc. - Walnut Creek</td>
</tr>
<tr>
<td>Shui Kwan Chandrasekaran, BCBA</td>
<td>Qualified Autism Provider</td>
<td>Goals for Autism, Inc. - Walnut Creek</td>
</tr>
<tr>
<td>Natalie Chase, BCBA</td>
<td>Qualified Autism Provider</td>
<td>Goals for Autism, Inc. - Walnut Creek</td>
</tr>
<tr>
<td>Pedro Maiz, BCBA</td>
<td>Qualified Autism Provider</td>
<td>Juvo Autism and Behavioral Health Services - Concord</td>
</tr>
<tr>
<td>Surmeet Sandhu, BCBA</td>
<td>Qualified Autism Provider</td>
<td>Juvo Autism and Behavioral Health Services - Concord</td>
</tr>
<tr>
<td>Niloofar Sanandaji, BCBA</td>
<td>Qualified Autism Provider</td>
<td>Juvo Autism and Behavioral Health Services - Concord</td>
</tr>
<tr>
<td>Emily Schuman, BCBA</td>
<td>Qualified Autism Provider</td>
<td>Juvo Autism and Behavioral Health Services - Concord</td>
</tr>
<tr>
<td>Jessica Magallon, BCBA</td>
<td>Qualified Autism Provider</td>
<td>Juvo Autism and Behavioral Health Services - Concord</td>
</tr>
</tbody>
</table>
HOLIDAYS OBSERVED BY CCHP
September 7, 2020       Labor Day

Our URAC accredited Advice Nurse Unit is available for our members 24 hours a day, 7 days a week including holidays. Members can call The Advice Nurse Unit at (877) 661-6230, Option 1.

Interpreter Services
Providers needing help with interpreter services or needing help with arranging face-to-face American Sign Language interpretation services may call (877) 800-7423 option 4.

CCHP Online Resources:
www.cchealth.org/healthplan/providers
CCHP Provider & Pharmacy
CCHP Electronic Provider Directory
CCHP Preferred Drug List (PDL)
CCHP Provider Manual
CCHP Provider Web Portal
Prior Authorization Forms
Clinical and Preventive Guidelines
No Prior Authorization List

Uninsured individuals:
www.cchealth.org/insurance

The ccLink Provider Portal is a free web-based tool that allows you to view your patients’ records, refer members, and request authorizations from any computer, at any time.

Request Access:
If you don’t already have access to the ccLink Provider Portal, complete the ccLink Provider Portal Agreement at https://cchealth.org/healthplan/providers/ and submit the request to CCHPPortalSupport@cchealth.org.

Technical Issues: (925) 957-7272
Passwords: Now you are able to reset from your password on the ccLink sign-in page.
Authorization Department / Hospital Transition Nurse

- Phone: (877) 800-7423, option 3
- Fax Numbers for Prior Authorization Requests:
  - **Medi-Cal Member Authorization eFax Numbers:**
    - Prior Authorizations/Outpatient/Routine: Fax: (925) 313-6058
    - Urgent/Additional Information: Fax: (925) 313-6458
    - Inpatient (Hospital)/Face Sheet: Fax: (925) 313-6645
    - Appeals: Fax: (925) 313-6464
    - Mental Health: Fax: (925) 313-6196
    - Specialty (CPAP): Fax: (925) 313-6069
  - **Commercial Member Authorization eFax Numbers:**
    - Prior Authorization Requests: Fax: (925) 252-2620
    - Confidential Mental Health: Fax: (925) 313-6196
- Email Auth Questions (do not email auth requests): CCHPauthorizations@cchealth.org

Claims Department

- Phone: (877) 800-7423, option 5
- Email Claims Questions: ClaimStatus@cchealth.org
- Email Appeals Questions: Appeals@cchealth.org

Interpreter Services

- Phone: (877) 800-7423, option 4

Member Eligibility and Primary Care Physician Assignment

- Phone: (877) 800-7423, option 1

Member Services Department (calling on behalf of a member that is with you)

- Phone: (877) 800-7423, option 7

Pharmacy Department

- Phone: (877) 800-7423, option 2

Provider Relations Department

- Phone: (877) 800-7423, option 6
- Fax: (925) 646-9907
- Email General Questions: ProviderRelations@cchealth.org
- Email Contract Related Questions: CCHPContracts@cchealth.org
- Email Credentialing Related Questions: CCHPcredentialing@cchealth.org