The purpose of the guidelines presented in this Manual is to assist the Provider with information about Contra Costa Health Plan processes. It will assist with referrals for health services, claims processing, member assistance, grievance procedures, and other procedures required by CCHP in the delivery of care to members. If you need further assistance or clarification regarding any information contained in this manual, please call the CCHP Provider Relations Department at 925-313-9500 or e-mail: ProviderRelations@cchealth.org or fax 925-646-9907. All information contained in this manual can be accessed on our website at www.cchealth.org/healthplan.
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Section 1 - WELCOME TO THE CONTRA COSTA HEALTH PLAN (CCHP)

MISSION STATEMENT

Contra Costa Health Plan provides managed care health insurance with its safety net community and county provider partners at an affordable price for diverse populations. We offer Patient-Centered care to assure coordinated, comprehensive, compassionate and quality care.

CCHP

CCHP is accredited for our Medi-Cal product by the National Committee for Quality Assurance (NCQA). As a Federally qualified HMO, the Contra Costa Health Plan (CCHP) enrolls employer groups (public and private), In Home Support Services (IHSS), Medi-Cal members that include Seniors and Persons with Disabilities and Chronic Conditions, Medi-Cal Expansion, Families and Low-Income Children’s Programs. We also manage the care of low income, uninsured County children eligible under the County’s Basic Health Care Program. CCHP’s commitment to serving the County’s most vulnerable populations is reflected in the composition of its membership. Above all, CCHP is committed to our motto:

“A Culture of Caring”

ORGANIZATIONAL STRUCTURE

The elected five-member County Board of Supervisors represents CCHP’s Board of Directors. In order to influence policies to meet the needs of health plan members, the Board appoints eleven individuals to serve on the CCHP Advisory Board, known as the Managed Care Commission (MCC).

The Board of Supervisors establishes the mission and goals of CCHP; the Director of Health Services has the responsibility for meeting these goals. The HMO Chief Executive Officer, who reports to the Director of Health Services and to the Board of Supervisors, is responsible for the overall administration and management of CCHP; the Medical Director is a Physician who is responsible for the overall clinical operations of CCHP. The MCC acts as a liaison between CCHP, the Board of Supervisors and the community.

CCHP is one of seven major divisions of the Contra Costa County Health Services Department. The organizational structure of the Department allows CCHP to work closely with the Regional Medical Center Network and its Ambulatory Care Centers (10 sites), Alcohol and Other Drugs, Mental Health, Public Health, Environmental Health and Finance Divisions in order to provide comprehensive health care services to members.
HEALTH CARE DELIVERY SYSTEM

CCHP uses a primary care model in delivering comprehensive health care services to members. The goals of this model are:

- to provide convenient and timely access to health care services;
- to ensure the provision of preventive health care;
- to maintain the health of its members;
- to coordinate referral and access to specialty care services including inpatient care.

Services provided to members vary depending on the member’s specific group benefit package. However, all plans include but are not limited to the following services:

- Physician Services – Primary and Specialty Care
- Preventive Health Care
- Consultation and Referral Services
- Diagnostic Services
- Durable Medical Equipment (DME) Services and Supplies
- Emergency/Urgent Care Services
- Inpatient Hospital Services
- Laboratory Services
- Outpatient Hospital Services

Depending on their benefit package, members choose or are assigned to one of three Networks:

- Regional Medical Center (RMC) Network. The RMC Network is comprised of Contra Costa Health Services medical staff; physicians, specialists, nurse practitioners, nurses, and ancillary providers providing care at the ten county health centers and the Contra Costa Regional Medical Center.
- Community Provider Network (CPN). The CPN is comprised of local physicians, nurse practitioners, physician assistants, nurses, specialists, and ancillary providers providing care in their private offices in the community and at our contracted hospitals.
- Kaiser Permanente Network (KP). The Kaiser Network is a member choice option for Medi-Cal members only. There are restrictions related to assignment to the KP Network. For more information call Member Services at 877-800-7423 (option 7).

Members receive care from the providers within the network they have chosen or been assigned. However, there may be a case when a member will be authorized to receive care outside of their network. CCHP does not allow providers to contract for specific product lines. Contracted providers agree to serve members enrolled in CCHP regardless of benefit plan and agree to accept Medi-Cal, Seniors and Persons with Disabilities and Chronic Conditions (SPD’s) members, and County Employees.
Section 2 – PROVIDER RELATIONS DEPARTMENT

The Provider Relations Department is responsible for the centralization of the following services to Providers:

- Enrollment and Screening
- Credentialing and Re-credentialing
- Contract Management
- Facility Site Reviews
- New Provider Health Plan Orientation
- On-line Provider Directory
- Provider Bulletin
- Provider Complaints
- Provider Web Portal

Additionally, Provider Relations Department staff functions as key liaisons to providers covering the following types of issues and concerns:

- Authorization and referral guidelines
- Claims submittal and payment
- Contractual requirements
- Member discharge from practice
- Provider recruitment and retention

Provider Enrollment

The Department of Healthcare Services (DHCS) mandated a new enrollment process starting January 1, 2018. As part of the new enrollment process all contracted providers or any new provider joining the Contra Costa Health Plan (CCHP) is required to enroll with DHCS Fee-For Service (FFS) Medi-Cal program. The required disclosure and enrollment options follow.

Managed Care providers have two options for enrolling with the Medi-Cal Program. Providers may enroll through:

Department of Healthcare Services (DHCS)
OR
Medi-Cal Managed Care plan (MCP)

If a provider enrolls through DHCS, the provider is eligible to provide services to Medi-Cal FFS beneficiaries and contract with CCHP.

If the provider enrolls through CCHP, the provider may only provide services to Medi-Cal Managed Care members and may not provide services to Medi-Cal FFS beneficiaries.

Generally, federal and state laws and regulations that apply to FFS providers will also apply to the enrollment process for Managed Care providers. Regardless of the enrollment option a provider chooses, the provider is required to enter into two separate agreements - the “Health Plan Provider Agreement” and the “DHCS Provider Enrollment Agreement.”
The Plan Provider Agreement is the contract between CCHP and a provider defining their contractual relationship. The DHCS Provider Enrollment Agreement is the agreement between DHCS and the provider and is required for all providers enrolled in the Medi-Cal program.

Enrollment Options

A. Enrollment through CCHP - The following provides an overview of the CCHP enrollment process:

- The provider will submit the same approved DHCS enrollment application to CCHP.
- As part of the application process, the provider will be required to agree that DHCS and the CCHP may share information relating to a provider’s application and eligibility, including but not limited to issues related to program integrity.
- CCHP will be responsible for gathering all necessary documents and information associated with the Provider’s application.
- The provider should direct any questions it has regarding its application to CCHP by phone at 925-313-9500 or e-mail Providerrelations@cchealth.org.
- If the provider’s application requires fingerprinting, criminal background checks, and/or the denial or termination of enrollment, these functions will be performed by DHCS and the results shared with CCHP.
- While CCHP’s enrollment process will be substantially similar to the DHCS enrollment process, timelines relating to the processing of the enrollment application may differ. In addition, CCHP will not have the ability to grant provisional provider status nor to authorize FFS reimbursement.
- Providers will not have the right to appeal CCHP’s decision to cease the enrollment process.
- CCHP will complete the enrollment process within 120 days of the provider’s submission of its application. During this time, the provider may participate in CCHP’s network for up to 120 days, pending approval from the CCHP.
- Once CCHP places a provider on the Enrolled Provider List, the provider is eligible to contract with all Managed Care Plans (MCPs). However, an MCP is not required to contract with an enrolled provider. Only DHCS is authorized to deny or terminate a provider’s enrollment in the Medi-Cal program.
- Accordingly, if CCHP receives any information that impacts the provider’s enrollment, CCHP will suspend processing the provider’s enrollment application and refer the provider to DHCS’ FFS Provider Enrollment Division (PED) for enrollment where the application process will start over again.
- In order for the provider to participate in the Medi-Cal FFS program, the provider must first enroll through DHCS.
B. Enrollment through a Managed Care Plan other than CCHP

- Submit Verification of Enrollment to CCHP. CCHP will accept this verification as proof of enrollment.

C. Enrollment through DHCS

- The provider will use DHCS’ standardized application form(s) when applying for participation in the Medi-Cal program. Applications can be found at the provided link.
  
  [http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx)

- Federal and state laws and regulations that apply to FFS providers will apply to the enrollment process for Managed Care providers.

- Upon successful enrollment through DHCS, the provider will be eligible to contract with CCHP and provide services to FFS beneficiaries.

Providers should consult with their own legal counsel before determining which enrollment process best suit its needs and objectives.

**PROVIDER CREDENTIALING AND RECREDENTIALING**

CCHP follows National Committee for Quality Assurance (NCQA) guidelines and standards for initial Provider credentialing and re-credentialing. The credentialing cycle is generally every three years and includes a comprehensive Facility Site Review for all Primary Care, Obstetrics and Gynecology, High Volume Providers, Ancillary Providers and Organizational Providers such as a stand-alone surgery center or Skilled Nursing Facility that is not accredited or has a current CMS survey (within three years of credentialing date). All providers must be qualified in accordance with current applicable legal, professional and technical standards and appropriately licensed, certified or registered and must have a good standing in the Medi-Cal and Medicare programs. Providers that have been terminated from either Medi-Cal or Medicare are ineligible to participate in the CCHP network.

All providers, including non-physician medical practitioners and organizational providers, applying to the CCHP network must be credentialed and approved by the CCHP Peer Review and Credentialing Committee (PRCC)and have an executed contract prior to the provision of services to CCHP members. The PRCC makes the decision to accept, retain, deny or terminate a provider’s participation in the CCHP network. The credentialing committee does not make credentialing or recredentialing decisions based on an applicant’s age, gender, race, ethnic/national identity, sexual orientation or types of procedures performed by the applicant.

Providers will be notified periodically of expired licensure, certifications and liability coverage and requested to send in the renewal copy of the documents. Failure to send in renewal documents within thirty days of expiration and notification may result in termination from the CCHP network.
For questions concerning credentialing contact:

Provider Relations Credentialing Unit
1-877-800-7423 (option 6) or 925-313-9500
E-Mail: CCHPCredentialing@cchealth.org

**FACILITY SITE REVIEW**

CCHP requires all PCP’s and OB/GYN’s to undergo a full scope Facility Site Review (FSR) initially as part of the credentialing and contracting process and every three years thereafter as part of the re-credentialing process. The FSR is CCHP’s method of evaluating provider offices to ensure that regulatory health and safety standards are met prior to the provision of medical services to plan members.

The FSR is conducted by the Provider Relations (PR) Nurse who is a Registered Nurse (RN) trained and certified by the state of California to conduct the review, and using the tool compiled by the California Department of Health Care Services Medi-Cal Managed Care Division. The PR Nurse will provide practitioners with a copy of the FSR tool in preparation for the review and will provide technical assistance to help providers meet the review standards and requirements. (Tool can also be located on our website at [www.cchealth.org/healthplan](http://www.cchealth.org/healthplan))

The full scope FSR includes a facility/site survey (FSR) and a medical record review survey (MRR). Any noted deficiencies are reported in a Corrective Action Plan (CAP) and returned to the provider.

Depending on the score of the FSR and the need for intense Corrective Action, the Credentialing process may be temporarily withheld at the discretion of the Peer Review and Credentialing Committee (PRCC).

At the same time as the FSR and MRR, CCHP performs a survey for Physical Accessibility at all PCP and OB/GYN sites as well as High-Volume Specialist sites every three years. All Ancillary Providers that join the network will have a Physical Accessibility survey performed at the time they join and anytime they make changes to the physical site. This information will be made accessible to members via our provider directories and our online provider directory. Physical Accessibility is not scored and will not be subject to CAPs.

CCHP utilizes a modified FSR tool to survey organizational providers that are not either accredited or have a current CMS survey. This includes Skilled Nursing Facilities, Free Standing Surgery Centers and Dialysis Infusion Centers.

CCHP collaborates with other Medi-Cal Managed care plans to share FSRs and avoid duplication of audits in providers’ offices whenever possible.
CORRECTIVE ACTION PLAN FOR DEFICIENCIES ON THE FSR

The Corrective Action Plan (CAP) is written specific to the noted deficiencies found during the FSR and MRR. It identifies modifications needed at provider offices to existing procedures or the development of new processes to meet standards and guidelines. A corrective action plan (CAP) is required for a total score on the FSR portion of less than 90%, OR for a total score of 90% or above if there are deficiencies in Critical Elements, Pharmaceutical Services or Infection Control.

The MRR score is based on a review standard of 10 records per individual primary care physician (PCP). Documented evidence found in the hard copy (paper) medical records and/or electronic medical records, including immunization registries, are used for survey criteria determinations. An Exempted Pass is 90%. Conditional Pass is 80-89%. Not Pass is below 80%. The minimum passing score is 80%. A corrective action plan (CAP) is required for a total MRR score below 90%. Also, any section that scores less than 80% requires a CAP for the entire MRR, regardless of the total MRR score.

A specific time frame for compliance will be noted on the CAP and any needed follow-up will be initiated by the PR RN responsible for Facility Site Review and reported to the CCHP Peer Review and Credentialing Committee.

NON-COMPLIANCE OR FAILURE ON THE FSR

Providers who do not comply with the FSR or the CAP timelines will be deemed as non-compliant and subject to administrative actions on the part of CCHP, including suspension or termination from the network. Providers who do not obtain a minimum passing score of 80% on the FSR for both the facility site and medical record review will need to complete a CAP according to the timelines. Member assignment cannot be made until the CAP is approved and all corrections are documented.

DELEGATED CREDENTIALING

CCHP follows DHCS, DMHC and NCQA guidelines and standards for delegated credentialing and is responsible for oversight of the delegated activity. CCHP delegates credentialing to Independent Physician Associates (IPA’s), Physician groups, hospitals and other entities that provide services to our members. CCHP is ultimately responsible and does ensure that all delegated entities and subcontractors comply with all applicable State and federal laws and regulations, contract requirements, reporting requirements, and other DHCS guidance including but not limited to All Plan Letters.

Before delegation is granted, the entity must submit written policies and procedures related to credentialing activities of potential network providers. The written policies and procedures must meet CCHP requirements for credentialing and recredentialing.

Delegated entities are required to sign a delegated credentialing agreement and contract with CCHP. In addition, delegated entities must submit quarterly or semi-annual reports that include network changes. Delegated entities credentialing files and Policies and Procedures are audited annually by the Provider Relations credentialing staff unless the entity is NCQA accredited.
CCHP designated staff, medical director and the PRCC have responsibility to perform oversight of any delegated entity’s credentialing and recredentialing activities to ensure compliance with CCHP policies and to make recommendations for improvement. If the delegated entity fails to meet its obligations, CCHP has the right to terminate the delegation.

**ORGANIZATIONAL PROVIDERS**

An organizational provider is a provider contracted with CCHP to provide inpatient or outpatient services. CCHP directs members to organizational providers to receive health care services rather than to an individual practitioner.

Organizational providers include:

- Dialysis Infusion Centers
- Home Health Agencies
- Hospice
- Hospitals
- Mental Health Facilities/Chemical Dependency Facilities
- Skilled Nursing Facilities
- Free Standing Surgery/Surgical Centers

All organizational providers requesting participation with CCHP must complete an application for participation, which is designed to perform a review of the organizational provider’s credentials and ability to provide services, and complete required contract documents. CCHP’s Peer Review and Credentialing Committee (PRCC) will review the assessment of each organizational provider prior to approval to participate in the CCHP provider network. Organizations accredited by an approved accrediting body will be deemed as meeting the required standards and will not be further reviewed by CCHP. An on-site quality assessment will be conducted if the organization is not accredited.

In lieu of an on-site quality visit, for a non-accredited organization, CCHP will accept a CMS or state review provided the review is not greater than three (3) years old at the time of verification. Prior to providing services, organizational providers must be approved by the PRCC and have an executed contract in place.

CCHP assesses organizational providers at a minimum of every three (3) years in accordance with DHCS, DMHC and NCQA standards and guidelines in order to ensure that providers meet health and safety standards required by the health plan. Organizational providers must maintain Medicare certification (if applicable). Providers will be notified periodically of expired licensure, certification and liability coverage and requested to send in the renewal copy of the documents. Failure to send in renewal documents within thirty days of expiration and notification may result in termination from the CCHP network.
**SPECIALTY CARE**

CCHP has a large Specialty Care Provider network to meet a wide-range of member needs. All contracted providers are listed on the CCHP Online Provider Directory located at [www.cchealth.org/healthplan](http://www.cchealth.org/healthplan). Searches will provide you with the names of providers, specialties, board certifications, hospital affiliations, directions, languages spoken, office hours, telephone numbers and more.

**PROVIDER CONTRACTS**

CCHP contracts with physicians, hospitals, ancillary, organizational providers and vendors for healthcare services and supplies that meet the participation requirements and are fully credentialed in accordance with CCHP’s Credentialing and Recredentialing policies. For medically necessary services not available in our network, CCHP may negotiate single patient Letters of Agreement with non-credentialed, non-contracted providers or vendors as necessary. CCHP is required by the Department of Healthcare Services (DHCS) to have all contracted entities complete and return the form indicating ownership status of all entities we contract with.

All contracts are required to be notarized. If you need assistance with notarizing a contract and are located within Contra Costa County, visit the County Contract & Grants Department located at 50 Douglas Dr. in Martinez Mon-Fri between 8a-5p. Contractors are expected to promptly notify the Health Plan should any information change at any time during the contract term.

Contract renewals begin six months in advance of the term expiration date. You will be notified and required to update your contract information. Signed copies are required to be promptly returned to the County by Contractors in order to continue timely payments.

For subcontractors and delegated entities, CCHP is ultimately responsible and does ensure that all comply with all applicable State and federal laws and regulations, contract requirements, reporting requirements, and other DHCS guidance including but not limited to All Plan Letters.

For questions regarding contracting, contact the Contract Management Unit.

Provider Relations Contract Management Unit
1-877-800-7423 (option 6) or 925-313-9500
E-Mail: ProviderRelations@cchealth.org

**PROVIDER ROLES AND RESPONSIBILITIES – NEW PROVIDER ORIENTATION**

The Provider Relations Department is mandated by regulatory bodies to orient new providers to the health plan within ten (10) business days of being placed active in the CCHP Network. The Provider Manual and Provider Orientation Power Points (Appendix R) are available on our website at [www.cchealth.org/healthplan](http://www.cchealth.org/healthplan). The Provider Manual is updated with new materials as changes occur. For the most recent edition, check the website.
Orientation materials are emailed to each provider. The provider or entity is required to review the material and return the attestation form. Failure to return the attestation form within the ten-day time frame will be cause to be placed inactive in our network until the form is returned.

Delegated entities receive their orientation materials during the onboarding process with the entity. CCHP has provided the orientation materials to each delegated entity. Until the onboarding process is completed, the provider is not allowed to practice.

Orientation materials cover the following areas:

- PCP and Specialty Provider Roles and Responsibilities
- Managed Care
- Seniors and Persons with Disabilities (SPD’s) Cultural Awareness and Sensitivity Training (Refer to Appendix P)
- Case Management Services (Refer to Appendix C)
- Claims submission
- Access to Health Plan Programs
- Advanced Health Care Directives. - Providers must document execution of an Advanced Health Care Directive and place in a prominent area in the medical record, or if not executed, documentation that it was offered to the member (Refer to Appendix B)
- Advice Nurse Services
- California Children Services
- Claims Filing Process
- Communicating to the member about health status, medical care or treatment options (including alternative treatments that may be self-administered), including sufficient information to provide the member with an opportunity to decide among all relevant treatment option. Information on the risks, benefits, and consequences of treatment or non-treatment providing members with the opportunity to refuse treatment and to express preferences about future treatment decisions
- Cultural Competency Training
- Facility Site Review (if applicable)
- Formulary
- Fraud, Waste and Abuse (Refer to Appendix H)
- Grievance, Complaints and Appeal Procedures and forms
- Independent Medical Review (IMR)
- Initial Comprehensive Health Assessments (IHA) - Documentation of IHA’s or the reason an IHA was not completed. Timelines for performing IHA’s. Procedures to assure that visits for the IHA’s are scheduled and members are contacted about missed IHA appointments.
- Interpreter Services
- Member Accessible Clinical Telephone Triage
- Member Assignment Process
- Member Discharge Process from Provider Panel
- Member Eligibility Verification - Provider must check eligibility (on-line or by phone) on the date of service. If a member is retroactively terminated after provider verifies
eligibility and if authorization was required, and Provider received authorization to provide services, provider will be compensated at their contracted rates.

- Member Rights
- Mental Health-AMSC—Alcohol Misuse Screening and Counseling, Mental Health services, including referrals for Applied Behavior Analysis
- Non-Physician Medical Practitioner Supervisor and Ratios
  1) Physician Supervisor to Non-Physician Medical Practitioner
     A full-time physician supervisor is required to supervise non-physician medical practitioners. The ratio must not exceed the following:
     - Nurse Practitioners 1:4
     - Physician Assistants 1:4
     Four (4) non-physician medical practitioners in any combination that does not include more than three (3) Nurse Midwives or four (4) Physician Assistants
- Provision of Health Services - Consistent with professionally recognized standards of care, Clinical protocols and evidence based practice guidelines.
- Provider hours-Offers hours of operation that are no less than the hours of operation offered to other patients or comparable to Medi-Cal Fee-For-Service.
- Re-credentialing
- Referral and Authorization Processes
- Reporting of any disease or condition to Public Health Authorities. CCHP will report diseases or conditions within the timeframe indicated on the Confidential Morbidity Report (PM-110) pursuant to the relevant disease or condition. CCHP’s Medical Director will be responsible for reporting to Public Health authorities. (Refer to Appendix E)
- WIC-(Refer to Appendix Q)
  1) Identifying and Referring Members to the Women, Infants and Children (WIC) program. Those eligible include pregnant, postpartum and breastfeeding members and infants and children under five years of age, including foster children and those members determined to be at nutritional risk. Two major types of nutritional risk are recognized:
     a) Medically based risks such as anemia, underweight, overweight, history of pregnancy complications, or poor pregnancy outcomes.
     b) Dietary risks, such as failure to meet the dietary guidelines or inappropriate nutrition practices. Providing current hemoglobin or hematocrit laboratory values to the WIC program with proper documentation of such values in the member's medical record.
  2) Including nutrition and health education assessments and interventions as part of prenatal care and include breastfeeding counseling and support after delivery. Assessment of breastfeeding support needs is part of the first newborn visit after delivery.

REGULATORY REQUIREMENTS

- CCHP may not prohibit providers from providing advice to patients based upon cost of care or any other factors.
• Providers may freely communicate to the member about their health status, medical care or treatment options regardless of benefit coverage limitations.
• Providers may not engage in marketing CCHP or any of its products to members.
• Providers are prohibited from billing CCHP members for any services covered by CCHP, except for co-payments and deductibles.
• Providers are prohibited from charging members to complete medically necessary forms.
• Providers that have “opted out” of the Medicare program or appear on the Medi-Cal Exclusions list are prohibited from credentialing and/or contracting with CCHP.

• Providers that “opt out” of the Medicare program or appear on the Medi-Cal exclusions list after being credentialed, recredentialed or contracted will be issued a thirty (30) day notice to terminate participation in the CCHP networks.
• Providers will update CCHP within five (5) business days if: (i) provider is not accepting new patients; or (ii) if provider had previously not accepted new patients, but provider is currently accepting new patients. If Provider is not accepting new patients, provider will direct a member or potential member to both the CCHP Member Services for additional assistance in finding a provider and to the Department of Managed Health Care to report any potential directory inaccuracy.

**QUARTERLY PRIMARY CARE PROVIDER NETWORK MEETINGS**

The CCHP Medical Director and Health Education staff convenes quarterly Provider meetings in Central, East and West Contra Costa County for Primary Care Providers (PCP). These meetings serve as a forum for Providers to learn more about CCHP, its programs and functions, new initiatives, regulations, standards and requirements; and to share clinical concerns and experiences serving Health Plan Members. Health Education staff conduct ongoing training at these meetings. Topics include: Public Health issues, immunizations, disaster preparedness, HEDIS and other topics as needed. All meeting materials can be accessed on our website [www.cchealth.org/healthplan](http://www.cchealth.org/healthplan) under the topic CPN quarterly meetings.

**PROVIDER AVAILABILITY AND COVERAGE**

CCHP requires primary care providers to be available twenty-four (24) hours a day seven (7) days a week, with appropriate coverage and/or on-call arrangements and clinical telephone triage.

Providers are requested to make coverage arrangements with a CCHP contracted provider whenever possible. The covering provider should indicate on the CMS-1500 billing form, in box 31 o/c and their name along with the contracted doctor's name underneath or attach a note stating that he/she is covering or on-call for the PCP in order to be reimbursed.
**PROVIDER CHANGES**

Prior to implementing material changes to terms of payment, credentialing and other rules of participation, CCHP will issue written notice by fax, e-mail or mail to providers within thirty (30) days of the change.

When a provider changes or adds a new office location, changes tax identification information or adds or terminates a provider within the practice, notification in writing must be made to CCHP at least ninety (90) days prior to the effective date of the change. Providers are also required to notify CCHP within thirty (30) days of any change in status such as licensure, malpractice claims settlement and hospital privileges.

When a Primary Care or Obstetrics and Gynecology Provider adds an office location or changes to a new location, the new location must undergo a Facility Site Review (FSR) at least thirty days prior to services being rendered at that new site. If a provider notifies CCHP after the move, existing members can continue to receive services, but no new members can be assigned until the FSR is complete. The FSR must be completed within thirty (30) days of the move.

When a contracting provider or CCHP decides to terminate a contract without cause, the provider and/or CCHP, must provide written notice at least ninety (90) days in advance of the requested date of termination. In addition, CCHP requests specialty providers send a list of members to whom they are providing services, in order for CCHP to redirect the member’s care to another contracted specialist. CCHP’s Provider Relations, in collaboration with Member Services and Utilization Management, will notify affected members within thirty (30) days of the Provider termination date.

**PROVIDER COMPLAINTS**

CCHP is committed to the delivery of excellent customer service. If you have received less than excellent service, there is a process to have your complaints evaluated and resolved in a timely manner. Complaints you would likely submit may include; member discharge from your practice, member behavior at your practice, facility site reviews, contractual concerns, interactions with CCHP staff or concerns regarding CCHP policies and procedures.

**MEMBER DISCHARGE FROM PRACTICE**

Providers may not discriminate against CCHP members based on health status. Members may be discharged from a provider’s practice for non-compliance, more than two missed appointments or disruptive and/or threatening behavior, but not for health status or diagnosis.

Missed appointments require documentation provider office has contacted the member, documented the reason missed and offered an opportunity to reschedule the appointment.

Missing the second appointment may be grounds to discharge the member from the panel, depending on the provider’s specific office policy.
If the provider is discharging the patient for abusive or threatening behavior, a detailed account of the interaction with words used by the member and the number of times/dates of the offense and if the behavior threatened office staff, the provider or concerned other patients in the office at the time of the occurrence, needs to be detailed on the Provider Complaint Form. Include the specific reason(s) for the request and any pertinent documentation, CCHP uses this information in a letter to the member to explain the reason of reassignment and address their unacceptable behavior. It also necessary for CCHP to know if the patient is undergoing any active care that will require review and intervention, upcoming appointments that need to be cancelled and/or if the member has any medically necessary prescriptions that will need to be renewed within the next thirty (30) days. Depending on the reason for the discharge, the provider may need to continue emergency care and refill prescriptions up to thirty (30) days post discharge If this is not reasonable, then the discharging provider will need to assist the plan’s member services staff with ongoing clinical information that will be needed by the newly assigned PCP.

To discharge a member from a provider’s practice, the request must be made in writing, using the Provider Complaint form (located on our website www.cchealth.org/healthplan under the topic Forms and Resources or in Appendix O) and include the reason for the request and any pertinent documentation. The form can be e-mailed or faxed to the Provider Relations Department.

Provider should notify the member in writing they are being discharged from the practice and to notify CCHP member services if they have any questions including information on how to contact CCHP Member Services if they have any questions. A copy of the discharge letter should be sent to CCHP Provider Relations.

All Provider Complaints are required to be submitted on the Provider Complaint Form (located on our website www.cchealth.org/healthplan under the topic Forms and Resources) no more than ninety (90) days from the action or inaction precipitating the complaint. Provider Relations will acknowledge receipt of your complaint within fifteen (15) business days and will send a written resolution within thirty (30) business days. Non-medically related complaints will be evaluated and resolved by the Director of Provider Relations. Medically related complaints will be referred to the Quality Management nurse for evaluation and resolution.

If a complaint is referred to professional peer review, all parties will be given written notification that a referral has been made and a final determination will require up to sixty (60) days from the acknowledgement of receipt of grievance or complaint.

Submit the Complaint form by mail, e-mail, fax or by calling:

Contra Costa Health Plan
Attn: Provider Relations
595 Center Avenue Suite 100
Martinez, California 94553
Telephone: 1 877-800-7423 (option 6) or 925-313-9500
Fax: 925-646-9907
E-Mail: ProviderRelations@cchealth.org
Appeals are complaints expressed in writing requesting a review of a denied service or claims denial. See Utilization Management (Section 3) and Claims (Section 6) for guidance on appeal submission.

**PROVIDER TERMINATION – COORDINATION AND CONTINUITY OF CARE**

In some instances, if a provider leaves the CCHP network, the member’s medical condition may require coordination and continuity of care to ensure that needed medical services are uninterrupted. CCHP will negotiate terms and conditions for continuity of care with the provider when a termination is requested. In addition, CCHP requests specialty providers send a list of members they are providing services to, in order for CCHP to redirect the member’s care to another contracted specialist.

**PROVIDER NETWORK UPDATE**

On a quarterly basis, CCHP is contractually required by the Department of Health Care Services (DHCS) and Centers for Medicaid and Medicare Services (CMS) to verify the information listed in our database and directories for your practice. Information verified includes, but is not limited to, all practice locations, phone and fax numbers, office e-mail address, languages spoken, providers practicing at each location and whether or not a provider is accepting new patients. Annually we are required to verify hospital affiliations and if your staff knows your practice is contracted with the health plan for all product lines. This information is used on our electronic Provider Directory at [www.cchealth.org/healthplan](http://www.cchealth.org/healthplan), and in printed directories distributed to our health plan members.

The Provider Network Update (PNU) link to electronically update information is e-mailed to your office designated staff or each provider or the PNU form faxed if an e-mail address has not been submitted. We request that providers or designated staff complete and return the PNU form or access the link within two weeks of receipt. However, providers are given thirty (30) business days to acknowledge receipt of the form or access to the link, completion of the form or electronic submission and return, confirming the information listed in the provider directory is current and accurate or update the information required to be in directories, including accepting new patients. If not returned within the first fifteen (15) business days, it is sent out again to the provider allowing another fifteen (15) business days to return the form. Providers who do not return the form after the second attempt will receive a verification call from credential staff within fifteen (15) business days. All information in the database will be queried and credential staff will review submitted electronic and hard copy form for changes. If you are non-complaint, we will notify you by fax, e-mail or mail that within ten (10) business days of the date of the notification your information will be removed from provider directories. If you respond prior to the ten (10) business days, your information will remain in the directories.

Our goal is to ensure all of your practice information is accurate. We appreciate your assistance and time in keeping the Provider Database and Directory accurate.
If your office/practice information has not changed since the last report, write no changes on the form and fax back to 925-646-9907. Group practices can send in a roster listing all providers, practice locations, the sites each provider is practicing, phone and fax numbers instead of completing the form. Electronic submissions will come to us directly and your submitted updates will be reviewed and updated in our database.

**PROVIDER DIRECTORIES**

All credentialed and contracted providers are listed in our printed member and Online Provider Directory). The Online Provider Directory can be accessed 24 hours a day, seven days a week at the following internet address: www.cchealth.org/healthplan.

Searches provide maps/directions, languages spoken, office hours, telephone numbers, physical accessibility and more. A user can enter the database by clicking “begin your search here”. This brings the user to an area to search by PCP or Specialist or, facility.

In the PCP or Specialty area, a user can search by name, hospital affiliation, medical group, specialty, location, network, gender, language, physical accessibility, CA license number, NPI and accepting patients by entering the requested information and clicking on “begin search”. The requested information will be displayed and can be printed or saved in a PDF file.

In the Facility area, a user can search by type of facility, name, location or physical accessibility. The hospital accreditation is displayed in the search results. The requested information will be displayed and can be printed or saved in a PDF file.

**ccLink PROVIDER PORTAL**

ccLink is a communication tool between the Community Provider Network (CPN) and Contra Costa Health Plan and the Specialty Care Providers and Primary Care Providers at Contra Costa Regional Medical Center (CCRMC) and Health Centers. ccLink Provider Portal is based on best practices from other medical centers and health plans. CCHP is not requiring our CPN doctors to utilize the ccLink (Epic) electronic records for our members.

ccLink allows on-line access to CCHP member information and provides real-time eligibility inquiries about CCHP members. If you are the member’s primary care provider or the “referred to specialist”, you will be able to access a list of patients that are assigned to you. It allows a provider to submit and check the status of any required referral and to attach documentation to a referral being sent to CCHP for evaluation of an authorization.

(This feature is under construction and will be available in the future.) You can also check the status of a submitted claim, facilitate communication and streamline patient care across locations and disciplines.
For Regional Medical Center members that are referred to a Community Provider Specialist, reports and notes about consultations can be received and included in the CCRMC and Health Centers’ patient electronic health record by faxing this information to (925) 370-5239.

If you have not already signed up for access to ccLink, you must complete and return required paper work to be assigned a user name and password. The documents can be downloaded from the CCHP website located at www.cchealth.org/healthplan under the topic Forms and Resources or requested by calling CCHP Provider Relations 925-313-9500, or e-mailing ProviderRelations@cchealth.org.

**FRAUD, WASTE AND ABUSE**

The Centers for Medicare and Medicaid Services (CMS) requires Fraud, Waste and Abuse (FWA) training for all contracted entities.

The requirements can be found in 42 C.F.R. 422.503 (b) (4) (VI) and 42 C.F.R. 423.504 (b) (4) (VI). A copy of the training materials is included in Appendix H and is available on our website located at www.cchealth.org/healthplan.

CCHP views the integrity of its staff, providers, contractors and members to be paramount and uncompromising. The materials provided reiterate the procedure for handling discovery of fraudulent activity involved with CCHP and to remind contracting entities that you must also have appropriate policies and procedures to address FWA.

A provider or downstream contractor may submit a potential or suspected FWA case directly to the CCHP Provider Relations Unit by mail, fax or e-mail to the following address:

Contra Costa Health Plan 595 Center Ave Ste. 100
Martinez, CA 94553
Phone: 925-313-9500
Fax: 925-646-9907
E-mail: ProviderRelations@cchealth.org

FWA may also be reported to the Office of Inspector General at: 1-800-HHSTIPS

For cases involving Medicare prescription drugs, to the Health Integrity Unit at: 1-877-772-3379
Section 3 – UTILIZATION MANAGEMENT

CCHP’s Utilization Management (UM) Department provides oversight and monitoring of services provided to members. UM decisions are based only on appropriateness of care and service and the member’s benefit package. The UM staff is neither compensated or rewarded for issuing denials of coverage or financially encouraged to make decisions that result in underutilization.

Normal Business hours for the Authorization and Utilization Management (UM) Department are Monday through Friday from 8:00am to 5:00pm, excluding weekends and holidays. During the hours of 11:00am to 5:00pm, staff is available for inbound and outbound communications regarding the authorization and UM processes. When making outbound or returning calls, staff identifies themselves by their name, title and organization. Members can reach the UM Department by calling the Member Call Center at 1-877-661-6230, option 4. Providers can reach the UM Department by calling the Provider Call Center at 1-877-800-7423, option 3.

Afterhours and during weekends, both callers have two options. For non-urgent matters, the caller can leave a message at the above number. Messages are addressed the next business day. For urgent matters, the caller can stay on the line and be automatically transferred to the Advice Nurse Unit, which operates 24/7. The Advice Nurse (AN) Unit has limited authority to approve medically necessary services on behalf of the UM Department and is able to reach a backline at the UM Department for assistance. As necessary, the AN Unit has access to the UM Manager and Medical Director. A toll free number, TDD/TTY for hearing impaired, and language assistance are available and accessible to members and providers. Providers can utilize the Health Plan’s language services to assist our members who are hearing impaired or need language translation services. Please refer to Section 11-Cultural and Linguistic Services for detailed information. Language services information is also available at our website www.cchealth.org/healthplan.

Providers may access a list of current clinical guidelines from CCHP’s website at https://cchealth.org/healthplan/providers/ and search on clinical guidelines. Providers can request, free of charge, copies of clinical criteria or guidelines used for decision-making by contacting CCHP’s Utilization Management Unit at 877-800-7423 (Option 3) or fax (925) 313-6458 and type Attn: Internal Audit/Charge Nurse. When requested services are denied or modified, providers have the opportunity to discuss the UM decision. Providers are notified (via Notice of Action, Notice of Non-Coverage, etc.) on how to contact and when the reviewer is available to discuss the decision.

**REFERRAL AUTHORIZATION FORM – CPN PRIMARY CARE PROVIDERS**

- A referral to a CCHP contracted specialty care provider is initiated by the CPN PCP completing a Community Provider Referral Form (HP 200-7). Each referral form has a number, which tracks patient visits. THIS FORM SHOULD NOT BE DUPLICATED FOR MULTIPLE REFERRALS.
CPN referrals are not valid for services such as:
  - Gastric Bypass Evaluations or Surgery
  - Neurosurgery referrals
  - Pain Management
  - PET scans
  - Tertiary Care referrals such as to UCSF, Stanford or Lucile Packard
  - Transgender consults and referrals

The referral is valid for one year for a consult and (6) follow-up visits. A consult and any procedure listed on the PCP referral form must be completed within 90 days of the initial referral date. Follow up visits are valid during the one year period of the initial referral. Any listed procedure can be performed one time.

Any repeated procedure would need prior auth and medical justification. Subsequent visits (beyond six) may require completion of the Procedure/Services Prior Authorization Request Form (PA001). (See Appendix L and O)

Fax a copy of the referral to the CCHP contracted specialist with all pertinent diagnostic and medical information and a copy to the CCHP Authorization Department fax at 925-313-6058. Place a copy of the referral in the chart for future reference.

The yellow page is given to the member to share with the specialty provider.

When the referral is received by CCHP, a referral number is generated for tracking and claims payment.

If the specialty provider needs to request additional follow up visits (for visits that require prior authorization), he or she can use the Prior Authorization Request Form (PA001).

In the near future, an electronic web portal, ccLink will be available to providers who wish to submit electronic authorization requests.

**REFERRAL FROM REGIONAL MEDICAL CENTER/HEALTH CENTER PROVIDERS**

Referrals from the Regional Medical Center Network (RMC) are submitted electronically to CCHP UM/Authorization through ccLink. CCHP reviews and authorizes the service. A faxed authorization letter will be sent to the Specialist, a copy to the member being referred and to the requesting Provider. The RMC Provider and/or Care Coordinator is responsible for sending all required documentation to the CPN specialist. The Specialist is responsible for faxing all clinical documentation back to the referring RMC Provider to be included in the member’s medical record at 925-370-5239. RMC Members can self-refer to Behavioral Health and Sensitive Services providers in the CPN network. No prior authorization is required.

**PRIOR AUTHORIZATION**

**SERVICES NOT REQUIRING PRIOR AUTHORIZATION**

No prior authorization or PCP referral is required for the following services if covered under the member’s benefit package and rendered by a contracted in-network provider.
The electronic No Authorization Required interactive list is located on our website at https://cchealth.org/healthplan/providers. This list can be searched by CPT code and should be checked periodically for updated versions. Please note that emergency treatment may be rendered without authorization by any contracted or non-contracted provider. Refer to HP 200-7 cover sheet for up-to-date listing. Please note that an asterisk (*) by any of the services listed below indicates that the service is not available for all benefit plans. You may call Member Services at 1-877-661-6230 (press 2) to ascertain if the services are covered for your patient.

- Acupuncture (Commercial members only)
- Behavioral Health-Mild to Moderate Mental Health Services - Medi-Cal members can self-refer or be referred by their primary care physicians (PCP) to the CCHP Mental Health Network. PCP’s or Medi-Cal members must call the Mental Health Access Line at 1-888-678-7277 to obtain mental health and substance abuse services. Commercial members can self-refer or be referred by their PCP by calling the Authorization Unit Mental Health nurse at 1-877-661-6230.
- Chiropractic Care (Commercial members only)
- CT & Thyroid Scan, EKG, EMG, MRA & MRI (subject to change for MRA/MRI)
- Dexa Scan: See referral form for guidelines
- Sonograms (pregnancy ultrasounds) – See referral form for guidelines
- Dental*
- EEG, ECHO, Pulmonary function tests
- Emergency Treatment - by any contracted or non-contracted provider within the United States. (some plans have Universal Emergency coverage)
- Global Outpatient OB care: Thirteen (13) visits in eleven (11) months
- GYN Services (routine women’s health preventive care services)
- Labs (excludes genetic testing, which requires authorization)
- Mammograms (no more than one every 12 months)
- Ophthalmology (Commercial members only)
- Optometry and Vision Care - includes diagnostic, ancillary and supplemental procedures used for the evaluation of the visual system (Commercial members only)
- Preventive Services including influenza vaccination. Preventive Services require no copayment on the part of the member.
- Primary Care Provider services
- Psychotherapy Services for commercial members. (Commercial Members can self-refer or be referred by their PCP by calling the Authorization Unit Mental Health nurse at 1-877-661-6230.)
- Sensitive Services: Includes family planning, HIV and STD testing and counseling, and abortions. Medi-Cal members can access these services with any provider who is contracted or with a non-contracted Medi-Cal provider

Please note: The No Authorization list is subject to change at CCHP’s discretion. It is the provider’s responsibility to obtain any required authorization prior to rendering services.


SERVICES REQUIRING HEALTH PLAN PRIOR AUTHORIZATION

(Refer to either HP 200-7 or PA001 for up to date listing)

Includes but not be limited to:

- Acupuncture (Medi-Cal members only)
- Audiology
- Chemo/Radiation Therapy (not related to cancer)
- Child Development Center (Autism, Behavior and Child Development Center), Craniofacial Clinic, Healthy Eating Active Living (HEAL) (Children’s Hospital Oakland)
- Chiropractic (Medi-Cal members only)
- Dialysis
- DME and Oxygen
- NCS, ENG
- Experimental/Investigational Services
- Follow Up Visits beyond 6 visits unless otherwise indicated
- Genetic or DNA Testing
- Hearing Aids
- Home Health Services including hospice* & home infusion therapy
- Inpatient Admissions including OB, Acute Rehab, SNF & Hospice
- PET Scans, Total Body Scan
- Non-Contracted Providers-Emergency services do not require prior authorization from CCHP.
- Non-emergency transportation**
- Non-network follow up visits
- Non-reusable medical supplies
- Mental Health Psychiatry- Organ Transplant Evaluation and services
- Ophthalmology (Medi-Cal members only)
- Out-of-Area Services
- Outpatient Surgery Center and Facility based procedures
- Prosthetics, Orthotics, Appliances and Braces
- RAST or MAST Testing
- PCP Referral to Self for Specialty Care
- Rehabilitation Services beyond one consult and five visits including physical, occupational, speech therapy and cardiac pulmonary rehabilitation (Excludes Developmental Delay Diagnosis)
- Special Programs and Subspecialty Providers: Pain Management, Urogynecological services, Weight Loss, Gastric Bypass Surgery and Sleep Studies
- Tertiary Care Centers, e.g. UCSF, UC Davis, Sutter West Bay, Stanford, Lucile Packard
- Tuberculosis Treatment (referral only)
- Vision Services (Medi-Cal members only)

*For Medi-Cal members, prior authorization is not required but notification of admittance to hospice care is required.

**Unaccompanied Minors require a signed Minor Consent form with the Prior Auth request.
A special worksheet is required for the following services:

- Bone Growth Stimulator
- Gastric Bypass Surgery
- Incontinence Supplies (creams and washes are excluded when supplies are covered) (Medi-Cal only)
- Manual Wheelchair
- Motorized Wheelchair/Power Operated Vehicle
- TENS Unit

Call the Authorization Unit for applicable worksheet Phone: 1-877-800-7423 (option 3)

**SUBMISSION OF PRIOR AUTH REQUEST**

Prior Authorizations should be submitted to CCHP Authorizations Unit by eFax using Procedure/Services Prior Authorization Request Form (PA001). Always indicate whether the authorization request is URGENT or ROUTINE.

- A request is considered urgent when the member faces an “imminent and serious threat” to his or her health and the standard timeframe of 5 business days for the decision-making process:
  1. Would be detrimental to the enrollee’s life or health, or
  2. Could jeopardize the enrollee’s ability to regain maximum function.
- Circumstances that are not considered urgent include:
  1. Late request for scheduled visit/service (e.g. appointment scheduled for the next day)
  2. Routine follow-up/annual appointment
  3. Ongoing continued care of an existing member
  4. Retro auth request

If a request does not meet the above guidelines, please document the reason that it does not meet the guidelines in the text notes. Urgent Requests will be reviewed for “Urgency.” Please note that Urgent Requests may take up to 72 hours to process.

Please fax only one referral at a time to promote timely processing.

**CCHP Authorization eFax Numbers:**

* Prior Authorizations/Outpatient/Routine – 925-313-6058
* Urgent/Additional Information – 925-313-6458
* Inpatient (Hospital)/Facesheet – 925-313-6645
* Appeals – 925-313-6464
* Mental Health – 925-313-6196
* Specialty (CPAP) – 925-313-6069
REVIEW OF PRIOR AUTHORIZATION REQUESTS

Utilization Management clinical staff review the request for medical necessity based on established and/or licensed clinical guidelines and appropriateness of services, which includes but not limited to:

- Availability of service/procedure within assigned provider network
- Diagnosis (ICD-10 code) and requested CPT/HCPCS codes
- History and physical and pertinent clinical findings
- Procedure
- Purpose of the referral
- Requested services
- Symptoms and significant physical findings
- Test, procedures, and lab results already performed and/or failed
- Specialist findings, recommendations and treatments

EXCLUDED SERVICES REQUIRING MEDI-CAL MEMBER DISENROLLMENT

CCHP has multiple product lines, each with their own benefit structure. Our Medi-Cal members have excluded (carved-out) services that Fee-For-Service (FFS) Medi-Cal will cover. CCHP will continue to cover and ensure that all medically necessary services are provided to our members who must disenroll and receive care through the FFS program. Our Utilization Management (UM) team will assist with these types of requests. Contact the UM or Member Services Department for assistance.

Excluded or limited Medi-Cal services include:

- Long Term Care
- Major Organ Transplants (excludes corneal and kidney)
- Waiver Programs
- California Children Services (CCS) Eligible Conditions

MEDI-CAL EXCLUDED SERVICES DESCRIPTION

LONG TERM CARE

Long-term care (LTC) is defined as care in a facility for longer than the month of admission plus one month. LTC services are not covered by the Health Plan. Hospice services are not long-term care and therefore are covered services. CCHP will cover medically necessary nursing care provided from the time of admission and up to one month after the month of admission. Beyond that time, the member will be disenrolled from CCHP and returned to Fee for Service (FFS) Medi-Cal.
**MAJOR ORGAN TRANSPLANTS**

Please contact the CCHP UM Department when a CCHP member is identified as a potential major organ transplant candidate. If the member is CCHP Medi-Cal, special handling is required. Major organ transplant procedures (except for Kidney and Corneal transplants) are covered by FFS Medi-Cal and are considered an excluded service.

**WAIVER PROGRAMS**

Waiver Programs are specific to our Medi-Cal product line. If a Medi-Cal member is accepted into a State Waiver Program, such as the AIDS Waiver Program, Model Waiver Program, or In-Home Medical Care Waiver Program the member would be disenrolled from CCHP in order to obtain necessary FFS benefits under the waiver program. The California Department of Health Care Services administers these services under FFS Medi-Cal. Contact the Member Services department for information and disenrollment assistance.

**CALIFORNIA CHILDREN'S SERVICES ELIGIBLE MEDICAL CONDITIONS**

Members under the age of 21 may have a health condition that is covered under CCS. Providers and the Health Plan may refer a member to CCS. Once eligibility for the CCS program is established, the Health Plan will continue to provide all medically necessary covered services that are not related to the CCS eligible condition(s). PCP’s are responsible for ongoing medically necessary diagnostic, preventive treatment and services not covered by CCS.

**PROVIDER APPEAL PROCESS FOR SERVICE DENIALS**

Providers and facilities may submit an appeal of an unfavorable determination made by CCHP for a prospective, concurrent or retroactive request for service or hospitalization of an enrollee.

Providers or facilities may also appeal unsatisfactory, disputed, or resubmission of a claim payment.

The appealing party must submit a written appeal request within 365 days from the receipt of a service or claim denial or modification, or in case of inaction, the expiration of the applicable claim/authorization filing period, for Medi-Cal or Commercial members. Timelines are subject to change. Requests should be accompanied by clinical records (hard copy or on an encrypted disc) to support the appeal. All appeals are required to be sent in by Certified Mail due to HIPAA regulations.

Failure to submit an appeal within the specified timeframe may result in the denial of an appeal request. No punitive action is taken against a provider who submits an appeal. If a provider submits an appeal on behalf of a member, the appeal must be accompanied by written member consent.

Consent forms can be obtained here:

https://cchealth.org/healthplan/for-providers/forms-and-resources/member-consent.
Member appeals must be filed within 60 days of Receipt of Notice of Action for Medi-Cal recipient and 180 days for Commercial members.

Provider Appeals

Contra Costa Health Plan
Authorization Unit Attn: Appeals Liaison
595 Center Avenue, Suite 100
Martinez, CA 94533
Section 4 – CASE MANAGEMENT

The purpose of the Case Management (CM) Programs at CCHP is to ensure that medically necessary care is delivered to our members in the most efficient and effective setting and those social determinants of health are addressed quickly to minimize their negative impact. Case Management programs include:

- Multiple Case Management Programs
- Health Risk Assessments and Care Coordination for our newly enrolled Medi-Cal members.
- Comprehensive Perinatal Services Program for pregnant members receiving OB care with a community provider
- Hospital Transitions Programs

CASE MANAGEMENT PROGRAM

Case Management is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Since complex case management is considered an opt-out program, all eligible members have the right to participate or decline participation.

The goal of complex case management is to help members regain optimum health or improved functional capability in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member’s condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

The primary goals of the program are to:

- Enhance the quality of life of the client
- Provide support and advocacy to member and provider
- Decrease fragmentation of care
- Promote cost-effectiveness
- Improve client and provider satisfaction
- Meet regulatory and accreditation requirements

Case Managers coordinate individual services for members whose needs include ongoing assistance with coordinating health care services. The Case Managers work collaboratively with all members of the healthcare team, including the Primary Care Provider, Specialist Providers, and Discharge Planners at the affiliated hospitals and Utilization Management staff at the Health Plan.

In order to make a referral to the program you may do one of the following:

- Complete the referral form (Refer to Appendix C) and fax it to the CM Program.
- Make a telephone referral. Leave a message including times you may be reached. A case management staff member will return your call promptly.
COMPREHENSIVE PERINATAL SERVICES PROGRAM

CCHP believes that every baby should have a healthy start in life. Our expectation of our perinatal providers is that each member receives services following Comprehensive Perinatal Services Program (CPSP) Guidelines. This includes:

- Initial assessment, trimester reassessments, post-partum assessment, interventions and follow-up services in:
  - Obstetrics
  - Nutrition (assessment, education, intervention and referrals)
  - Health Education (needs assessment, information and linkage to community educational resources)
  - Psychosocial Services (support including crisis intervention, community resources, transportation needs, or any psychosocial problem affecting her care)

- Individual Case Coordination
- Prenatal Vitamin/Mineral Supplements
- Referrals to Related Services

A prenatal care provider may choose to provide CPSP services within their own practice, and bill the Health Plan for those services. If so, the provider should contact the CPSP program at https://cchealth.org/perinatal/providers.php or call 925-313-6254 to become a Certified Provider. Online training is available.

If a provider is unable to provide CPSP services to the member, CCHP has a Medical Social Worker available for the purpose of providing CPSP services in the client’s home or physician office. In order to facilitate early entry into this program, we are requesting that your office fax to us the first prenatal visit records within one week of the visit. We will make every effort to complete the Combined Initial Assessment and have the assessment and individualized care plan to you before the patient’s next prenatal visit.

Fax First Prenatal Visit Records to:
Case Management-CPSP
Phone: 925-313-6852
Fax: 925-313-6284

BABY WATCH PROGRAM

The Baby Watch program is part of CCHP Perinatal Case Management program. The goal of the Baby Watch incentive program is to promote good prenatal care with the goal of reducing the incidence of low birth weight babies and infant morbidity.

Certain pregnant CCHP members are eligible for the incentive program. In order to receive an incentive, eligible members need to do the following:
• Receive their first prenatal visit in the first trimester of pregnancy
• Return for a post-partum follow up visit within six (6) weeks of delivery

For more information about Baby Watch or to refer a CCHP member, please call:

Baby Watch Program
Phone: 925-313-6852

HEALTH-RISK ASSESSMENTS AND CARE COORDINATION FOR NEW AND RETURNING MEMBERS

Under CCHP Care Management Department direction and oversight, our contracted provider Eliza will place automated calls to perform a combined Health Information / Health Risk Assessment (HRA) for all new members and yearly for returning members. The goal of the assessment is to identify members that are high-risk and/or at-risk and enroll them with case management and other appropriate services. This solution will target members from Contra Costa’s Medicaid population in order to gain a better view into medical and health needs. It will also satisfy the requirements for Long Term Supportive Services by DHCS as well as requirements set forth in APL 17-013. Any questions about the HRA may be addressed to the team by contacting the Care Management unit at 925-313-6887.

HOSPITAL TRANSITION PROGRAMS

• Contra Costa Health Plan (CCHP) Hospital Transition Coordination Program facilitates the transition of CCHP clients admitted to a community hospital back to their assigned PCP within the RMC network. The program consists of a designated phone line at CCHP which is answered by a specially trained RN. Services include identifying a member’s assigned PCP and coordinating the transition of discharged patients back into primary care. Additionally, the RN will assist in coordinating specialty appointments to maximize appointment productivity, connecting patients to outside resources, and providing linkages to member services and financial counselors for health coverage. Through this program we will not only enhance continuity of care between our health systems, but also reduce unnecessary ED visits and hospital readmissions.

• Our Hospital Transitions Coordination Program RN is available from 8am-5pm Monday-Friday.

    Hospital Transition Nurse
    Phone: 925-313-6885
    877-800-7423 Option 3, then Option 3

• Contra Costa Health Plan (CCHP) Hospital Transition Outreach Program is an effort to contact CCHP clients that are frequent utilizers of the Emergency Department, those that had a visit to the ED that was determined to be avoidable or those that are readmitted within 90 days of a hospital discharge. The members are identified by multiple reports. Each member receives either a call or a letter from the Transition Outreach RN.
The PCPs are also notified that CCHP reaches out to members for this purpose. The goal is to decrease ED utilization and readmissions, as well as, offering case management assistance and services to meet their medical needs.

- Additional outreach programs include the polypharmacy report and opiate use. Those members either have 15 + prescriptions per month or receive narcotic prescriptions from 3 or more pharmacies and/or 3 or more providers. PCPs are notified of members that are on the narcotic report. The goal is to ensure PCPs are aware of all medications prescribed to their members for care coordination purposes; as well as to engage those members with complicated medical conditions to offer case management assistance and services to meet their medical needs.

Palliative Care Services for Medi-Cal Members

Palliative Care Services is a covered benefit for Medi-Cal members. Palliative care consists of patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Members who are chronically ill and have a life expectancy greater than 6 months are eligible for Palliative Care services. A member with a serious illness who is receiving Palliative Care services may choose to transition to Hospice care if they meet the hospice eligibility criteria. A member may not be concurrently enrolled in Hospice and Palliative Care.

Eligibility Criteria:

- Member has an advanced illness
- Member’s life expectancy is greater than one year and not in hospice
- Member has received the appropriate patient desired medical therapy, but it is no longer affective

Disease Specific Eligibility Criteria:

1. Congestive Heart Failure (CHF):
   a. Member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association (NYHA) heart failure classification III or higher; and
   b. Member has an Ejection Fraction of less than 30 percent for systolic failure or significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease (COPD):
   a. Member has a Forced Expiratory Volume (FEV) 1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
   b. Member needs a 24-hour oxygen requirement of greater than or equal to three liters per minute

3. Advanced Cancer:
   a. Member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
   b. Member has a Karnofsky Performance Scale (KPS) score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).
4. Liver Disease:
   a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, and International Normalized Ratio (INR) greater than 1.3, and
   b. Member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
   c. Member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.

CCHP’s Palliative Care providers include clinicians who have Palliative Care training and/or certification to conduct palliative consultations or assessments. Clinician include: Primary Care Providers, such as: PCPs if Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO) or Nurse Practitioner if a PCP, a Registered Nurse (RN), Licensed Vocational Nurse (LVN), and a Social Worker. Chaplain Services are recommended from the community to be part of the Palliative Care Team. Chaplain services are not a paid service under the Medi-Cal Benefit structure. CCHP has Palliative Care contracts with Hospice of the East Bay, Noble Hospice Care and Continuum Care.

Non-Medical Transportation

Non-Medical Transportation is a benefit provided to all Contra Costa Health Plan Medi-Cal members who do not have access to get to their medically necessary appointments, including dental, mental health and AODS. This transportation benefit is member driven and is scheduled and facilitated entirely within the Home and Community Based Service Unit. Member input is vital / required to ensure accuracy of information and successful completion of transportation logistics. This benefit is easily accessible through the health plan’s non-medical transportation 800 number. This benefit is separate and in addition to Non Emergent Medical Transportation / Emergent Medical Transportation benefits.
Section 5 – PHARMACY SERVICES

CCHP manages the utilization of pharmacy services and ensures quality, appropriate and timely services for its members by utilizing established written clinical criteria approved by the CCHP Pharmacy and Therapeutics Committee (P&T).

CCHP uses a preferred drug list/formulary (PDL) that is designed to promote cost-effective medication use based on published medical literature and community standards of care. The PDL is subject to revision, on a quarterly basis, as necessary to keep pace with continuous advances in pharmaceutical treatments and the needs of the members served by CCHP.

There are a few ways to access the Preferred Drug List:

1. A printable PDL is available online at www.cchealth.org https://cchealth.org/healthplan/pdf/pdl.pdf
2. Epocrates also hosts the CCHP formulary (available on all mobile devices).
3. An online searchable formulary can be found at https://formularynavigator.com/Search.aspx?siteID=MMREQ3Q8C

CCHP’s pharmacy network consists of two national pharmacy chains, Walgreens and Rite Aid, and many independently owned pharmacies in Contra Costa County. If you need help finding a pharmacy for your patients, use the search engine available at the above website or call CCHP Pharmacy services for assistance.

HOURS OF OPERATION

• The CCHP Pharmacy Authorization Unit is available to answer questions from providers and members from 8:00 am – 5:00 pm, Monday through Friday.
• Our Pharmacy Benefits Manager, PerformRx, also handles provider calls. They are available 24 hours per day, 7 days per week to answer questions related to the CCHP formulary or prior authorization status. They can be reached at 877-234-4269. Note: for contract related questions, the PerformRx Network Management unit can be reached at 1-800-555-5690.
• After hours – CCHP Pharmacy Unit personnel are available to process prior authorization requests 6 days per week (Mon-Sat). Unless the dispensing pharmacist determines that the member cannot wait, requests for drugs requiring prior authorization received outside of CCHP’s prior authorization processing hours will not be processed until the next business day.
• In the event that an urgently needed medication that requires prior authorization is needed, an emergency fill procedure may be utilized.
• The pharmacy will need to enter a special code to allow for a temporary five (5) day supply of medication to process while the provider submits an authorization request. Please note, that this does not eliminate the need for a prior authorization.
• For pharmacy specific processing instructions, contact CCHP pharmacy services during normal business hours or the Advice Nurse line after normal business hours.
**PRIOR AUTHORIZATION**

Providers must submit a Medication Prior Authorization form (located on our website [www.cchealth.org/healthplan](http://www.cchealth.org/healthplan) under the topic Forms and Resources and in the Appendix) to request a non-preferred drug or for an amount above our plan’s quantity limits. CCHP requires prior authorization for non-preferred medications before the provision of a prescription of such medication to the member. Providing samples of a non-preferred drug for use is highly discouraged by the plan and is not considered continuation of therapy for authorization review purposes.

Prior authorizations are usually good for a period of 12 months for maintenance medications unless the prescriber submitting the prior authorization requests a shorter duration. Prescribers who want to know the status of a prior authorization or wish to know when a prior authorization will end can call CCHP Pharmacy services for help at the number listed above.

Drugs requiring a prior authorization may include but not limited to:

- Drugs with a high potential for adverse reactions
- Drugs that are frequently prescribed inappropriately
- Drugs with a high potential for abuse
- High cost drugs with therapeutically equivalent alternatives
- Second-line agents that frequently are used as first-line treatments

**RESPONSE TIME**

- All prior authorization requests will be evaluated by the CCHP pharmacy unit as quickly as possible. Per regulatory guidance, decisions will be sent to the appropriate provider, member, and/or pharmacy (via fax and/or mail) within 24 hours of receipt of a valid prior authorization request.

**PROVIDER MEDICATION APPEALS**

Medication appeals are made directly to CCHP by contacting the Member Services Department. There are appeals processes and time standards for Medi-Cal and Commercial members. For questions regarding the appeals process call:

CCHP Member Services:
Phone: 1-877-800-7423 (option 7)

**FORMULARY CHANGES**

Providers may request changes to the CCHP PDL that will be reviewed by the Pharmacy and Therapeutics (P&T) Committee, which meets at least four (4) times per year.
Providers who submit a formulary change will be notified after the P&T committee has reviewed the request. To request a change in the formulary, use the Request for Formulary Review form. (Located on our website www.cchealth.org/healthplan under the topic Forms and Resources and in Appendix I)
Section 6 – CLAIMS DEPARTMENT

The CCHP Claims Unit is responsible for the following:

- Claims processing
- Management of claims dispute processes and provider redeterminations
- Responding to claims inquiries via telephone, fax or mail
- Returning claims to the provider if there is missing information

GENERAL BILLING INSTRUCTIONS

- Claims must be submitted on the UB04 or CMS 1500 or other appropriate, and CCHP approved format.
- In order to expedite the Claims reimbursement process, a Detail Bill is to be accompanied with any Claim that exceeds $300,000 or meets the stop loss threshold.
- For Medi-Cal members, follow the fee-for-service Medi-Cal Provider Manual for billing instructions. CCHP accepts the Medi-Cal billing codes.
- For members receiving fee-for-service Medicare services. Providers must bill Medicare first (primary payor). CCHP is responsible for all applicable co-pays and deductibles for contracted providers. Authorization is required for non-emergency, non-contracted providers. Should CCHP be a secondary payor, provider must submit EOMB from Medicare with their claim.
- CCHP Secondary payor-Provider must submit the EOB from the primary payor with the claim. If the primary payor reimbursed at a higher rate than contracted with CCHP, no further payment would be given. If provider receives partial payment, CCHP’s responsibility is the difference between the allowable amount and other payor payment.
- Providers must submit claims within one hundred and eighty calendar days from the date of service or date of EOM or EOMB from other coverage.
- Claim forms must be submitted in the original format. No copies of claims can be accepted for processing.
- Clean claims are claims that are completed fully and accurately with all appropriate information indicated in the appropriate boxes.
- Claims are more easily processed if typed or pre-printed in black ink, not handwritten.
- Providers should follow the AMA Current Procedural Terminology (CPT) for guidance on appropriate coding and descriptions.
- Providers must use Evaluation and Management (E&M) codes for office visits for new or established members.

NATIONAL PROVIDER IDENTIFICATION (NPI) NEEDED ON CMS-1500 & UB-04 CLAIMS

Providers must include their NPI number on all claim forms. Claim forms with the NPI field incomplete will reject from our payment system and will not be able to be paid until the form is submitted correctly.
Your NPI number must be registered with the Medi-Cal program before using it to bill CCHP. We report all claims data to the Department of Health Care Services (DHCS) and NPI reporting is a DHCS requirement. If you don’t have an NPI number, visit the CMS website [www.cms.hhs.gov](http://www.cms.hhs.gov). If you need to register your NPI with DHCS go to [www.medical.ca.gov](http://www.medical.ca.gov). As a result of the NPI implementation, providers are encouraged to submit the complete nine-digit ZIP code for the billing provider address on claims.

**NATIONAL DRUG CODES (NDC)**

The collection of drug information is a mandate of the Affordable Care Act (ACA) that requires states to collect specific drug information. This mandate requires CCHP claims submissions for physicians administered drugs given in an outpatient setting (i.e. provider’s office or ambulatory care) to be submitted with the product’s 11 digit NDC number, metric quantity, and unit of measure. If the number is not included, in the valid format, the claims will be rejected and returned for correction.

**CLAIM REMINDERS:**

- To correct a claim submitted in error; mark the claim "CORRECTED CLAIM" before resubmitting. A letter of explanation would also be helpful to prevent claim denial.
- To inquire about electronic claim submission, please contact Rosulo (Ross) Donida: Phone (925) 313-7103 or email Rosulo.donida@cchealth.org
- If you have claim questions, would like to create a claims adjustment request or check on payment status please access our Provider Web Portal, or call the Claims Unit at 1-877-800-7423 Option 5. Our staff is here to help you from 8 am to 1 pm. You may also submit a claims tracer sheet that can be faxed in to the claims unit for review. (Refer to Appendix D or the form can be located on our website [www.cchealth.org/healthplan](http://www.cchealth.org/healthplan))
- Claims status for contracted providers can also be viewed on-line at the ccLink provider web portal. Contact Provider Relations for more information on web portal access.
- To speed the processing of your claims please verify the claim forms are fully completed.
- Duplicate claims- A duplicate claim is a claim submitted for the:
  - Same beneficiary; for the
  - Same item or service; for the
  - Same date of service

Although CCHP believes that most providers and suppliers are not deliberately trying to receive duplicate payment by submitting duplicate claims, CCHP wants to remind providers and suppliers that submitting such duplicate claims for the same service encounter is inappropriate.

CCHP will not make payment for duplicate claims that you might submit. CCHP will pay
the first claim that is approved and will deny subsequent claims for the same service as duplicates.

Please check on your original claims status before submitting duplicates, duplicate billing creates unnecessary work for all parties involved. If you have not received payment within 45 business days you can call CCHP to check claim status, use our web portal, or fax a claims tracer sheet to (925) 957-5173 for review.

All claims must be mailed to: Contra Costa Health Plan
Attn: Claims
PO Box 2157
San Leandro, CA 94577

For Electronic Claims filing:
Rosulo Donida  rosulo.donida@cchealth.org  Phone: 925-313-7103

For Electronic Funds Transfer (EFT) (electronic payments to providers):
Rosulo Donida  rosulo.donida@cchealth.org  Phone: 925-313-7103

CLAIM PAYMENTS

Clean claims will be processed within thirty (30) business days of receipt of clean Medicare claims and forty-five (45) business days for non-Medicare claims (Medi-Cal, Basic Health Care, and Commercial). Providers should allow the stated time frame prior to inquiring about a claim payment. Checks are issued by the Contra Costa County Auditor’s office and this process can take an additional seven (7) to ten (10) days. If claims are not processed within the mandated time frames interest will be paid. Claims must be submitted within six (6) months, or 180 days from the date of service.

Every January the reimbursement rates for Medi-Cal and Medicare CPT Codes are updated by the associated federal and state agencies. When these updates occur, it takes CCHP approximately 3 weeks to update our system to ensure that our providers are paid correctly. Please note that you may notice a delay in your payments during the month of January. We apologize for any inconvenience this may cause.

FRAUD, WASTE AND ABUSE

The Patient Protection and Affordable Care Act (H.R. 3590) Section 6507 (Mandatory State Use of National Correct Coding Initiative (NCCI) required State Medicaid programs to incorporate "NCCI methodologies" in their claims processing systems. The purpose of the NCCI edits is to prevent improper payments when inappropriate code combinations or unlikely units of service are reported.

The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Medicare Part B claims. Medicare carriers and FFS Medi-Cal have already implemented NCCI payment methodology. CCHP has applied NCCI edits for claims processed on or after April 1, 2016.
The CMS annually updates the National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual). The Coding Policy Manual should be utilized by providers as a general reference tool that explains the rationale for NCCI edits.

CMS NCCI Overview:


The CMS developed its coding policies based on the following:

- Coding policy defined in the American Medical Association’s CPT manual,
- Coding based on national and local policies and edits,
- Coding guidelines developed by national societies,
- Through analysis of standard medical and surgical practices, and
- By review of current coding practices.

NCCI edits consist of two types:

1. Procedure-to-procedure (Column1/Column2) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons.

2. Medically Unlikely Edits (MUE), which are units of service edits, that define for each HCPCS/CPT code identified, the allowable number of units of service; units of service in excess of this value are not feasible for the procedure under normal conditions (e.g., claims for excision of more than one gall bladder or more than one appendix).

You may be contacted regarding billing practices and application of these claims edits by the CCHP Claims Unit or Provider Relations.

For any questions regarding the Fraud, Waste and Abuse Program please call the CCHP Claims Unit at: 925-957-5185

**CLAIM DISPUTES – NOTICE OF PROVIDER DISPUTE**

Contracted providers have three hundred and sixty-five (365) days after the last date of action or in case of inaction, the expiration of the applicable claim/authorization filing period, that led to the dispute for Medi-Cal and Commercial members. Timelines are subject to change.

To file a payment dispute on a claim submitted to CCHP, providers or their provider billing service must submit the dispute in writing and provide all supporting documentation. (Hard copy or on an encrypted disc) to support the dispute. All disputes are required to be submitted in writing with all relevant information for dispute processing. Necessary information includes: Member name, date of birth, claim number in reference, date of service, billed amount and expected reimbursement and clearly state the expected outcome of the dispute. (Refer to Appendix D-Provider Dispute Form). Payment redeterminations follow the Claims Unit’s policies and procedures. Providers can request copies of these policies and procedures by calling the Claims Unit.
Please note: The No Authorization list was expanded effective for Dates of Service after December 1, 2018. All services requiring authorization prior to December 1, 2018 that now are on the No Authorization list will **not** have the prior authorization requirement removed for dates of service prior to December 1, 2018.

The No Authorization list is subject to change at CCHP’s discretion. It is the provider’s responsibility to obtain any required authorization prior to rendering services.

Provider claims disputes must be submitted **in writing by mail or fax** to the Claims Department at:

Contra Costa Health Plan Claims Department  
595 Center Avenue Suite 100  
Martinez, CA 94553  
Phone: 925-957-5185  
Fax: 925-957-5173
Section 7 – ADVICE NURSE

The Advice Nurse Telephone Triage Program (URAC accredited) is available twenty-four (24) hours a day, seven (7) days a week (including holidays) to all CCHP members regardless of their CCHP benefit plan. Providers may refer their CCHP patients to this service after the close of business or on weekends and holidays.

Advice Nurses, who are Registered Nurses, triage the member according to his/her reported symptoms and determine the appropriate level of care. All Advice Nurses are experienced in telephone triage and in providing multi-lingual services.

TRIAGE SYSTEM

Advice Nurses use computerized medical protocols that are tailored to community needs and resources. Medically approved guidelines assist the Nurses in identifying high-risk situations to ensure that members are appropriately directed to care as needed.

Services include but are not limited to the following:

- Answering questions regarding medications
- Guiding members to recognize significant changes in symptoms
- Monitoring conditions meeting stay-at-home criteria
- Non-English-speaking language capabilities of up to one-hundred and forty (140) languages
- Referral to appropriate level of needed care when services are needed outside regular hours of provider operation
- Addressing benefit related questions after hours

To access the Advice Nurse Telephone Triage Program Call:

Advice Nurse Program
Phone: 1-877-661-6230 (option 1)

URGENT CARE

- Members may occasionally have the need for immediate, Urgent Care services, especially when their community Primary Care Provider’s practice is impacted or off hours. Members needing Urgent Care appointments may call the Advice Nurse/Triage Unit and depending on reported symptoms, be referred to one of our contracted Urgent Care Centers. Members may also self-refer for services. In addition to the contracted Urgent Care Centers, members can go to the nearest emergency service facility providing care on a twenty-four (24) hour seven (7) days per week basis.
- The patients may be initially triaged by an Advice Nurse, who decides based on patient’s disposition and symptoms whether an urgent care appointment is needed. Acceptable dispositions are usually in a range of See Within 8 to 24 hours. Once the decision has been made, and the patient agrees to an urgent care appointment with one of our contracted urgent care centers, the Advice Nurse either makes the
appointment with the urgent care facility or the patient is directed to call the facility to schedule the appointment. The Advice Nurse documents the call in ccLink and faxes the information to the specific urgent care facility. The Advice Nurses conduct a follow up call the following day to assure the patients was seen and to follow up on the patient’s condition. Being able to schedule an appointment with a contracted urgent care facility decreases the number of unnecessary emergency visits. It also increases the patient’s satisfaction as they are seen for their urgent medical needs in a timely manner.

**TELEPHONE CONSULTATION CLINIC**

The Telephone Consultation Clinic (TCC) program allows for patients calling in to the Advice Nurse to be referred to a medical provider working with the ANs for assistance in obtaining lab orders, refills for maintenance medications, referrals, and most importantly, advice to help address patient needs without requiring them to be seen in clinic, urgent care, or the emergency department whenever possible.

This program began as a pilot in late 2011, now available seven days a week, to increase the level of care and access to care for CCHP patients and all others handled by CCHP. With appointments difficult to come by, some of the common concerns patients have are able to be managed by providers speaking with patients over the phone. This initial contact helps to streamline the patient care process, allowing for patient needs to be met by providers to hold them over until they’re next able to be seen by their physician in clinic. It’s also aimed to help cut back on unnecessary emergency room visits due to a lack of availability of appointments elsewhere, difficulties in reaching PCPs, and other such factors.

- **Advice:** TCC providers can offer advice and reassurance to patients in regards to at-home care, or further assessment of symptoms.
- **Labwork:** Often, TCC can assist in ordering lab work for patients ahead of a clinic visit, allowing patients to complete lab work beforehand for discussion during their visit. TCC can also order treatment room nurse services, such as throat swabs, to rule out and identify cases of strep throat.
- **Medication changes:** In cases where a patient or pharmacy is unclear on medication directions, unable to fill based on insurance limitations, or a patient is reacting to their current medication, TCC providers may be able to provide assistance when PCPs are unavailable.
- **Medication refills:** TCC is also able to assist with medication refills for patients having a difficult time getting in to the clinics to see a provider in person. In most cases, these are refills for maintenance medication, dealing with diabetes or asthma or blood pressure medication.
- **Prescriptions:** TCC can also write and fill new prescriptions depending on what the provider feels will benefit the patient. For example, this may be in response to finalized lab results received for potential urinary tract infections or bacterial vaginosis, allowing the TCC provider to order an appropriate anti-biotic as indicated in the lab results themselves. Patients who suffer from chronic UTIs and BV may also be given a prescription prior to completing lab results, dependent on patient history. The situations in which TCC providers may order a medication run a broad range.
such as conjunctivitis, well described and identifiable rashes, cough (for standard cough medicines), flu exposure, and more.

- Referrals: TCC providers are also able to assist in inputting new referrals into the CCHP system. This encompasses changing urgency of a referral, assisting in putting in referrals based on Urgent Care provider request, and/or referrals into Physical or Occupational Therapy, and other such programs within CCHS as appropriate.

- TCC Clinic Appointments: The Appointment Program is usually able to set aside one to three (on average) appointments in the Extended Clinics at the CCHP Clinics. TCC providers who believe a patient will best benefit from being seen by a provider firsthand may ask the support staff working with them in the Advice Nurse Program to schedule a patient into one of the on-hold clinic appointments. This is particularly useful for patients who are followed in CCHP clinics but who do not have qualifying insurance for Urgent Care. (Straight Medi-Cal, Straight Medicare.)

- Urgent Care: In cases where TCC providers believe it’s beneficial for a patient to be seen and evaluated for their symptoms, they can ask the support staff working with them in the Advice Nurse Program to assist in scheduling an Urgent Care appointment in one of CCHP’s contracted urgent care providers.

**EMERGENCY PROTOCOLS**

Provider may list the Advice Nurse number 877-661-6230 (option 1); on their afterhours message as well as listing 911 for all emergencies.

When a member reaches the Advice Nurse, the member will be triaged according to:

**Telephone Triage Protocols - Adult and Pediatric After-Hours Version 2018 - David A. Thompson, MD and Barton D. Schmitt, MD**

Should emergency care be indicated, the member is referred to Contra Costa County Regional Medical Center or other contracted emergency care sites.

Confirmation of a member visit to emergency care will include care given during visit and referral back to PCP for follow up and include recommendation for referral to specialist as indicated.

Member emergency room tracking is monitored through encounter data, collected by the Case Management Department.
Section 8 – MENTAL HEALTH SERVICES

GENERAL GUIDELINES – MENTAL HEALTH

CCHP ensures that access to Mental Health Services will be available in a timely manner, at the appropriate level of care, and in accordance with Health Plan benefits. CCHP covers mild to moderate mental health issues. Moderate to severe issues are covered through County Mental Health.

In our Federally Qualified Health Centers (FQHC) practices, PCPs can refer a member to their embedded mental health providers for mild to moderate mental health issues. The mental health provider must utilize the Mental Health screening tools for Adults and Children to document acuity of issue. Forms can be found on the website at http://cchealth.org/healthplan/providers/. If the mental health provider has availability, they can then provide the service. If the FQHC mental health provider does not have availability, the member must be referred to the Mental Health Access Line (see number below). If the member is identified as having a moderate to severe mental health issue at any time, they must be referred to County Mental Health, also through the Access Line. CCHP does not reimburse for moderate to severe mental health services.

Medi-Cal members:

- Can self-refer or be referred by their primary care physician (PCP) to the CCHP Mental Health Network by calling the Mental Health Access Line. When the member calls, an assessment will be performed and if appropriate, a referral made.

  Mental Health Access Line
  Phone: 1-888-678-7277

- or the PCP may submit a referral. (Referral forms for PCPs are available in Appendix K or at www.cchealth.org/healthplan Forms and Resources)

  If available, PCPs at Federally Qualified Health Centers (FQHCs) can refer mild to moderate issues to the credentialed mental health providers embedded at their center.

- Inpatient Specialty Mental Health Services for Medi-Cal members are carved out to the County Mental Health Department.

Commercial members:

- CCHP Commercial Plan Members may access Mental Health Services in accordance with their benefit plan and limitations. For questions regarding member benefits call:

  Member Services
  Phone: 1–877-800-7423 (option 7)

- To access Mental Health Services, members must call the CCHP Mental Health Authorization Unit. All messages left for the Utilization Management (UM) nurse are confidential.

  Mental Health Authorization Unit
  Phone: 1–877-800-7423 (option 3) or 925-313-6683
☐ All mental health services for commercial members require prior authorization from CCHP.
☐ Providers must have written confirmation of authorization prior to rendering services.
☐ Unauthorized services are subject to payment denial.
☐ Requests for additional visits must include current symptoms and diagnosis to support continuing treatment.
☐ Updated clinical information is required for authorization of additional visits beyond the initial authorization.
☐ Members in mental health treatment must see their PCP at least annually.

**ALCOHOL MISUSE SCREENING AND COUNSELING (AMSC)**

When an issue with alcohol use is identified in a member, the PCP must perform the Alcohol Misuse Screening and Counseling (AMSC) using the Audit or Audit C Tools. (See website [www.cchealth.org/healthplan](http://www.cchealth.org/healthplan) Forms and Resources). If intervention is needed, the PCP can then perform a brief 15 minute intervention. The PCP can perform up to 3 brief interventions per year. Further need for mental health and/or substance use disorders services must be referred to a licensed mental health care provider via the Mental Health Access line. It is recommended that at least one provider per clinic or practice receive 4-hour AMSC training and submit an attestation to CCHP. Trainings can be found on the Department of Health Care Services website at [http://www.dhcs.ca.gov/services/medical/Pages/SBIRT_Trainings.aspx](http://www.dhcs.ca.gov/services/medical/Pages/SBIRT_Trainings.aspx)

**ACCESS FOR COMMERCIAL MEMBERS TO PSYCHOTHERAPY AND PSYCHIATRY SERVICES**

**PSYCHOTHERAPY**

A member may directly request psychotherapy services from the CCHP Mental Health Authorization Unit by contacting the UM Nurse for initial authorization and referral.

The UM Nurse will triage the needs of the member and direct the member to a Mental Health Specialist or inform the member to contact his/her (PCP) to rule out any underlying physical condition that may contribute to Mental Health symptoms. If the member is directed to a Mental Health Specialist, a provider will be assigned and initial visits authorized.

**PSYCHIATRY**

A referral from the member’s assigned PCP or Specialist is required for psychiatry services. The PCP or specialist will provide the UM Nurse with clinical information for review. Upon completion of the review, the UM Nurse will assign the member to a psychiatrist, if appropriate, and authorize an initial and three follow up visits.
BEHAVIORAL HEALTH TREATMENT- COVERAGE FOR CHILDREN DIAGNOSED WITH AUTISM SPECTRUM DISORDER

CCHP ensures that Behavioral Health Treatment (BHT) services are provided to Medi-Cal and Commercial members under 21 years of age that meet the eligibility criteria for services when medically necessary, based upon recommendation of a licensed physician or a licensed psychologist. BHT services include a variety of behavioral interventions that have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence and are designed to be delivered primarily in the home and in other community settings.

☐ Primary Care Providers (CCRMC and CPN) who suspect autism or other behavioral diagnoses should submit a referral request to Autism Behavior and Child Development Center (ABCD) at CCRMC to rule out autism. See Section 13, page 2 for referral instructions. The member will be screened by the ABCD Center, and a Comprehensive Diagnostic Evaluation will be performed as needed.

☐ After diagnosis is confirmed, if Applied Behavior Analysis, speech or other modalities are ordered, CCHP Authorization Unit will contact appropriate providers and authorize services.

☐ For individuals diagnosed with ASD who are under the age of three with a rule out or provisional ASD diagnosis, or those diagnosed with an intellectual disability, CCHP will refer to the Regional Center and Special Education Local Plan Area (SELPA) for Regional Center services and supports and/or special education services, respectively.
Section 9 – SENSITIVE SERVICES

ABORTION, CONTRACEPTION, HIV, AND STD’s

Sensitive Services include diagnosis and treatment of sexually transmitted diseases (STD), family planning services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy, initial HIV testing and counseling, abortion and treatment for rape. Only our Medi-Cal members may self-refer (without referral by the PCP or authorization from CCHP), to any Medi-Cal provider even if not under contract with CCHP. A Medi-Cal member may go out-of-network/out-of-plan for abortion services at any time for any reason. However, no physician or other healthcare provider who objects to performing an abortion may be required to do so, and no person refusing to perform an abortion may be punished for such a choice (H & S Code, Section 123420). All other members must receive Sensitive Services through their chosen Network. CCHP informs potential members (through our directories and on-line search engine) when they enroll if hospitals, clinics and other providers, in their network refuse to provide abortions.

MINOR CONSENT SERVICES

Members under the age of eighteen (18) may access certain services, considered sensitive services, without approval from their parents and without parental consent. These services include:

- Family Planning Services
- Substance Use Disorders for members twelve (12) and older (Refer to Section 8)
- HIV testing
- Outpatient Mental Health Services for members twelve (12) & older (Refer to Section 8)
- Pregnancy testing and other pregnancy-related services
- Treatment for rape and sexually transmitted diseases for members twelve (12) and older

Abortion is also a sensitive service. A minor who is alleged to have been sexually assaulted may consent to medical care related to the diagnosis and treatment of the condition, and the collection of medical evidence with regard to the alleged sexual assault. Minors may call the Advice Nurse Program to get information, or they can go to their PCP, local Public Health Department or, for Medi-Cal members, any other qualified provider.

Advice Nurse Program Phone:
1-877-661-6230 (option 1)

DOMESTIC VIOLENCE/CHILD ABUSE REPORTING

If child abuse is suspected, it is mandatory to report the case. The Suspected Child Abuse form must be completed and submitted as indicated on the bottom for each episode of suspected or identified abuse.
Children and adult domestic violence are reported on Suspected Violent Injury Report, and elder abuse is reported on Suspected Dependent/Elder Abuse Report. Prior to submitting the written report, it is required to call the Abuse Reporting Line to report verbally. Reports should be submitted within twenty-four (24) hours. (See Appendix A)

Abuse Reporting Lines:

<table>
<thead>
<tr>
<th>Region</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>East County</td>
<td>925-427-8811</td>
</tr>
<tr>
<td>West County</td>
<td>510-374-3324</td>
</tr>
<tr>
<td>Central County</td>
<td>925-646-1680</td>
</tr>
</tbody>
</table>
Section 10 – HEALTH EDUCATION

Contra Costa Health Plan is committed to improving the health of our members and their families by providing resources that meet their needs. We have added new health education topics, videos, interactive tools, and links to community resources on our website. If you would like printed material, phone assistance, or are interested in additional information, please contact:

Elisa Hernandez, Senior Health Education Specialist Phone:
925-313-6019
Or
E-Mail: Elisa.Hernandez@cchealth.org.

Health Education Services are available for members through the Contra Costa Regional Medical Center (CCRMC), for members in that network, and through the Health Plan directly. We would like to encourage all providers to access our health education website section and become familiar with the newest resources. To access the website go to http://www.cchealth.org/healthplan/health-ed.php.

CCHP’s Health Education Department can assist providers in locating a variety of Health Education modalities that are culturally appropriate in either network for your diverse patient population. Examples include:

- Health Coaching groups
- Health education materials and information
- One-on-one health education and dietician services

Community Provider Network (CPN) providers can refer members to contracted Health Education services. For additional questions, please call 925-313-6019.

HEALTH EDUCATION ONE-ON-ONE APPOINTMENTS

Appointments with patient educators or dieticians are available at the county clinics for health problems requiring an individual approach. Services are provided at Contra Costa Regional Medical Center (CCRMC) health centers or clinics. Please call 1-800-495-8555 to make an appointment. These services are for members served in the CCRMC network.

CPN members can contact the Health Educator to arrange an appointment with an educator or dietician.
**CHILDBIRTH PREPARATION CLASSES**

Contra Costa Regional Medical Center (CCRMC) providers can refer pregnant members to CCRMC’s Healthy Start Program for childbirth preparation classes. For more details call Healthy Start:

<table>
<thead>
<tr>
<th></th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Martinez Health Center</td>
<td>925-370-5495</td>
</tr>
<tr>
<td>Pittsburg Health Center</td>
<td>925-431-2345</td>
</tr>
<tr>
<td>West County Health Center</td>
<td>510-231-9469</td>
</tr>
</tbody>
</table>

Community Provider Network (CPN) providers, please see the Case Management section for information on our Comprehensive Perinatal Services Program.

**OTHER RESOURCES**

American Lung Association
Helpline: 1-800-LUNGUSA

Car Seat Fitting Stations
Services are offered in English and Spanish

California Smokers’ Help Line (Phone Counseling):

<table>
<thead>
<tr>
<th>Language</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>1-800-662-8887</td>
</tr>
<tr>
<td>Spanish</td>
<td>1-800-456-6386</td>
</tr>
<tr>
<td>Mandarin &amp; Cantonese</td>
<td>1-800-838-8917</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>1800-778-8440</td>
</tr>
<tr>
<td>Hearing Impaired</td>
<td>1-800-933-4833</td>
</tr>
</tbody>
</table>

Chewing Tobacco:

<table>
<thead>
<tr>
<th>Language</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>1-800-844-2439</td>
</tr>
<tr>
<td>Korean</td>
<td>1-800-556-5564</td>
</tr>
<tr>
<td>Hearing Impaired</td>
<td>1-800-933-4833,</td>
</tr>
<tr>
<td>Teens</td>
<td>1-800-662-8887.</td>
</tr>
</tbody>
</table>

Smoking Cessation website:
[http://www.nobutts.org/county-listing](http://www.nobutts.org/county-listing)
Section 11 – CULTURAL AND LINGUISTIC SERVICES

By law, Contra Costa Health Plan (CCHP) must ensure members have access to free interpreter services when English is not their primary language. Interpreter services must be available 24-hours a day, 7-days a week for medical encounters. CCHP provides access to interpretation services 24- hours a day, 7-days a week. Providers are required by regulations to discourage members from using their own interpreters, such as family members, friends or minors.

Please note that the member has the choice to refuse professional interpreters and use adult family members or friends. If the member chooses to bring an interpreter after they were offered a professional interpreter, the provider must document this choice in the member's medical record.

INTERPRETER SERVICES – Over the Phone and Face to Face Options

Community Provider Network

These instructions are valid for Community Providers only and do not include hospitals, skilled nursing facilities or Regional Medical Center facilities. Hospitals and SNF’s please use your own contracted vendor. Instructions are also available on our website at https://cchealth.org/healthplan/provider-interpretation.php

1 WHEN YOU NEED AN INTERPRETER OVER THE PHONE:

DIAL: 1-866-874-3972

PROVIDE: your 6-digit Client ID 298935 (Mental Health Providers: use ID525970)

INDICATE: the language you need or press

☐ 1 for Spanish
☐ 2 for all other languages and state the name of the language you need
☐ 0 for assistance if you don’t know what language you need

PROVIDE: Additional information, if required:

☐ Patient Name
☐ Patient Date of Birth

- Contra Costa Health Plan Member ID
  □ Doctor Name
  □ Doctor Phone Number

2 CONNECT: to an interpreter, document his/her name and ID number in patient’s chart for reference. Summarize what you wish to accomplish and give any special instructions.

When calling or receiving a call from a patient who needs language services: Use the conference feature on your phone to make a 3-way call and follow the instructions above to connect to an interpreter.
In Person/Face to Face Interpretation Guidelines: **We require 5 full business days advance notice**

CPN providers can only ask for in-person or face to face interpretation services for:

- ASL (American Sign Language) for deaf or hard of hearing
- End of life issues
- Sexual assault/abuse issues
- Life threatening diagnosis like: cancer, chemotherapy, transplants
- Allergy testing, food trials, asthma education
- Surgical procedure consent
- Initial physical therapy evaluation
- Complex behavioral health appointments
- Other conditions by exception determined by medical director

To arrange for Face to Face Interpreter Services call 1-877-800-7423 (option 4), and we will assist you.

Printed materials for your reception area:

We provide flyers you can post in your office which state: Point to your language! We will get you an interpreter. To print a copy of the flyer, go to our website at: [www.cchealth.org/health_plan/provider_interpretation.php](http://www.cchealth.org/health_plan/provider_interpretation.php) at the bottom of the page.

If you have any problems accessing the Linguistic Services listed above, you can call:

Cultural & Linguistic Services Phone: 925-313-6063

Again, providers can request an American Sign Language interpreter for a CCHP member, by calling

Phone: 1-877-800-7423 (option 4)

To make a California Relay Service Call-Dial 711 or 1-800-735-2922.

California Relay Service - may be used when the provider needs to call a person who is deaf, hard of hearing, deaf-blind, or has a speech-disability.

**REGIONAL MEDICAL CENTER NETWORK**

The RMC Network and clinics have procedures on how to use interpreter services, provide American Sign Language or alternative resources for members who have communication limitations such as people who are deaf or hearing impaired. RMC Network providers should be referred to the clinic coordinator/manager for specific procedures.
**CULTURAL COMPETENCY REQUIRED TRAINING**

*Under Final Rule, 42CFR 438.10, h/l/vii, the California State Department of Health Care Services (DHCS) now requires all health plans to list in their on-line and hard copy directories if a contracted provider has completed Cultural Competency training.*

To meet this requirement, CCHP is offering brief (no more than 30 minutes) training, free and easily accessible on our website called “Connecting to your Patients”. We have included an attestation at the end of the training to verify the training has been completed. Please go to cchealth.org/health plan/ For Providers/Training Resources/How to Communicate with Diverse Populations/ Cultural Competency Training for Healthcare Providers or go to this link: [http://cchealth.org/healthplan/pdf/provider/Cultural-Competency-Training.pdf](http://cchealth.org/healthplan/pdf/provider/Cultural-Competency-Training.pdf).

When you complete the training, please click on the Attest button at the end, and then Submit. This sends the attestation directly to Provider Relations Credentialing Unit. Credentialing staff will review the attestation and update your listing in our database to reflect you have completed the training.

Here are more details about the short training. "Connecting with your Patients" is an excellent Power Point training you can review at your leisure developed by ICE – Industry Collaboration Effort.

This training will assist providers and their staff to:

- Understand culture and cultural competence
- Strive towards clear communication
- Better understanding lesbian, gay, bisexual and transgender (LGBT) communities
- Address health care for refugees and immigrants
- Reflect on strategies to support seniors and people with disabilities

Click this link for the power point slides:

If you have already taken a similar training for another Health Plan, please send us the documentation, along with the name of the training and the other Health Plan’s name, and we will accept it as completion of the training. If you have any questions, please contact Provider Relations at 925-313-9500.

**ADDITIONAL CULTURAL COMPETENCY TRAINING RESOURCES ON OUR WEBSITE**

Contracted CCHP providers must ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.
Provider Tool Kit - Better Communication Better Care

This provider resource was developed by ICE - Industry Collaboration Effort as a helpful tool to care for Diverse Populations. By downloading this toolkit you will find a variety of useful resources such as:

☐ Communicating with diverse patients and addressing health literacy issues
☐ Tips for working with interpreters and language issues/common sentences in multiple languages
☐ Pain management and sensitive services across cultures
☐ Laws and standards regarding languages issues and cultural competency web resources

Download the tool kit on our website:


ON-LINE CULTURAL COMPETENCY TRAINING WITH CME’S

Providers can receive up to nine (9) CME credits, free of charge by taking this online cultural competency course from Think Cultural Health. The following information refers to the course:

☐ “Think Cultural Health” provides free web-based training A Physicians Practical Guide to Culturally Competent Care supported through the Office of Minority Health at the United States Department of Health and Human Services
☐ Register at the web site below to start earning up to 9 free CME credits (Physicians and Physician Assistants) or 9 contact hours (Nurse Practitioners), while exploring engaging cases
☐ and learning about cultural competency in health care.
☐ Go to: https://cccm.thinkculturalhealth.hhs.gov

We encourage you to go visit the CCHP website at https://cchealth.org/healthplan/provider-training.php and view the latest articles and training resource.
Section 12 – MEMBER SERVICES DEPARTMENT

CCHP’s Member Services Department Representatives are available Monday through Friday from 8 a.m. to 5 p.m. CCHP safeguards the rights of its members to file a grievance and will ensure that there are no discriminatory actions (including disenrollment) taken against a member because they have filed a grievance. (Refer to Appendix J)

**REFERRING TO MEMBER SERVICES**

Contact Member Services for the following:

- A member wants to know about CCHP or has questions about benefits or CCHP services
- A member wants to choose or change a PCP for themselves, a family member (with member consent) or a minor family member
- A member’s CCHP identification card is lost or stolen
- A member wants to request a second opinion or option for treatment
- A member has received a medical bill
- A member wants to discuss or file a grievance or an appeal

Member Services  
Phone: 1-877-800-7423 (option 7)

**CHECKING MEMBER ELIGIBILITY**

Providers must check eligibility on the date of service. If a member is retroactively terminated after a provider verifies eligibility, but received authorization to provide services, the provider will be compensated at their contracted rate. To verify CCHP member eligibility and/or PCP assignment, providers should use one of the options below:

1. Use the Automated Provider Web Portal for instant access to CCHP eligibility system.
2. Check member roster sent weekly to PCP’s, and/or
3. Call the automated eligibility line at 1-877-800-7423 (option 1). Interactive Voice Response (IVR), prior to providing services this system also gives callers the Network to which the member is assigned, the name of the member’s PCP and office visit copayment amount.
4. Fax eligibility verification form (refer to Appendix J)

To access the Provider Web Portal, you will need to apply by submitting the web portal access application. The application can be located on our website: www.cchealth.org/healthplan

The following information can be viewed:

- CCHP member information
- Real-time eligibility
- PCP panel
- Claims status
To use the IVR system you will need your NPI number and the member’s CCHP ID number or Social Security Number to access the automated line. You will be given a certification number that you may use when billing the health plan.

The following is the information that will be given:

- Member’s CCHP ID number
- Eligibility status for current date
- Member’s name
- Member’s CCHP ID Number
- Member’s Network
- Member’s PCP
- Member’s copayment for office visits (if any)
- Medi-Cal Member’s CIN number if needed

If you are unable to use either of the automated eligibility systems, fax member names to Member Maintenance unit for verification on the eligibility verification form (located on our website www.cchealth.org/healthplan under the topic Forms and Resources and Appendix J) before 12pm the day before appointment. Member Maintenance will return the eligibility list by fax within 24 work hours. Fax eligibility verification forms to 925-313-6614.

Please use our automated systems rather than calling Member Services or faxing the Health Plan. The IVR and Provider Web Portal will give you an immediate answer to eligibility requests, and you are able to check multiple members’ eligibility.

**MEMBER COMPLAINTS AND GRIEVANCES**

If a member is dissatisfied with the service delivered by the provider, providers should offer the member the CCHP grievance form to complete and return it immediately to CCHP’s Member Services Department or go online to fill out the grievance form https://cchealth.org/healthplan/cchp/.

Or you may advise the member to call Member Services at 1-877-661-6230 (option 2) to help resolve the member’s issue. The member may also go to the CCHP office to talk to Member Services staff in person.

Complaints regarding providers of CCHP (Doctors, Nurses, Health Centers, etc.) should be sent to CCHP for resolution.

It is the member’s right to talk to someone who speaks his or her own language. Members have the right to see the files pertaining to their concern such as, medical records, plan policies, and any information maintained by CCHP. It is also the member’s right to designate a friend, family member, or a lawyer to help them. The member’s Evidence of Coverage (EOC) is also available to members to read more about the complaints and grievances process. Refer members to Member Services if they would like a copy of the CCHP Grievance Policy.
TIME FRAMES FOR RESOLVING MEMBER COMPLAINTS AND GRIEVANCES

CCHP Member Services Representatives will make every attempt to resolve the complaint or grievance immediately. If an immediate resolution is not possible, the member may file a formal grievance.

- Commercial members have one hundred and eighty (180) days from the date of the incident to file a formal grievance.
- Medi-Cal members can file a grievance at any time.

After receiving a grievance, Member Services staff will inform the member within five (5) days that CCHP is in receipt of the grievance and will submit to the member, in writing, a resolution within thirty (30) days. If the member’s clinical condition is critical, the grievance may be expedited. Members can file grievance by telephone, fax, through the Health Plans’ website, in person or in writing.

Written member grievances should be sent to:

Contra Costa Health Plan
Member Services Department
595 Center Avenue, Suite 100
Martinez, California 94553
Phone: 1-877-661-6230 (option 2)
website: http://www.cchealth.org/healthplan

MEMBER APPEALS FOR DENIED CLAIMS OR SERVICES

If a member believes that a service or payment for a service has been denied, deferred or modified inappropriately, the member may submit an appeal in writing to Member Services.

- For Medi-Cal members, the appeal must be submitted within sixty (60) days from the date of the notification of the denial of the service or claim.
- Commercial members have one hundred and eighty (180) days from the date of the notification to file an appeal.

Providers can file a Member Appeal on behalf of their patients. However, the provider needs to submit a signed member consent form to file the appeal. This form is located on the website: https://cchealth.org/healthplan/forproviders/forms and resources/Member Consent.
EXPEDITED REVIEWS

The Expedited Review process applies to requests for services and/or supplies that:

- the member has not received, which is believed to be medically urgent;
  OR
- the member is not getting, which the Provider believes should be urgently provided.

The member can ask CCHP for an expedited review (72 hour) when they file a grievance. The Plan will provide an expedited review if waiting thirty (30) days for a resolution could seriously harm the health of the member.

For cases requiring expedited review, The Plan will make a decision no later than 72 hours after the request is received. If CCHP denies the request for an expedited review the member will be notified in writing within three (3) days and then CCHP will follow the thirty (30) day grievance process. When an expedited review is requested, the member also has the right to immediately notify the Department of Managed Health Care (DMHC) about the grievance.

MEMBER RIGHTS

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.
- 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 best degree possible.

☐ The responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

☐ The responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.

**Commercial and Medi-Cal Members**

**DEPARTMENT OF MANAGED HEALTH CARE (DMHC)**

The California Department of Managed Health Care is responsible for regulating health care service plans for commercial and Medi-Cal members. If you have a grievance against your health plan, you should first telephone your health plan at Contra Costa Health Plan 1-877-661-6230 (option 2) and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number 1-888-HMO-2219 and a TDD line 1-877-688-9891 for the hearing and speech impaired. The department’s website http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

**MEDI-CAL OMBUDSMAN**

Medi-Cal members can also call the Medi-Cal Ombudsman to help with enrollment problems or with complaints about our plan. You can contact them at 1-888-452-8609.
MEDI-CAL FAIR HEARINGS OR INDEPENDENT MEDICAL REVIEW (IMR)

IF YOU DISAGREE WITH THE APPEAL DECISION

If you filed an appeal and received a “Notice of Appeal Resolution” letter telling you that your health plan will still not provide the services, or you never received a letter telling you of the decision and it has been past 30 days, you can:

- Ask for an “Independent Medical Review” (IMR) and an outside reviewer that is not related to the health plan will review your case
- Ask for a “State Hearing” and a judge will review your case

You can ask for an IMR and State Hearing at the same time. You can also ask for one before the other to see if it will resolve your problem first.

For example, if you ask for an IMR first, but do not agree with the decision, you can still ask for a State Hearing later. However, if you ask for a State Hearing first, but the hearing has already taken place, you cannot ask for an IMR. You will not have to pay for an IMR or State Hearing.

Members have only 120 days after the order or action you are complaining of to file your Fair Hearing by calling 1-800-952-5253 (TDD call 1-800-952-8349) or write to:

Medi-Cal Fair Hearing Rights:
California Department of Social Services
State Hearing Division
Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

By Fax to 833-281-0905

The Department of Managed Care also has a toll-free telephone number 1-888-HMO-2219 and a TDD line 1-877-688-9891 for the hearing and speech impaired. The Department’s Internet Website https://www.dmhc.ca.gov/ has complaint forms, IMR application forms and instructions online.

CCHP is required by Senate Bill 853 to provide access to IMR information in formats that our members can speak and understand. Non-English formats for the IMR are available at https://www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx

If you have any questions or problems, please contact Member Services: 595 Center Avenue, Suite 100, Martinez, CA 94553
Phone: 1-877-661-6230 (option 2)
Section 13– QUALITY MANAGEMENT PROGRAM

The goal of CCHP's Quality Management Program (QMP) is to ensure that high quality, appropriate health care and related services meet or exceed members’ and other stakeholders’ expectations. The Program’s mission is carried out in accordance with CCHP's organizational mission to provide affordable, high quality, accessible health care with integrity and compassion to all that use our programs.

The scope of CCHP’s Quality activities include the quality of clinical care and the quality of service for all services including, but not limited to, preventive, primary, specialty, emergency, and ancillary care services. The scope of activities reflects CCHP’s population in terms of age groups, disease categories and special risk status, and includes, but is not limited to, services provided in institutional settings, inpatient settings, ambulatory care, home care, and mental health.

CCHP has a comprehensive Quality Management Program Description and Work Plan that is revised each year with the input from various committees including CCHP’s Quality Council.

QUALITY IMPROVEMENT INITIATIVES

Specific quality improvement, disease management, health education/promotion, and cultural and linguistic initiatives will be determined through collaborative processes including CCHP/CCHS clinical and administrative management staff. Providers are expected to cooperate with Quality Improvement activities.

Quality Improvement Projects include:

- Reducing Health Disparities
- Improving Diabetes Care
- Reducing Pediatric Obesity
- Improving Blood Pressure Control
- Improving Asthma Care
- Increasing Pediatric Well Visits

We have also begun a Population Health Management program which is implementing targeted interventions based on analysis of our population. So far, areas of focus have included asthma, diabetes, opiates, and members with multiple chronic illnesses, in addition to preventive reminders for the general population.

HEDIS HEALTHCARE QUALITY MEASUREMENT

CCHP’s Quality Management Department is responsible for calculating and reporting a set of HEDIS (Healthcare Effectiveness Data and Information Set) measures as required by the State. The results of these measures are reported to CCHP’s providers annually through the quarterly Provider Bulletin or in a separate mailing. In contracting with CCHP, a provider agrees to allow the health plan to use the provider’s performance data.
**NCQA ACCREDITATION**

CCHP’s Medi-Cal line of business has been accredited by NCQA since March 2014. This is the gold standard in health plan recognition, demonstrating a high level of excellence in our operations.

Accreditation status is good for three years; CCHP was again awarded Accreditation in February 2017 and in September 2017, NCQA updated our Accreditation status to Commendable.

**DELEGATION AUDITS**

CCHP is responsible for assuring that quality care and services are administered to CCHP members when services are delegated to contracted providers. CCHP may fully or partially delegate care and/or services to contracted providers. Delegation arrangements are part of the contracting process. Delegated quality monitoring status is granted to contracted providers upon successful demonstration of the required scope of quality monitoring activities. CCHP monitors delegation via routine reporting and/or on-site audits of delegated providers on an annual basis. The frequency of audits may be more often if needed and if identified as part of a corrective action plan. Audit tools are based on NCQA standards in addition to state and federal requirements.

Delegates’ NCQA Accreditation may be considered when reviewing specific standards. CCHP may fully or partially delegate any of the following functions to contracted providers:

- Appeals
- Claims Processing
- Credentialing
- Cultural Linguistics
- Disenrollment
- Grievances
- Health Education
- Marketing
- Member Rights
- Population Health Management
- Provider/Facility Contracting
- Quality Improvement
- Utilization Management

The QM Director and/or designee coordinates the audit process for CCHP. Several CCHP staff members are involved in reviewing appropriate information according to their expertise.

Audit/report findings and corrective action plans are reported to the CCHP Medical Director and Quality Council, and as appropriate, Peer Review and Credentialing Committees.
**ACCESS STANDARDS**

The following table contains CCHP’s access standards. These standards will be monitored utilizing a variety of methods. The following are examples of access monitoring methods used by CCHP: Member Satisfaction Surveys, Member Grievances, Facility Site Reviews, Provider Surveys, Appointment Reports, Advice Nurse Reports, Delegation Oversight Monitoring, and DMHC’s Provider Appointment Access Survey. Monitoring member complaints and reviewing member satisfaction survey results will be used to monitor and measure wait time standards for telephone responsiveness and provider in-office wait time, as well as for obtaining appointments. Data on telephone and office wait times are also gathered in provider surveys.

Access data will be presented to Quality Council regularly for evaluation and determination of any action needing to be taken.

<table>
<thead>
<tr>
<th>ACCESS TOPIC</th>
<th>STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>URGENT CARE APPointments for services that do not require prior authorization</td>
<td>48 hours</td>
</tr>
<tr>
<td>URGENT CARE APPointments for services that require prior authorization</td>
<td>96 hours</td>
</tr>
<tr>
<td>Non urgent care APPointments for primary care</td>
<td>10 business days</td>
</tr>
<tr>
<td>Non urgent care APPointments for specialist care</td>
<td>15 business days</td>
</tr>
<tr>
<td>Non urgent APPointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition.</td>
<td>15 business days</td>
</tr>
<tr>
<td>Emergency care</td>
<td>Immediate</td>
</tr>
<tr>
<td>First Prenatal visit</td>
<td>10 business days</td>
</tr>
<tr>
<td>Mental health (Non-physician provider)-routine non-urgent</td>
<td>10 business days</td>
</tr>
<tr>
<td>Mental health- Urgent</td>
<td>48 hours</td>
</tr>
<tr>
<td>Mental health- Emergency</td>
<td>Immediate</td>
</tr>
</tbody>
</table>
FOLLOW UP ON MISSED APPOINTMENTS

Providers are expected to review all members that do not show up for scheduled appointments and to identify those requiring follow-up, based on their medical condition.

TELEPHONE WAIT TIME for PLAN and PRACTICE TO ANSWER

10 minutes

TELEPHONE CALL BACK WAIT TIME

30 minutes

WAITING TIME IN PROVIDER OFFICE

The amount of time a member waits in a provider office and exam room must be reasonable according to the urgency of the individual’s condition. In most cases, it is reasonable for a member to wait 45 minutes or less from the scheduled appointment time until the provider enters the exam room.

INITIAL HEALTH ASSESSMENT (Medi-Cal only)

Within 120 calendar days of enrollment

RISK ASSESSMENT (Medi-Cal SPDs only)

45 calendar days

**SHORTENING OR EXPANDING TIMEFRAMES**

Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally recognized standards of practice. If the timeframe is extended, it must be documented within the Member’s medical record that a longer timeframe will not have a detrimental impact on the Member’s health.

Interpreter services are available at all CCHP points of contact where members may reasonably need such services. Interpreter services can be accessed by calling 1-866-874-3972 and provide the 6 digit client ID 298935. Refer to Provider Manual Section 11 Cultural and Linguistics Services for instructions on how to obtain interpreter services including face to face or in person interpreters, American Sign Language or to make a California Relay Service call.

Please see your CCHP Provider Manual Section 3 Utilization Management which explains in detail the process for you to obtain timely referrals to specialists for your patients. If you have a timely access concern, you can contact CCHP's Utilization Management at 1-877-800-7423 option 3 or file a complaint with the California Department of Managed Health Care by calling the DMHC Toll-free provider complaint line at: 1-877-525-1295.

**REPORTING OF PROVIDER PREVENTABLE CONDITIONS**

By Federal law, a provider must report the occurrence of any Provider Preventable Condition (PPC) that did not exist in any Medi-Cal patient prior to the provider initiating treatment.
A provider must report the occurrence regardless of whether or not the provider seeks Medi-Cal reimbursement for services to treat the PPC. Reporting a PPC for a Medi-Cal beneficiary does not preclude the reporting of adverse events, pursuant to *Health and Safety Code* (H&S Code), Section 1279.1, to the California Department of Public Health (CDPH).


Instructions are found here: [http://www.dhcs.ca.gov/individuals/Pages/PPC_Form_Instructions.aspx](http://www.dhcs.ca.gov/individuals/Pages/PPC_Form_Instructions.aspx)

Providers must submit the form within five days of discovering the event and confirming that the patient is a Medi-Cal beneficiary. The provider must also send a copy of the information to the member’s health plan: Fax to (925) 313-6870.

**Health Care Acquired Conditions** (For Any Inpatient Hospital Settings in Medicaid)

- Any unintended foreign object retained after surgery
- A clinically significant air embolism
- An incidence of blood incompatibility
- A stage III or stage IV pressure ulcer that developed during the patient’s stay in the hospital
- A significant fall or trauma that resulted in fracture, dislocation, intracranial injury, crushing injury, burn, or electric shock
- A catheter-associated urinary tract infection
- Vascular catheter-associated infection
- Any of the following manifestations of poor glycemic control: diabetic ketoacidosis; nonketotic hyperosmolar coma; hypoglycemic coma; secondary diabetes with ketoacidosis; or secondary diabetes with hyperosmolarity
- A surgical site infection following Coronary artery bypass graft (CABG), mediastinitis.
- Bariatric surgery; including laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery
- Orthopedic procedures; including spine, neck, shoulder, elbow
- Cardiac implantable electronic device procedures
- Deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement with pediatric and obstetric exceptions
- Iatrogenic pneumothorax with venous catheterization
- A vascular catheter-associated infection

**Other Provider Preventable Conditions** (For Any Health Care Setting)

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient
Section 14 – PREVENTIVE HEALTH SERVICES

CCHP expects PCPs to follow the most current US Preventive Health Task Force (USPSTF) guidelines for preventive health services. CCHP requires providers to follow all USPSTF A and B level recommendations, which are listed here: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Preventive Services require no copayment by the member.

CCHP’s preventive guidelines can be found at http://cchealth.org/healthplan/clinical-guidelines.php.

Initial Health Assessment (IHA)

PCPs are required to provide primary care services including follow-up and referral for specialty care as appropriate. For Medi-Cal members, PCPs are required to provide an Initial Health Assessment (IHA). The IHA is a comprehensive assessment that is completed during the member’s initial visit(s) with his or her primary care provider within 120 days, unless the PCP believes the member should be exempt from the IHA. Exemption and the reason member is exempt must be documented in the medical record. Exemption reasons include:

- All elements of the IHA have been completed within 12 months of the member’s effective date of enrollment, and the provider has reviewed/updated the member’s medical record.
- If the provider is able to incorporate relevant information from the member’s existing medical record and has received a physical exam within 12 months of the member’s effective date of enrollment.
- The member loses his or her eligibility prior to performance of the IHA.
- The member refuses the IHA (and the provider documents the refusal in the medical record. There is an available field on the SHA form for refusal.)
- The member misses the scheduled appointment and two additional documented attempts to reschedule are unsuccessful.

The purpose of the IHA is to assess and set the baseline for managing the acute, chronic and preventive health needs of the member. The IHA should include the following three parts:

- History and Physical, sufficiently comprehensive to assess and diagnose acute and chronic conditions, which may include the following elements:
  - Member’s history of present illness
  - Member’s past medical history
  - Member’s social/mental health history
  - Review of the member’s organ systems
- Provision of any preventive services due
- Individual Health Education Behavioral Assessment
An essential part of the IHA is the completion of the Individual Health Education Behavioral Assessment (IHEBA), also known as the Staying Healthy Assessment (SHA). The IHEBA must be documented in the member’s medical record and reviewed annually and re-administered at age-appropriate intervals by PCPs. The provider must sign and date the SHA whenever administered and discussed. Updated SHA forms with expanded age categories including 0–6 months, 7–12 months, 1–2 years, 3–4 years, 5–8 years, 9–11 years, 12–17 years and adults. See http://cchealth.org/healthplan/providers/, under Forms and Resources, Staying Healthy Assessment.

**ALCOHOL MISUSE SCREENING AND COUNSELING (AMSC)**

Annually, PCP’s are required to complete the Alcohol Misuse and Screening form for Medi-Cal members who misuse alcohol and if necessary perform a brief 15 minute intervention. Further need for mental health and/or substance use disorders services must be referred by the PCP to a licensed mental health care provider via the Mental Health Access line.

**CHILD HEALTH AND DISABILITY PREVENTION**

CCHP encourages Providers to maintain certification with the Child Health and Disability Prevention Program (CHDP), and we expect the same standards in care to be provided to our members.

Children requiring CHDP care coordination should be referred to the CHDP program using the CHDP Care Coordination form. Referral forms should be filled out and returned to the CHDP Program via one of the following methods:

Confidential Fax: 925-372-5118
Secure email: chdp@cchealth.org
Mail: CHDP Program, 2500 Bates Ave. Suite B Concord, CA 94520

Referral forms can be downloaded from the CCHS website at https://cchealth.org/chdp/provider.php

For questions about the CHDP Program and provider enrollment, contact them by email at chdp@cchealth.org or by phone at 925-313-6150.

**THE GATEWAY PROGRAM**

The Gateway Program allows CHDP providers to pre-enroll eligible children into Medi-Cal. Once enrolled, the child qualifies for paid doctor’s visits (including sick care), prescription medicines, dental care, mental health care, vision care including glasses, hospital services, x-rays, lab tests and specialty care for the month of enrollment and the month after.

Enrolling children into Gateway is very simple. It consists of a quick eligibility screening based on age and the amount of money the child’s family earns. The parent/guardian then completes a one page application that is entered into the internet. A temporary Medi-Cal number is issued within minutes. The provider is not responsible for verifying Immigration status or information on the pre-enrollment form. Fee For Service (FFS) Medi-Cal and CHDP Gateway visits are to be billed using the CMS 1500 or the electronic 837P form.
For questions about billing FFS Medi-Cal and Gateway visits contact the Medi-Cal Telephone Service Center at 1-800-541-5555.

Providers can obtain additional information by going to the CHDP website at www.dhcs.ca.gov/services/chdp click on CHDP Provider Manual and scroll down to CHDP Gateway Transaction User Guides, Internet or POS Device Transactions.
Section 15 – SPECIAL NEEDS SERVICES

TUBERCULOSIS PROGRAM

The following process is in place with Public Health with a Memorandum of Understanding:

- Physician will be oriented within 10 days of contract/credentialing about how to report patients with suspected or confirmed TB disease to Contra Costa Public Health Tuberculosis Control Program. The Confidential Morbidity Report (CMR) form is available on the website including instructions and additional information required at http://cchealth.org/tb/providers.php.
- Physicians, Clinical Lab directors and other providers are required by law to report confirmed and suspected cases of TB to Public Health within one working day of the diagnosis of TB or suspected TB. Providers should complete a Confidential Morbidity Report (CMR). This form is available on the website including instructions and additional information required at http://cchealth.org/tb/providers.php. After completing the form, fax it to Contra Costa Public Health (CCHP) at 925-313-6465.
- When the report is received by the Contra Costa Public Health Tuberculosis Control Program, physician will be contacted to provide records, x-rays and treatment plan to Public Health TB Control Program. Patient is contacted, interviewed, and if the diagnosis will be confirmed, patient will be assigned a Public Health Nurse Case Manager. The TB Control Program will facilitate Directly Observed Therapy if necessary. DOT staff is culturally, ethnically and gender diverse.
- The TB Control Program will share information with the provider about the patient including medication adherence. The TB Control Program will provide information to CCHP about TB patients upon request.
- For questions about TB reporting, diagnosis, management of patients with LTBI confirmed or suspected TB disease or any medical consultation providers should call 925-313-6740.

CHILDREN WITH SPECIAL NEEDS (CCS)

California Children’s Services (CCS) offers medical coverage and case management services to children for catastrophic or chronic illness on a financial sliding scale. When a CCHP Medi-Cal child has a CCS condition, the medical services related to the CCS condition are covered by CCS. CCHP will cover eligible medical services until CCS eligibility is determined and will cover services that are not related to the CCS condition. Submitting a completed Prior Authorization Form (PA001) to CCHP when requesting services assures that the request will be evaluated by the Utilization Review Team and referred to CCS for ongoing medical supervision if the condition is eligible. The physician’s office can also send a direct referral by fax to CCS. In either instance, copies of medical documentation must accompany the referral.

A listing of CCS eligible providers can be found on the CCS website here: https://www.dhcs.ca.gov/services/ccs/Pages/CCSProviders.aspx
The PCP is responsible for performing an appropriate baseline health assessment and diagnostic evaluation for children who are identified with conditions that may be CCS eligible. Referrals sent to CCHP are reviewed by Utilization Management Unit for completeness of clinical information before a referral is submitted to CCS. Early identification of possible CCS eligible conditions is an important step to timely specialty care with a CCS provider. Once CCS determines that a child has a CCS medically eligible condition, the provider can fax prior authorization requests related to the CCS, to the local CCS Office.

California Children’s Services (CCS)
Fax: 925-313-6115

DEVELOPMENTAL DELAY

Behavioral Health Treatment for autism and other diagnoses is a covered benefit for children (both Medi-Cal and Commercial members). Autism spectrum disorder is diagnosed through a comprehensive assessment at ages 0 up to 21. Referrals to evaluate a child for Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) can be sent to the Autism Behavior and Child Development Clinic (ABCD)

ABCD
Phone: 925-370-5025
Fax: 925-370-5277

For all referrals, leave child’s name, date of birth, parent’s name, call back number, address, and reason for referral. If you suspect autism, it is helpful to note that on the original referral, in order to obtain services more rapidly. Always send a copy of any referral to CCHP.

Children with developmental delays or disabilities under three (3) years of age may be eligible to receive services through The Regional Center of the East Bay (RCEB). These services are available without financial qualifications. The provider office can refer their member directly to the center:

Regional Center of the East Bay Phone:
510-618-6195
Website: www.rceb.org

At age three (3) years, children with hearing, vision or other developmental delays may be eligible to receive services for these conditions from local education systems. This may require that each child has an Individual Education Plan (IEP) to assure that all needs are met, and services are delivered. This may involve enrollment in the Early Start Program. Referral may be made directly to the involved School District, or referral may be directed to our Referral and Authorization Unit, who in turn, will forward to the school district for processing.
Section 16 – MEDICAL RECORDS

REQUIREMENTS

- CCHP will delegate the responsibility of maintaining medical records to contracted Providers.
- Provider is responsible for appointing an on-site medical records staff member with the responsibility of maintaining and securing medical records at each Provider site.
- All PCP offices will maintain policies and procedures consistent with requirements for the maintenance of member medical records.
- Medical records must be kept protected and confidential in accordance with state and federal laws.
- An individual medical record will be created for each member treated by a PCP and will be designed to create a format for maintaining a member’s medical information in a consistent, logical, legible and uniform manner.
- The medical record will reflect continuity of care for any emergency treatment rendered in a Hospital, Emergency Room, or Urgent Care setting and include provisions for follow-up or continued treatment. Physicians will document referrals to specialists, treatments rendered or recommendations made, and follow-up care to be instituted. Provider will also maintain pathology and lab reports. Abnormal results shall be noted.
- Provider will obtain appropriate written consent for treatment prior to actual procedure performance, including the human sterilization consent procedures required by Title 22, CCR, and Section 51305.1 through 51305.6, if applicable.
- The expressed written consent of the member or legal representative is necessary for release of medical records to another party outside of the provider. In special circumstances for treatment of sensitive services such as sexually transmitted disease, HIV, and family planning, Members have the right to sign a limited Release of Information form that prohibits the release of medical records but does allow release of sufficient information for billing purposes.

PCP’S WILL COMPLY WITH THE FOLLOWING:

1. Providers will maintain procedures for storage and filing of medical record including: collection, processing, maintenance, storage, retrieval identification, and distribution.
   - Providers will maintain a record-keeping system to make the individual medical record available for each member visit or contact.
   - Member ID will be noted on each page of the medical record.
   - Members will be linked to their individual medical records through an assigned unique identifier for filing purposes and to distinguish that record from any other Member’s record.

2. Medical records will be protected, confidential and maintained in a secure area not readily accessible to unauthorized parties. Providers will limit medical records access to physicians and associated staff.
3. Medical records will be maintained in a legible, current, detailed, organized and comprehensive manner. This will be reviewed during FSR.
4. All CCHP records related to the quality of covered services and delivery of care will be retained for a period of five years from the end of the Department of Health Care Services’ fiscal year in which IPA’s contract is in effect.
5. Providers will establish a uniform medical records organization format and maintain all medical records in a consistent and comprehensive manner.

**DOCUMENTATION**

Medical records documentation will include the following:

1. Each medical record entry will contain all pertinent information related to the member contact including complaints, examination results, medical impression, treatments, member condition, test results and proposed follow-up.
2. Providers will maintain a complete and comprehensive medical record for each member. The record will include all provider services rendered including examinations, member contacts tests, procedures, ancillary services, off-site treatments, emergency room records, hospital admission/discharge information, informed consents, and correspondence regarding the member’s medical condition such as consultation records, specialist reports, and referrals.
3. Each entry or member contact noted in a member’s medical record will be dated and signed by the provider of service and/or ancillary staff, if applicable, including the title of the person making the chart entry.
4. All therapies, procedures, and medications administered to a member will include the signature and date of the person providing the procedures, next to the original order for that therapy, procedure, or medication.
5. The PCP will include a problem list, record of immunization, and record of health maintenance or preventive services rendered. Any member allergies or adverse reactions will be prominently noted.
6. Adult medical records will contain information regarding execution of advanced directives such as a living will or Durable Power of Attorney for Health Care. Such information will be prominently noted.
7. The member’s primary language will be noted with documentation of a request for or refusal of interpreter services.

An initial preventive health screening will be performed for all members to assess the member’s current medical condition, institute any necessary treatments, and outline preventive health care programs. Specific notations will be made concerning use of cigarettes, alcohol, and substance abuse for members age twelve (12) or older. Included with the notation will be health education or counseling and anticipated guidance regarding such use.
Section 17 – HIPAA

CONFIDENTIALITY

All providers, their subcontractors and affiliates are expected to treat Protected Health Information (PHI) in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as all other applicable laws governing patient confidentiality.

Expectations Include But Are Not Limited To:

- Implementation of appropriate policies and procedures
- Ensuring staff members are appropriately trained in confidentiality policies and procedures, including appropriate use and disclosure, minimum necessary rules and penalties for noncompliance
- Implementation of safeguards for physical PHI in offices, including safeguarding patient records, files and all communication pertaining to patients
- Implementation of the appropriate computer security safeguards, ensuring only appropriate and authorized access to confidential information
- Ensuring secure electronic transmissions of confidential data
- Reporting any possible or real breach or unauthorized disclosure of PHI to the CCHP

Some Examples of Good Confidentiality Practices:

- Never discuss a person's medical care in a public area, including hallways and break rooms, or in employee-only areas when a member of the public is present
- Never give out a person’s status or information to unauthorized person(s)
- Never include health information, Social Security Number or any information that can identify a specific individual in unencrypted e-mails
- Never access information in any form that you do not need to perform your job duties. For example, accessing a neighbor's medical record out of curiosity and/or concern
- Confirm contact information prior to sending confidential faxes. Confirm receipt if necessary. (Pre-programmed numbers are highly recommended)
- Immediately route all confidential material inadvertently faxed, e-mailed, or sent to the wrong location to the appropriate department/person. Call sender to correct information.

Recommended Security Practices Include:

- Do not bring software or disks from home to download onto a work computer. Disks can carry viruses that can infect your system
- Do not download software from the Internet, as you can't be sure of its integrity.
- Do not open e-mail attachments you aren't expecting, even if it's from someone you know. Some virus programs access your friends' address books and send you attachments that sound friendly but are really viruses.
- Keep your password(s) confidential and secure - See below
- Do not use another individual's user ID/password
• Report any violations of security policies and procedures to your immediate supervisor
• Use virus protection software regularly

**PASSWORD DO’s AND DON’Ts**

Almost 90% of computer network security incidents can be traced to poor or mismanaged passwords. Following several basic rules for passwords is critical in preventing misuse:

• Don't share your password with anyone
• Don't write your password down
• Don't embed your password in a login script or assign it to a function key
• Don't use your name, your spouse's name or your children's name as a password
• Do follow the basic rules for constructing good passwords. A good password is at least eight (8) digits long and includes at least one number and/or punctuation character. Good passwords are words that are not found in the dictionary
• Do choose a password that you can remember. Combine two meaningful words with punctuation or select a phrase and use the first letter from each word. If your system accepts long passwords, you may want to use a "pass phrase", which is a phrase that you can remember easily but that someone else cannot guess (e.g., 49ersAre#1)
• Do change your password often

**PENALTIES FOR HIPAA VIOLATIONS**

Under the criminal provisions of HIPAA, a person may be punished for knowingly and willfully obtaining, disclosing or using individually identifiable health information. Although the Office of Civil Rights does not enforce the criminal standards, they will notify the Department of Justice of a suspected criminal violation. The penalties that may be imposed are as follows:

• $50,000 fine and/or one (1) year imprisonment for wrongful disclosure offenses
• $100,000 fine and/or five (5) years imprisonment if the offense was committed under false pretenses
• $250,000 fine and/or ten (10) years imprisonment if the offense is committed with intent to sell transfer or use individually identifiable health information for commercial advantage, personal gain or malicious harm.
  o California Penal Code Section 502 states, in part, that any person is guilty of public offense who:
  • Knowingly access and without permission alter, damage, delete, destroy, or otherwise uses any data, computer, computer system or computer network in order to either a) devise or execute any scheme or artifice to defraud, deceive, or extort, or b) wrongfully control or obtain money, property or data
• Knowingly access and without permission take, copy, or make use of any data from a computer, computer system, computer network, or take or copy any supporting documentation, whether existing or residing internal or external to a computer, computer system, or computer network
• Knowingly accesses and without permission add, alter, damage, delete or destroy any data, computer software, or computer programs which reside or exist internal or external to a computer, computer system, or computer network
• Knowingly and without permission disrupt or cause the disruption of computer services or deny or cause the denial of computer services to an authorized user of a computer, computer system, or computer network
• Knowingly introduces any computer contaminant into any computer, computer system, or computer network
Section 18 – AFTER HOURS CARE

After hours care is a critically important element in the delivery of quality healthcare. The following is designed to assist our providers in clarifying specifics regarding after hours care visits.

**REFERRAL SOURCES**

CCHP members may self-refer or referred to afterhours care from one of two sources, either our Advice Nurse (AN) Unit or our Case Management (CM) unit. CCHP encourages members to call the AN prior to obtaining services.

**COORDINATION OF CARE WITH THE PCP**

After-hours care service providers have an important role in the continuity of care of CCHP members. Patients seeking treatment are for single visits. Patients requiring continuing treatment must be redirected to their PCP for follow up care. After-hours care providers are obligated to send a copy of the medical record to the member’s PCP within forty-eight (48) hours of their after-hours care appointment. Primary care providers who are also after-hours care providers will not receive additional compensation for treating their assigned panel members.

**CO-PAYMENTS**

Co-payment information can be found on the provider web portal or by calling the 24/7 Eligibility line at 1-877-800-7423 (option 1) or can be found on the member’s ID card.

**BILLING PROCEDURE**

All after-hours care visits provided by contracted CCHP providers must be billed with place of service (POS) code 20. After-hours care services not billed with POS code 20 may be denied.
FREQUENTLY ASKED QUESTIONS

WHAT IS CONTRA COSTA HEALTH PLAN (CCHP)?
CCHP is an HMO and Medi-Cal Managed Care health plan that has been serving the health care needs of people in Contra Costa County for over forty-five (45) years.

WHO ARE CCHP MEMBERS?
CCHP serves over 200,000 health plan members in Contra Costa County and continues to be at the forefront in offering comprehensive, quality health coverage. CCHP serves Medi-Cal recipients as well as County Employees. CCHP is the largest single provider of Child Health and Disability Program (CHDP) services and care for mothers and children in Contra Costa County.

DOES CCHP USE PROVIDERS FROM THE COMMUNITY?
Yes. Most of the members in CCHP have the choice of receiving care from County Health Centers or from primary care and specialty care providers contracted with CCHP in their community.

WHERE ARE MEMBERS OF CCHP HOSPITALIZED?
Our members can be hospitalized at our contracted facilities (located on our on-line search engine www.cchealth.org/healthplan under facilities) however, based upon medical necessity, CCHP will allow hospitalization outside of the contracted network (with authorization) to meet the needs of the member.

WHO TAKES CARE OF HOSPITALIZED MEMBERS?
When members are admitted to a hospital, typically the hospital staff cares for them. Community Providers are usually not expected to care for members while hospitalized, but when discharged, the member's on-going care is assumed by their Primary Care Provider (PCP).

HOW ARE MEMBERS ASSIGNED TO PRIMARY CARE PROVIDERS?
Assignment of members to PCPs is accomplished through CCHP assignment and/or member choice. When CCHP assigns a PCP to a member, consideration is given to community of care, the member’s location and expressed language and other preferences. Members may change their PCP assignment by calling Member Services at 1-877-661-6230 (press 2).

WHAT IS THE TURN AROUND FOR PAYMENT ON CLAIMS?
Clean claims are usually paid within a few weeks after receipt of the claim. CCHP has up to forty-five (45) business days to reimburse clean claims for Medi-Cal members.

HOW DO I REFER A MEMBER TO A SPECIALTY CARE PROVIDER?
CCHP maintains a comprehensive listing of contracted Specialty Care Providers that PCP’s may refer to or obtain authorization for services for members. A copy of the Referral and Prior Authorization Forms is located on our website www.cchealth.org/healthplan under
the topic Forms and Resources. These forms list the type of services that can be referred to by the PCP without CCHP’s approval and those that require prior authorization.

ARE THERE RESOURCES WITHIN CCHP THAT WOULD HELP ME MANAGE A MEMBER’S MEDICAL CARE?

CCHP has a twenty-four (24) hour Advice Nurse line available to all health plan members and a Case Management system to facilitate access to ongoing care. Also, there are other valuable member support programs such as asthma management, diabetes management, prenatal nurse follow-up, and referrals for mental health services. (Please note: Medi-Cal members may self-refer for mental health services through the County’s Access Line at 1-888-678-7277).

WHAT PHARMACY COVERAGE SHOULD MEMBERS EXPECT?

CCHP contracts with a Pharmacy Benefit Manager (PBM) that subcontracts with local pharmacies to fill prescriptions. Most but not all of our members have a prescription benefit through CCHP.

Providers must use the CCHP Preferred Drug List (formulary) when prescribing for members with drug coverage. The PDL can be accessed at on our website www.cchealth.org/healthplan. The formulary is updated quarterly.

HOW DO I CONFIRM THAT MEMBERS ARE ELIGIBLE CCHP MEMBERS AND HAVE BEEN ASSIGNED TO MY PANEL?

There is a toll free eligibility and PCP assignment verification number available twenty-four (24) hours every day at 1-877-800-7423 (press 1). Community PCP’s also receive a weekly listing of assigned members. Providers can also sign up for access to the Provider Web Portal, ccLink to obtain real time eligibility and member assignment. Applications can be obtained on our website www.cchealth.org/healthplan or by calling Provider Relations at 925-313-9500 or by e-mail Providerrelations@cchealth.org.

IF I WANT TO REFER OTHER PROVIDERS TO CCHP TO BECOME A CCHP PROVIDER, HOW DO I DO THAT?

All CCHP contracted providers must be credentialed prior to contracting and providing services to members. To obtain a credentialing application, contact the Provider Relations Credentialing Unit at 925-313-9500 or by e-mail Providerrelations@cchealth.org.
# Appendices

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