A Speciality Medi-Cal Managed Care Plan

Provider Manual

Effective July 1, 2018

Contracting and Provider Relations
1001 N. Martel Ave.
Los Angeles, CA 90046
Tel: (888) 726-5411
Fax: (888) 235-7695
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AHF
AIDS HEALTHCARE FOUNDATION

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Section 1: Introduction

We would like to welcome you to PHC California, formerly known as Positive Healthcare California. As a network provider, you play a very important role in the delivery of health care services to our enrollees.

This Provider Manual is intended as a guideline for the provision of covered services to PHC California enrollees. This manual contains policies, procedures and general reference information, including the standards of care required by PHC California.

We hope this information will help you better understand the health plan's operations. We look forward to working with you and your staff to provide quality managed health care services to PHC California enrollees.

PHC California is a specialty Medi-Cal managed care plan designed for individuals living with HIV/AIDS. It was created by AIDS Healthcare Foundation (AHF) and the California of Department of Health Services (DHCS), the Medi-Cal Managed Care Division in 1994 and serves eligible Medi-Cal beneficiaries who live in Los Angeles County.

PHC California is AHF's first managed care plan with was followed in 2006 by PHP, a special needs Medicare Advantage plan with prescription drug coverage. PHP currently operates in Los Angeles County; Duval, Broward and Miami-Dade Counties, Florida, and Fulton County, Georgia. In 2010, AHF expanded is Medicaid plan operations to Florida and currently offers an HIV-specialty managed care plan in Broward, Miami-Dade and Monroe Counties.

Should you ever have questions about PHC California, please contact Contracting and Provider Relations at (888) 726-5411, Monday through Friday, 8:30 am to 5:30 pm. You may also visit our provider section on our website at www.phc-ca.org/providers.

Section 2: How to Contact the Plan

Administration:
PHC California
1001 N. Martel Ave.
Los Angeles, CA 90046
Tel: (323) 436-5000
Fax: (888) 235-5889

After-Hours Nursing Advice Line:
Tel: (800) 797-1717

Care Coordination:
Tel: (800) 474-1434
Fax: (888) 235-8327

Claims Department:
Tel: (888) 662-0626
Fax: (888) 235-9274

Claim Submissions:
Attn: Claims
PHC California
P.O. Box 7490
La Verne, CA 91750

Contracting and Provider Relations:
Tel: (888) 726-5411
Fax: (888) 235-7695
Email: capr@aidshealth.org

Credentialing:
Tel: (323) 436-5019
Fax: (888) 235-8256

Eligibility:
Tel: (800) 263-0067
Fax: (888) 235-8552
Email: php@positivehealthcare.org

Member Services:
Tel: (800) 263-0067
Fax: (888) 235-8552
Email: php@positivehealthcare.org

Pharmacy Services/Pharmacy Technical Help Desk:
Tel: (888) 554-1334
Fax: (888) 238-2244

Utilization Management:
Tel: (800) 474-1434
Fax: (888) 238-7463

Section 3: Eligibility and Enrollment

Plan Eligibility

PHC California is a voluntary prepaid health plan. Enrollees are not subject to cost sharing for medical services and prescription drugs. Eligibility requirements are as follows:

- Residence in Los Angeles County
- Be 21 years of age or older
- Have full-scope Medi-Cal eligibility (no share-of-cost)
- Have a prior AIDS diagnosis, CD4 count less than 200 or 14% or less, or an AIDS-defining illness documented in the medical record
- Be assigned an eligible DHCS aid code

Medi-Cal beneficiaries who are interested in learning more about PHC California or enrolling into the plan should contact Member Services at (800) 263-0067. Agents are available Monday through Friday, 8:00 a.m. to 8:00 p.m. TTY users should call 711.

Information about the plan, covered services, and provider and pharmacy networks is available at www.phc-ca.org.

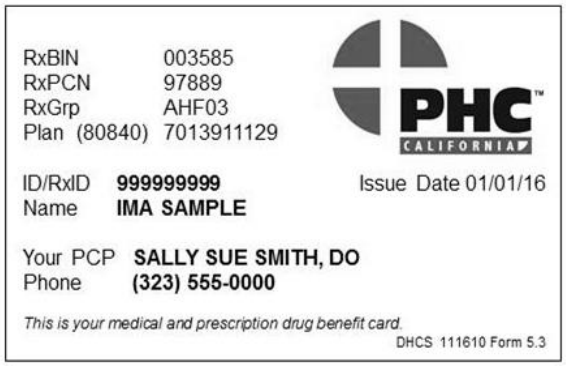
Eligibility Verification

Member Services provides enrollee eligibility to providers by phone. Providers must verify eligibility for the date(s) of service to ensure plan responsibility for services to be rendered. To check the eligibility of a PHC California enrollee, please call Member Services at (800) 263-0067, Monday through Friday, 8:00 a.m. to 8:00 p.m. When your staff calls, please have our enrollee's ID number available to give to the agent. The ID number is on the enrollee's plan ID card.

Enrollee Identification (ID) Card

PHC California sends an enrollee ID card to each enrollee in the plan at the time of enrollment and whenever the enrollee's PCP assignment changes from what is indicated on the card.

An example of the plan's ID card is below.



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The plan instructs enrollees to show their PHC California ID card and their Medi-Cal Benefits Identification Card (BIC) whenever they obtain medical services or prescription drugs.

If an enrollee does not have an ID card at the time he or she presents to your practice or facility, please call Member Services at (800) 263-0067, Monday through Friday, 8:00 a.m. to 8:00 p.m. The plan will verify eligibility and, if necessary, send our enrollee a new ID card.

New Enrollee Assignment to Primary Care Provider (PCP)

PHC California will notify PCPs when an enrollee is assigned to him or her either through a new enrollment into the plan, or a PCP assignment change at the request of the enrollee or initiated by the plan. PCPs may opt to receive notice via US mail, fax or secure email. Please contact Contracting and Provider Relations to specify how your primary care practice would prefer to receive notices of new enrollee assignment. Call (888) 726-5411, Monday through Friday, 8:30 a.m. to 5:30 p.m. or email capr@aidshealth.org.

Enrollee Rosters

PHC California sends enrollee rosters by primary care provider (PCP) assignment to its network PCPs on a monthly basis. The roster includes enrollee ID number, address, phone number and enrollment effective date. PCPs may opt to receive the roster via US mail, fax or secure email. Please contact Contracting and Provider Relations to specify how your primary care practice would prefer to receive its roster. Call (888) 726-5411, Monday through Friday, 8:30 a.m. to 5:30 p.m. or email capr@aidshealth.org.

PCPs should review the roster monthly to ensure each enrollee listed on the roster is a

current patient. If any enrollees listed on the monthly rosters are no longer under the care of the assigned PCP or have not seen the PCP within 90 days of appearing on the roster, please advise Member Services by either calling (800) 263-0067, Monday through Friday, 8:00 a.m. to 8:00 p.m., or sending a fax to Member Services at (888) 235-8552.

Enrollee Disenrollment

Enrollees may voluntarily disenroll from PHC California any time for any reason. Should an enrollee wish to disenroll, he or she may contact Member Services at (800) 263-0067 (TTY 711) Monday through Friday, 8:00 a.m. to 8:00 p.m. Enrollees may also request to disenroll from PHC California by contacting California Department of Health Care Services' (DHCS) enrollment broker, Health Care Options (HCO), at (800) 430-4263, Monday through Friday, 8:00 a.m. to 5:00 p.m. TTY users should call (800) 430-7077.

Enrollees who wish to leave PHC California will have to choose either LA Care or Health Net for their Medi-Cal coverage. Enrollees who wish to enroll in Regular Medi-Cal (fee-for-service) must request a medical exemption from plan enrollment from HCO.

PHC California must involuntarily disenroll enrollees from the plan for any of the following reasons:

- Loss of Medi-Cal eligibility;
- Enrollee moves out of the plan's service area, Los Angeles County;
- Enrollee gains Medi-Cal share of cost;
- Enrollee's DHCS-assigned aid code changes to one that is excluded from the plan's contract with DHCS;
- Enrollee requires major organ transplantation (except kidney transplantation), which is covered through Regular Medi-Cal; or
- Enrollee qualifies for certain waiver programs that require disenrollment from the plan.

In addition, PHC California may involuntarily disenroll enrollees from the plan, subject to approval from DHCS, for the following reasons:

- Enrollee refuses to cooperate with his or her primary care provider (PCP);
- Enrollee repeatedly obtains non-emergency care services from providers outside the PHC California provider network without prior authorization;
- Enrollee behaves in an abusive or violent manner in the presence of PHC California network providers, ancillary or administrative staff;
- Enrollee allows somebody else to use his or her PHC California enrollee ID card or Medi-Cal beneficiary ID card (BIC) to obtain medical services or prescription drugs; or
- Enrollee has been prosecuted and convicted of Medi-Cal fraud involving the

inappropriate use of Medi-Cal coverage under the plan.

Should your practice encounter a PHC California enrollee who behaves in an abusive, disruptive, violent or uncooperative manner, please contact Contracting and Provider Relations at (888) 726-5411, Monday through Friday, 8:30 a.m. to 5:30 p.m., or fax your concerns to (888) 235-7695. Please also contact Contracting and Provider Relations should you wish to discharge an enrollee for behavior issues. When you report an enrollee for behavior issues, please provide the following details:

- Enrollee name and ID number;
- Date(s) of incident(s);
- Description of incident(s) and enrollee's behavior and actions;
- Names and titles of staff members involved in the incident(s);
- Intervention(s) taken to deescalate and redirect the enrollee's behavior; and
- Any counseling or warnings given to the enrollee.

PHC California will work with providers to determine which course of action is most appropriate to address an enrollee behavior problem, such as warning the enrollee that such behavior could be grounds for involuntary disenrollment; reassigning the enrollee to a new PCP or practice, if applicable; moving the enrollee's specialty care to another specialist or practice; or requesting permission from DHCS to involuntarily disenroll the enrollee from the plan.

PHC California requires that network providers consult with the plan prior to discharging any enrollees from their practices.

Section 4: Covered Services

PHC California covers the medical services, equipment and supplies and prescription drugs listed in the table below and on the following pages. PHC enrollees are never subject to any copayments or coinsurance for covered services.

Services	Limitations
Acupuncture	Covered when medically necessary; no limits; requires prior authorization
Alcohol Abuse Treatment	Available through the Los Angeles County Public Health Substance Abuse Prevention and Control Program. PHC California will refer enrollees who require such services.
Allergy Care	Covered when medically necessary; no limits; requires prior authorization
Ambulance Services	For emergencies; covered when medically necessary; no limits
Ambulatory Surgery at an Ambulatory Surgery Center	Covered when medically necessary; no limits; requires prior authorization
Case Management and Disease Management Services	Covered; no limits
Certified Nurse Midwife Services	Covered; no limits; certified nurse midwife services are not appropriate high-risk pregnancies; requires prior authorization
Certified Nurse Practitioner/Physician Assistant Services	Covered when medically necessary; no limits; certain services require prior authorization
Chiropractic Services	Covered when medically necessary; limited to two (2) services per month; limited to the treatment of the spine by means of manual manipulation; procedures require prior authorization

Services	Limitations
Clinical Services from Los Angeles County Health Services Clinics	Primary care and preventive physician services covered; limit of one (1) visit per day
Clinical Services from Federally Qualified Health Centers (FQHCs)	Primary care and preventive physician services covered; limit of one (1) visit per day
Dermatology Services	Covered when medically necessary; no limits; certain services require prior authorization
Dialysis Services (hospital-based and free standing)	Covered when medically necessary; no limits; requires prior authorization
Durable Medical Equipment and Medical Supplies	Covered when medically necessary; no limits; certain services require prior authorization
Emergency Room Services	Covered when medically necessary; no limits
Family Planning Services	Covered; no limits. Available through any participating Medi-Cal provider.
Hearing Aids	Covered when medically necessary; no limits; certain services require prior authorization
Home Health Care Services *Includes supplies, appliances and durable medical gear for use in the home.*	Covered when medically necessary; no limits; requires prior authorization
Hospice	Covered when medically necessary; limited to three hundred and ninety (390) days per lifetime; requires prior authorization. Hospice care is covered in clinical setting or in a home.
Immunizations	Covered; no limits

Services	Limitations
Inpatient Hospital Services	Covered when medically necessary; requires prior authorization. PHC California requires that facilities notify the plan within twenty-four (24) hours of admission. Call (800) 474-1434, Monday through Friday, 8:30 a.m. to 5:30 p.m. or send notification via fax to (888) 238-7463. Upon receipt of notification, Utilization Management will request medical records for concurrent review for continued stay authorizations.
Inpatient Psychiatric Services	Inpatient psychiatric services are coordinated through the Los Angeles County Department of Mental Health. PHC California is responsible for the review and approval of Medi-Cal Treatment Authorization Requests (TARs) for in-patient psychiatric services for PHC California enrollees. (PHC California acts as the equivalent of a Medi-Cal field office for processing TARs for inpatient psychiatric services.) Providers must seek reimbursement from Medi-Cal's fiscal intermediary (EDS) once the TAR is approved.
Investigational Services	Covered when conventional therapies will not adequately treat condition or prevent disability or death; no limits; requires prior authorization
Laboratory/X-Ray/Imaging Services	Covered when medically necessary; no limits; certain services require prior authorization

Services	Limitations
Long-Term Care	Covered; no limits; requires prior authorization
Maternity Services including: • Hospital Inpatient Care • Physician Care • Pharmacy	Covered when medically necessary; no limits; certain services require prior authorization
Medical/Drug Treatment Therapies • Chemotherapy • Radiation Therapy	Covered when medically necessary; no limits; requires prior authorization
Mental/Behavioral Health Services *See also Inpatient Psychiatric Services.*	Medically necessary emergency mental health services provided at a hospital emergency room are covered when the emergency room visit does not result in a psychiatric admission. Services that are within the scope of practice of a primary care provider (PCP) covered; services no co-pay. Inpatient and outpatient mental health services referred to the Los Angeles County Department of Mental Health. PHC California will refer enrollees who require such services. For enrollees whose mental health diagnosis is not covered by the Los Angeles County Department of Mental Health because of the enrollee's level of impairment is mild to moderate, or the recommended treatment for enrollees does not meet the criteria for specialty mental health services, PHC California shall refer the enrollee to a network mental health provider.

Services	Limitations
Ophthalmology Services	Covered when medically necessary; no limits; requires prior authorization
Outpatient Hospital Services	Covered when medically necessary; no limits; requires prior authorization
Outpatient Rehabilitation Services • Cardiac Rehabilitation • Pulmonary Rehabilitation	Covered when medically necessary; no limits; requires prior authorization
Outpatient Surgery (Hospital-Based)	Covered when medically necessary; no limits; requires prior authorization
Physician Primary Care Services	Covered; limited to one (1) visit per day
Physician Specialty Care Services	Covered when medically necessary; limited to one (1) visit per day per specialist; referral and/or prior authorization required.
Podiatry Services	Covered when medically necessary; no limits; requires prior authorization
Prescription Drugs *Includes drugs administered during a medical office visit or in an emergency room.*	Covered when medically necessary; no limits; prior authorization required on certain drugs
Prosthetic and Orthotic Appliances	Covered when medically necessary; no limits; requires prior authorization
Sexually Transmitted Disease (STD) Testing, Counseling and Treatment	Covered; no limits. Available through any participating Medi-Cal provider.

Services	Limitations
Skilled Nursing Facility Services	Covered when medically necessary; no limits; requires prior authorization
Substance Abuse Treatment	Heroin detoxification available through Regular Medi-Cal (fee-for-service) providers. Treatment for other substance abuse available through the Los Angeles County Public Health Substance Abuse Prevention and Control Program. PHC California will refer enrollees for such services if necessary.
Therapy Services (Hospital- and Community-Based) including: • Occupational Therapy • Physical Therapy • Speech Therapy	Covered when medically necessary; no limits; requires prior authorization
Transplant Services	Kidney transplant covered when medically necessary; no limits; requires prior authorization. Other major organ transplants covered under Regular Medi-Cal (fee-for-service) program and require disenrollment from the plan.
Transportation (Non-Emergency Medical Transportation and Non-Emergency Transportation)	Covered; no limits; plan must arrange transportation to and from plan-approved locations.

Services	Limitations
Tuberculosis (TB) Screening and Treatment including Direct-Observed Therapy and Follow-Up	Covered; no limits; requires prior authorization. Direct-observed therapy, when medically necessary, is provided by the Los Angeles County Department of Public Health. PHC California will refer you for such services if you need them.
Vision Care Services	Routine eye exams and prescriptions for eye glasses/corrective lenses covered. No limits. Eyeglasses are covered for members under the age of twenty-one (21) and pregnant women through postpartum.
Expanded Benefits	**Limitations**
Health and Wellness Benefit	Choice of gym membership or up to $200-worth of over-the-counter pharmacy items per year.

Services Available Through Medi-Cal Fee-for-Service (FFS)

The following services are available to PHC California enrollees through Medi-Cal FFS:

- Dental services such as the following below are available through Denti-Cal. Medi-Cal covers these dental services for adults effective January 1, 2018.
    - Exams and x-rays
    - Cleanings (prophylaxis)
    - Deep cleanings (scaling and root planning)
    - Fluoride treatments
    - Fillings
    - Laboratory and prefabricated crowns
    - Partial dentures
    - Root canals in front and back teeth
    - Full dentures
    - Other medically necessary dental services

  If medically necessary, dental services may exceed the yearly $1,800 limit.

  PHC California enrollees who require dental services should call Denti-Cal at (800)

322-6384 (TTY (800) 735-2922) or visit denti-cal.ca.gov.

- Transplant services except for kidney transplant, major organ transplants are covered by Medi-Cal FFS. Should a PHC California enrollee require an organ transplant, other than kidney, PHC California will refer to him or her a Medi-Cal-approved transplant center. If the transplant center physician determines that the enrollee is a candidate, he or she will submit a treatment authorization request (TAR) to Medi-Cal to do the transplant. If authorization is given, the enrollee will be disenrolled from PHC California and covered by Regular Medi-Cal (FFS).

Excluded Services

The following services are not covered by PHC California or Regular Medi-Cal:

- Experimental procedures
- Cosmetic surgery (except when required to repair trauma or disease related disfigurement)
- Drugs and medications when used for cosmetic purposes
- Common household items which can be used as durable medical equipment
- Routine non-medically necessary foot-care services
- Personal comfort or convenience items, such as, but not limited to, telephones, televisions, and guest trays

Limitations

PHC California will make all reasonable attempts to provide covered services; however, it is not responsible for a lapse in care under the following conditions:

- Delay or failure to render service due to major disaster or epidemic affecting facilities or personnel;
- Interruption of services due to war, riot, labor disputes, or destruction of facilities; or
- Failure to provide service when a member has refused a recommended service for a personal reason and/or when a plan provider believes no professionally acceptable alternative treatment exists.

Questions of medical appropriateness or necessity of treatment will be subject to review by PHC California's Medical Director who will consider all opinions and determine whether services are covered by the contract.

Transportation

PHC California covers emergency (ambulance) transportation and coordinates and

arranges non-emergency medical and non-medical transportation for its enrollees follows:

- **Emergency transportation** is covered when an enrollee's medical or physical condition is acute and severe and requires immediate diagnosis and treatment so as to prevent death or disability. Emergency transportation may be provided via ground or air ambulance.

  If an enrollee presents in a facility and experiences a medical emergency requiring hospitalization, the attending practitioner must arrange emergency transportation by a licensed ambulance company to the nearest emergency room or call 9-1-1 to obtain ambulance service.

- **Non-emergency medical transportation (NEMT)** is covered when prescribed in writing by a physician, dentist, behavioral health provider, etc. for an enrollee to obtain medically necessary covered services. NEMT is subject to prior authorization, except when an enrollee is transferred from an acute inpatient facility to a SNF. PHC California may provide NEMT through:
  1. Ambulance
     a. Transfers between facilities for enrollees who require continuous intravenous medication, medical monitoring, or observation.
     b. Transfers from an acute care facility to another acute care facility.
     c. Transport for enrollees who have recently been placed on oxygen (does not apply to enrollees with chronic emphysema who carry their own oxygen for continuous use).
     d. Transport for members with chronic conditions who require oxygen if monitoring is required.

  2. Litter van service when an enrollee's medical and physical condition does not meet the need for NEMT ambulance, but meets both the following:
     a. Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period needed to transport.
     b. Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs, or other forms of public conveyance.

  3. Wheelchair van services when an enrollee's medical and physical condition does not meet the need for litter van services, but meets any of the following:

a. Renders the enrollee incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport.
b. Requires that the enrollee be transported in a wheelchair or assisted to and from a residence, vehicle, and place of treatment because of a disabling physical or mental limitation.
c. Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs, or other forms of public conveyance.

Enrollees with the following conditions may qualify for wheelchair van transport when their provider submits a signed Physician Certification Statement (PCS) form:

- Members who suffer from severe mental confusion.
- Members with paraplegia.
- Dialysis recipients.
- Members with chronic conditions who require oxygen but do not require monitoring

4. Air service only when transportation by air is necessary because of the enrollee's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist, or behavioral health or substance use disorder provider.

- **Non-medical transportation (NMT)** is provided to enrollees so that they may obtain medically necessary services, including those not covered PHC California, but available through Medi-Cal FFS or Los Angeles County providers. NMT does not include transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with State and local statutes, ordinances, or regulations. PHC California may authorize NMT for an enrollee who uses a wheelchair, but whose limitation is such that the enrollee is able to ambulate without assistance from the driver. The NMT requested must be the least costly method of transportation that meets the enrollee's needs. PHC California provides NMT in a form and manner that is both physically and geographically accessible for the member and is consistent with applicable State and federal disability rights laws.

  PHC California provides round-trip transportation for an enrollee by passenger

car, taxicab, bus, train, or any other form of public or private conveyance (including a private vehicle). NMT also includes mileage reimbursement for medical purposes when conveyance is in a private vehicle arranged by the enrollee and not through a transportation broker, bus passes, taxi vouchers, or train tickets.

Round-trip NMT is available for the following:

1. Medically necessary services, including those not covered under the Contract.
2. Members picking up drug prescriptions that cannot be mailed directly to the member.
3. Members picking up medical supplies including prosthetics, orthotics, or other equipment

Enrollees who wish to book NMT should call Member Services at (800) 263-0067, Monday through Friday, 8:00 am to 8:00 pm. TTY users should call 711.

PCP Scope of Services Requirements

A PCP is required to provide the following services to members assigned to them:

- Detect, diagnose, and effectively manage common symptoms and physical signs.
- Treat and manage common acute and chronic medical conditions.
- Perform ambulatory diagnostic and treatment procedures (injections, aspirations, splints, minor suturing, etc.) Periodic health assessments including history and physical examinations appropriate for the age, sex and medical history of the patient.
- Preventive medical care including health risk identification and reduction and periodic screening.
- Foster health promotion and disease prevention (age-specific screening, health assessment and health maintenance activities, health education and promotion, etc.).
- Provide medical case management (refer to community resources and available supplemental programs, coordinate care with specialists, etc.). Refer to specialists appropriately.
- Follow required procedures for specialist, diagnostic, or service referral as promulgated by PHC.

Section 5: Member Rights and Responsibilities

This document explains the rights of PHC California members, as stated verbatim in the Member's Membership Services Guide. Providers and their office staff are encouraged to be familiar with this document, post in their office (poster provided by PHC) and are expected to abide by these rights. PHC's member rights and responsibilities are as follows:

Member Rights

A PHC California member has the right to:

- To be treated with respect, with PHC giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about PHC and its services
- To be able to choose a Primary Care Provider within PHC's network
- To participate in decision making regarding your own health care, including the right to refuse treatment
- To file grievances and appeals, either verbally or in writing, about the organization or the care received (Please see Section 11, Grievances and Appeals for specifics.)
- To receive oral interpretation services for your language
- To formulate advance directives
- To have access to family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and Emergency Services outside the Contractor's network pursuant to the Federal law
- To request a state Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible, the availability of assistance in filing for a hearing, continuation of benefits during a hearing, and the representation rules at a Hearing. (Please see Section 11, Grievances and Appeals for specifics.)
- To have access to, and where legally appropriate, receive copies of, amend or correct your Medical Record
- To dis-enroll upon request
- To access minor consent services
- To receive written Member informing materials in alternative formats, including Braille and large size print upon request
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- To receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand
- The freedom to exercise these rights without adversely affecting how you are treated by PHC, your provider, or the State.

Member Responsibilities

Members have the responsibility to:

- Participate in your health care and the health care of your family. This means taking care of medical problems before they become more serious.
- Keep in touch with and regularly visit your PHC Primary Care Physician (PCP)/doctor.
- Cooperate with your PCP/doctor, follow his/her instructions regarding your care and take all of your doctor-prescribed medications as directed.
- Arrive on time for your doctor visits. Call if you will be late or need to cancel/reschedule your appointment.
- Be courteous and cooperative to people who provide you or your family with health care services.
- Not let anyone else use your PHC ID card or Medi-Cal (BIC) card or pretend to be you.
- Not participate in Medi-Cal fraud or any inappropriate use of your Medi-Cal coverage through PHC or Medi-Cal fee-for-service.
- Be proactive in your health care. Let us know how you like our Plan and how we can improve our services. Participate in our Satisfaction Survey, Client Advisory Committee, and Public Policy meetings. Help us ensure that we are providing you with the highest quality of health care.

Member Confidentiality

According to PHC California's Medi-Cal Member Rights, members have the right to full consideration of their privacy concerning their medical care program. They are also entitled to confidential treatment of all member communications and records. Case discussion, consultation, examination, and treatments are confidential and should be conducted with discretion. Written authorization from the member or his/her authorized legal representative must be obtained before medical records are released to anyone not directly connected with his/her care, except as permitted or necessitated by the administration of the health plan.

Office Procedure

All participating Providers must implement and maintain an office procedure that will guard against disclosure of any confidential patient information to unauthorized persons. This procedure should be composed of the following elements:

- Written authorization obtained from the member, or his /her legal representative, before medical records are made available to anyone not directly concerned with his/her care: except where otherwise permitted or required by law of subpoena.
- All signed authorizations for release of medical information must be carefully reviewed for authorization information and for any limitations to the release of medical information.

- Each medical record should be reviewed prior to making it available to anyone other than the member or legal representative or the member.
- Only the portion of the medical record specified in the authorization should be made available to the requester and should be separated from the remainder of the member's medical records.
- Any portion of the medical record not indicated by the authorization will be omitted.

Release of Medical Information Forms

All Providers must maintain a proper release of medical information form for each record request within the patient's medical records.

Confidential Information

Confidential information also refers to any identifiable information about a member's character, conduct, avocation, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment. More than the medical record constitutes, conversations, whether in a formal or informal setting, e-mail, faxes and letters are other potential sources of confidential member information. Member confidentiality must be maintained at all times when providing health care services and during claims processing.

Member Satisfaction Survey

PHC California or the State of California, conducts an annual satisfaction survey of its Medi-Cal members. The purpose of the survey is to gather information from members regarding their perception of the health plan; their health care, practitioners, access to care and health plan customer service. The data is used to identify systemic issues that need to be addressed.

Section 6: Access Standards

Clinical Access Standards PHC is committed to timely access to care for all members. The Access to Care Standards below is to be observed by all Providers.

Appointments with the Primary Care Physician (PCP)

Members are instructed through their member orientation packets to call their Health Care Center to schedule appointments for routine care or urgent/emergency visits. The Health Care Center is expected to ensure timely access to the Plan members.

If the need for specialty care arises, the Health Care Center is responsible for coordinating all services that fall out of the scope of its practice.

Standards of Access

Access standards have been developed to ensure that all health care services are provided in a timely manner. These standards are based on community norms. PHC monitors the PCP's compliance to the standards. Appointment and waiting time standards are listed below:

Type of Care	Standard (Measured from Time of Request)
Emergency/Urgent Care	Immediate
Urgent Care Appointment – Services that Do Not Require Prior Auth.	Within 48 hours
Urgent Care Appointment – Services that Require Prior Auth.	Within 96 hours
Primary Care Appointment (Non-Urgent)	Within 10 business days
Specialist Appointment (Non-Urgent)	Within 15 business days
Mental Health Care Appointment (Non-Physician)	Within 10 business days
Ancillary Services to Diagnose or Treat a Health Condition (Non-Urgent)	Within 15 business days
Physical Exam/Preventive Care	Within 30 calendar days of request
First Prenatal Visit	Within 2 weeks

After-Hours Care and Emergencies

The Health Care Center designee must be available twenty-four (24) hours a day, seven (7) days a week. PHC requires a practitioner or a registered nurse under his/her supervision to maintain a twenty-four (24)-hour phone service, seven (7) days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct members with an emergency to hang-up and call 911 or go immediately to the nearest emergency room. After hour phone calls or pages must be returned within thirty (30) minutes.

Primary Care Office Hours

Generally, office hours are from 8:30 a.m. to 5:00 p.m. However, the Provider has flexibility to maintain his/her own reasonable and regular office hours. All primary care sites are required to post their regular office hours. Office hours are expected to remain the same for all patients, regardless of insurance or other service eligibility.

Urgent and Emergency Care at the Primary Care Practitioner's Office

The facility must have procedures in place to enable access to emergency services twenty-four (24) hours a day, seven (7) days a week. The facility staff needs to be knowledgeable about emergency procedures and be capable of coordinating emergency services.

The recommended equipment for required emergency procedures needs to be easily accessible. The emergency inventory list needs to be posted with drug expiration dates. Examples of emergency drugs are epinephrine and Benadryl. Oxygen needs to be secured, full and equipped with a flow meter. The mask and cannula need to be attached. Oral airways and ambu bags appropriate for patient population need to be available. If there is need for Basic Life Support or Emergency Medical Services (EMS), dial 911.

Facility Access for the Disabled

PHC ensures that participating Health Care Centers provide access for disabled members in accordance with the Americans with Disabilities Act (ADA) of 1990. Access should include availability of ramps, elevators, modified restrooms, designated parking spaces close to the facility, and drinking water provisions.

Monitoring Access for Compliance with Standards

PHC regularly monitors and audits the appointment and access standards identified in this Section, and others per applicable rules, regulations, contracts, and guidance. PHC conducts quarterly random appointment checks to determine if the providers' offices

meet access standards. This may be accomplished through periodic surveys and/or test calls. A random sample of contracted Providers offices are selected for the survey. Results of the survey are distributed to the providers after its completion. Contracted providers are responsible for responding to any appointment and/or access deficiencies identified by PHC review methods, including the following:

- Access to care studies
- Facility Site Review (FSR)
- Exception reports generated from Member grievances
- Medical records review
- Random Member surveys
- Feedback from PCP regarding other network services (i.e., pharmacies, vision care, hospitals, laboratories, etc.)
- Provider office surveys or visits including but not limited to, routine care, urgent care, preventative care, after hours information, and secret shopper.

Timely Access to Care: Sensitive and Confidential Services for Adolescents and Adults Sensitive Services:

- Sexual Assault
- Drug or alcohol abuse for children 12 years of age or older
- Pregnancy
- Family Planning
- Sexually transmitted diseases for children 12 years of age or older
- Abortion Services
- HIV testing/counseling

The following is a brief guide on providing access to members for these sensitive areas.

Timely Access to Services and Treatment Consent

Members under the age of twelve (12) years require parental or guardian consent for obtaining services in the areas of sexually transmitted diseases or drug/alcohol abuse. Minors under the age of twelve (12) years seeking abortion services are subject to state and federal law. Those aged twelve (12) and over can obtain any and all of the above services by signing the Authorization for Treatment form.

Timely access is required by providers for members seeking the sensitive medical services for family planning and/or sexually transmitted diseases. HIV testing & counseling, as well as confidential referrals for treatment of drug and/or alcohol abuse are required to be coordinated in a timely manner.

Family Planning Services

To enhance coordination of care, PCPs are encouraged to refer members to Plan Providers for family planning. Members, however, do not require prior authorization from their PCPs to seek family-planning services. This freedom of choice provision is the result of federal legislation.

Contract includes an additional section on Out-Of-Network Family Planning Services as reflected below:

Members of childbearing age may access the following services from out of plan family planning Providers to temporarily or permanently prevent or delay pregnancy:

a) Health education and counseling necessary to make informed choices and understand contraceptive methods.

b) Limited history and physical examination.

c) Laboratory tests if medically indicated as part of decision-making process for choice of contraceptive methods. Contractor shall not be required to reimburse out-of-network providers for pap smears, if Contractor has provided pap smears to meet the U.S. Preventive Services Task Force guidelines.

d) Diagnosis and treatment of a sexually transmitted disease episode, as defined by DHCS for each sexually transmitted disease, if medically indicated.

e) Screening, testing, and counseling of at risk individuals for HIV and referral for treatment.

f) Follow-up care for complications associated with contraceptive methods provided or prescribed by the family planning Provider.

g) Provision of contraceptive pills, devices, and supplies.

h) Tubal ligation.

i) Vasectomies.

j) Pregnancy testing and counseling.

Missed Appointments

PHC contracted Providers are responsible for the follow up of missed appointments. PHC physicians must have a process in place to follow-up on missed appointments that includes at least the following:

- Notation of the missed appointment in the Member's medical record
- Review of the potential impact of the missed appointment on the Member's health status including review of the reason for the appointment by a licensed staff member of the physician's office (RN, PA, NP, or MD).
- Notation in the chart describing follow-up for the missed appointment including one of the following actions:
    - no action if there is no effect on the Member due to the missed appointment, a letter or phone call to the Member as appropriate, given the type of appointment missed and the potential impact on the Member.
    - The chart entry must be signed or co-signed by the Member's assigned PCP or covering physician.
- Three (3) attempts, at least one by phone and one by mail, must be made in attempting to contact a Member if the Member's health status is potentially at significant risk due to missed appointments.
    - Examples include Members with serious chronic illnesses, Members with test results that are significant (e.g., critical lab result) and Members judged by the treating physician to be at risk for other reasons.
    - Documentation of the attempts must be entered in the Member's medical record and copies of letters retained.

Emergency Care Services

Emergency Services means those services needed to evaluate or stabilize an emergency medical condition.

Emergency medical condition means a medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions or,
- Serious dysfunction of any bodily organ or part

Emergency services using the prudent layperson definition or that meet Title 28, CCR Section 1300.67(g), and Title 22, CCR, Section 53216 criteria for an emergency do not require prior authorization. In accordance with California Department of Health Services

policies and current law, members presenting to an emergency room facility may be triaged by the emergency room staff, and PHC will pay the Medical Screening Exam fee.

Emergency room staff is required to notify PHC's Utilization and Care Management Department at the following number of a member's emergency room visit: (800) 474-1434.

Emergency Room Discharge and After-Care

After care instructions should be documented in the emergency facility medical record and communicated to the patient, parent or guardian. Discharge from the emergency facility is performed on the order of a practitioner.

Notification Requirements

Any emergency service resulting in an impatient admission requires notification and authorization within twenty-four (24) hours (or the next business day) of the admission. Furthermore, "Out of Area" and/or non-contracted emergency service Providers are required to notify PHC when the member's condition is deemed stable for follow-up care in PHC's service area and at a contracted facility. PHC adheres to the regulations set forth in Title 28, California Code of Regulations, Chapter 3, Section 1300.71.4, Emergency Medical Condition and Post Stabilization Responsibilities for Medically Necessary Health Care Services.

After Hours Nursing Advice Line

PHC California delegates after hour advice for members to Citra. Access to the advice line is available to all members. Licensed nurses provide the services:

- Advise and refer members to appropriate level of care in a timely manner
- Coordinate the member's care with the physician
- Notify physicians of member's ER visit and need for future care
- Educate members on health issues
- Assist in identifying members who might benefit from care management

Members can contact the PHC Urgent Care/Nursing Advice Line at (800) 797-1717. The line is available after PHC's standard business hours of 8:30 am to 5:30 pm PST, Monday thru Friday, twenty-four (24) hours a day on weekends and PHC holidays.

PHC Holidays include:

- New Year's Day
- Martin Luther King Day
- President's Day
- Memorial Day

- July 4th
- Labor Day

- Thanksgiving
- Christmas

Section 7: Utilization Management

Utilization Management (UM) is an on-going process of assessing, planning, organizing, directing, coordinating, monitoring, and evaluating the utilization of health care services for PHC members.

Licensed utilization management staff is responsible for obtaining all pertinent clinical indications and medical record information necessary to perform thorough assessments of requested referrals and service authorizations. The licensed UM staff is responsible for application of utilization review criteria/guidelines to each individual case and for referral to the Medical Director when criteria are not met.

The UM Department staff are responsible for identification of potential or actual quality-of-care issues, and cases of over or under utilization of health care services for PHC members during all components of review and authorization.

The comprehensive methods of review and authorization include the following processes:

Admission Review

The Utilization Management representative obtains either telephonic or on-site medical record review within twenty-four (24) hours of notification of admission (or next business day) to ensure the admission to an acute care hospital is appropriate/medically indicated in accordance with the illness or condition or to confirm information obtained during prior authorization of elective admissions. UM processes review on all inpatient admissions via the emergency department for medical necessity and appropriateness.

Notification of Admissions

All elective and emergency inpatient admissions must be reported to PHC within twenty- four (24) hours of the admission (or the next business day). These notifications can be submitted by faxing the patient's admission face sheet to PHC California UM Department Fax: (888) 272.7656, (888) 238-7463 or by telephoning the UM Department at (800) 474-1434.

Concurrent/Continued Stay Review

Concurrent/Continued Stay Review is a process coordinated by the Utilization Management representative during a member's course of hospitalization to assess the medical necessity and appropriateness of continued confinement at the requested level

of care. Hospital UM staff should call-in continued stay updates to and fax all necessary information for UM review to PHC California UM Department Fax: (888) 272.7656, (888) 238-7463 or by telephoning the UM Department at (800) 474-1434.

Discharge Planning Review

Discharge planning begins as early as possible during an inpatient admission. Such planning is designed to identify and initiate cost-effective, quality-driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physician, hospital discharge planner, PHC Utilization Management staff, including the Medical Director, ancillary providers, practitioners, and community resources to coordinate care and services.

Retrospective Review

Retrospective Review is a review process performed by the PHC UM Claim Review staff and Plan Medical Director, after services have been rendered, to determine:

- If unauthorized services were medically necessary/appropriate.
- If services were rendered at the appropriate level of care and in a timely manner.
- If any quality of care issues exists.
- If provider claims appeals are in order.

The attending physician, and/or hospital/facility is notified in writing of the claim payment determinations via the "Explanation of Benefits."

Ancillary Services (Home Health, Durable Medical Equipment, Hospice)

Referrals for any ancillary services including Home Health and Durable Medical Equipment require authorization from the Utilization Management (UM) Department.

Skilled Nursing, Long Term Care or Rehabilitation Facility Review

When a member is transferred or admitted to a Skilled Nursing Facility (SNF) or Rehab facility, PHC uses Title 22 SNF criteria and guidelines to determine appropriate level of care. All admissions to SNF, LTC or Rehab facility require authorization by the PHC UM Department.

Referral Process

Purpose of Prior Authorization

Prior authorization is designed to promote the medical necessity of service, to prevent unanticipated denials of coverage and ensure that participating Providers are utilized and that all services are provided at the appropriate level of care for the member's

needs.

The following services typically require prior authorization:

- PCP pediatric referrals to specialist
- Adult 21 and over Post Initial Specialist Consult treatment plans (SMO and Direct)
- Elective Inpatient admissions
- Hospital Admissions via the Emergency Department require notification of admission within one (1) business day
- Outpatient surgeries (except where otherwise specified, i.e. abortions, minor office procedures)
- Major Diagnostic Tests, e.g. MRI, CT Scan, Angiography
- Endoscopies
- Hospice Care
- Durable Medical Equipment
- New Medical Technology (considered investigational or experimental) - includes drugs, treatment, procedures, equipment, etc.
- Pharmacy Drug Formulary overrides
- Home Health Care
- Medical Specialty Referrals
- Non-Participating Practitioners/Non-Contracted Facilities
- Chiropractic (limited to treatment of the spine by means of manual manipulation and to a maximum of two (2) services per calendar month
- Acupuncture is limited to treatment of chronic pain to a maximum of two (2) services per calendar month
- Vision Services

PHC does not require referral or prior authorization for the following services:

- Emergency services
- Family planning services
- Treatment of sexually transmitted diseases
- Confidential HIV testing and counseling
- Obstetrical care
- Sensitive and confidential services (e.g. services related to sexual assault, drug and alcohol abuse for children aged 12 and over)
- Therapeutic and elective pregnancy termination
- Annual Well Woman visit

Referrals and requests for prior authorization of services are sent by Providers to the PHC California Utilization Management Department by mail, fax, and/or telephone based on the urgency of the requested service.

PHC Utilization Management
Prior Authorization Services/Referrals
Telephone: (800) 474-1434
Fax: 888.272.7656
Mail: PHC
1001 North Martel Avenue
Los Angeles, CA 90046

Providers are required to supply the following information, if applicable, for the requested service:

- Member demographic information (name, date of birth, etc.)
- Provider demographic information (Referring and Referred to)
- Requested service/procedure, including specific CPT/HCPCS Codes
- Member diagnosis (ICD-10 Code and description)
- Clinical indications necessitating service or referral
- Pertinent medical history, and treatment, laboratory data
- Location where service will be performed
- Requested length of stay (inpatient requests)

Pertinent data and information is required by the UM staff to enable a thorough assessment for medical necessity and assign appropriate diagnosis and procedure codes to the authorization.

Eligibility

Authorization is based on member eligibility at the time of service and is verified by the Utilization Management staff, by the Eligibility representatives in Member Services or by Medi-Cal's automated Eligibility Verification System (AEVS).

Benefits

Benefit coverage for a requested service is verified by the UM staff during the authorization process.

Referral to Non-Participating Practitioners or Non-Contracted Facilities In-Area

Except in true emergencies, PHC provides coverage for only those services rendered by contracted Providers and facilities. The exceptions are:

- PHC is notified, approves, and authorizes the referral in advance. In these instances, the UM Outpatient Services/Referrals Department will issue an

authorization number for the services to be provided. Prior approval must be obtained by the Provider recommending an out-of-plan referral before arrangements have been made for those services. To obtain an authorization number, contact the PHC UM Outpatient Services/Referrals Department at (800) 474-1434; Fax (323) 436-5032 or (323) 436-5033.

- The patient's medical needs require specialized or unique service available only through a non- contracted Provider or facility. In this case, PHC will assist the referring Provider in identifying specialists or facilities with the needed capabilities. PHC must authorize any such referral.

Referral Form

The Referral Form must be completed and an authorization obtained for all services described above as requiring prior authorization before the service is provided, except in emergencies.

For a referral to be valid the following conditions must be met:

- The member must be currently enrolled with PHC.
- The member must be assigned to the PCP initiating the primary referral.
- Authorizations are valid for ninety (90) calendar days.
- A Prior Authorization number must be obtained from PHC prior to services being rendered as described above (except in emergencies).

When Referral Forms and Notifications Are Required

- Procedures not related to the admitting diagnosis (or presenting symptom/diagnosis in the Specialist's office) require prior authorization by PHC. PHC retains the right to retrospectively review inpatient and specialist claims to identify inappropriate consultations and procedures. The right to deny such consultations and procedures is also reserved.
- Inpatient Admission Notification Fax 888.272.7656, phone: 800.474.1434

Completion of a Referral Form

- A thoroughly completed Referral Form is essential to assure a prompt authorization.
    - A copy of pertinent clinical notes may be attached and substituted for the Clinical History segment of the Referral Form if the required information is present on those clinical notes.
    - The form should be transmitted by fax to PHC for review by the Utilization Management Department and assignment of an authorization number: Fax: 888.272.7656

- To assure maximum benefit from a referral, the PCP must clearly state the purpose of the referral and desired services. Patient progress notes, labs, and imaging should be attached to the referral.
- Referral appointments to specialists must be on the same day for emergency care, within three (3) days for urgent care and within thirty (30) days for routine care.

Prior Authorization Requests

Primary Care Practitioners (PCPs)

- The PCP is always the initial source of care for members. A member may see the PCP without a referral and the PCP may perform essential services in the office environment.
- Prior Authorization is required for necessary member services ordered by the PCP, which cannot be performed in the office.
- If the PCP determines that a specialist is necessary for consultation or care of the patient, the PCP must complete a Referral Form (see below) and obtain a Prior Authorization Number for that referral (unless the service does not require prior authorization as described above).
- Referrals are only made to specialists in the PHC Network. Exceptions will be made only in rare circumstances and then only with the prior approval of the Medical Director.
- Complete referrals are essential, stating exactly what is to be done and including any clinical information and previous diagnostic testing for the specialty provider's/practitioner's review.
- A system within the PCP's practice should be developed to assure that written responses from specialty referrals are received and incorporated into the Member's medical record, e.g. a Specialty Referral Log.

Specialists Referrals

- A specialist may see a PHC member only upon an initial referral from the member's assigned PCP or as a secondary consultant from the primary referred specialist along with the approved prior authorization from UM (Medical emergencies excluded)
- If there is any question regarding the scope of the referral, the PCP should be contacted for clarification.
- The PCP will specify the type of referral:
    - Consultation for diagnostic purposes
    - Consultation to recommend treatment plan
    - Consultation and request to assume care
- When the member is referred for "Consultation to Recommend Treatment Plan"

the PCP will specify on the referral form to UM if:

- The referral is for a consultation visit only, or
- The referral is for consultation plus one follow up visit.

Only those diagnostic procedures, tests, and treatments specifically related to the consultation and not defined in the services/referral guidelines, may be performed by the Specialist. This authorization is obtained directly by the specialist following PHC's prior authorization policies and procedures.

- Tests, procedures, and treatments must be performed in network facilities.
- This type of referral is valid for a ninety (90) day period.

This authorization is obtained by the PCP following PHC Prior Authorization policies and procedures. Such tests, procedures, and treatments must be performed in network facilities. This referral is valid for ninety (90) days (unless otherwise specified on the Referral Form).

If the specialist determines that a secondary specialist who is out of the PHC Network is required, a Medical Review is required.

NOTE: PHC California is **ONLY** financially responsible for those services that are Medically Necessary and specified in the Referral form by the PCP to Specialist (or Referred Specialist to Secondary Specialist), and have been Prior Authorized by PHC.

- Verbal communication from the PCP should be provided on any urgent referrals.
- A written response from the specialist should be provided to the PCP within three (3) weeks of care for inclusion in the member's medical record.
- The Prior Authorization/Referral number must be clearly written on the bill submitted to PHC:

Attention: Claims Department
PHC California
P. O. Box 7490
La Verne, CA 91750

If the member is Medicare eligible or has other insurance, submit the claim to that entity first, then to PHC with the appropriate EOB.

Prior Authorization Decision Turnaround Time Standards

- Determinations regarding requests for elective services/procedures are made within five (5) working days of request and receipt of medical record information required to evaluate medical necessity and appropriateness.
- Determinations regarding urgent service/procedures are made within seventy-

two (72) hours of receipt of medical record information required to evaluate medical necessity and appropriateness. If the request does not meet medical urgency, the UM department will downgrade the status to standard and notify the provider and member accordingly. In the notification, UM will include the member and provide adverse benefits determination process. The PHC Medical Director makes the final determination to downgrade any authorization from urgent to standard.

- The Provider will be notified of the decision within one (1) calendar day of the decision.
- A list of resources used to make utilization and clinical decisions includes but is not limited to:
    - Medi-Cal Policies and Procedures
    - InterQual
    - Medicare Policies and Procedures (for duals)
    - UptoDate
    - American College of Obstetrics and Gynecology (ACOG) Guidelines
    - Clinical Practice Guidelines adopted by Utilization Management Committee (UMC) as approved the physician's Medical Administration Policy & Procedure Committee.

Providers who wish to discuss denial or modification of services may contact the **PHC Medical Director at (800) 474-1434.**

Clinical Criteria used in a denial or modification decision may be requested by calling **(800) 474-1434.**

Provider Referral Tracking System

Providers can track and monitor referrals requiring prior authorization:

1. Staff model providers may access the electronic medical record system, which contains in detail the status of the referral or contact UM as indicated in #2.
2. Contracted providers may contact the **Utilization Management department directly at 800-474- 1434**

Continuity of Member Care

PHC and its affiliated health plans and contracted Providers within these networks must ensure that members receive medically necessary health care services in a timely manner without undue interruption.

The cornerstone of continuity of care is the maintenance of a single, confidential medical record for each patient. This record includes documentation of all pertinent

information regarding medical services rendered in the Primary Care Practitioner's (PCP) office or other settings, such as, hospital emergency departments, in-patient and out-patient hospital facilities, specialist offices, the patient's home (home health), laboratory and imaging facilities.

Providers must have systems in place to ensure the following:

- Maintenance of a confidential medical record.
- Monitoring of patients with ongoing medical conditions.
- Appropriate referral of patients in need of specialty services.
- Documentation of referral services in the member's medical record.
- Forwarding of pertinent information or findings to specialist.
- Entering findings of specialist in the member's medical record.
- Documentation of care rendered in the emergency or urgent care facility in the medical record.
- Documentation of hospital discharge summaries and operative reports in the medical record.
- Coordination of post-hospital follow-up, discharge planning, and after-care.

PHC does not provide incentives to PHC Staff for UM decision-making.

Routine Medical Care

The member's PCP is responsible for providing routine medical care to members, following up on missed appointments, prescribing diagnostic tests and procedures, referrals, and/or laboratory tests. The PCP also ensures that each newly enrolled member receives an initial health assessment within ninety (90) days of enrollment. Each of these items is discussed in more detail within this Provider Manual.

Referrals

Referrals are made when medically necessary services are beyond the scope of the PCP's practice or when complications or unresponsiveness to an appropriate treatment regimen necessitates the opinion of a specialist. In referring a patient, the PCP should forward pertinent patient information/findings to the specialist. Upon initiation of the referral, the PCP is responsible for initiating the referral tracking system.

Second Medical/Surgical Opinion

A member may request a second medical/surgical opinion at any time during the course of a particular treatment, in the following manner:

- PHC members may request a second opinion through their PCP or PHC's Utilization & Care Management Department. PHC's Utilization & Care Management Department will assist the member in coordinating the second

opinion request with the member's PCP and specialist.

- Members will have their second opinion request submitted to and reviewed by PHC's Medical Director.
- Second Opinion requests will be reviewed and provided written approval or denial within forty-eight (48) hours of request receipt. In cases where the request identifies an urgent or emergent need, formal approval or denial will be provided within one (1) working day.
- If the request for second medical/surgical opinion is denied, both the member and provider have the opportunity to appeal the decision through the Member Appeals Process.
- If the requested specialty care provider or service is not available within the PHC network; an approval to an out of network provider will be facilitated by PHC's Utilization Management Department.
- Only one request for a second medical/surgical opinion will be approved for the same episode of treatment. This applies to both the in network and out of network requests for second medical/surgical opinion.

Under the authorization process utilized by the Utilization Management Department, any medical or surgical procedure that does not meet medical policy criteria (refer to on-line InterQual criteria) is reviewed with a Medical Director. The Medical Director may request a second opinion at any time on any case deemed to require specialty practitioner advisor review. The Utilization Management review criteria may be obtained upon request to the Utilization Management Department.

Upon approval of the request for a second medical/surgical opinion, the PCP's office staff will assist the member in scheduling an appointment with the second opinion practitioner for the member. The PCP or his staff will instruct the member to take a copy of the authorization form and pertinent medical records to the second opinion practitioner.

Continuity of Care When a Practitioner Contract is Terminated

- Members shall be notified at least thirty (30) calendar days prior to the effective date of a practitioner contract termination, or within fourteen (14) calendar days prior to the change in cases of unforeseeable circumstances. In cases of unforeseeable circumstances, the Compliance Department will coordinate with the Regulatory Contract Managers for approval. PHC will adhere to the most stringent regulatory standard for all lines of business.
- This policy shall encompass all members assigned to a PCP or that have been treated by a Specialist Practitioner any time during the eight (8) months preceding the effective termination date, currently in treatment or open

authorizations.

- PHC shall arrange for, upon request by the member or a practitioner on behalf of the member, for continuity of care by a terminated practitioner who has been providing care for:
    - An acute condition (defined as medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration).
    - Serious chronic condition (defined as a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following: (a) persists without full cure or worsens over an extended period of time, and (b) requires ongoing treatment to maintain remission or prevent deterioration.
    - High-risk pregnancy and/or pregnancy that has reached the second or third trimester.
- For cases involving an acute condition or a serious chronic condition, PHC will continue to provide the member with health care services in a timely and appropriate basis from the terminated practitioner for up to ninety (90) days or a longer period if necessary for a safe transfer to another practitioner as determined by PHC's Medical Director, in consultation with the PCP, and terminated practitioner, consistent with good professional practice.
- For cases involving pregnancy, PHC shall furnish the member with health care services on a timely and appropriate basis from the terminated practitioner, until postpartum services related to the delivery are completed or for a longer period if necessary for a safe transfer to another practitioner as determined by PHC's Medical Director, in consultation with the PCP, and terminated practitioner, consistent with good professional practice.
- Continuity of care during an inpatient admission shall be reviewed and determined by PHC's Medical Director in consultation with the PCP, and terminated practitioner.
- Continuity of care for outpatient services, outstanding and ongoing authorizations, for a terminated practitioner, shall be reviewed by PHC's Medical Director in consultation with the PCP and other practitioners involved with the patient's care.

Chronic Care Management Program

PHC provides a comprehensive Chronic Care Management program to all members. Care Management (CM) focuses on procuring and coordinating the care, services, and resources needed by members with complex issues through a continuum of care.

Care Management is individualized to accommodate a member's needs. In collaboration

with and approval by the member's Primary Care Practitioners (PCP), the PHC RN Care Manager will arrange individual services for members whose needs include ongoing medical care, home health care, hospice care, rehabilitation services, and preventive services. The PHC RN Care Manager is responsible for assessing all members and notifying the PCP of the evaluation results, as well as making recommendation for a treatment plan.

The RN Care Manager works in conjunction with the PCP, the member, the member's family, other providers, etc., to coordinate and implement the individualized treatment plan of members.

- PHC adheres to Case Management Society of America (CMSA) Standards of Practice Guidelines in its execution of the program.
- The PHC RN Care Manager, in conjunction with the PCP and other providers, develops and implements a care plan appropriate to the member's medical needs.
- Care Management services are not delegated to medical groups.

The CM Program is based on a member advocacy philosophy designed and administered to assure the member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes.

Referral to Medical Care Management

Unlike many other Care Management models, all PHC Enrollees are eligible for Care Management. All enrollees are assessed to determine their level of acuity and appropriateness for Care Management interventions. Referral by the PCP is not required.

PCP Responsibilities in Care Management

The member's PCP is the primary leader of the health team involved in the coordination and direction of care services for the member. The PHC Case Manager provides the PCP with reports, updates, and information regarding the member's progress through the Care Management plan.

The PCP is responsible for the provision of preventive services and for the primary medical care of members eligible for or requiring "carved out" services. The PCP is responsible for early identification of members eligible for "carved out" services and for referrals to specialist/ancillary providers.

Section 8: Claim & Encounter Data

Unless otherwise stated in this Manual, PHC follows Medi-Cal guidelines for claims processing and payment. These guidelines are contained in the Medi-Cal Provider Manual.

As required by Assembly Bill 1455, the Department of Managed Health Care (DMHC) has set forth regulations establishing certain claims settlement practices and the process for resolving claims disputes for managed care products regulated by the DMHC.

This section describes PHC of California's (PHC) requirements for provider claims settlement practices and provider disputes applicable to claims with dates of service on or after January 1, 2004.

Claim Definitions

Clean Claim — a "clean claim" is defined as a claim for services submitted by a practitioner that is complete and includes all information reasonably required by PHC, and as to which request for payment there is no material issue regarding PHC's obligation to pay under the terms of a managed care plan.

Timely Filing Limit — the claim's "Timely Filing Limit" is defined as the calendar day period between the claim's last date of service, or payment/denial by the primary payer, and the date by which PHC must first receive the claim.

Received Date — the "Received Date" is the oldest PHC date stamp on the claim. Acceptable date stamps include any of the following:

- PHC Claims department date stamp,
- Primary payer claim payment/denial date

Initial Claim Submission

Claims for services provided to members assigned to PHC must be submitted on the appropriate billing form (CMS1500, UB04, etc.) within six (6) months following the month in which services were rendered, or as stated in the written service agreement with PHC.

The provider is responsible to submit all claims to PHC within the specified timely filing limit. PHC may deny any claim billed by the provider that is not received within the specified timely filing limit.

Claims submitted within 7-9 months following the month in which services were

rendered will be paid at 75% of amounts due if timely submitted. Claims submitted within 10-12 months from the last day of the month of service are paid at 50% of amounts due if timely submitted. If a claim is denied for non-timely filing but the provider can demonstrate "good cause for delay" through the Provider Dispute and Resolution process, PHC will accept and adjudicate the claim.

The following information must be included on every claim:

1. Provider name
2. Provider address
3. Member Name
4. Date of birth
5. Member ID- (i.e.) HIC or MBI
6. Date(s) of service
7. All ICD-10 diagnosis code(s) present upon visit
8. Revenue, CPT, HCPCS code for service or item provided
9. Billed charges for services provided
10. Place of service or UB04 bill type code
11. Tax ID number
12. NPI number
13. Name and state license number of rendering provider

Claims that do not meet the criteria described above will be returned to the provider indicating the necessary information that is missing. PHC will process only legible claims received on the proper claim form that contains the essential data elements described above. Electronic submission of claim forms is strongly encouraged for accurate processing and efficiency.

Only current standard procedural terminology is acceptable for reimbursement per the following coding manuals:

- Current Procedural Terminology (CPT) for physician procedural terminology
- International Classification of Diseases (ICD-10-CM) for diagnostic coding
- Health Care Procedure Coding System (HCPCS)

CMS-1500 paper claim submissions must be submitted on form OMB-0938-0999(08-05) as noted on the document's footer. The Plan accepts the revised CMS-1500 and UB-04 forms printed in Flint OCR Red, J6983, (or exact match) ink.

Claims Documentation

To ensure timely claim processing, PHC requires that adequate and appropriate documentation be submitted with each claim filed. Documentation required with a

CMS1500 or UB04 claim form:

Documentation	Applies to
Other coverage explanation of benefits	All Providers
Dialysis log	Dialysis Service
Doctor's orders, nursing or therapy notes	Home Health
Full medical record with discharge summary	Hospital
Consult, procedures report	Physician
Emergency room report	Emergency Medicine Physician
Operative report	Surgeon
Minimum Data Set (MDS) Assessment	Skilled Nursing Facility

Providers who are billing PHC must follow these guidelines.
The following information must be included on every inpatient UB04 claim:

- Patient name, identification number, and date of birth. If subscriber is different from patient, also include subscriber name and identification number
- Provider name and address
- Bill Type
- Tax identification number (Box 5)
- Provider's Medi-Cal identification number (Box 51)
- Accommodation codes (Revenue Codes)
- Attending provider name and Medi-Cal identification number/State License number (Box 82)
- Date(s) of service
- Admit Type (Box 19)
- Discharge Status (Box 22)
- ICD-10
- Principal procedure code(s) (Box 80-81)
- Authorization number (Box 63)

Standard Code Sets

Standard Code Sets as required by HIPAA are the codes used to identify specific diagnosis and clinical procedures on claims and encounter forms. All providers are required to submit claims and encounters using current HIPPA compliant codes which include the standard CMS codes for ICD-10, CPT, HCPCS, NDC, and CDT, as appropriate.

Claims Processing

PHC will return incomplete claims within fifteen (15) working days of receipt. A Provider may call the Claims Dept. at (888) 662-0626 to determine whether a claim has been

received. PHC will reimburse each complete claim or portion thereof according to the agreed upon contract or prior authorized rate no later than forty-five (45) working days after receipt unless the claim is contested or denied. If a claim is contested or denied, the provider will receive a written determination stating the reasons for this status no later than forty-five (45) working days after receipt.

PHC will adjudicate complete claims, which is a claim or portion of a claim that provides reasonably relevant information or information necessary to determine payer liability and that may vary with the type of service or provider. PHC may require additional information from a provider where the plan has reasonable grounds for suspecting fraud, misrepresentations or unfair billing practices.

Claims will be submitted to PHC with the appropriate documentation. The requirements for documentation are designed to streamline the claims payment process. Submission of complete, timely claims allows the payer to process the claims with a minimum of manual handling.

Claims Submission Address:

Attn: Claims
PHC California
P.O. Box 7490
La Verne, CA 91750

Claim Receipt Verification

For verification of claims receipt by PHC, please contact:

PHC Claims Department
(888) 662-0626

Provider Disputes

A Provider Dispute is defined as a written notice prepared by a provider that:

- Challenges, appeals, or requests reconsideration of a claim that has been denied, adjusted or contested.
- Challenges a request for reimbursement for an overpayment of a claim
- Seeks resolution of a billing determination or other contractual dispute

For claims with dates of service on or after January 1, 2004, all provider disputes require the submission of a Provider Dispute Resolution Request which serves as a written first level appeal by the provider. For paper submission, PHC will acknowledge the receipt of the dispute within fifteen (15) working days and within two (2) days for electronic

submissions. If additional information is needed from the provider, PHC has forty-five (45) working days to request necessary additional information. Once notified in writing, the provider has thirty (30) working days to submit additional information or the claim dispute will be closed by PHC.

Providers may initiate a first level appeal by submitting and completing a Provider Dispute Resolution Request within three hundred and sixty-five (365) days from the last date of action on the issue. The written dispute form must include the provider name, identification number, contact information, date of service, claim number, and explanation for the dispute. In addition, the following documentation is required to review and process a claims appeal:

Provider Dispute Resolution Request

- A copy of the original claim(s)
- A copy of the disposition of the original claim(s) in the form of the Explanation of Benefit or Remittance Advice
- Documented reason for appeal
- A copy of the medical record/progress notes to support the appeal, when requested Provider Disputes and supporting documentation (via paper) should be submitted to:

Attn: Claims
PHC California
P.O. Box 7490
La Verne, CA 91750

The Provider Dispute Resolution Request information can be found in the exhibits at the end of this chapter and on our website at **www.positivehealth care.org**

If you need further information related to claims processing and provider disputes please contact PHC at (323) 436-5038.

Submission of Provider Inquiry Requests

Please use the Provider Inquiry Request Form for routine claim or payment follow-up and to resubmit claims contested with missing information, mailing them to:

Attn: Claims
PHC California
P.O. Box 7490
La Verne, CA 91750

Contracted provider disputes involving an issue of medical necessity or utilization review shall have an unconditional right for a secondary level of appeal if filed within 60 working days from the last date of determination.

Prohibition of Billing Plan Members

A provider or its agent, trustee, assignee, or any subcontractor rendering covered medical services to Plan Members may not bill, charge, collect a deposit or other sum; or seek compensation, remuneration or reimbursement from, or maintain any action at law or have any other recourse against, or make any surcharge upon, a Plan Member or other person acting on a Plan Member's behalf to collect sums owed by Plan.

Should PHC FL receive notice of any surcharge upon a Plan Member, the Plan shall take appropriate action including but not limited to terminating the provider agreement for cause. The Plan will require that the provider give the Plan Member an immediate refund of such surcharge.

Your agreement with PHC Florida requires providers to accept payment directly from the health plan. Payment from the health plan constitutes payment in full, with the exception of applicable co-payments and any other amounts listed as member responsibility on the Explanation of Benefits/Provider Remittance Advice.

This means providers cannot bill PHC Florida members for:

- The difference between actual charges and the contracted reimbursement amount
- Services denied due to timely filing requirements
- Covered services for which a claim has been returned and denied for lack of information
- Remaining or denied charges for those services where the provider fails to notify the health plan of a service that required prior authorization – payment for that service will be denied
- Covered services that were not medically necessary, in the judgment of the health plan, unless prior to rendering the service the provider obtains the member's informed written consent and the member receives information that he/she will be financially responsible for the specific services

Overpayment of Claims

If PHC determines that a claim was overpaid, then PHC will notify the provider in writing within three hundred and sixty-five (365) calendar days of the date of payment.

Notification of an overpaid claim to the provider requires the following information: member name and ID number date of service, and an explanation why PHC believes the claim was overpaid. The provider has thirty (30) working days to dispute an overpayment notification, which then becomes a provider dispute and follows the applicable procedures listed above under **Provider Disputes.**

Timely Claims Processing

Claim payments will be made to providers in accordance with the timeliness provisions set forth in the Provider's contract and/or by the Department of Managed Health Care.

Unless the Subcontracting Provider and Contractor have agreed in writing to an alternate payment schedule, ninety percent (90%) of "clean" claims will be adjudicated within thirty (30) calendar days of receipt. A "clean" claim is one that may be processed without obtaining additional information from the Provider of service or from a third party. However, "clean" claims do not include claims under investigation for fraud or abuse, or claims under review for medical necessity. All claims submitted for which no further written documentation or substantiation is required are to be processed within forty-five (45) working days of receipt.

Coordination of Benefits

PHC has the liability for payment of authorized claims after all other third parties. Private insurance carriers, including Medicare, must be billed by the Provider prior to billing PHC. The Provider must include a copy of the other insurance's explanation of benefits (EOB) with the claim.

Proof of third party billing is not required for:

- Services provided to Members with Other Health Coverage (OHC) codes A, M, X, Y and Z
- Services defined by DHCS as prenatal or preventive pediatric services
- Child-support enforcement cases

Third-Party Tort Liability

PHC must identify and notify the California Department of Health Services within ten (10) days of the discovery of cases in which action by the member involving the tort or Worker's Compensation liability of a third party could result in recovery by the member of funds to which the Department has lien rights.

PHC must be notified in writing of all potential and confirmed third party tort liability cases that involve a PHC Medi-Cal Member. Notification must include:

- Member name
- Member identification number and Medi-Cal number
- Date of birth
- Provider name and address
- Date(s) of service
- ICD10 code and/or description of injury
- CPT code and description of service(s) rendered
- Billed charges for service(s), Any amount paid by other coverage (if applicable)
- Date of denial and reason(s) for denial

Any requests received by subpoena from attorneys, insurers or members for bill copies must be reported to PHC. Copies of the request and responses must be forwarded to PHC.

Notification and information should be sent to the following addresses:

Attn: Third Party Liability
PHC California
1001 N Martel Ave
Los Angeles, CA 90046

When PHC receives a request for information from the Department of Health Services (DHCS) on an individual case, a response is required within ten (10) to thirty (30) days of the DHCS request. PHC will be contacting the Provider of service for assistance if needed. The information requested must be returned within ten (10) days.

All claims for services rendered in relation to a third-party tort liability case should be submitted for processing as described in the "Claims Submission" section of this Manual. The claims will follow normal processing guidelines.

Claims Auditing: Fee-For-Service Providers

To verify the accuracy of fee-for-service provider billings, a PHC representative will conduct random provider audits.

A sample of claims paid will be pulled and verified against the member's medical record maintained by the Provider. This audit may occur in the Provider's office or in the offices of PHC. Where the billing substantially differs from the medical record, the information will be forwarded to the Claims Manager for follow-up and/or screening for fraud and abuse, with subsequent reporting to the DHCS.

Encounter Reporting (Capitated Providers)

The collection of encounter data is vital to PHC. Encounter data provides the Plan with information regarding all services provided to our membership. Encounter data serves several critical needs. It provides:

- Information on the utilization of services
- Information for use in HEDIS and other quality management studies
- Information that fulfills state reporting requirements

DHCS has implemented standards for the consistent and timely submission of Medi-Cal encounter data.

PHC is required to submit encounter information to DHCS within ninety (90) days following the date of service. To meet this requirement, Providers must submit this information to PHC sixty (60) days from date services were rendered. This allows PHC thirty (30) days to process the information prior to submission to DHCS.

Encounter Data Policy

PHC requires all Providers to submit encounter data reflecting the care and services provided to our members. This policy applies to all Primary care Practitioners (PCPs), contracted with PHC. It is important to note the encounter data must also reflect services provided by any ancillary personnel that are under the direction of the PCP, including any physicians (specialists) providing care and services to our patients as defined in their contract with PHC.

Encounter Data Procedure

Single encounter (for our purposes) is defined as all services performed by a single Provider on a single date of service for an individual member.

The following guidelines are provided to assist our Providers with submission of complete encounter data:

- Reporting of services must be done on a per member, per visit basis
- A reporting of all services rendered by date must be submitted to PHC
- Encounter Data must reflect all the same data elements required under a fee for service program
- All encounter data reporting is subject to, and must be in full compliance with, the Health Insurance Portability and Accountability Act (HIPAA) and any other regulatory reporting requirements

Important Submission Information

- Encounter data for all Medi-Cal capitated services must be submitted only on a

CMS1500 form.

- Hard Copy encounter data must be received by the fifth (5^{th}) day of the second month following the encounter (e.g., by September 5th for all encounters occurring in July). Threshold Requirement 151.8 encounters per one thousand (1000) members per month. Twenty percent (20%) of CHDP submissions will be applied towards the threshold.

All hard copy encounter data must be submitted to the following address:

Attn: Claims
PHC California
P.O. Box 7490
La Verne, CA 91750

Sanctions

Providers will be sanctioned for non-compliance. These sanctions may include ineligibility for the encounter incentive program, freezing new enrollment, capitation withhold, and/or ultimately terminating the capitation contract.

Section 9 • Credentialing & Recredentialing

Credentialing

AIDS Healthcare Foundation ensures the provision of superior health care to the community and for people living with HIV/AIDS. This is accomplished with a well-defined credentialing and recredentialing program for evaluating and selecting practitioners and health care delivery organizations to provide medical care and treatment. The Credentialing scope includes the following covered program and services (as applicable)

Specifically, the program provides for the following:

- Direct credentialing and recredentialing activities to ensure quality care for people living with HIV/AIDS. Review all new applicant practitioner credentials prior to full participation using established criteria.
- Obtain meaningful advice and expertise from participating practitioners for credentialing decisions. Review of credentials for practitioners who do not meet established thresholds.
- Use a peer-review process to make recommendations regarding credentialing decisions. Approve or deny participation of all practitioners and institutional and ancillary providers.
- Review delegated credentialing documentation of provider groups, institutional or ancillary, including pre-delegation audit results.
- Conduct peer review clinical cases of potential quality of care to determine the need for disciplinary action.
- At least annual review of Credentialing and Peer Review policies and procedures.
- Monitor compliance with regulatory, accreditation and contractual requirements.

Through the credentialing and recredentialing program, AHF ensures that the network consists of quality practitioners who meet clearly defined criteria and standards. The credentialing and recredentialing program was developed in accordance with the health plan standards of the National Committee for Quality Assurance (NCQA) and Accreditation Association for Ambulatory Health Care (AAAHC) and relevant federal and state requirements. The credentialing program is reviewed annually and revised and updated as needed.

The decision to accept or deny a credentialing applicant is based on the following criteria:

- Primary source verification
- Recommendation of peer practitioners
- Additional information as required.

The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law.

Initial Credentialing

At the time of initial credentialing, the applicant must complete a Practitioner Application and any applicable attachments to the application. The application must be completed in its entirety, including a current and signed attestation signed by the applicant within three hundred and sixty-five (365) calendar days of the credentialing decision. A signature stamp or date stamp is not acceptable on the attestation. The attestation must include:

- Reason for any inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary action
- Current malpractice insurance coverage and
- The correctness and completeness of the application

The completed application will be processed upon submission. If the application has not been signed or if information provided on the application is incomplete, the practitioner will be notified in writing and the missing information will be requested. If the practitioner does not provide the information in the time period requested, he/she will be deemed to have withdrawn his/her application for participation.

If the signature attestation will be older than three hundred and sixty-five (365) calendar days at the time of the credentialing decision, the practitioner is required to update the attestation. A copy of the completed application with a new attestation form will be sent when requesting the practitioner update the attestation.

Practitioners are not eligible to apply for participation if:

- There are potential actions pending against their License by any state agency in the United States that disciplines practitioners (e.g. Statement of Chargers)
- Licensure is currently suspended, restricted, reduced, limited, sanctioned and/or on probation by any state agency in the United States that disciplines practitioners.
- Practitioner is currently censured or excluded (e.g. suspended or disqualified) by - Medicare/Medi-Cal or have an invalid National Provider Identifier (NPI) number.

An additional attestation regarding HIV/AIDS CME and qualifications is required. AIDS Healthcare Foundation has qualifications for HIV/AIDS Specialist, which are verified at the

time of credentialing and recredentialing. For California providers, AHF requires the completion of the *AHF / PHC California Designation of HIV specialist Attestation* on an annual basis. Providers who specialize in HIV/AIDS may be listed as an HIV/AIDS Specialist in California if s/he meets specific criteria in Section 1374.16 of Standard Referral to HIV/AIDS Specialist Act. This Act provides the qualifications for Specialist designation. AHF Credentialing Department submits the approved qualified practitioners list to the Provider Relations Department and the Quality Management Committee. Provider Relations shares the list with Utilization Management and the Medical Executive Committee.

Delegation of Credentialing

Organizations that are in compliance with state credentialing regulations, AAAHC and NCQA credentialing standards are welcome to apply for delegated status. Following submission and review of related policies and procedures, an on-site visit or a desk top review is made to audit credential files. Subsequent to the audit, a report is made to the PHC Credentials Committee, which makes the final decision about delegation approvals and denials.

If the Provider is a member of a contracted group that is delegated for credentialing, please be aware that the credentialing/re-credentialing accountability guidelines and operational procedures will be relatively unchanged from those described below.

Provider's Participation in the Process

An applicant, whether being credentialed or re-credentialed, has the burden of producing adequate information for a proper evaluation of experience, background, training, demonstrated ability, and ability to perform as a Provider, without limitation, including physical and mental health status as allowed by law and the burden of resolving any doubts about these or any other qualifications to be a PHC provider. Should an application be incomplete in any way, a fax will be sent from PHC requesting the need for information. In order to keep an application on active status, the provider will be asked to provide the needed information by a specified time. Failure to provide the information within the required time will result in administrative termination from the PHC network as a non-compliant provider. Note: All Providers must be in good standing with the Medicare and Medi-Cal programs.

Once appointed, subsequent review of credentials for re-credentialing will be performed no less than every three (3) years. A re-credentialing application and release form will be sent approximately six (6) months before your credentialing period is to expire. Again, the format used is that of a "universal reapplication" and only information that may have changed since the last credentialing will be requested. In fact, the reapplication will be

populated with information from the previous credentialing cycle.

Physician Facility Reviews: Facility Site Reviews (FSR) & Medical Record Review (MRR)

The review and certification of Primary Care Practitioner (PCP) sites is a requirement of the California Department of Health Services (DHCS) which mandates that all PCP sites or facilities rendering services to Medi-Cal eligible patients must be certified. Facility Site Reviews and Medical Record Review are required for PCPs and OB-GYN specialists upon initial credentialing and re-credentialing. A review of office sites that are accessible to PHC members will be scheduled as soon as the credentialing application is received by the Credentialing and Provider Relations Departments. A score of ninety percent (90%) or higher is required for submission of a completed application to the Credentials Committee. Cooperation in working with the QI Facility Site Review Nurse on resolving any corrective action plans quickly will facilitate a credentialing decision.

A PCP is defined as a General Practitioner; a Family Practitioner; an Internist; an OB/GYN who requests PCP status; or, a Pediatrician who, by contract, agrees to accept responsibility for primary medical care services. PHC will remain the primary responsible party for the facility review activities and monitoring of all Medi-Cal PCP Sites.

An OB-GYN specialist, or any other kind of specialist requesting designation as a PCP, will be requested to review a scope of services document that requires signed commitment to provide the services required of a PHC PCP. Also required is documentation of, general medical training or experience, liability insurance coverage for general medicine, hospital privileges in general medicine or an agreement with a PHC PCP who can admit medical patients, and, back- up coverage by a practitioner qualified to treat general medical conditions.

PHC will assure that facility reviews are part of the credentialing process to be completed on 100% of all PHC PCPs and OB/GYNs, in compliance with the Department of Health Services (DHCS). For more information on FSR's, please see Section 22 on the Quality Improvement Program.

Verification of Application Information

The Credentialing and Provider Relations Departments, or its agent, will verify at least the following information from primary sources:

- Current, valid license to practice
- Other certifications appropriate to the services offered by the Provider
- Current, valid Drug Enforcement Administration (DEA) registration or Controlled

Dangerous Substances (CDS) certification
- Board certification or education from highest level of learning, the latter on initial credentialing only
- Professional liability claims history for the last seven (7) years on initial credentialing and two (2) years, if applicable, on re-credentialing

Practitioner Education and Training:
- Graduation from the appropriate professional school is verified through the appropriate licensing Board or directly with the educational source. Completion of residency or specialty/sub- specialty training is verified through the appropriate Board Certification body; directly with the specialty/sub-specialty-training program; or through the American Medical Association for physicians.

The following information is verified or attested to from the CPPA:
- Clinical privileges, in good standing, at the hospital designated by the physician as his or her primary admitting facility, as applicable and agreed to in the physician's contract
- Current, adequate malpractice liability coverage according to PHC's policy (coverage of one million per occurrence and three million aggregate are required)

The Medical Staff/Credentialing Department will also:
- Identify any disciplinary actions and/or sanctions.
- Query the National Practitioner Data Bank.

Should any information gathered during the verification process differ substantially from the information provided, the Practitioner will be notified and the Provider's "rights process" will be initiated. This process is explained on the "Notice to Practitioners of Credentialing Rights/Responsibilities" that accompanies the credentialing/re-credentialing application.

Credentialing Committee Review

PHC maintains a Credentialing Committee chaired by the Medical Director and made up of your peers. The Committee is required to meet no less than bi monthly, but can meet on a monthly basis to facilitate timely processing of applicant files.

Once the credentials file contains all the necessary information, verifications and facility site review findings, it will be reviewed by the Credentialing Committee. If the Credentialing Committee determines that further information is necessary to evaluate an application, the Credentialing and Provider Relations Departments will request any such information on behalf of the Credentialing Committee. The Credentialing Committee

may, in its sole discretion, request an in-person interview.

Credentials Committee Recommendation

The Governing Board receives recommendations to either approve or deny applicants from the Credentialing Committee. Once acknowledged, the Credentialing Committee notifies applicants of its decision.

Ongoing Monitoring of Sanctions, Complaints, Adverse Events and Quality Issues

Practitioner sanctions, complaints, grievances, adverse events and other potential quality of care issues are monitored between recredentialing cycles and appropriate action is taken against practitioners when occurrences of poor quality are identified. Information obtained during the ongoing monitoring process is always included in the practitioner's credentials file and is also evaluated at the time of recredentialing. The list of entities below is queried for sanctions, complaints, grievances, adverse events and other potential issues:

- Office of Inspector General-List of Excluded Individuals Entities
- Medi-Cal Provider Suspended and Ineligible List
- SAM- System For Award Management

Medicare and Medicaid Sanctions

The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program releases a monthly report identifying individuals and entities excluded from Medicare and Medicaid programs. This report is reviewed within 30 calendar days of its release. If it is determined that a participating practitioner or health care delivery organization (HDO) is on the exclusion report, the practitioner or HDO contract with AHF / PHC will be immediately terminated.

Medi-Cal Provider Suspended and Ineligible List

Medi-Cal law, *Welfare and Institutions Code* (W&I Code), sections 14043.6 and 14123, mandate that the Department of Health Care Services (DHCS) suspend a Medi-Cal provider of health care services (provider) from participation in the Medi-Cal program when the individual or entity has:

- Been convicted of a felony;

- Been convicted of a misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service;

- Been suspended from the federal Medicare or Medicaid programs for any reason;
- Lost or surrendered a license, certificate, or approval to provide health care; or
- Breached a contractual agreement with the Department that explicitly specifies inclusion on this list as a consequence of the breach.

The Medi-Cal Provider Suspended and Ineligible List are reviewed within thirty (30) calendar days of its release. If it is determined that a participating practitioner or health care delivery organization (HDO) is on the Suspended and Ineligible list, the Credentialing department will notify Provider Relations immediately and Provider Relations will terminate the contract of the practitioner or HDO immediately. Credentialing will forward this information to the next credentialing committee meeting for informational purpose. AHF will notify the Medi-Cal Managed Care Program/Program Integrity Unit within ten (10) State working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in AHF network.

AHF Medi-Cal Screening and Enrollment Process of All Network Providers

AHF will screen and enroll network providers in a manner that is substantively equivalent to DHCS' provider enrollment process. However, AHF may also rely on the enrollment and screening results conducted by DHCS or other Medi-Cal Managed Care Health Plans (MCPs). AHF will access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal FFS providers. MCPs are required to issue network providers a "verification of enrollment" that AHF can rely on to prevent enrollment duplication. MCPs may collaborate with each other to share provider screening and enrollment results. AHF is not required to enroll providers that are providing services pursuant to temporary Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis.

AHF Enrollment Processes

If the Medi-Cal Managed Care Health Plan elects to enroll a provider, AHF will comply with the following processes: AHF will ensure that all the appropriate information, data elements, and supporting documentation required for each provider type is collected. In addition, AHF will ensure that every network provider application they process is reviewed for both accuracy and completeness. AHF will ensure that all information specified in Title 22, California Code of Regulations (CCR), including but not limited to, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60, including all required submittals and attachments to the application package have been received. AHF must obtain the provider's consent in order for DHCS and the MCP to share information

relating to the provider's application and eligibility, including but not limited to issues related to program integrity.

Corrective Action, Fair Hearing Plan, and Reporting to the Medical Board of California and the National Practitioner Data Bank

Practitioners have a procedural right to appeal in the event that peer review recommendations and actions result in filing a report to the Medical Board of California (MBOC) and the National Practitioner Data Bank (NPDB). The appeal right, the Fair Hearing Process, and the requirement to report to the MBOC and NPDB are described in PHC Policy CR 2.0. Copies of these policies and procedures will be mailed as an enclosure to the Credentials Committee letter advising you of initial approval status.

Recredentialing Requirements

In addition to verifying that Providers continue to meet the basic qualification set forth in PHC CR 1.2, Practitioner/Provider Credentialing and Re-credentialing-Basic Qualifications for Provider Status, and the following information will be reviewed as part of the re-credentialing process:

- Results of quality reviews. The Quality Management staff will complete a Provider profile for all Providers, gathering information from reported quality performance issues, utilization management performance, member satisfaction surveys, and non-administrative member services reports. Findings will be sent to the Credentialing and Provider Relations Departments for inclusion in the credentialing profile and for the consideration of the Credentials Committee.
- Utilization management issues. PHC staff will review each Provider's UM profile for acceptability of performance and for compliance with UM requirements. Findings will be forwarded to the Quality Management Department for inclusion in the Provider re-credentialing profile.
- Satisfaction surveys and Member Grievances/Complaints. Member Services will report quarterly to the Credentialing and Provider Relations Departments each Provider who has been identified through member grievances/complaints and member satisfaction surveys as having deficiencies in the area of customer service.

Practitioners Credentialing Rights/Responsibilities Right of Review

As an applicant for credentialing/re-credentialing, you have a right to review non-privileged information obtained for the purpose of evaluating your application. This includes information obtained from outside sources such as liability insurance carriers, Medical Boards, National Practitioner Data Bank. It does not include review of information that is privileged, such as references or recommendations that are protected by law from disclosure.

You may request to review such information at any time by sending a written request, via fax or letter, to:

Director of Credentialing
1001 N Martel Ave
Los Angeles, CA 90046
Fax number (888) 235-8256

Following receipt of your request, you will be contacted by the Director, or his/her designee, within three working days in order to arrange a date and time for review of the information in the PHC Credentialing Department located in Los Angeles.

Notification of Discrepancy

You will be notified in writing, by fax or email, when information obtained by primary sources varies significantly from information provided on your application. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

If you believe that erroneous information has been supplied to PHC by primary sources, you may correct such information by submitting written notification to the Director of Credentialing department at the above cited address/fax number. Your notification, via letter or fax, must include a detailed explanation of the discrepancy and must be returned to PHC within three (3) working days of your credentials file review date and/or the date that PHC notified you of the discrepancy.

Upon receipt of your notification, PHC will re-verify the primary source information under consideration. If the primary source information has changed, an immediate correction will be made to your credentials file. You will be notified of this action. If the primary source information remains inconsistent with your notification, you will be advised of same through letter or fax. You will be requested to provide proof of correction by the primary source to Credentialing department of PHC via letter or fax as cited above within ten (10) working days. Subsequently, a second re-verification of primary source information will be performed by PHC. If, after ten (10) working days, primary source information remains inconsistent and in dispute, you will be subject to adverse action up to administrative termination from the PHC Network

Physician Facility Reviews: Facility Site Reviews (FSR)

The review and certification of Primary Care Practitioner (PCP) sites is a requirement of

the California Department of Health Services under Title 22, California Code of Regulations, Section 53230. This section mandates that all PCP sites or facilities rendering services to Medi-Cal eligible patients must be certified. Additionally, site review and certification is a standard for accreditation set forth by the National Committee for Quality Assurance (NCQA).

A PCP is defined as a General Practitioner; a Family Practitioner; an Internist; an OB/GYN who requests PCP status; or, a Pediatrician who, by contract, agrees to accept responsibility for primary medical care services. PHC will remain the primary responsible party for the facility review activities and monitoring of all Medi-Cal PCP Sites.

Section 10: Provider Services

Contracting and Provider Relations Department

The Contracting and Provider Relations Department is dedicated to working with you and your staff to educate, train, and ensure that you have a positive experience working with both PHC members and the PHC health plan. Provider Relations is also here to assist you with any questions or concerns you have in your participation with the Plan.

The Provider Relations Department acts as the liaison between PHC departments and the external provider network to promote positive communication, conduct orientations, facilitate exchange of information, and to seek efficient resolution of provider issues. Please send all requests to your Provider Relations Representative, as your Provider Relations Representative is your primary source of information.

We encourage you to make recommendations and suggestions to better serve our members and to improve the processes within our organization.

Provider Manual

A Provider Manual is available to all newly contracted providers upon execution of an agreement with PHC, and can be requested by any contracted provider at any time. It is periodically reviewed and updated as content changes.

Provider Orientations/In-Services

Orientations are conducted by the Provider Relations Representative to educate new providers on plan operations, policies and procedures within ten (10) working days of contracting with PHC. If, as a new provider, you are unable to schedule your training within the ten (10)day period, as required by DHCS, your training will be scheduled at a more convenient time, but your contract with PHC will not become effective until your orientation is completed. Failure to complete your required training within thirty (30) days may result in suspension of the PHC product. It is critical that you make time for the training DHCS requires.

Periodically, and as needed, Provider Relations will share training, education, and pertinent required information with providers using a variety of media, including Blastfax, web posting, provider bulletins, newsletters or mailings.

Existing providers may also request additional training by scheduling an in-service with a Provider Relations Department team member.

Provider Orientations/In-Services include the review of the following information:

- Enrollment & Eligibility
- Member Benefits
- Access Standards
- Referral Submission, Referral Status, STAT/Urgent Requests
- Claim Submission, Claim Status, Provider Disputes
- Provider Relations Contacts
- Health Education

Provider Rights

Providers who treat PHC members have the right to:

- Be informed of participating contractual obligations placed on the provider by the Health plan and the sponsoring government agency.
- File a grievance or complaint about the program and/or any associated functions of the Health plan.
- An overview of the PHC and AIDS Healthcare Foundation.
- Contact information for Plan departments.
- Give feedback on the program, including participation in any activity soliciting provider input or feedback as to provider satisfaction and/or Plan performance surveys.
- Receive current HIV/AIDS treatment guidelines from nationally accepted sources.
- View applicable assessments and plans of care upon request.
- Member information obtained through the program in the coordination of disease management services for clinical decisions, as applicable.
- Respectful and courteous interactions with Health plan staff.

Collaboration with other HIV/AIDS primary care providers and specialists who work with the Health plan for support when interacting with their patients to make decisions about their healthcare.

Provider Directory

The PHC Provider Directory is updated monthly. It is available to enrollees in print and though the PHC California website at www.phc-ca.org/provider-find. The directory is solely used as a member handbook referencing participation to primary care physicians, hospitals, specialty care physicians, ancillary providers and vision providers.

All providers are responsible for reviewing their information in the directory and submitting any changes to PHC California's Contracting and Provider Relations

Department. Providers may also review information on the PHC California website at www.phc-ca.org/provider-find. PHC California is committed to ensuring the integrity of the directory. The Contracting and Provider Relations Department will periodically contact your office to validate your information that is listed in the directory. Contracted providers are required to respond to the plan's request for verification pursuant to Section 1367.27 of the California Health and Safety Code.

Provider Validation Activities

In addition to verifying provider data, DHCS also requires additional verification/validation of provider information. Every effort is made to make these activities as easy for providers as possible. Such activities include capturing data required by the State for your practice, access and availability for members to obtain routine and urgent appointments, wait times, speed of answer of your office phones, etc. These calls will be as brief as possible but we may also send surveys or ask to come to your office to make inspections of your office for compliance with ADA measures and ensure members can safely and comfortably be treated in your office.

Specialty Provider Network Oversight

PHC monitors the specialty network to identify deficiencies in the provider network service areas. All efforts to obtain specialist contracts to complete specialty network gaps and ensure PHC members have access to all required specialties. If you find that specialists you work with regularly are not in the PHC network we encourage you to let us know or have referral specialists call us so we can discuss contracting. It is our commitment to have the best referral network available to our members and providers.

Provider Network Changes

All provider changes should be submitted in writing to PHC's Provider Relations Department sixty (60) days in advance for the following:

- Terminations
- Office relocations
- Leave of absence or vacation
- Tax Identification Number or other billing change

Provider Terminations

- Provider must send written notification sixty (60)-days in advance of a withdrawal or termination. Termination dates are determined by your contract.
- For continuity of care, PHC reserves the right to obligate the provider to provide medical services for existing members until the effective date of termination according to the terms of your contract with PHC.

- PHC is responsible for transitioning member care for all terminated providers.

Office Relocations

- Primary Care Providers changing office locations require a Facility Site Review. Once the site is approved, the provider's address is updated and members are transferred to the existing site. If the PCP moves outside of the former office's geographic area, PHC will reassign the members to a new PCP within the access standard of ten (10) miles.
- Written notification must also be submitted to PHC's Provider Relations Department for all telephone and fax number changes.

Provider Leave of Absence or Vacation

- PCPs must provide adequate coverage for providers on leave of absence or on vacation. Absences over ninety (90) days require transfer of members to another PHC PCP.
- Specialist must provide a written notification to PHC's Provider Relations Department for absences over thirty (30) days.

Section 11: Grievances & Appeals

This section addresses the identification, review, and resolution process for four distinct topics:

- Provider Appeal (related to an authorization determination)
- Provider Disputes-AB 1455 (related to provider claims appeals)
- Member Appeals (related to an authorization determination)
- Member Grievances

Provider Grievances or Complaints - the Appeal Process

A provider grievance or complaint is described in Title 22, California Code of Regulations (CCR), as a written entry in to the appeals process. PHC maintains two types of appeals:

- Appeals regarding non- payment or
- Processing of claims, known as provider disputes.

A provider of medical services may submit an appeal concerning the modification or denial of a requested service or the payment processing or non-payment of a claim by the Plan. PHC will comply with the requirements specified in Section 56262, of Title 22 of the CCR, and the DMHC Assembly Bill 1455 Provider Disputes/Claims Appeals.

Provider Appeals Regarding Modifications or Denial of a Service Request.

The provider appeal process offers recourse for practitioners who are dissatisfied with a denial or decision form PHC. There are two types of appeals-provider disputes and appeals for prior authorization denials.

The initial appeal is considered to be a First Level appeal. If the disputed denial is upheld during the First Level appeal, a final or Second Level appeal may be requested from the Department of Health Services, State of California. No punitive action will be taken against a provider who supports a member's appeal or denial or delay of services.

Provider Disputes (AB 1455)

A provider dispute is defined as a written notice prepared by a provider that:

- Challenges, appeals, or requests reconsideration of a claim that has been denied, adjusted or contested.
- Challenges PHC's request for reimbursement for an over-payment of a claim.
- Seeks resolution of a billing determination or other contractual dispute.

For claims with dates of service after 2004, all provider disputes require the submission of a Provider Dispute Resolution Request Form, which serves as a written first level appeal

by the provider. For paper submission, PHC will acknowledge the receipt of the dispute within fifteen (15) working days and within two days for electronic submissions. If additional information is needed from the provider, PHC has forty-five (45) working days to request necessary additional information. Once notified in writing, the provider has thirty (30) working days to submit additional information or the claim dispute will be closed.

Providers may initiate a first level appeal by submitting and completing a Provider Dispute Resolution Request Form within three hundred and sixty-five (365) days from the last date of action on the issue. The written dispute form must include the provider name, identification number, contact information, date of service, claim number, and explanation for the dispute. In addition, the following documentation is required to review and process a claims appeal:

- Provider Dispute Resolution Request Form
- A copy pf the original claims(s).
- A copy of the disposition of the original claim(s) in the form of the Explanation of Benefit (EOB)
- Documented reason for appeal
- A copy of the medical record/progress notes to support the appeal, when applicable

Provider Disputes and supporting documentation (via paper) should be submitted to:

Attn: Contracting and Provider Relations
PHC California
1001 N Martel Ave
Los Angeles, CA 90046

Balance Billing

PHC prohibits Providers from balance-billing a member when the denial disputed in a First Level or Second Level appeal is upheld. The Provider is expected to adjust off the balance owed if the denial is upheld in the appeals process.

Member Appeals and Grievances

Health plan members, also known as enrollees should file a complaint (also known as an appeal or grievance) if they have a problem with their health plan. A Provider, on behalf of a member, may appeal a Utilization Management decision to deny or modify a requested service. Providers or members can file a complaint with PHC California a few different ways:

- Over the phone
- In writing
- Fax

If the health problem is urgent, if you already filed a complaint with PHC California and are not satisfied with the decision, or it has been more than thirty (30) days since you filed a complaint with PHC California you may submit an Independent Medical Review/Complaint Form with the DMHC.

How to File an Appeal or Grievance

If the Member or Provider on behalf of a member is dissatisfied with an adverse authorization decision or has a grievance, he or she may initiate the appeal/grievance process by telephone, fax or in writing:

Attention: Member Services
PHC California
PO Box 46160
Los Angeles, CA 90046
Phone: (800) 263-0067
Fax: (888) 235-8552

Standard (30-day) and Expedited (72-hour) Appeal Processes

Health plans have thirty (30) days to process a standard appeal. In some cases, members have the right to an expedited, seventy-two (72)-hour appeal. Members can get a faster, expedited appeal if the member's health or ability to function could be seriously harmed by waiting for a standard appeal, which may take up to thirty (30) days. If a member requests an expedited appeal, the health plan will evaluate the member's request and medical condition to determine if the appeal qualifies as an expedited, seventy-two (72)-hour appeal. If not, the appeal will be processed within the standard thirty (30) days. The member and provider will be notified of the downgrade status to a standard appeal process and UM will provide both parties with their rights in regards to adverse benefit determinations.

Standard (30-day) and Expedited (72-hour) Grievance Processes

PHC will provide the member or representative with written notification acknowledging the member grievance within five (5) working days of its receipt unless the issue submitted can be resolved in less than twenty-four (24) hours. The member or representative will be informed in writing of the proposed resolution or outcome of the grievance within thirty (30) days. In instances where an imminent and serious threat of health of a beneficiary, including, but not limited to, severe pain or potential loss of life,

limb or major bodily function that do not involve the appeal of an Adverse Benefit Determination, yet are "urgent" or "expedited" in nature have a timeframe for resolution in seventy-two (72) hours. Grievances can be filed anytime from the date of incident subject to the beneficiary's dissatisfaction.

It is important to note that a member grievance may be a potential quality issue or service issue and PCP's as well as their office staff, should be ready to assist a member with needed information. You must have a grievance form in your office conveniently located for your members. If you need to order grievance forms, please contact Member Services at: 800-263-0067.

Member complaints may include, but are not limited to:

- Excessive waiting time in a Provider's office
- Inappropriate behavior and/or demeanor (PCP's/Office Staff's).
- Denied services. Clinical grievance subject to member/Provider appeal of the UM decision and expedited appeal of the UM decision.
- Inadequacy of the facilities, including appearance.
- Any problem that the member is having with PHC contracted Providers.
- Members billed for covered services.

PHC will investigate member grievances, attempt to resolve the concerns, and take action as appropriate Resolutions and findings are considered confidential and are privileged under California law. A member must not be discriminated against because he/she has filed a member grievance.

Independent Medical Review and Consumer Complaints

If your patient has a health problem that is urgent, if you already filed a complaint with PHC California and are not satisfied with the decision, or it has been more than 30 days since you filed a complaint with PHC California, the patient may submit an Independent Medical Review/Complaint Form with the DMHC. (Please refer to: http://www.dmhc.ca.gov/FileaComplaint/SubmitanIndependentMedicalReviewComplaintForm.aspx)

In most circumstances, the enrollee or representative is required to file a grievance regarding each issue/request with your health plan and participate in the process for thirty (30) days before submitting a complaint to the DMHC. Exceptions to this requirement include when there is an immediate threat to the enrollee's health or the request was denied as experimental/investigational. In either of these instances, you may seek immediate assistance from the DMHC.

An Independent Medical Review (IMR) is a review of the patient's case by independent doctors who are not part of PHC California. The patient has a good chance of receiving the service or treatment he or she needs by requesting an IMR.

If the IMR is decided in the patient's favor, PHC California must authorize the service or treatment the patient requested. IMR's are free to enrollees.

Consumer complaints may also be submitted using the same form. Consumer Complaints include issues such as:

- Balance billing
- Billing for services that PHC California states is not a covered benefit
- Disputes on the amount paid on a claim
- A co-pay dispute
- Cancellation of the enrollee's coverage
- A complaint about the plan or provider's attitude or quality of care

If the person who is submitting the Independent Medical Review/Complaint Form needs help, please call the DMHC Help Center at 1-888-466-2219 or visit https://wpso.dmhc.ca.gov/contactform/.

Urgent Cases for Independent Medical Review

The IMR process allows for exceptions to be made when there is a serious or imminent threat to the patient's health. CIC Section 10169.3(c) states that if the "insured's provider [doctor/medical professional] or the California Department of Insurance (CDI) certifies in writing that an imminent and serious threat to the health of the insured may exist, including but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the insured," the IMR organization must make its determination within three days of receiving the proper case information. Moreover, your insurance company must deliver the necessary information and documents to the IMR organization within twenty-four (24) hours of approval from the CDI of your IMR request.

When the CDI reviews your request for an IMR, the Department may waive the requirement that complainant first go through PHC California's appeals/grievance process when an extraordinary or compelling case exists. The Insurance Commissioner may make exceptions based on the criteria listed in CIC Section 10169.3(c) above and based on the Insurance Commissioner finding that you have acted reasonably in the dispute with your insurance company.

State Fair Hearing

In addition to the grievance processes offered you have the right to request a Fair Hearing from the State of California. Enrollees must exhaust PHC California's internal Appeal process and receive notice that the Adverse Benefit Determination has been upheld prior to proceeding to a State Hearing. If PHC California fails to adhere to the required timeframe when resolving the Appeal, the enrollee is deemed to have exhausted PHC California's internal Appeal process and may request a State Hearing.

You may request a State Fair Hearing by contacting the California Department of Social Services (CDSS) within one hundred and twenty (120) days of the Notice of Appeal Resolution. You may write or call CDSS, toll-free, at any time during the grievance process, at the following address and telephone number:

California Department of Social Services State Hearings Division
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94424-2340
1 (800) 952-5253 (Voice) 1 (800) 952-8349 (TDD)

You have the right to bring someone who knows about your case to attend the hearing with you, if you wish. You may also seek legal counsel to represent you. For more information on obtaining free legal aid, contact CDSS at their toll-free number.

If you are currently receiving a medical service that is going to be reduced or stopped, you may continue to receive the same medical service until the hearing, as long as you request the hearing before the effective date of the action.

Expedited State Fair Hearing

A member may request an Expedited State Hearing by calling, writing, faxing California Department of Social Services State Hearings Division.Expedited Hearing Unit, P.O. Box 944243, Mail Station 9-17-37, Sacramento, CA 94244-2430, Fax: (916) 651-5210 or (916) 651-2789. For a verbal request, call the California Department of Social Services Public Inquiry and Response at (800) 952-5253 (Voice) or (800) 952-8349 (TDD). PHC or your provider must indicate that taking the time for a standard resolution could seriously jeopardize your life or health or ability to attain, maintain or regain maximum function.

When the Expedited Hearing Unit determines that your appeal satisfies the expedited criteria and when all necessary clinical information has been received by the Unit, the expedited hearing will be scheduled. If the criteria are not met, it will be scheduled for a routine State Fair Hearing as described above.

Department of Health Services (DHCS) Assistance

The California Department of Health Services (DHCS) is available to provide assistance in investigating and resolving any complaints or grievances you may have regarding your care and services. If you wish to use the services of the DHCS to address your concerns, complaints, or grievances, please call the Medi-Cal Managed Care Ombudsman toll-free at (888) 452-8609, Monday through Friday, between the hours of 8:00 a.m. and 5:00 p.m. excluding holidays.

State Regulations Available

State regulations, including those covering state hearings, are available at the local office of the county welfare department.

Authorized Representative

Members can represent themselves at the state hearing. They can also be represented by a friend, attorney, or any other person, but are expected to arrange for the representative themselves. Members can get help in locating free legal assistance by calling the toll-free number of Public Inquiry Response Unit (800) 952-5253, (Voice) (800) 952-8349 (TDD).

Further Information

If you have any questions regarding the member grievance process, or if you would like a copy of the Membership Services Guide please call **Member Services at (800) 263-0067, TTY/TDD 711.**

Section 12: Health Education

As providers, you are in the best position to meet the many educational needs of PHC members at the time of their medical visits. You are the most credible educator for your patients.

DHCS Health Education Contract Requirements for Managed Medi-Cal Members

- Member education - preventive and primary care, complementary and alternative care, health education services, and community resources
- Risk-reduction/health promotion - tobacco use and cessation, alcohol and drug use, injury prevention, dental health, Sexually Transmitted Disease (STD), Tuberculosis, Human Immunodeficiency Virus(HIV), and family planning, nutrition, and physical activity
- Patient education - asthma, diabetes, hypertension, pregnancy, and obesity

All education must be documented in the member's medical record. This information should become part of the member's ongoing medical care as all team members can reinforce new behaviors. This documentation also becomes critical in the event of an audit by any regulatory organization.

Health Education supports all contracted Providers by offering the following:

- Written materials in many languages
- Health promotion campaigns
- Direct mailings to members
- Medical Care Management Department referrals for any identified health education needs for either the Provider or an individual member.
- HIV Medication Adherence Program (all ages)

Health Education Resources and Written Patient Education Materials

PHC can assist you in obtaining available materials through your local Child Health and Disability Prevention (CHDP) Program or other public health programs in your community. Additionally, PHC develops and selects patient education materials that are culturally and linguistically appropriate for various target populations in key subject areas. The most appropriate setting for a member to receive written literature is from his or her primary care practitioner (PCP) with a brief discussion. To obtain education materials for your PHC members, please advise our Health Education Dept. All materials are written at the sixth (6th) grade reading level or below to meet literacy needs.

PCP Responsibilities for Health Education

DHCS and PHC require that all Medi-Cal managed-care contract requirements be met for health education.

Individual Health Education Behavioral Risk Assessment

All Providers of managed Medi-Cal members must administer an individual health education behavioral assessment. This must be done with new patients at their Initial Health Assessment and with existing members at their next scheduled non-acute care visit (but no later than their next scheduled health screening visit). PHC has adopted the DHCS-produced "Staying Healthy" Assessment that consists of five (5) specific age categories (0-3 years, 4-8 years, 9-11 years, 12-17 years, and 18 and older).

Assessment is to be completed by members twelve (12) years of age and older and by parents of children eleven (11) years of age and younger while waiting for their medical visit. Providers must review the assessment, provide needed counseling or other intervention, document on the assessment and file in the member's medical record with other continuity of care forms. This assessment is reviewed with the member or parent at least annually and is re-administered when the member enters the next age category. PHC recommends that the adolescents complete the assessment annually as they change behaviors rapidly during this period. (Although the plan currently cannot accept members under the age of twenty–one (21), the discussed assessments would apply if a child were assigned to the plan.)

All completed "Staying Healthy" Assessments for 12-17 year olds should be placed under the "sensitive tab" in the medical record, preventing photocopying should parent/guardian request the record. This precaution protects the confidentiality of the minor's disclosures.

A supply of the "Staying Healthy" Assessment Packages is available from PHC. Call your Provider Relations Representative at 888-726-5411 if you need training on the requirement.

Individual Patient Education and Counseling

Providers, as the most credible educator for members, should provide education relative to individual needs at each patient visit. All education must be documented in the member's medical record.

Appropriate and Timely Health Education Referrals

Members requiring additional education support should be referred to PHC's Care Management Department. All referrals for health education should be documented in the

medical record. All documentation provided by Care Management following the interventions should be filed in the member's medical record. Providers should follow-up with the member on educational referrals at the next scheduled visit and should reinforce key concepts.

Print Materials

All written material provided to a PHC member must be written at the sixth (6th) grade reading level or below. All materials should also be culturally sensitive and appropriate for the member. Call the Care Management Department if you need assistance in meeting this requirement.

Tobacco Cessation

PHC offers a tobacco cessation program, *Quit for Life*, that will help members break both the physical and psychological addiction to cigarettes.

Primary care providers (PCPs) should screen and educate members regarding tobacco cessation by:

- Making members aware of and recognizing dangers of using tobacco products
- Teaching members how to anticipate and avoid temptation
- Provide basic information to the member about tobacco use and successful quitting
- Encourage the member to quit
- Encourage the patient to talk about the quitting process

PCPs should direct members who smoke or desire to quit using tobacco to contact the *Quit for Life* Program:

Call: 1-866-784-8454 (1-866-QUIT-4-LIFE)
Join online: www.quitnow.net/ahf

Instruct the member to tell the operator they are a PHC member. For more information, members can contact Member Services at (800) 263-0067, 8:00 a.m. to 8:00 p.m., seven days a week. TTY users should call 711.

Five Wishes (Advance Care Planning) Workshop

PHC provides an ongoing class, Five Wishes, to all members about advance care planning. The Five Wishes Workshops provide our clients with a safe and informative small group setting to ensure that the documents are completed correctly and completely. Please contact Provider Relations at (888) 726-5411, Monday through Friday,

8:30 a.m. to 5:30 p.m. for more information.

Section 13: Cultural & Linguistic Services

PHC is committed to be respectful of and responsive to the cultural and linguistic needs of our members. The US Department of Health & Human Services, Office of Minority Health, has issued national culturally and linguistically appropriate services (CLAS) standards. PHC is committed to a continuous effort to perform according to those standards.

PHC uses Language Line for interpreter services as needed to communicate with members who have limited English proficiency. Providers are expected to have access to interpreter services to accommodate their non-English speaking patients. If you do not have access to interpreter services to accommodate a non-English speaking patient who is a member of the plan, PHC will provide such access. Please contact Member Services at (800) 263-0067 to request assistance.

Providers may request a "Self-Assessment Checklist for Personnel Providing Primary Health Care Services," from PHC to assess their cultural competency in the delivery of health care services. The checklist is also available online: http://nccc.georgetown.edu/documents/Checklist%20PHC.pdf

Cultural competency training modules for clinical staff working with people living with HIV/AIDS are available on the website: www.phc-ca.org/providers/pubs. The health plan will arrange for follow-up assistance and/or training to providers who report a need for technical assistance.

If PHC receives any member grievance related to the delivery of culturally or linguistically appropriate care by providers, it will immediately assess the provider's competency and require corrective action where necessary.

Contracted providers are expected to provide services in a culturally competent manner that includes, but is not limited to, removing all language barriers to service, and accommodating the special needs of the ethnic, cultural, and social circumstances of the patient. Providers must also meet the requirements of all applicable state and Federal laws and regulations as they pertain to provision of services and care including, but not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973.

PHC operates the health plan pursuant to a Cultural and Linguistic Competency Plan. To obtain a copy of the plan at no charge, you may request one by calling Provider Relations at (888) 726-5411, Monday through Friday, 8:30 a.m. to 5:30 p.m. The plan is also

available at www.phc-ca.org/providers/pubs.

PCP Responsibilities for Cultural and Linguistic Services

The California Department of Health Services (DHCS) and PHC expect providers to adhere to the following:

24-Hour Access to Interpreters

When the provider does not speak the member's language, he/she must ensure twenty-four (24)-hour access to interpreters for members whose primary language is not English. To access interpreters for PHC members at no cost to you or the patient, call Member Services at:

(800) 263-0067, TTY/TDD 711 during normal business hours of 8:30 a.m. to 5:30 p.m. Monday through Friday

After Hours and Nurse Advice Line

After hours, weekends and holidays, you can contact the **PHC UrgentCare/Nursing Advice Line** at:

(800) 797-1717

State and Federal laws state that it is never permissible to turn a member away or limit the services provided to them because of language barriers. It is also never permitted to subject a member to unreasonable delays due to language barriers or provide services that are lower in quality than those offered in English. Linguistic services must be provided at no cost to the member.

Documentation

If a patient insists on using a family member as an interpreter after being notified of his or her right to have a qualified interpreter at no cost, document this in the member's medical record. PHC is available to assist you in notifying members of their right to an interpreter.

All counseling and treatment done via an interpreter should be noted in the medical record by stating that such counseling and treatment was done via interpreter services. Practitioners should document who provided the interpretation service. That information could be the name of their internal staff or someone from a commercial vendor such as Language Line. Information should include the interpreter's name, operator code number and vendor.

Facility Signage

DHCS requires that practitioner offices post important signs in the threshold languages for the area. For assistance with any signage, please contact **PHC at (323) 436-5023.**

Section 14: Medication Management

Drug Formularies

PHC California maintains its own drug formulary. The Pharmacy and Therapeutics Committee meets quarterly to review and recommend medications for formulary consideration. Each update of the plan's formulary, is available on the plan's website at www.phc-ca.org/providers/pubs.

Over-the-Counter (OTC) Drugs

PHC covers a wide selection of over-the-counter products. Although specific products may at times differ from the State's Medi-Cal Formulary, all appropriate therapeutic categories are represented with a wide selection of alternatives.

Generic Substitution

Generic drugs should be dispensed whenever available, excluding those with a narrow therapeutic index. If the use of a particular brand name becomes medically necessary, as determined by the practitioner, prior authorization must be obtained from PHC.

Non-Formulary Drugs - Drug Prior Authorization

The practitioner should call PHC to request approval for drugs not included in the Plan's respective Formulary.

Drug Prior Authorizations & Non-Formulary Drugs

Prescriptions for medications requiring prior approval or for medications not included on the PHC Drug Formulary may be approved when medically necessary and when Formulary alternatives have demonstrated ineffectiveness. When these exceptional needs arise, the Practitioner or Pharmacy may fax a completed Prior Authorization Request form to PHC.

Requesting Practitioners may expect a response within twenty-four (24) hours, or sooner depending upon the urgency of the request. This form may be requested by calling the PHC Pharmacy Services Department at (888) 554-1334.

Furnishing of Medication by Physician Assistants and Nurse Practitioner

Furnishing (including transmittal orders) of medication by Physician Assistants (PAs) and Nurse Practitioners (NPs) should be done pursuant to Chapters 3502.1 and 2836.1 of the California Business and Professions Code. PAs hold a valid California physician-assistant

license issued by the Physician Assistant Examining Committee, and their supervising physicians hold a valid California physician license to supervise PAs. NPs must have obtained a furnishing number from the Board of Registered Nursing. Mid-level Practitioners should prescribe medication within the scope of standardized procedures developed and approved by a supervising physician, surgeon, facility administrator, or designee.

Management and Documentation of Controlled Substances
Storage of Controlled Substances

All controlled substances should be stored in a double-locked cabinet. Only licensed personnel may assume responsibility for handling or carrying keys to the controlled medication cabinet. All missing or lost keys should be reported to the practitioner in charge immediately.

Inventory of Controlled Substances

There should be a current inventory maintained on each controlled substance. A printed log should be produced which lists only those controlled substances stocked by the office/clinic. Controlled substances added to the inventory should be recorded in the log and verified by two (2) licensed personnel.

Security of Controlled Substances

Obvious signs of tampering with controlled substances and/or the locked cabinet should be reported to the Drug Enforcement Agency (DEA) if significant or chronic loss occurs. DEA notification is not needed for a rare loss of a small quantity or if a small discrepancy in the inventory log is noted. However, documentation must be maintained regarding any discrepancies.

Controlled Substance Administration Documentation

Documentation should be maintained regarding the administration of all controlled substances.

Controlled Substance Discrepancy

If at any time a discrepancy in the controlled substances inventory is found, it should be reported to the Practitioner in charge. The practitioner in charge should report the discrepancy to the DEA if a significant loser chronic loss of controlled substances occurs. The discrepancy should be documented and kept on file with the inventory log. All licensed personnel who have had access to the controlled medication cabinet keys should remain on duty until the practitioner in charge has finished investigating the

discrepancy.

Disposal of Controlled Substances

All wasted, contaminated, deteriorated or expired controlled substances should be destroyed in the presence of two (2) licensed personnel (i.e. Practitioner in Charge, Registered Nurse (RN), or Licensed Vocational Nurse (LVN)). The following information should be documented:

- Medication name and strength
- Amount destroyed
- Lot number and expiration date
- Signatures of both licensed personnel
- Patient for whom medication was intended, if applicable

General Medicine Policy Medication Storage

All medications, needles, syringes, and dangerous medical supplies should be stored in an area accessible only to authorized personnel. Medications must be stored separately, according to their route of administration, e.g. oral, injectable, or topical. Germicides, disinfectants, test/reagents, household cleaning supplies, and other products for external use must be stored separately. All medications should be stored in their original containers.

Medications must be stored at temperature levels specified by the manufacturer (e.g. room temperature; refrigerated at 35-46°F; frozen at -4-14°F). PHC policies require that a system is in place to ensure that temperature levels are maintained (e.g. thermometers, temperature logs). Polio vaccine must be stored in the freezer or freezer compartment of the refrigerator in the original packaging.

Expiration Dates

All medications and related items should be routinely checked for expiration. Drugs should not be kept in stock after the expiration date on the label, and no contaminated or deteriorated drugs should be used. All unopened expired medications should be returned to the manufacturer if possible or discarded in a manner safe to the environment. Documentation of the destruction of all scheduled medications should be in accordance with DEA policies.

For injectable products designed for multiple use, the expiration date should be the manufacturer's printed expiration date. If, upon inspection, the product does not show signs of contamination, such as discoloration or particulate matter, and the expiration date has not passed, the medication is deemed appropriate for use. All single dose

containers should be discarded immediately after use.

For diagnostic products or test strips which are acceptable for multiple use, the manufacturer's printed expiration date should be considered the expiration date.

Labeling Requirements

All medications should be properly labeled with the name and strength of medication, the manufacturer's name and lot number (#) and expiration date. All medications that are transferred from their original container into another (repackaged) or those that are extemporaneously prepared (compounded) should be labeled with the following information:

- Name, strength, and quantity of medication
- Expiration date (of original container if re-packaged or of ingredients if compounded)
- Manufacturer's name and original lot number (#)
- Date of re-packaging (or compounding) and initials of re-packager

Pharmaceutical Samples

Provider offices should keep the following in mind:

- The practitioner is ultimately responsible for the storage, inventory, and dispensing of all samples.
- Samples should be dispensed only by the practitioner. This responsibility should not be delegated toothier office staff.
- Samples should be dispensed only to the provider's own patient and should not be sold.
- Samples should be stored in the secured manner described previously.
- If samples are dispensed, they must meet all labeling requirements as described previously.
- A sample log should be maintained and used whenever samples are received or dispensed.
- An appropriate notation should be entered in the patient's record, in a similar manner as if a prescription had been written.

Section 15: Medical Record Documentation

Requirements of Medical Records Documentation

By contract, the Health Plan requires contracted Provider Sites to do the following:

a) Maintain an electronic, typewritten or legibly written in ink paper permanent and/or paper medical record system from which clinical information can be retrieved promptly by authorized personnel/health care providers.
b) Maintain one medical record for each member.
c) Implement measures to protect the medical records from loss, tampering, alteration, and destruction electronically and/or physically.
d) Comply with all Federal and State regulations, relevant accreditation standards, AHF policies related to patient confidentiality and release of member's record.
e) Use a consistent organized format of its medical records.
f) Update and sign member medical record in a timely manner. Discharged patient records are to be completed and filed within thirty (30) days after termination.
g) All medical records shall be legible and readily available to authorized personnel as stipulated by law.
h) Designate a staff member delegated the responsibility of securing and maintaining medical records to ensure that the medical records are handled in accordance with all applicable Federal and State regulations and the Health Plan policies and procedures.
i) Keep medical record for a minimum of ten (10) years regardless of contract status including exposed X-ray film.
j) Make medical record available to the Health Plan or new providers if needed, such as for quality improvement activity and reporting, and utilization management etc.
k) Store medical records so as to protect against loss, destruction or unauthorized use.
l) File medical records in an easily accessible manner in the clinic. Storage of records shall provide for prompt retrieval when needed for continuity of care. Prior approval of the Department is required for storage of inactive medical records away from the facility.
m) Medical records shall be the property of the facility and shall be maintained for the benefit of the patient, health care team and clinic and shall not be removed from the clinic except for storage purposes after termination of services.

n) If a clinic ceases operation, arrangements shall be made for the safe preservation of the patients' health records. The Department shall be informed by the clinic of the arrangements within forty-eight (48) hours before cessation of operation.
o) The Department shall be informed within forty-eight (48) hours, in writing, by the licensee whenever patient health records are defaced or destroyed before termination of the required retention period.
p) It the ownership of a clinic changes, both the licensee and the applicant for the new license shall, prior to change of ownership, provide the Department with written documentation stating:

    The new licensee shall have custody of the patients' health records and these records shall be available to the former licensee, the new licensee and other authorized persons; orThat other arrangements have been made by the current licensee for the safe preservation and location of the patients' health records, and that they are available to both the new and former licensees and other authorized persons.

The following information is required in each member's medical record:

a) A unique medical record number. Member identification on each page; personal/biographical data in the record.
b) Demographic information: name, identification number, date of birth, gender, primary language, communication needs (vision, hearing etc.), emergency contact and preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.
c) Primary care provider (if applicable)
d) Allergies or absence of allergies and untoward reaction to drugs and materials in a prominent location
e) Histories and physicals that are updated annually or as needed
f) A problem list, a complete record of immunizations and health maintenance or preventive services rendered.
g) Advance directive information and/or executed.
h) Age appropriate "Individual Health Education Behavioral Assessment must be documented by having the patient or legal guardian complete the age appropriate Staying Healthy Assessment Tool and the clinician documenting review and counseling on the form." Referrals to health education services, as applicable, should be documented.

i) Consent forms where applicable including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6.
j) Significant medical advice given to a member by phone, including after-hours telephone information
k) Members involved in any research activity is identified
l) Reports of emergency care provided (directly by the contracted Provider or through an emergency room) and the hospital discharge summaries for all hospital admissions with inpatient and outpatient medication lists reconciled.
m) Consultations, referrals, Specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.
n) Records shall be kept current in detail consistent with good medical and professional practice and shall describe subjective complaints, objective findings, the plan for diagnosis and treatment and the services provided to each patient.
o) All entries shall be dated and be authenticated with name, professional title and classification of person making the entry.

Progress note are required to be updated in each patient encounter and include the following where applicable:

a) Date of the encounter and department
b) Member's chief complaint or purpose of visit
c) Medication reconciliation including over-the-counter products and dietary supplements
d) Physical, mental exams and clinical findings
e) Studies ordered, such as laboratory or diagnostic imaging and the results. The provider will have a specific process in place to advise a patient of any abnormal health finding or test result, with evidence of process compliance available in the medical record. Notation of the method of communication, date & time of the notification should be noted. If a follow-up appointment or referral is required evidence of the ordering and/or scheduling should also be noted.
f) Referrals/consultation ordered and the results. Any information regarding results of the specialist visit will be recorded by the Provider including reports and the specialists' consultation record with readings, findings, and treatment recommendations. Notation should be made if a follow-up appointment is required.
g) Objective Findings/Diagnosis

h) Plan for Findings/Diagnosis
i) Treatment Plan including all medications prescribed or ordered need to be noted in the chart. Likewise, prescription refills must be documented and dated. Documentation on medications should include drug name, strength, quantity, and instruction for use. Medication education needs to be documented whenever a new medication is prescribed to insure that the patient understands what the medication is for, how to safely take it and the frequency of dosing.
j) All injections, immunizations and medications of any type administered in the facility must be documented, indicating drug name, dosage, route, site, date, time, drug manufacturer, lot number, and signature of administering staff.
k) Care rendered and therapies administered including preventive care provided or refusal of care or therapies.
l) Documentation of follow-up instructions and a definite time for return visit or other follow-up care. Time period for return visits or other follow-up care is definitely stated in number of days, weeks, months or PRN (as needed).
m) Previous complaints and unresolved or chronic problems are addressed in subsequent notes until problems are resolved or a diagnosis is made. Each problem need not be addressed at every visit but all problems must be addressed within the calendar year. Documentation must demonstrate that provider follows-up with member about treatment regimens, recommendations and counseling.
n) Care plan or discharge plan including prescriptions, recommendations, education, instructions, necessity of surgery or other procedures etc.
o) Provider signature

1. Provider sites are required to contact the Plan member and document in medical records when there is:
    a. missed appointment
    b. abnormal laboratory or imaging results with notation that Member was notified of result
    c. referral results that require attention with notation that Member was notified of result
    d. discharge from an institution such as hospital, emergency room, or skilled nursing facility
    e. inquiry that occurred out of regular business hour

The Health Plan will audit medical records kept by contracted providers during the Full Scope Facility Site Review at a minimum. Additional monitoring may occur during HEDIS record review and other audits conducted by the Plan or required by individual State or Federal requirements.

Practitioner Responsibilities for Documenting Life-Sustaining Procedures

In accordance with Title 22 of the California Code of Regulations, adult medical records must include documentation of whether the patient has been informed of and has executed an advance directive such as a Durable Power of Attorney for Health Care (DPAHC).

Complete documentation is essential whenever life-sustaining procedures are withheld or withdrawn and should include:

- Patient diagnosis and prognosis, including test results or other evidence that the attending Practitioner and the second confirming Practitioner used in forming their conclusion.
- Declaration of whether the patient is likely to regain mental function and the factors upon which the determination of the patient's mental incapacity was based, when applicable.
- A statement that the patient or surrogate has been fully informed of the facts and the consequences of withholding or withdrawing life-sustaining procedures and that the surrogate decision-maker has consented to the withholding or withdrawing of such procedures.
- A copy of any DPAHC Declaration or non-statutory Living Will signed by the patient.
- A description of any desires orally expressed by the patient and of any discussion with family members or other surrogate.
- A copy of a certified letter of guardianship or conservatorship, when applicable. Clear written orders to withhold or withdraw specific medical procedures.

PHC Access to Member Medical Records

Be advised that PHC, via AHF, requires access to Plan member medical records for a variety of reasons. The following section is copied from your provider agreement to remind you of the requirements for this activity. In an effort of mutual cooperation, and in the best interest of patients, PHC will expect compliance with this requirement by you and your staff. Should you ever have questions or concerns about access to medical records by the Plan you are encouraged to call Provider Relations.

Provider Agreement Extract:

8.3 AHF Access to Medical and Administrative Records and Facilities: Provider will maintain and ensure ready availability of medical records to AHF of all pertinent information relating to the health care of each Enrollee records and papers, risk adjustment validation data, computer or other electronic systems relating to the Covered Services provided to the Enrollees, the quality, appropriateness, timeliness, and cost of those services, and any payments received by Provider from Enrollees (or from others on their behalf), and unless the Provider is compensated on a fee-for-service basis, to the financial condition of the provider. (Cal. Health & Safety Code, § 1300.67.8(c).) Specifically, and without limiting the foregoing, AHF shall have the right to access/inspect Provider facilities and records for purposes of paying Provider, as well, as to perform quality management utilization monitoring and peer review activities. Provider shall require any and all Subcontractors to be bound by this paragraph.

Chart Review Requirements

Upon receipt of medical records for case review, clinical record audits, or other considerations, details of the clinical documentation will be considered. If a record is found to be lacking in any of the required elements or procedural follow-ups required, where indicated, the provider will be contacted to discuss findings. In the event clinical documentation discrepancies are sufficient to warrant more than a verbal discussion, Provider Relations will be required to work with the provider, in conjunction with clinical management (Director of UM, QM or Medical Director), to remediate the discrepancies. All providers who require this level of intervention are expected to comply with the training and/or education so the medical records can accurately and appropriately reflect the standards of care expected for Plan members.

Section 16: Infection Control Practices

The Medical Administration Policy and Procedure Committee adopted by PHC Managed Care Utilization Management Committee (UMC) has approved the use of clinical practice guidelines for HIV/AIDS published by the U.S. Department of Health and Human Services (DHHS). This information is available at: https://aidsinfo.nih.gov/guidelines/search?q=infection%5bspace%5dcontrol&c=guidelines&htmldocId=1&startAt=0. Please refer to these guidelines for treatment de-escalation in HIV infected adults and adolescents and virological control.

Disease Reporting Statement

PHC complies with disease reporting standards as cited by Section 2500 of Title 17 of the California Code of Regulations, which requires public health professionals, medical Providers, and others to report approximately 85 diseases or conditions to their local health department. The primary objective of disease reporting and surveillance is to protect the health of the public, determine the extent of morbidity within the community, evaluate risk of transmission, and intervene rapidly when appropriate. Forms to report the required diseases or conditions as well as additional information are available at: https://admin.publichealth.lacounty.gov/phcommon/complaints/phcomp.cfm

Training

Per the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division's(MMCD) Facility Site Review (FSR) Full Scope Survey, site personnel receive documented safety training/information in: (8 CCR §5193; CA H&S Code §117600; CA Penal Code §11164, §11168; 29 CFR §1910.1030)

1) Infection control/universal precautions (annually)
2) Blood Borne Pathogens Exposure Prevention (annually)
3) Biohazardous Waste handling (annually)
4) Child/Elder/Domestic Violence Abuse

Infection Control

Similarly, DHCS/MMCD FSR requires providers to adhere to the following criteria:

A. Infection control procedures for Standard/Universal precautions are followed. (8 CCR §5193; 22 CCR §53230; 29 CFR §1910.1030; Federal Register 1989, §54:23042)
    1) Antiseptic hand cleaner and running water are available in exam and/or treatment areas for hand washing.
    2) A waste disposal container is available in exam rooms, procedure/treatment rooms and restrooms.
    3) Site has procedure for effectively isolating infectious patients with potential

communicable conditions.

B. Site is compliant with OSHA Bloodborne Pathogens Standard and Waste Management Act. (8 CCR §5193 (Cal OSHA Health Care Worker Needlestick Prevention Act, 1999); H& S Code, §117600-118360 (CA Medical Waste Management Act, 1997); 29 CFR §1910.1030.)
    1) Personal Protective Equipment is readily available for staff use.
    2) Needlestick safety precautions are practiced on site.
    3) All sharp injury incidents are documented.
    4) Blood, other potentially infectious materials and Regulated Wastes are placed in appropriate *leak proof, labeled* containers for collection, handling, processing, storage, transport or shipping.
    5) Biohazardous (non-sharp) wastes are contained separate from other trash/waste.
    6) Contaminated laundry is laundered at the workplace or by a commercial laundry service.
    7) Storage areas for regulated medical wastes are maintained secure and inaccessible to unauthorized persons.
    8) Transportation of regulated medical wastes is only by a registered hazardous waste hauler or by a person with an approved limited-quantity exemption.

C. Contaminated surfaces are decontaminated according to Cal-OSHA Standards. (8 CCR §5193; CA H&S Code §118275)
    1) Equipment and work surfaces are appropriately cleaned and decontaminated after contact with blood or other potentially infectious material.
    2) Routine cleaning and decontamination of equipment/work surfaces is completed according to site-specific written schedule.
    3) Disinfectant solutions used on site are:
        - approved by the Environmental Protection Agency (EPA).
        - effective in killing HIV/HBV/TB.
        - used according to product label for desired effect.

D. Reusable medical instruments are properly sterilized after each use. (22 CCR §53230, §53856)
    1) Written site-specific policy/procedures or Manufacturer's Instructions for instrument/equipment sterilization are available to staff.
    2) Staff adheres to site-specific policy and/or manufacturer/product label directions for the following procedures:
        - Cleaning reusable instruments/equipment prior to sterilization

- Cold chemical sterilization
- Autoclave/steam sterilization
- Autoclave maintenance

3) Spore testing of autoclave/steam sterilizer with documented results (at least monthly)
4) Sterilized packages are labeled with sterilization date and load identification information.

Please note these are minimum standards. As information becomes available and/or new policies and procedures are written, the Provider Relations Department will inform you via fax, the Provider Newsletters and/ or presentations by the Physician Chair or designee of the Infection Prevention and Control Committee at Provider Meetings.

Section 17: Environmental Safety

Safety Program

Any facilities providing healthcare services need to adhere to all Federal, State, local and regulatory agency laws, rules and regulations regarding fire and safety. The Occupational Safety & Health Administration (OSHA) states that people have the right to a safe work environment, and employers must take the proper precautions to maintain safety in the workplace. Equally important is the right that patients have to receive their care & treatment in a safe environment.

Training

Per the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division's(MMCD) Facility Site Review (FSR) Full Scope Survey, site personnel receive documented safety training/information in: (8 CCR §5193; CA H&S Code §117600; CA Penal Code §11164, §11168; 29 CFR §1910.1030)

A. Site personnel are qualified and trained for assigned responsibilities. CA B&P Code §2069; 16 CCR §1366; 22 CCR §75034, §75035)

1) Only qualified/trained personnel retrieve, prepare or administer medications.
2) Only qualified/trained personnel operate medical equipment.
3) Documentation of education/training for non-licensed medical personnel is maintained on site.
4) There is evidence that staff has received safety training and/or has safety information available in the following:
    - Fire safety and prevention
    - Emergency non-medical procedures (e.g. site evacuation, workplace violence)

B. Site environment is maintained in a safe, clean and sanitary condition for all patients, visitors and personnel. (8 CCR §5193;§3220; 22 CCR §53230; 24 CCR, §2, §3, §9; 28 CCR §1300.80; 29 CFR §1910.301, §1926.34)

1) All patient areas including floor/carpet, walls, and furniture are neat, clean and well maintained.
2) Restrooms are clean and contain appropriate sanitary supplies.
3) The following fire and safety precautions are evidenced on site:
    - Lighting is adequate in all areas to ensure safety.
    - Exit doors and aisles are unobstructed and egress (escape) accessible.
    - Exit doors are clearly marked with "Exit" signs.
    - Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location.

- Electrical cords and outlets are in good working condition.
- At least one type of firefighting/protection equipment is accessible at all times.

C. Emergency health care services are available and accessible twenty- four (24)hours a day, seven (7) days a week. (22 CCR §51056, §53216; 28 CCR §1300.67**)**

1) Personnel are trained in procedures/action plan to be carried out in case of medical emergency on site.
2) Emergency equipment is stored together in easily accessible location.
3) Emergency phone number contacts are posted.
4) Emergency medical equipment appropriate to practice/patient population is available on site:
    - Airway management: oxygen delivery system, oral airways, nasal cannula or mask, Ambu bag.
    - Anaphylactic reaction management: Epinephrine 1:1000 (injectable), and Benadryl 25 mg. (oral) or Benadryl 50 mg./ml. (injectable), appropriate sizes of ESIP needles/syringes and alcohol wipes.
    - Medication dosage chart (or other method for determining dosage) is kept with emergency medications.
5) There is a process in place on site to:
    - Document checking of emergency equipment/supplies for expiration and operating status at least monthly.
    - Replace/re-stock emergency equipment immediately after use.

D. Medical and lab equipment used for patient care is properly maintained. (CA Health & Safety Code §111255; 28 CCR §1300.80; 21 CFR §800-1299)

1) Medical equipment is clean.
2) Written documentation demonstrates the appropriate maintenance of all medical equipment according to equipment manufacturer's guidelines.

As in the prior section on Infection Control, please note these are minimum standards. As information becomes available and/or new policies and procedures are written, the Provider Relations Department will inform you via fax, the Provider Newsletters and/or presentations by the Director of Safety and Security of designee at Provider Meetings.

Section 18: Oversight Monitoring

Compliance and Oversight Monitoring

The Medi-Cal Contract between the State Department of Health Services (DHCS) and PHC defines a number of performance requirements that must be satisfied by both PHC and those Providers agreeing, through descending contracting relationships (or subcontracts), to provide services to eligible and enrolled PHC members. Among these are:

- The Provider's agreement to maintain books and records for a period of five (5) years and make such documents available to regulatory agencies. Medical records must be maintained for ten (10) years.
- The Provider's agreement to furnish PHC with encounter data. Providers are encouraged to review their contracts with PHC to become thoroughly familiar with these and additional performance requirements.
- The Provider's agreement to participate in medical and other audits (e.g. Health Employer Data Information Set (HEDIS) and/or mandated) conducted by DHCS and other regulatory agencies. This means sending medical records free of charge when requested.

Compliance and Provider Relations Oversight Monitoring

Under the terms of its contract with DHCS, PHC conducts ongoing reviews of provider performance. Among the elements to be reviewed are the following:

- Provider-to-Patient Ratios - A physician to active patient ratio may not exceed one (1) Provider or two thousand (2000) patients. Nurse Practitioners (NP)/Physician Assistants (PAs) patient ratio may not exceed one (1) NP/PA to one thousand (1000) patients. Reviews will validate the maintenance of appropriate ratios.
- Access Standards - PHC will review the time it takes members to access emergency care, urgent care, non-urgent (routine) care, specialty care, initial health assessments, first prenatal visits, physical exams, and wellness checks in accordance with access standards disclosed later in this section under Quality Improvement Program.

Monitoring Access to Care

PHC Provider Relations Department will use various methods for studying and monitoring access to care at the provider level. The access standards listed above will be used for studying compliance. These methods may include, but are not limited to the following:

- Telephone, mail or email surveys
- Review of appointment availability
- Reports such as the Geo-Access Report
- Review of member waiting time in provider office

Access and Availability of care is reported out and monitored at the Member Provider Committee Meetings. Any issues are referred to appropriate department or committee for action if MPC cannot resolve such as Credentialing Committee, Provider Relation, QI, particularly the Facility Site Review Program, Compliance, etc.

Section 19: Anti-fraud Program

PHC regards health care fraud as unacceptable, unlawful and harmful to providing quality health care in an efficient and affordable manner.

PHC has therefore, implemented a Fraud, Waste and Abuse program to prevent, investigate and report suspected health care fraud in order to reduce health care costs and to promote quality health care.

Fraud

The term includes any act that constitutes fraud under applicable federal or state law. Fraud, generally involves a person's or entity's intentional use of false statements or fraudulent schemes, such as kickbacks, to obtain payment for, or to cause another person or entity to obtain payment for, items or services payable under a federal health care program. Some examples of fraud are:

- Billing for services not furnished
- Soliciting, offering, or receiving a kickback, bribe, or rebate
- Violations of the physician self-referral ("Stark") prohibition
- Using an incorrect or inappropriate provider identifier in order to be paid, i.e., using a deceased individual's provider identifier
- Signing blank records or certification forms that are used by another entity to obtain Medicare or Medicaid payment
- Selling, sharing, or purchasing Medicare/Medicaid Health Insurance Claim (HIC) numbers in order to bill false claims to the Medicare/Medicaid Program
- Offering incentives to Medicare/Medicaid beneficiaries that are not offered to other patients, i.e., routinely waiving or discounting Medicare/Medicaid deductibles, coinsurance, or co-payments
- Falsifying information on applications, medical records, billing statements, cost reports, or on any statement filed with the government or its agents
- Using inappropriate procedure or diagnosis codes to misrepresent the medical necessity or coverage status of the services furnished
- Consistently using billing or revenue codes that describe more extensive services than those actually performed (upcoding)
- Misrepresenting himself or herself as a Medicare/Medicaid beneficiary for the purpose of securing Medicare/Medicaid payment for their health care by presenting a Medicare/Medicaid health insurance card or Medicare/Medicaid HIC number that rightfully belongs to another person.

Waste

Waste involves using or expending carelessly, extravagantly, or to no purpose

Abuse

Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care. Recipient practices that result in unnecessary cost to the Medicaid program.

Abuse may be intentional or unintentional, and directly or indirectly results in unnecessary or increased costs to the Medicaid Program.

Some of the significant anti-fraud, waste, and abuse laws are:

- The False Claims Act (31 USC §§ 3729-3733) prohibits knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval. Additionally, it prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by the federal government or its agents, like a carrier, other claims processor, or state Medicaid program.
- The Anti-Kickback Statute (42 USC § 1320a-7b) provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable (or reimbursable) under the Medicare or other Federal health care programs. In addition to applicable criminal sanctions, an individual or entity may be excluded from participation in the Medicare and other Federal health care programs and subject to civil monetary penalties. For purposes of the anti-kickback statute, "remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.
- The Physician Self-Referral ("Stark") Statute (42 USC §1395nn) prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.

Investigation

The Compliance Department reviews all reports of suspected health care fraud, and investigate where appropriate. If the suspected fraud is verified to be a valid concern, Compliance reports the suspected activity to the appropriate government agency.

Common fraudulent acts include, but are not limited to:

- Billing for services, procedures and or supplies that were not provided.
- The intentional misrepresentation of any of the following for purposes of manipulating the benefits payable:
- The nature of services, procedures and/or supplies provided;
- The dates on which the services and/or treatments were rendered;
- The medical record of service and/or treatment provided;
- The condition treated or diagnosis made;
- The charges or reimbursement for services, procedures, and/or supplies provided;
- The identity of the provider or the recipient of services, procedures and/or supplies.
- The deliberate performance or unwarranted/non- medically necessary services for the purpose of financial gain.
- Routinely waiving required deductibles and co-payments.
- Failure to report a patient's forgery/alterations of a prescription.
- Exaggerating/understating the services/materials received (up-coding/down-coding).
- Concealing patients' misuse of Medi-Cal/PHC card.
- Multiple payments issued on the same day to one payee.
- Asking the patient to pay the difference between the discounted fee negotiated and the provider's usual and customary fees.
- Offering or acceptance of kickbacks.
- Using telemarketing and door-to-door selling as marketing tools.
- Charges submitted for payment for which there is no supporting documentation available, such as x-rays, lab results, etc.

By joining forces, providers, members and health plans can help prevent health care fraud.

Reporting Resources

If you suspect fraud, report it immediately without reprisal and on a confidential, anonymous and/or private basis through one of the following:

E-Mail: PHC Compliance Officer, at khurrum.shah@aidshealth.org
Regular Mail: Write (marked Confidential) to:
PHC
Attn: Compliance Officer
1001 N. Martel Ave.
Los Angeles, CA 90046

Telephone: Call the Toll-Free number of the PHC Compliance Anti-Fraud Line at (800) 243-7448 (AIDSHIV)

Other avenues for reporting suspected fraud are:

Call the Department of Health Services- Anti-Fraud Line toll-free: **(800) 822-6222**
Call the Office of the Inspector General toll-free: **(800) 447-8477**
Call the Attorney General's Bureau of Medi-Cal Fraud & Elder Abuse toll free: **(800) 722 - 0432**

For sources of on-line training and more information on Fraud, Waste and Abuse and Compliance, the following web sites are available:

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html
- www.hhs.gov.org
- http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx
- https://oig.hhs.gov/fraud/report-fraud/

The following agencies below are where you can report potential FWA:

U.S. Department of Health and Human Services
Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS
P.O. Box 23489
Washington, DC 20026
Phone: (800) HHS-TIPS

Medi-Cal Fraud Complaint – Intake Unit
Audits and Investigations
P.O. Box 997413, MS 2500
Sacramento, CA 95899-7413

Anti-Retaliation Policy

PHC has a strict policy against retaliating against anyone who, in good faith, makes a report, complaint, or inquiry regarding a compliance issue. Providers must follow this same policy with respect to their employees. Under the Whistle Blower or qui tam provision of the False Claim Act, any individual who has knowledge of a false claim may file a civil suit on behalf of the U.S. Government and may share a percentage of the recovery realized from a successful action.

Section 20: Quality Improvement Program

Quality Improvement Program

PHC's Quality Improvement Program (QIP) is written to assure that the quality of health care provided to members meets or exceeds community, professional, regulatory and accreditation standards and that health care and its delivery are continuously monitored and improved based on data driven decisions. PHC's Executive Oversight Committee (EOC) of Board of Directors oversees the QIP.

PHC's QIP is designed to ensure that quality of care and quality of service issues are tracked and trended to review identify and analyze opportunities for improvement and that appropriate corrective actions are taken to address problems. The vehicle used to monitor quality activities is the Quality Management Committee (QMC). All Providers are invited via faxed invitation and requested to RSVP to Provider Relations Department. Quality Improvement activities will not be delegated directly to contracted providers.

In brief, the QIP features review of outcomes data (such as HEDIS) complaints/grievances, potential quality investigations, access and availability, member experience of care surveys (CAHPS), member health outcomes survey (HOS-Medicare only), provider satisfaction surveys, accreditations, population-based programs such as disease management, medical record reviews, facility site reviews, education of providers on practice guidelines, access and availability and other appropriate topics, health education aligned with approved practice guidelines for members, the model of care: chronic disease management, pharmacy and adherence to medication, and performance improvement projects. This comprehensive program is completed through the efforts of seven (7)committees that report up to Quality Management Committee (QMC).

Highlights of Selected Quality Activities

Adherence to Medication

PHC's key indicator is "Viral Load Suppression". This requires adherence to medication. This indicator is monitored at each QMC Meeting.

HEDIS (Healthcare Effectiveness Data and Information Set)

The Providers are required to participate in HEDIS measures as part of CMS regulation for receiving payment from government programs such as MediCal and Medicare. Providers contractually agree to send plan medical records upon request for HEDIS or any other review required by regulatory or accreditation agencies.

PQI (Potential Quality Investigation)

A PQI is a process to request an investigation on a quality of care or quality of service issue that appears to be trending. The submitter will complete the PQI form (see attached) with the concern and send to the Quality Department. Please note: this is not the mechanism for a complaint or grievance. Information on complaints and grievances can be found in the section with the same name. Results of the Investigation is reviewed at Risk Management Committee which reports up to Quality Management Committee.

CAHPS (Consumer Assessment of Healthcare Providers & Systems)

CA-PHC participates in CAHPS annually. These surveys ask patients (or in some cases their families) about their experiences with, and ratings of, their health care providers and plans, including hospitals, home health care agencies, doctors, and health and drug plans, among others. The surveys focus on matters that patients themselves say are important to them and for which patients are the best and/or only source of information. CMS publicly reports the results of its patient experience surveys, and some surveys affect payments to CMS providers

CAHPS is a patient experience survey. Patient experience surveys sometimes are mistaken for customer satisfaction surveys. Patient experience surveys focus on how patients experienced or perceived key aspects of their care, not how satisfied they were with their care. Patient experience surveys focus on asking patients whether or how often they experienced critical aspects of health care, including communication with their doctors, understanding their medication instructions, experience with front office staff and the coordination of their healthcare needs. They do not focus on amenities.

CAHPS surveys follow scientific principles in survey design and development. The surveys are designed to reliably assess the experiences of a large sample of patients. They use standardized questions and data collection protocols to ensure that information can be compared across healthcare settings. Finally, many CAHPS measures are statistically adjusted to correct for differences in the mix of patients across providers and the use of different survey modes.

CAHPS surveys are an integral part of CMS' efforts to improve healthcare in the U.S. Some CAHPS surveys are used in Value-Based Purchasing (Pay for Performance) initiatives. These initiatives represent a change in the way CMS pays for services. Instead of only paying for the number of services provided, CMS also pays for providing high quality services. The quality of services is measured clinically, administratively, and through the use of patient experience of care surveys. For more information please view the CAHPS website at:
https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/

Model of Care

As an added benefit to our members, AHF Plans use a CMS approved "Model of Care" (MOC) as the framework for chronic disease management. The MOC establishes that the Plan will deliver health service based on Chronic Care Disease Management Program. The program is based on a strong working relationship with the Plan's RN Care Manager (RNCM), the Primary Care Provider and the Member. Other's may be included on the team as needed or as requested such as a family member, significant other or other health care professional such as a social worker.

The high-level steps of the program include:

- Identifying chronic disease status by using the Health Risk Assessment (HRA) by RN Care Manager (RNCM). Every member in our Plans has at least one chronic condition HIV/AIDS.
- Severity Level (SL) calculated from HRA results (SL 1, 2 or 3 – 3 being most severe)
- Members assigned SL 3 are place under complex care management – the rest are placed under disease or population health management. A Care Plan is established with at least the member and Primary Care Provider including establishing goals with the final version shared with the member's care team.
- Interdisciplinary Care Team Meetings held to coordinate care & discuss best options for care and its delivery
- Ongoing support by RNCM – working the care plan – teaching self-management to member
- Annual re-evaluation of member is completed by RNCM and shared with care team.

QI produces an annual MOC Dashboard to measure our success with implementing the MOC for every member. Results are presented at QMC Meeting and EOC with this information sent to providers and members, usually via the newsletters (or blast fax for providers only).

Accreditations

CA-PHC has full, three -year accreditation from Accreditation Association for Ambulatory Health Care (AAAHC). AAAHC accreditation means that the organization participates in on-going self-evaluation, peer review and education to continuously improve its care and services. The organization also commits to a thorough, on-site survey by AAAHC surveyors, who are themselves health care professionals, at least every three years. CA PHC also has full-three-year accreditation from National Committee for Quality Assurance (NCQA) for Patient and Practitioner Oriented Disease Management Program.

Facility Site Review and Medical Record Review

- PHC's responsibility to its members is to contract with providers of health care who provide safe, comfortable offices and deliver high quality medical care.
- The Provider/Clinic to be reviewed will be advised in advance, by telephone and in writing, of the selected date(s) for the audit of his/her office/facility. Using the approved DHCS Facility Site Reviews Checklist, PHC's assigned/credentialed Facility Site Review Nurse will visit the Provider's site on the previously arranged date (see DHCS Facility Review Checklist).
- Results of each audit will be reviewed by the Facility Site Review Nurse for compliance with and maintenance of standards. Results of the completed site audit will be conveyed to the Provider, where applicable. Quality Improvement Corrective Actions will be implemented as necessary following the review. Facility Site Review scores are shared with the Credentialing and Peer Review Office and filed in the appropriate providers file for re-privileging and re-contracting purposes. For more details on Facility Site Review and review forms, please refer to the chapter on Physician Facility Licensure, section 21.

Medical Record Review

- PHC has a responsibility to ensure that ambulatory medical records are maintained to document that care has been provided appropriately. This includes pediatric, if applicable, and adult health care.
- The provider to be reviewed will be advised in advance, either by telephone or in writing, of the selected dates for the audit of their ambulatory medical records. Using the Medical Record Audit Tool, the Facility Site Review Nurse will review the selected charts for appropriate medical records management and documentation. Whenever possible, the facility audit and medical record review will be conducted concurrently. Quality Improvement corrective actions will be implemented as necessary following the review. For more details, refer to the Chapter 15. Medical Record Documentation.

Corrective Action Plans

When it is found that Providers do not meet the terms of their contracts, applicable policies and procedures, licensing and related requirements, and the provisions of this Manual, they will be notified in writing of deficiencies. Quality Improvement Corrective Action Plans (CAP) will be forwarded to providers and will include corrective actions and dates by which corrective actions are to be achieved.

PHC representatives will work with and offer support to providers to ensure the timely resolution of CAP requirements. Providers who fail to respond to an initial corrective

action plan by the date specified will be provided a second iteration of CAP requirements and may be assigned an extended action plan due date. Ongoing monitoring of compliance with any corrective action will be a joint effort, with Quality Management leading the effort, in cooperation with Provider Relations.

Non-Compliance with Quality Improvement Corrective Actions

PHC's Quality Management Department may assist the Provider with the development and implementation of the corrective action plan. Non-compliance with Quality Improvement corrective actions may result in any of the following:

- Contact by the PHC's Quality Management Department
- Possible referral to Credentialing and Peer Review Committee and/or Compliance Committee, as appropriate.
- Conduct in service/education
- Implementation of Provider Compliance Department corrective action program which may result in the following sanctions:
    - The termination of new member enrollments
    - Moving current members to another provider
    - Formal contract termination

Re-Audits

Re-audits are conducted to assure corrective actions have been effective in improving compliance with previously identified deficiencies.

Child Health and Disability Prevention (CHDP) Reviews

- The CHDP, a part of the Children's Medical Services State Program, is a preventive health program serving California's children and youth under the age of twenty-one (21). Currently, PHC does not enroll members under twenty-one (21) years of age. Through the CHDP program, regular preventive health assessments to identify and treat problems, or suspected problems, are available to eligible children and youth to prevent or reduce the severity of illnesses. Through this program, PHC provides preventive health care to eligible members together with the continuity that comes with care provided by the member's selected Primary Care Practitioner (PCP).
- Incorporated into the Medical Record Review Tool are CHDP specific questions. The provider to be reviewed will be advised in advance, either by telephone or in writing, of the date for the review. A specific number of records will be reviewed by a licensed PHC staff member. The CHDP review maybe done concurrently with the medical record review.
- Any provider not meeting CHDP standards will be so advised in writing. Quality

Improvement corrective actions will be implemented as necessary following the audit. Details pertaining to the CHDP Program are in section 11, titled Children's Services.

Perinatal/Postpartum Services Program

Should the need arise, the Plan will refer any pregnant member to an OB/GYN that specializes in HIV high risk pregnancies.

Quality Improvement Requirements

- Medical Records - PHC will review medical records to ensure that they are being appropriately maintained and that they reflect the care and follow-up provided to PHC members. The Provider will be notified in advance of review dates.
- Medical Facilities Site Review - PHC must ensure care is provided in service sites that meet licensing, contractual, and other requirements intended to support the delivery and management of high quality medical care. Facility site reviews will be conducted at no less than three (3) year intervals by PHC representatives using a DHCS-prescribed facility checklist and review tools. Providers will be informed in advance of selected review dates.
- Telephone Access Survey - Access studies will be conducted to identify current or potential problems specific to appointment scheduling. Periodic and unannounced telephone surveys will be conducted to obtain current access information and, as indicated, assist Providers in maintaining timely access.
- Member Complaint and Grievance Indicators - Member concerns specific to the care and services of specific Providers are collected and acted upon by PHC's Member Services Department. Providers will be engaged in the review of specific concerns and will be asked to assist in remedial endeavors, as indicated.

Glossary

Appeal - An appeal is a request for reconsideration of a determination for authorization of a service or the denial of a claim.

Authorization - Approval requested and obtained by Providers for designated service before the service is rendered. Used interchangeably with preauthorization or prior authorization.

Beneficiary Identification Card (BIC) - A permanent plastic card issued by the State of California Medi-Cal program to recipients of Medi-Cal which can be used by contractors to verify eligibility for PHC. Files are updated monthly, as well as daily in special circumstances.

California Children Services (CCS) - A State and County program providing medically necessary specialized medical care and rehabilitation to persons under twenty-one (21) years of age (as defined in Title 22, CCR, Section 41800) who meet medical, financial, and residential eligibility requirements for the CCS program.

Child Health and Disability Prevention Program (CHDP) - Preventive well-child screening program for eligible beneficiaries under twenty-one (21) years of age provided in accordance with the provisions of Title 17, CCR, Section6800 et seq. Includes the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, and the Prenatal Guidance Program.

Central Issuance Division (CID) - A unit at DHCS that reports for eligibility data systems.

Claim - A request for payment for the provision of Covered Services prepared on a CMS1500 form, UB04, or successor.

Comprehensive Perinatal Services Program (CPSP) - A State sponsored program developed to provide quality health care for women during and surrounding pregnancy by encouraging evaluation in obstetrical, nutritional, social, and educational spheres to assess and address high-risk conditions.

Contracting Provider - A physician, nurse, technician, hospital, home health agency, nursing home, or any other individual or institution contracted to provide medical services to health plan members.

Credentialing - The verification of applicable licenses, certifications, and experience to assure that Provider status be extended only to professional, competent Providers who

continuously meet the qualifications, standards, and requirements established by PHC.

Department of Managed Health Care (DMHC) - The State department responsible for administering the Knox-Keene Act of 1975. Knox-Keene established the DMHC as the legally designated State regulatory agency for managed health care organizations.

Department of Health Services (DHCS) - The California State department solely responsible for administration of the Medi-Cal, CPSP, CCS, CHDP, and other health-related programs.

Department of Mental Health (DMH) - The State agency that sets policy and administers the delivery of community-based public mental-health services statewide.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program - The initial, periodic, or additional health assessment of a Medi-Cal eligible individual under 21 years of age provided in accordance with the requirements of the Child Health and Disability Prevention (CHDP) program as set forth in Title 17,CCR, Sections 6800 et seq. The program consists of periodic and episodic screening services, diagnostic and treatment services, and supplemental services, including care management services.

Eligible Beneficiary - For PHC, this is a Medi-Cal beneficiary residing in Los Angeles County with a current or previous diagnosis of AIDS and no Medi-Cal share of cost.

Emergency Care - The provision of medically necessary services required for the immediate alleviation of severe pain or the immediate diagnosis and treatment of an unforeseen illness or injury. Lack of such care could lead to disability or permanent damage to the patient's health if not diagnosed and treated without delay. Emergency Care requires no pre-authorization and is subject to the reasonable person's standard of an emergency.

Encounter Data - Reports submitted by Providers, Medical Groups, and affiliated subcontractors documenting encounters with plan members. Encounter data may also be drawn from PHC via aggregate claims data from the Management Information System.

Enrollment Form - See "Medi-Cal Choice Form."

Membership Services Guide - The document provided to PHC plan members describing access, benefits, and exclusions of plan services. It is the equivalent of an Evidence of Coverage.

Fee-For-Service (FFS) - A method of charging based upon billing for a specific number of units of services rendered to an Eligible Beneficiary. Fee-For-Service is the traditional

method of reimbursement used by Providers, and payment almost always occurs retrospectively.

Health Care Options (HCO) (formerly Health Choice) - The State Department of Health Services' program that provides Medi-Cal beneficiaries with information about health-care benefits and with enrollment and disenrollment assistance.

Health Maintenance Organization (HMO) - An organization that, through a coordinated system of health care, provides or assures the delivery of an agreed upon set of comprehensive health maintenance and treatment services for an enrolled group of persons through a predetermined, periodic, and fixed prepayment.

Management Information System (MIS) - System of organizing and aggregating data so as to enable rapid access to data. Often used to refer to computer systems used to pay claims, maintain Provider databases, and generate reports.

Maximus - The vendor contracted by the Department of Health Services that provides Medi-Cal beneficiaries with information about selecting a health plan. Maximus is also responsible for the mailing of enrollment packets to new Medi-Cal beneficiaries.

Medi-Cal Choice Form - aka Medi-Cal Enrollment Form. This form is distributed by Health Care Options (HCO) and is used for Medi-Cal Beneficiaries to select their health plan and primary care practitioner. This form may also be used for beneficiaries to dis-enroll from a health plan.

Medical Group - A medical group practice that holds a contract with a health plan.

Medical Records - A confidential document containing written documentation related to the provision of physical, social, and mental health services to a member.

Medically Necessary - The level of medical or surgical treatment and supplies and/or behavioral health care requisite for the diagnosis and treatment of disease, illness, or injury.

Member - Any enrolled individual on whose behalf periodic payments are made to PHC by the State of California.

Member Complaint/Grievance - A grievance is any expression of dissatisfaction or complaint by a member or member's designated representative.

NCQA - The National Committee for Quality Assurance.

Newborn Child – A newborn child is covered for the month of birth and the following month when delivered by the mother during her membership with the Plan.

Plan - PHC

Potential Quality Issue – A trend or sentinel event in the quality of care or services provided to members that requires investigation beyond the usual and customary processes to identify systemic problems and correct, root cause and/or needed widespread improvement.

Practitioner - The professional who provides health care services. Practitioners are required to be licensed as defined by law. A practitioner may be referred to as a "participating or contracted" practitioner.

Preventive Care - Health care designed to prevent disease and/or its consequences. There are three (3) levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, such as disease screening programs, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after disease has occurred.

Primary Care - A basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and/or mid-level practitioners. This type of care emphasizes caring for the member's general health needs as opposed to focusing on specific needs involving the use of specialists.

Primary Care Practitioner (PCP) - Physician that provides primary care services (including family practice, general practice, internal medicine, and pediatrics) and manages routine health care needs. A woman may select an obstetrician/gynecologist as her PCP.

Provider - An institution or organization that provides services for the managed care organization's members. Examples of providers include hospitals and home health agencies. NCQA uses the term "practitioner" to refer to the professionals who provide health care services. However, NCQA recognizes that a "provider directory" generally includes both providers and practitioners, and the inclusive definition is the more common usage of the term "provider." A provider that participates in PHC's network may be referred to as a "participating or contracted" provider.

Provider Grievance or Complaint - That written action which sets into motion the appeal process concerning claims or authorization disputes according to Title 22, sections 53914.5 and 56262 of the California Code of Regulations.

Quality Management (QM) - A formal set of activities to assure the quality of clinical and non-clinical services provided as outlined in PHC's Quality Improvement Program. Quality Management includes assessment and improvement actions taken to remedy any deficiencies identified through the assessment process. The Providers agree to abide by and participate in PHC's QM Program. Providers receive an invitation to the Quality Management Committee (QMC) and are asked to RSVP to Provider Relations (PR). The information for QMC will be found on a fax from PR and will also be found in the first Provider Newsletter of the year.

Referral - The practice of sending a patient to another practitioner for services or consultation that the referring Provider is not prepared or qualified to provide.

Sensitive Services - The following services are considered sensitive: sexual assault, confidential HIV testing and counseling, drug or alcohol abuse for children of twelve (12) years of age or older, pregnancy, family planning, abortion services, and sexually transmitted diseases (drug or alcohol abuse and sexually transmitted diseases are designated by the Director of DHCS for children twelve (12) years of age or older).

Service Area - The geographic area that the Plan services as designated and approved by the California Department of Managed Health Care or by the Department of Health Services.

Medi-Cal Mental Health Services (SD/MC) - Program operated by the State Department of Mental Health to provide necessary community mental health services to Medi-Cal beneficiaries that meet Short-Doyle eligibility criteria as defined in Title 22, CCR, Section 51341. Services include crisis intervention, crisis stabilization, inpatient hospital services, crisis residential treatment care management, adult residential treatment, day treatment intensive, rehabilitation, outpatient therapy, medication, and support services.

Specialist - a physician, who specializes in one particular medical area and is responsible for the specialized health care of a member.

Utilization Management (UM) - A formal prospective, concurrent, and/or retrospective critical examination of appropriate use of segments of the health care system.