



**Scripps Health Plan Services
("SHPS")
A California Limited Knox-Keene Licensed Health Plan**

Provider Reference Manual for:

Contracted Providers: Professional, Facilities & Ancillary Providers

**Effective March, 2015
Prepared by SHPS Contracting/Provider Relations Department**

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**SCRIPPS HEALTH PLAN SERVICES
MANAGED CARE OPERATIONS
KEY CONTACTS**

**Hours of Operation: Monday- Friday 8:00am – 5:00pm
Voice mail available after hours**

Mailing Address – Claims

**SHPS
P.O. Box 2079 SV-4
La Jolla, CA 92038**

Mailing Address – Non Claims

**SHPS
10666 N. Torrey Pines Rd. SV-4
La Jolla, CA 92037**

Claims Status Inquiry	1-888-680-2273
Provider Disputes (Claims)	1-888-680-2273
Provider Disputes Fax Number	858-260-5845
Provider Relations	
Irene Evans	858-784-5845
Kimberly DeDonatis	858-784-5892
Janis Aiello	858-784-5886
Da'Jon Howden	858-784-5722
Payer Relations	
Ruby Paragas	858-678-7924
Credentialing	858-678-7939
Credentialing Fax Number	858-260-5845
Customer Service	1-888-680-2273
Customer Service's Fax Number	858-260-5844
Enrollment Inquiry	1-888-680-2273
Enrollment Fax Number	858-260-5874
Quality Improvement	858-678-7939
Quality Improvement Fax Number	858-260-5826
Utilization Management Referral Inquiry	1-888-680-2273
Utilization Management Fax Numbers	
Intake	858-260-5861
SCMG RN	858-260-5871
SCMG Medical Records	858-260-5868
SCMC North RN	858-260-5869
SCMC Escondido Medical Records	858-260-5863
SCMC North Medical Records	858-260-5866
SCMC South Medical Records	858-260-5867
DME	858-260-5833
Home Health	858-260-5835
Out of Network	858-260-5859
Physical Therapy	858-260-5862

www.scripps.org

SCRIPPS HEALTH PLAN SERVICES (“SHPS”) Core Values, Mission, and Vision

Core Values

- ❖ We provide the highest quality of service.
- ❖ We demonstrate complete respect for the rights of every individual.
- ❖ We care for our patients every day in a responsible and efficient manner.

Core Mission

- ❖ We strive to provide superior health services in a caring environment and to make a positive, measurable difference in the health of individuals in the communities we serve.
- ❖ We devote our resources to delivering quality, safe, cost effective, socially responsible health care services. We advance clinical research, community health education, education of physicians and health care professionals and sponsor graduate medical education.
- ❖ We collaborate with others to deliver the continuum of care that improves the health of our community.

Core Vision

- ❖ We will continue to be the leading health care delivery system in the greater San Diego community, as evidenced by the highest clinical quality, patient safety, and patient, physician and employee satisfaction. This will be achieved through unending focus on patient-centered and compassionate care, cost-effective operations, research, advanced technology and innovation.

SCRIPPS HEALTH PLAN SERVICES (“SHPS”) ROLES AND RESPONSIBILITIES

SHPS is a health plan that is licensed by the California Department of Managed Health Care (“DMHC”). Our Limited Knox-Keene HMO license allows us to function as a health maintenance organization, except that we do not market ourselves as a health plan. We partner with fully licensed HMOs that operate within our service area. Our role is to provide comprehensive health care services to our enrolled membership. Health care services are provided by SHPS’ integrated network of participating contracted providers (hospitals, physicians, and ancillary providers). SHPS provides managed care services to the following medical groups:

- ❖ Scripps Clinic Medical Group (“SCMG”)
- ❖ Scripps Coastal Medical Center (“SCMC”)
- ❖ Scripps Cardiovascular and Thoracic Surgery Center (“SCTSC”)
- ❖ SHPS also adjudicates some institutional claims for Mercy Physicians Medical Group (“MPMG”), Primary Care Associates Medical Group (“PCAMG”), San Diego Physicians Medical Group (SDPMG) and MultiCultural

The following are our responsibilities:

- ❖ Claims Payment
- ❖ Contracting
- ❖ Credentialing
- ❖ Eligibility Administration
- ❖ Financial Management
- ❖ Customer Service
- ❖ Provider Relations
- ❖ Quality Improvement
- ❖ Regulatory Compliance
- ❖ Reporting
- ❖ Sub capitation Administration
- ❖ Utilization Management
- ❖ Third Party Recovery

SHPS is committed to meeting the requirements within our contracts, both with our Health Care Service Plan (“HCSP”) partners and our health care provider partners. Specific departments within SHPS ensure compliance with the contractual obligations.

Provider Relations

Contracting/Provider Relations performs the following services for SHPS:

- ❖ Capitation Payment Inquiries
- ❖ Complex Claim and Utilization Management Issue Resolution
- ❖ Contract Analysis
- ❖ Contract Negotiation, Implementation and Interpretation
- ❖ Enrollment Issue Resolution
- ❖ Joint Operation Meeting Facilitation
- ❖ Liaison Between Contracted Providers and SHPS Departments
- ❖ Maintain Provider Directories
- ❖ Provider Education

Credentialing

SHPS is fully delegated to perform all credentialing activities for contracted HCSPs. Practitioners should contact any Scripps Health Hospital Medical Staff Office if they are interested in hospital privileges for that facility. The same application will be used for hospital privileges as is used for SHPS credentialing.

The Quality Improvement (QI) staff, as part of the credentialing and recredentialing process, performs Site Visits and Medical Record Review. You will be contacted in advance if a site visit or audit is needed.

Each contracted practitioner and allied health care professional, i.e. Physician Assistant (“PA”) and Nurse Practitioner (“NP”), is recredentialed no less than every (thirty-six) 36 months. The credentialing staff will send out a practitioner profile and recredentialing questionnaire to be completed. In order to maintain an active status as a SHPS provider, you must complete and return all applications and other requested credentialing documents immediately.

Utilization Management

The purpose of the SHPS Utilization Management (UM) Program is to maintain a comprehensive, coordinated process, which promotes and monitors the effective utilization of health care resources within the SHPS health care delivery system.

SHPS contracts with licensed Health Care Service Plans (“HCSP” or “HMOs” or “Payors”) to provide certain health care services to HCSP enrollees. Health care services will be provided by SHPS’ integrated network of contracted participating providers (hospitals, physicians, and ancillary providers). Recognizing that HCSP may delegate varying levels of UM functions to SHPS, the UM program is designed to encompass all levels within SHPS’ health care delivery system.

The Utilization Management/Quality Improvement Committee (“UMQIC”) is responsible for the ongoing monitoring, evaluation, and improvement of the UM Program. This committee is also responsible for monitoring clinical practices, evaluation of provider utilization and compliance issues, and monitoring and trending of HCSP provider appeals and grievance determinations. The SHPS Medical Director chairs this committee.

Authorization Review is performed by each Primary Medical Group (“PMG”) Medical Director or assigned physician advisor. Each specialty department head is responsible to provide expert review consultation upon request. Other responsibilities of the department heads includes business unit-specific review and analysis of business unit-specific UM performance indicator monitoring in conjunction with the UMQIC and the Medical Director.

Activities within the scope of the UM Program include the following:

- ❖ Elective Admission Authorization
- ❖ Concurrent Review
- ❖ Discharge Planning
- ❖ Case Management
- ❖ Referral Management
- ❖ Ambulatory/Outpatient Services

composed of participating physicians). These criteria and guidelines are subject to annual review and revision, as applicable, by the Committees to ensure that they are consistent with current literature and national guidelines as well as the outcomes and experience of SHPS.

Contracted providers may request copies of any guidelines or review criteria used by SHPS in the course of UM activities by calling the Customer Service Department at 1-888-680-2273.

Medical Necessity Determination Process: UM staff obtains and reviews any necessary clinical information and uses clinical guidelines and criteria approved by the UM/QIC and based on professionally recognized standards of practice in addition to his/her clinical expertise to determine the medical necessity of proposed care. The UM staff will consider the following factors when applying criteria to a given individual:

- ❖ Age
- ❖ Co-morbidities
- ❖ Complications
- ❖ Progress of treatment
- ❖ Psychosocial situation
- ❖ Home environment (when applicable)

Characteristics of the local delivery system available to members such as skilled nursing or sub-acute care facilities and home care to support the patient following hospital discharge and the ability of local hospitals to provide all recommended services within the estimated length of stay must be considered.

If the UM staff is not able to approve the proposed care based on the available information, he/she refers the case to the appropriate Medical Director/Physician Advisor for review and determination of medical necessity. When expert review is indicated, the Medical Director/Physician Advisor will consult with an appropriate specialist not involved in providing the member's care. SHPS adheres to the following policy when reviewing service authorization requests and/or request for payment for services:

- ❖ UM decision making is based only on appropriateness of care and service and existence of coverage.
- ❖ The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or service care.
- ❖ Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization.

Denial Determination – A SHPS Physician Advisor must review the request and any available clinical information, prior to issuance of any denial based on lack of medical necessity. As a part of the review, the Medical Director/Physician Advisor may discuss the case with the attending physician. Denials of service based on medical necessity will always be issued by a physician reviewer. Denial notification will include the name and phone number of the appropriate physician to contact should you wish to discuss the specific SHPS UM criteria.

A written denial notice is faxed within one (1) working day of the decision to the involved parties, which includes, but is not limited to, the following:

- ❖ The facility, if applicable
- ❖ Requesting physician or specialist, as applicable
- ❖ The HCSP when required by contract
- ❖

A written denial notice is mailed within one (1) working day of the decision to the requesting physician, the enrollee or enrollee's legal guardian, if the member is a minor or an incompetent adult.

Denial Determinations for emergent services will be given to the requesting physicians (and enrollee when applicable) verbally or via fax, immediately upon completion of the review. Written notification of determination will follow within one (1) working day.

It is the policy of SHPS to notify all members and providers of the routine and expedited appeal process for the denied authorization request.

If you believe the denial determination is incorrect, you have the right to appeal to the member's HCSP. SHPS and the HCSP request that you submit the appeal within sixty (60) days of the denial notice. You may also appeal directly to the HCSP by following the instructions in the denial notice. Provider appeals received directly by SHPS will be copied to the member's HCSP for review within one (1) working day of receipt.

HCSPs normally have thirty (30) days to process an appeal. In some cases, an expedited (seventy-two) 72-hour appeal is appropriate when the delay in the decision making might pose an imminent and serious threat to the member's health, including but not limited to potential loss of life, limb, or major bodily function. If you, a physician, request an expedited appeal, the HCSP will automatically expedite the appeal. You may file an oral or written request for a (seventy-two) 72-hour appeal.

An extension up to fourteen (14) calendar days is permitted for a standard or an expedited appeal, if the extension of the appeal is needed to provide the HCSP with additional information or if diagnostic tests need completion.

Note that most HCSP will not accept direct provider appeals without written approval from the patient for the provider to appeal on their behalf. However, providers may submit appeals directly to SHPS at the address noted on the denial letter without written patient approval. Information for appeals is also available through SHPS' UM Department, the Customer Service Department, or from the Medical Director.

Customer Service

The Customer Service Department is the initial contact for both members and providers. Their responsibilities vary and are an integral part of the health plan. They coordinate with each and every department within SHPS, act as a liaison to the HCSPs, and coordinate provider inquiries.

Customer Service Representatives are prepared to answer inquiries from members and providers for an array of issues, ranging from:

- ❖ Provider claim and authorization status for those claims and authorizations that are SHPS' responsibility
- ❖ Authorization or Claim Denial Issues
- ❖ Member Eligibility Issues
- ❖ Primary Care Physician changes
- ❖ Member Grievance and Complaint resolution
- ❖ Inquiries regarding the Contracted Provider Dispute Resolution Process
- ❖ General questions regarding UM criteria

Eligibility Administration

SHPS is responsible for implementing and maintaining an accurate database of HMO and POS managed care members enrolled with SHPS contracted medical groups (e.g. Scripps Clinic Medical Group or Scripps Coastal Medical Center) where SHPS has financial risk or has Utilization Management responsibilities. SHPS works very closely with the contracted HCSPs to obtain timely and accurate membership data. There is a time delay, as the HCSPs must also rely upon receipt of accurate data from their clients. Policies and Procedures are in place to ensure that a member's eligibility is verified by the HCSP prior to enrolling a new HMO member in the SHPS database. The majority of HCSPs have contract language, which enables them to retroactively add or terminate an HMO or POS member.

Claims Adjudication

SHPS is delegated by **specific** HCSPs to pay claims for members. Please refer to the most recent Health Plan Matrix – Professional or Institutional to determine where to submit claims. The Health Plan Matrices provide general guidelines.

The Claims Department is responsible for accurately and promptly processing claims for which SHPS is financially responsible. SHPS utilizes a claim scrubbing software program that automatically applies Medicare Correct Coding Initiative (“CCI”) edits along with other coding guidelines for appropriate billing practices. This software provides auditing logic for all modifiers allowing payment modifications, if appropriate. SHPS will process claims based on the industry standards, CPT guidelines, CCI edits, Medicare guidelines and in compliance with State and Federal regulations.

Claims Submission Instructions: Effective January 1, 2014, you will be able to submit your claims electronically via 837-5010 format to Office Ally. SHPS' Client ID number is: SHPS1. You may register to submit claims electronically to Office Ally calling 1-360-975-7000 #3 for New Users; by completing the Enrollment Request Form online at www.officeally.com for New Users; or by calling 1-360-975-7000, #1 for Existing Users. Please remember to follow instructions below when submitting your claims to ensure acceptance.

Authorization Requirements: SHPS is responsible for authorizations for services provided to managed care members consistent with Scripps Clinic Medical Group (“SCMG”), Scripps Coastal Medical Center (“SCMC”) procedures. For Mercy Physicians Medical Group (“MPMG”), Primary Care Associates Medical Group (“PCAMG”), San Diego Physicians Medical Group (“SDPMG”) and MultiCultural please obtain your authorization directly from the respective medical group. Provider must verify whether any procedures require pre-authorization from SHPS, NAMM or the individual IPA.

Institutional Claims Direct Entry: When submitting your claim, be sure you are using the correct Type of Bill Code, such as for services with locations of Inpatient, Outpatient hospital, Skilled Nursing and Home Health, etc.

Special or Unique Billing Codes: If you are a provider whose contract has the approval to use special billing or unique billing codes please follow there instructions:

We are requesting that the special billing code(s) be sent at the line level (2400 loop) or the 837 claim file. Specifically the 2400 NTE segment with qualifier of ADD. For example: NTE*ADD*EP

In cases where a description needs to be sent along with the code, the caret character (^) needs to be added to separate the code from the description.

All other 5010 Requirements are to be followed.

Timeliness Claims Submission

Commercial Enrollees: Claims that are the financial responsibility of SHPS must be submitted **within ninety (90) calendar days from the date of service.**

- ❖ If SHPS is not the primary payer based on the Coordination of Benefits (COB), the provider may submit a supplemental or COB claim within ninety (90) calendar days from the Date of Payment or Date of Contest or Denial, or notice from the primary payer. The Explanation of Benefits (EOB) from the primary payer must be included with the claim.
- ❖ If SHPS receives a claim that is not our financial responsibility, but the responsibility of the member's HCSP, SHPS will forward the claim to the member's HCSP within ten (10) working days of the receipt of the claim that was incorrectly sent to SHPS. Please review your Health Plan Matrix – Professional and Institutional before rebilling to ensure you are submitting your claims to the correct entity.

Senior Enrollees: Claims that are the financial responsibility of SHPS must be submitted **within sixty (60) calendar days from the date of service.**

- ❖ If SHPS is not the primary payer based on the Coordination of Benefits (COB), the provider may submit a supplemental or COB claim within sixty (60) calendar days from the Date of Payment or Date of Contest or Denial, or notice from the primary payer. The Explanation of Benefits (EOB) from the primary payer must be included with the claim.
- ❖ If SHPS receives a claim that is not our financial responsibility, but the responsibility of the member's HCSP, SHPS will forward the claim to the member's HCSP within ten (10) working days of the receipt of the claim that was incorrectly sent to SHPS. Please review your Health Plan Matrix – Professional and Institutional before rebilling to ensure you are submitting your claims to the correct entity.

Sending Claims to SHPS: Claims for services provided to SHPS Enrollees for whom SHPS has financial responsibility must be sent to the following:

Via mail: PO Box 2079, SV-4, La Jolla, CA 92038

Via physical delivery: 10170 Sorrento Valley Road, SV-4, San Diego, CA 92121

Calling SHPS Regarding Claims: For claim filing requirements or status inquiries, you may contact Customer Service at **1-888-680-2273**. Providers who have access to Cerecons/Aerial Care Coordination ("ACC") may view claims status online.

Claim Submission Requirements: The following is a list of the necessary claims documentation required by SHPS:

- ❖ **ICD -10 General Claims Submission Information, Effective October 1, 2014**
 - Professional and Institutional claims received electronically or on paper with ICD-9 codes will not be accepted with dates of services on or after October 1, 2015. These claims will be returned to the provider. The provider will be required to resubmit the claims with the appropriate ICD-10 codes.

- A claim cannot contain both ICD-9 and ICD-10 codes if the services span after October 1, 2015. These claims must be split on separate claims to reflect either Dates of Service September 30, 2015 and prior with ICD-9 codes or Dates of Service October 1, 2015 and after with ICD-10 codes.

- ❖ The CMS 1500, UB-04 or equivalent form shall include, but not be limited to, the following data elements:
 - ❖ Enrollee's full name and address
 - ❖ Enrollee's HCSP identification number
 - ❖ Enrollee's date of birth
 - ❖ Enrollee's sex
 - ❖ Enrollee's HCSP affiliation
 - ❖ Diagnostic code and description (ICD-9 or ICD-10, if applicable)
 - ❖ Date of service
 - ❖ Place of service
 - ❖ Procedures, services or supplies furnished. CPT codes (current year) shall be used for all professional services and HCPCS codes shall be used for supplies, equipment, injections, etc. Items not listed shall be billed utilizing CPT and HCPCS guidelines
 - ❖ Physician Group, Physician's name and Facility Name
 - ❖ Required National Provider Identifier ("NPI") Number
 - ❖ Physician's address and telephone number
 - ❖ Charges
 - ❖ Units
 - ❖ Prior Authorization Number

Claim Receipt Verification: For verification of claim receipt by SHPS, please call Customer Service at 1-888-680-2273. Providers who have access to Cerecons/Aerial Care Coordination ("ACC") may view claims status online.

Reimbursement Timeliness

SHPS will adjudicate complete claims **within sixty (60) calendar days (Forty-five [45] working days)** of Date of Receipt. A complete claim is defined as a claim that may be processed without obtaining additional information from the provider of service or from the patient.

SHPS may contest or deny a claim, or portion thereof, by notifying the Provider, in writing on the Explanation of Benefits (EOB), that the claim is contested or denied, **within sixty (60) calendar days (Forty-five [45] working days)** after the Date of Receipt of the claim by SHPS.

If an uncontested Provider claim is not processed **within sixty (60) calendar days (Forty-five [45] working days)**, then the Provider is entitled to applicable State or Federal interest. A \$10.00 charge will also be imposed if SHPS fails to include the interest amount in a payment to a Provider. Late payments on complete claims for emergency service shall include \$15.00.

Dispute Resolution Process for Contracted Providers

Definition of Contracted Provider Dispute: **A Contracted Provider Dispute is a provider's written notice to SHPS and/or the member's applicable HCSP, challenging, appealing or requesting reconsideration of:**

- ❖ A claim or a bundled group of substantially similar multiple claims that are individually numbered, that have been denied, adjusted or contested, or
- ❖ Seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billings), or
- ❖ Other contractual disputes that are individually numbered, or
- ❖ Disputing a request for reimbursement of an overpayment of a claim.

Resubmitted claims that have additional information attached such as records, authorization or itemized statements that have been previously processed and paid at zero should be marked "corrected claim" and are not considered Provider Disputes. Please do not submit these types of claims as a Provider Dispute.

- ❖ Each Contracted Provider Dispute must be in writing and contain at a minimum the following information:
 - Written notation on the cover sheet that it is a Provider Dispute Request
 - Provider's Name
 - Provider's Identification Number (Tax ID)
 - Provider's Contact Information, and
 - If the Contracted Provider Dispute concerns a claim the following must be provided:
 - Member/Patient Name and Date of Birth
 - Corrected claim (if appropriate)
 - Reports or other supporting attachments, i.e. progress notes, operative reports, etc.
 - A clear written identification of the disputed item(s)
 - SHPS claim number(s)
 - Copy of the SHPS Explanation of Benefits (EOB)The Date of Service
 - A clear explanation in writing of the basis upon which the Provider believes the payment amount, request for additional information, contest, denial, adjustment or other action is incorrect

If the Contracted Provider Dispute involves a bundled group of substantially similar claims each claim must be individually numbered.

If the Contracted Provider Dispute is not about a claim, a clear written explanation of the issue and the provider's position on such issue.

If the Contracted Provider Dispute represents an enrollee or group of enrollees the following written information must be provided:

- ❖ The names and identification number(s) of the enrollee or enrollees
- ❖ The Date of Service
- ❖ A clear written explanation of the disputed item and the Provider's position on the dispute
- ❖ An enrollee's written authorization for Provider to represent said enrollee.

The member's HCSP Grievance and Appeal Program shall process these disputes.

If the Contracted Provider Dispute involves an issue of medical necessity or utilization review, Provider shall have an unconditional right of appeal. Provider shall appeal the claim dispute to the

member's HCSPs' dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from SHPS' Date of Determination.

Exhibit (1) Provider Dispute Resolution Request Form: Included in this Provider Reference Manual is the Provider Dispute Resolution Form. It must be used to submit a Provider Dispute Resolution Request.

Sending a Contracted Provider Dispute to SHPS: Contracted Provider Disputes submitted to SHPS must include the information listed in Section 1 of Dispute Resolution Process for Contracted Providers for each Contracted Provider Dispute. All Contracted Provider Disputes must be sent to the attention of **SHPS Provider Disputes Department** at the following:

Via Mail:	PO Box 2079, SV-4, La Jolla, CA 92038
Via Physical Delivery:	10170 Sorrento Valley Road, SV-4, San Diego, CA 92121
Via fax:	858-260-5845

Time Period for Submission of Provider Disputes

Commercial Enrollees: Contracted Provider Disputes for Commercial Enrollees **must be received by SHPS within three hundred and sixty-five (365) calendar days** from SHPS' date of last action that led to the dispute, or in the case of inaction, Contracted Provider Disputes must be received by SHPS **within three hundred and sixty-five (365) calendar days** after the time for contesting or denying a claim has expired. Contracted Provider Disputes that do not include all required information set forth in Section "1" may be returned to the submitter for completion. An amended Contracted Provider Dispute, which includes the missing information, must be submitted to SHPS **within thirty (30) working days** of the receipt of a returned Contracted Provider Dispute.

Senior Enrollees: Effective January 1, 2011, SHPS will apply the Centers for Medicare & Medicaid Services (CMS) Provider Dispute Resolution for Non-Contracted Providers timelines to Contracted providers. Submission of a Senior Provider Dispute **must be received by SHPS within one hundred and twenty (120) calendar days** from SHPS' date of last action that led to the dispute (i.e. EOB's, RA's, or Letters). Additionally, Senior Enrollee Provider Disputes must include all of the data elements noted in DISPUTE RESOLUTION PROCESS FOR CONTRACTED PROVIDERS, Section "1" **Definition of Contracted Provider Dispute**. Provider Disputes that do not include all required information set forth in Section "1" may be returned to the submitter for completion. An amended Contracted Provider Dispute, which includes the missing information, must be submitted to SHPS **within fourteen (14) calendar days** of the receipt of a returned Provider Dispute.

Providers Disputes would include:

- ❖ Decisions where a provider contends that the amount paid for a covered service is less than the contracted rate including those claims denied for no authorization.
- ❖ Provider payment disputes where there is a disagreement between provider and SHPS about SHPS' payment policies related to coding.
- ❖ Providers must provide documentation and good cause for late filing.

Providers Disputes would ***not*** include:

- ❖ Medical necessity determinations
- ❖ Disputes for which no initial determination has been made

Acknowledgement of Commercial and Senior Enrollee Contracted Provider Disputes: SHPS will acknowledge receipt of all Contracted Provider Disputes by sending an acknowledgment letter **within fifteen (15) working days** from the Date of Receipt by SHPS.

Contacting SHPS Regarding Contracted Provider Disputes: Inquiries regarding the status of a Contracted Provider Dispute or about filing a Contracted Provider Dispute must be directed to SHPS' Customer Service Department at 1-888-680-2273.

Time Period for Resolution and Written Determination of Commercial Enrollee Contracted Provider Dispute: SHPS will issue a written determination stating the pertinent facts and explaining the reasons for its determination **within forty-five (45) working days** after the Date of Receipt of the Commercial Enrollee Contracted Provider Dispute or the amended Commercial Enrollee Contracted Provider Dispute.

Time Period for Resolution and Written Determination of Senior Enrollee Contracted Provider Dispute: For Provider Disputes received on or after January 1, 2011, SHPS will issue an EOB or letter noting the disposition of the Senior Enrollee Contracted Provider Dispute. Notification will be made **within sixty (60) calendar days** after the Date of Receipt of the Senior Enrollee Contracted Provider Dispute or the amended Senior Enrollee Contracted Provider Dispute. Notification will be made **within thirty (30) calendar days** after the Date of Receipt of the Senior Enrollee Non-Contracted Provider Dispute or the amended Senior Enrollee Non-Contracted Provider Dispute.

Past Due Payments: If the Contracted Provider Dispute involves a Commercial enrollee's claim and it is determined in whole or in part in favor of the Provider, SHPS will pay any outstanding monies determined to be due, and applicable State interest and penalties required by law or regulation.

If the Contracted Provider Dispute involves a Senior enrollee's claim and it is determined in whole or in part in favor of the Provider, SHPS will pay any outstanding monies determined to be due, and applicable Federal interest and penalties required by law or regulation.

Claim Overpayments – SHPS' Request for Provider to Reimburse SHPS for an Overpayment of a Claim or Claims

Time Period for Request of an Overpayment: SHPS must submit a written request for a refund of an overpayment to the Provider **within three hundred and sixty-five (365) calendar days** from the Date of Payment.

Notice of Overpayment of a Claim: If SHPS determines that SHPS has overpaid a claim or claims, SHPS will notify the Provider in writing through a separate notice. The notice will clearly identify the claim, the name of the member/patient, the Date of Service(s) and a clear explanation of the basis upon which SHPS believes the amount paid on the claim(s) was in excess of the amount due, including applicable State or Federal interest and penalties on the claim.

Contested Notice: If the Provider contests SHPS' notice of overpayment of a claim, the Provider, **within thirty (30) working days** of the receipt of the notice of overpayment of a claim, must send written notice to SHPS. The notice must state the basis upon which the Provider believes that the claim was not overpaid. SHPS will process the contested notice in accordance with SHPS' Contracted Provider Dispute Resolution Process described in this Provider Reference Manual.

No Contest: If the Provider does not contest SHPS' notice of overpayment of a claim, the Provider must reimburse SHPS **within thirty (30) working days** of the Provider's receipt of the notice of overpayment of a claim.

Offsets to Payments: SHPS may only offset an uncontested notice of overpayment of a claim against Provider's current claim submission when the Provider fails to reimburse SHPS within the time frame set forth above. In the event that an overpayment of a claim or claims is offset against the Provider's current claim or claims pursuant to this section, SHPS will provide the Provider with a detailed written description. The Claims Department will send a letter **within ten (10) calendar days** identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

Coordination of Benefits

Coordination of Benefits (COB) determines responsibility for paying eligible expenses amongst insurers providing group coverage to the member. This ensures that the total of all reasonable expenses for covered services and supplies are paid up to the coverage limits, but will not exceed the total expense incurred for those services and supplies.

Prime Carrier Rule

Responsibility for paying benefits is determined by using the Rules Establishing the Order of Benefits Determination, which was developed by the Department of Managed Health Care.

The Member's Evidence of Coverage describes in detail the primary coverage determination rules. For commercial members the most common dual coverage is for dependent children.

Quality Improvement (QI)

Quality Improvement Overview: The purpose of the SHPS Quality Improvement (QI) Program is to maintain a comprehensive, coordinated process that continually evaluates, monitors, and improves the quality of clinical care and service provided to enrollees within the SHPS health care delivery system.

The QI Department should be notified immediately if you identify a potential quality or risk management issue. Also, the QI Department must be involved in all patient behavioral issues such as patient disenrollment or discharge from a practice.

Quality Improvement Program Components: SHPS' QI Program incorporates review and evaluation of all aspects of the health care delivery system. Following is an outline of several components of the QI Program.

Medical Record Review/Documentation Audits: SHPS will use approved standards that are communicated to providers. Medical record audit activities are often directed to the PCP, however audits of other practitioners and ancillary providers will be conducted as directed by the Healthcare Operations Oversight Committee ("HOOC") and Utilization Management Quality Improvement Committee ("UMQIC").

Grievances and Complaints: SHPS will maintain a process for resolving enrollee complaints in conjunction with the HCSPs. The QI Department will have overall responsibility for:

- ❖ Maintaining and updating grievance policies and procedures
- ❖ Review and evaluation of the operations and results of the grievance process
- ❖ Review and assessment of trended data for identification and implementation of care service, and/or process improvements
- ❖ Utilization of any emergent patterns of grievances in the formulation of policy and procedure changes
- ❖ Utilization of any emergent patterns of grievances in the formulation of policy and procedure changes

Recommendations for grievance policy changes will be referred to the UMQIC for review and approval as applicable.

Organizational Provider Quality Assessments: Prior to contracting with a hospital, skilled nursing facility, free standing surgical center, or home health agency, SHPS will confirm that the facility has obtained accreditation from a recognized accreditation body and has met all state and federal licensing requirements. Re-verification of this information is performed at least every three (3) years.

Corrective Action Process: When the UMQIC, HCSP or one of the related Review Panels determines that inappropriate care or sub-standard services have been provided or services which should have been furnished have not been provided, the Associate Medical Director of QI is responsible for communicating concerns identified by the UMQIC and working with the provider to develop a corrective action plan. The SHPS UMQIC reserves the right to terminate a Provider contract. SHPS also recognizes that HCSPs retain the right to make final decisions on all recommendations pertaining to a provider's participation in the HCSPs delivery system.

Sanction activities currently used by SHPS are described in the Disciplinary Policy/Appeals Process and Reduction, Suspension or Termination of Provider Status Policy.

Regulatory Compliance, Fraud, Waste and Abuse

The purpose of the SHPS' Compliance Department is to provide oversight of the regulatory communications, reporting, auditing, monitoring and ensuring compliance auditing, management, administration and document file control for the Limited Knox-Keene license issued by the DMHC. Establish methods for objectively and systematically evaluating and investigating potential fraud and/or abuse of the Scripps Health Plan Services Health Care delivery system. Scripps Health Plan Services strives to continuously improve the structure, processes and outcomes of its anti-fraud activities.

The DMHC is responsible for the following activities:

- ❖ Ensure SHPS is in compliance with the DMHC, Knox-Keene Health Care Service Act of 1975 as amended
- ❖ Coordinate information flow among the various constituents within the Managed Care Department regarding all compliance and regulatory issues
- ❖ Develops and coordinates internal compliance review activities to assure timeliness, progress and improvement
- ❖ Is the Liaison to the DMHC
- ❖ Ensuring that all contracted providers have met the fraud, waste, and abuse certification requirements through enrollment into the Medicare program or through accreditation as a

supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the FWA training and education requirements

Fraud and Abuse Prevention and Detection: Potential fraud and/or abuse cases will be submitted to the Manager, Managed Care Compliance for tracking, review, investigation, and reporting to the UMQIC, Healthcare Operations Oversight Committee, and the HCSP as necessary. Potential fraud or abuse cases may come from a variety of sources including:

- ❖ Enrollees
- ❖ UM Staff
- ❖ Claims Staff
- ❖ HCSPs
- ❖ Providers
- ❖ Regulatory Agencies
- ❖ Customer Service Staff
- ❖ Case Management Staff

Types of data accessed to identify potential fraud or abuse issues may include:

Claims data	Assessment of PCP panel size
Medical records	Grievances and complaints
Enrollee surveys	Risk management reports
Provider surveys	Utilization management statistics
Staff surveys	Sentinel event reports
Financial data	Laboratory reports

What is fraud? Fraud is defined as "...knowingly or willfully executing, or attempting to execute, a scheme to defraud any health care benefit program, or to obtain money or property from a health care benefit program through false representations..."

One of our primary goals with our Fraud and Abuse Prevention Plan is to educate our staff and providers about fraud and how to report suspected fraud for investigation. Some of the more common types of fraud include:

- ❖ Billing for unnecessary services
- ❖ Billing for services that were not provided
- ❖ Upcoding and unbundling
- ❖ Kickback/referral schemes
- ❖ Falsification of documentation
- ❖ Misrepresentation by a patient to obtain coverage or obtain treatment for uncovered services
- ❖ Identity theft to obtain treatment for a non-member or falsely bill as a provider
- ❖ Illegal sale of member ID numbers

Complete details of the SHPS Compliance Program, Anti-Fraud Training and processes may be obtained by contacting the Manager of Managed Care Compliance at 858-784-5961.

Our Corporate Compliance Program, SHPS' Standard of Conduct, Conflict of Interest and Harassment Free Work Place policies are also accessible on our website home page at www.scrippshealth.org under the vendor information section.

Reporting Compliance Issues and Concerns: SHPS' policies and the *Standards of Conduct* require all contracted providers and employees of SHPS to promptly report instances of non-compliance with relations to a managed care patient. Providers and employees are advised to report concerns to the Manager of Managed Care Compliance, Linda Pantovic at 858-784-5961, via email at

Pantovic.Linda@ScrippsHealth.Org or via the **Scripps Compliance and Patient Safety Alertline (1-888-424-2387)**. All communications are maintained in a confidential manner, to the extent permitted by applicable law, and will be used only for the purpose of investigating and correcting instances of non-compliance, as necessary. If an employee reports a compliance issue directly to management, that manager is required to promptly notify the Manager of Managed Care Compliance or Audit & Compliance Services of the matter.

SHPS' Non-Retaliation Policy: It is SHPS policy that neither retribution nor retaliation for reporting a compliance violation or concern will be tolerated. Efforts will be made to protect the identity of the employee to the extent allowable by law. Anonymity cannot be protected if individuals identify themselves or provide information that may reveal their identity.

Training-: Contractor has implemented written compliance policies and procedures and Standards of Conduct compliant with the requirements of Chapter 21 and distributes the foregoing to all employees who provide health or administrative services for Medicare beneficiaries who are enrolled in a Medicare Part C or Part D plan (hereinafter referred to as "Employees"). Contractor requires employees within (ninety) 90 days of hire and at least annually thereafter to take general compliance training required by CMS and communicates to its employees general compliance information provided by SHPS.

CONTRACTED PROVIDERS ROLE AND RESPONSIBILITIES

Access Standards: As a contracted provider of SHPS, you are required to comply with HCSP and regulatory standards regarding access to care and services for SHPS members. The following standards are monitored on an ongoing basis:

Non-Emergent Appointment Access Standards – Medical	
Appointment Type	Time-Elapsed Standard
Non-urgent appointments for Primary Care Physician (PCP)	Must offer the appointment within 10 Business Days of the request
Non-urgent appointments with Specialist physicians (SPC)	Must offer the appointment within 15 Business Days of the request
Urgent Care appointments that do not require prior authorization (PCP)	Must offer the appointment within 48 hours of request
Urgent Care appointments that require prior authorization	Must offer the appointment within 96 hours of request
Non-urgent appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within 15 Business Days of the request
<p><u>Exceptions:</u> Preventive Care Services and Periodic Follow Up Care:</p> <p>Preventive Care Services and periodic follow up care including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.</p>	

Preventive Care Guidelines

SHPS has adopted the US Preventive Services Task Force (USPSTF) Preventive Care Guidelines as the standard that will be used from a utilization and quality perspective. Your review and usage of these guidelines will ensure best practices for your patients. The link to review these standards is: <http://www.ahrq.gov/clinic/prevenix.htm>

Advanced Directives

The Omnibus Budget Reconciliation Act of 1990 is intended to provide individuals with information about their state's laws regarding advanced directives and encourage compliance by health care providers with any advance directives. An advanced directive is any written document, made in advance of an incapacitating illness or injury, in which an individual specifically makes choices about health care treatments or names someone to make these treatment decisions if he or she is incapable.

Under this law, you are required to inform patients about their rights to institute an Advance Directive. Since SHPS does not have direct contact with its members as patients:

- ❖ The physician must communicate information to each patient regarding the right to institute an advance directive and,
- ❖ The physician is required to document the results of this discussion in the patient's medical record file. If the patient completes an advance directive, a copy of it should be included in this file.

What We Expect From You

As a Provider of SHPS, since this is an extension of your contract, you are required to:

- ❖ Understand and abide by the Knox Keene Health Care Service Plan Act of 1975 that protects members from receiving bills or statements of any kind, except for non-authorized services (if member is made aware of financial responsibility in advance and in writing), non-covered services and/or co-payments
- ❖ Provide all covered Hospital or Professional or Ancillary services to members enrolled through SHPS as authorized
- ❖ Freely communicate with patients regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations
- ❖ Obtain prior Authorization from SHPS when required. Failure to obtain prior authorization may result in non-payment of claims. It is your responsibility to request retro-authorization
- ❖ Adhere to the HCSP Formularies and Mandatory Generic Prescription policies.
- ❖ Participate in the Quality Improvement and Utilization Management procedures defined by SHPS
- ❖ Comply with credentialing and re-credentialing requirements as stipulated
- ❖ Ensure SHPS has current Medical and DEA Licenses on file
- ❖ Use SHPS contracted providers for your Hospital, Professional and Ancillary service needs
- ❖ If an out-of-plan second opinion is authorized, co-payments should be consistent with in-plan co-payments to the same type of provider
- ❖ Adhere to SHPS Fraud, Waste, and Abuse & Compliance training as stipulated above in accordance to *Chapter 21, Section 50.3, 42 CFR §§ 422.503(b)(4)(vi)(C), 423.504(b)(4)(vi)(C)*

- ❖ Contractor retains records to support all Compliance Activities for at least **ten (10) years** or longer if required by applicable law

Verifying Eligibility

SHPS members should present for services with their insurance identification card issued by their HCSP. HCSP ID cards contain pertinent information about the member's Primary Medical Group (PMG) and co-payments. SHPS members will have SCMG or SCMC listed as their PMG. You are responsible for verifying eligibility with the HCSP prior to rendering authorized services.

Referrals and Authorizations

As a contracted provider with SHPS your contract is for the provision of authorized services to enrolled members of SHPS contracted HCSPs.

You will receive a written authorization form that will specify the extent of the services authorized. You may not exceed those authorization limits without an additional authorization form, except in the case of a medical emergency. You should inform the patient's primary care physician of the need for further referral, treatment, or consultation. Please use the required authorization form or enter via Cerecons/Aerial Care Coordination (ACC) to request additional services. ACC access requires a user name and password. Should you not have access to Cerecons/Aerial Care Coordination (ACC), you may fax the request for authorization to the SHPS UM department at 858-260-5861. For additional information on ACC, contact Provider Relations at 858-784-5722. If you have any questions about an authorization, please call Customer Service at 1-888-680-2273 and request the Utilization Review Coordinator who deals with your type of service (e.g. home health, hospice, DME, etc.).

Member Billing

As a provider you agree contractually to look solely to SHPS as the source of final payments for HMO patient's referred by SHPS contracted medical groups (e.g. SCMG or SCMC). **You understand it is a violation of law to bill HMO patients directly except for co-payments, co-insurance or for benefits not covered by HMO insurance.** For benefits not covered by HMO insurance, please obtain a written waiver from the patient to prevent misunderstandings.

SHPS has various contracts including dual eligible contracts. It should also be noted that **under no circumstances** should a provider of Medi-Cal services submit claims to, or demand or otherwise collect reimbursement from, a Medi-Cal beneficiary or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal Managed Care Program's scope of benefits as well as any applicable Medicare deductibles or coinsurance.

ICD-9 / ICD-10 Coding Accuracy

As a health care provider you are expected to report all diagnosis codes that impact the patient's care and ensure these diagnoses are accurately documented in a medical record. This includes the main reason for the episode of care; and all co-existing, acute or chronic conditions; and pertinent past conditions that impact clinical evaluation and therapeutic treatment. Symptoms that are

common to the main reportable diagnosis should not be coded. Report ICD-9-CM / ICD-10-CM codes to the highest level of specificity on all billing forms and/or encounter data forms. The Risk Adjustment Payment model implemented by The Centers for Medicare and Medicaid Services (“CMS”) relies upon the diagnosis code to ensure that physicians and providers are paid appropriately for the services they render to Medicare Advantage Beneficiaries.

Confidential Information

It is the responsibility of every health care provider and governed by law that their employees ensure the confidentiality of records and related information for all patients. Each contracted provider (Business Associate) must comply with certain provisions of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), and such regulations as may be lawfully promulgated thereunder by the federal Department of Health and Human Services (“HHS”) that relate to the privacy of individually identifiable health information. Confidential information includes, but is not limited to:

- ❖ Patient Records
- ❖ Medical Records (Including Electronic Health Information)
- ❖ Files
- ❖ Faxes
- ❖ Medical Claims
- ❖ Information from organizational or medical staff committees
- ❖ UR Committees
- ❖ Information received from non-SHPS physicians and external agencies

Each provider must maintain a Confidentiality Policy and Procedure, which ensures patient information, remains confidential. SHPS reserves the right to request a copy of a provider’s Confidentiality Policy and Procedure.

Language Assistance

As required by law, each SHPS has established and implement a language assistance program. When SHPS is acting as the primary plan it establish and maintain an ongoing language assistance program to ensure Limited English Proficient (“LEP”) enrollees have appropriate access to language assistance while accessing health care services as required by the Language Assistance Program Regulations. Provider shall cooperate and comply, as applicable, with the SHPS language assistance program; however, SHPS shall maintain ongoing administrative and financial responsibility for implementing and operating on an ongoing basis the language assistance program for its enrollees. The provider may SHPS Customer Service at 1-888-680-2273. When SHPS is not the primary plan and not delegated for the language assistance program the provider may contact the enrollee’s primary health plan for assistance.

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Exhibit 1

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to:

Scripps Health Plan Services PDR Department
 PO Box 2079, SV-4, La Jolla, CA 92038
 La Jolla, CA 92038
 Fax: 858-260-5845

*PROVIDER NPI:	PROVIDER TAX ID:
*PROVIDER NAME:	
PROVIDER ADDRESS:	

PROVIDER TYPE MD Mental Health Professional Mental Health Institutional Hospital ASC
 SNF DME Rehab Home Health Ambulance Other _____
(please specify type of "other")

CLAIM INFORMATION Single Multiple "LIKE" Claims (complete attached spreadsheet) *Number of claims:* _____

* Patient Name:		Date of Birth:
* Health Plan ID Number:	Patient Account Number:	Original Claim ID Number: (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	Original Claim Amount Billed:	Original Claim Amount Paid:

DISPUTE TYPE	
<input type="checkbox"/> Claim	<input type="checkbox"/> Seeking Resolution Of A Billing Determination
<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision	<input type="checkbox"/> Contract Dispute
<input type="checkbox"/> Disputing Request For Reimbursement Of Overpayment	<input type="checkbox"/> Other:

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print)	Title	Phone Number
Signature	Date	() Fax Number

For Health Plan/RBO Use Only

TRACKING NUMBER _____ PROV ID# _____

CONTRACTED NON-CONTRACTED

PROVIDER DISPUTE RESOLUTION REQUEST
For use with multiple "LIKE" claims (claims disputed for the same reason)

	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid
	Last	First						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

PROVIDER DISPUTE RESOLUTION REQUEST

For use with multiple “LIKE” claims (claims disputed for the same reason)

INSTRUCTIONS

- This optional form may be used to track the status, time-frames and disposition of the Provider Dispute Resolution.
- The entity processing the Provider Dispute Resolution should track the following information internally for ensuring compliance with regulations and for later reporting to the appropriate entity.

TRACKING NUMBER:	PROVIDER ID or NPI#:
a. PROVIDER NAME:	b. CONTRACTED PROVIDER: ____ YES ____ NO
c. DATE DISPUTE RECEIVED (Date Stamped):	d. DATE OF INITIAL PAYMENT OR ACTION:
e. WAS DISPUTE RECEIVED WITHIN TIMEFRAME? (c – d) ____ YES ____ NO (If NO, should be returned to provider without action)	
f.1. DISPUTE TYPE: <input type="checkbox"/> CLAIM <input type="checkbox"/> APPEAL OF MEDICAL NECESSITY/UM DECISION <input type="checkbox"/> BILLING DETERMINATION <input type="checkbox"/> OVERPAYMENT DISPUTE <input type="checkbox"/> CONTRACT DISPUTE <input type="checkbox"/> OTHER _____ (Please specify type of “other”)	
f.2. PROVIDER TYPE: <input type="checkbox"/> PROFESSIONAL <input type="checkbox"/> INSTITUTIONAL <input type="checkbox"/> OTHER	
g. DATE DISPUTE ACKNOWLEDGED:	h. TURNAROUND TIME (g – c):

TYPE OF LETTER SENT: (List the various ICE letters as applicable)

IF NO ADDITIONAL INFORMATION REQUESTED:

j. DATE OF ACTION:	k. ACTION TURNAROUND TIME (j – c):	l. TYPE OF ACTION <input type="checkbox"/> UPHELD <input type="checkbox"/> OVERTURNED <input type="checkbox"/> OTHER
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IF ADDITIONAL INFORMATION REQUESTED:

m. DATE ADDITIONAL INFO REQUESTED:	n. TURNAROUND TIME (m – c):	
o. DATE ADDITIONAL INFO RECEIVED:	p. RECEIPT TURNAROUND TIME (o – m):	
q. DATE OF ACTION:	r. ACTION TURNAROUND TIME (q – o):	s. TYPE OF ACTION <input type="checkbox"/> UPHELD <input type="checkbox"/> OVERTURNED <input type="checkbox"/> OTHER

COMPLETE DESCRIPTION OF DETERMINATION RATIONALE: