Scripps Health Plan

Scripps Health Plan
(SHP)
A California Knox-Keene Licensed Health Plan

Provider Operations Manual

Contracted Providers: Professional, Facilities & Ancillary Providers

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Scripps Health Plan
KEY CONTACTS
Hours of Operation: Monday- Friday from 8:00am – 5:00pm
Voice mail available after hours

Mailing Address: Scripps Health Plan Mail Drop: 4S-300 10790 Rancho Bernardo Road San Diego, California 92127 **Claims** P.O. Box 2529 La Jolla, CA 92038	**Provider Dispute Resolution** P.O. Box 1928 La Jolla, CA 92038 **Member Services** P.O. Box 2749 La Jolla, CA 92038
Claims Status Inquiry **Claims Fax**	**844-337-3700** **858-260-5852**
Provider Disputes Inquiry **Provider Disputes Fax**	**844-337-3700** **858-260-5878**
Provider Relations **Irene Evans** **Contracts & Provider Relations Specialist, Sr.** **Loretta Moody** **Contracts & Provider Relations Specialist, Sr.** **Annette Carter** **Contracts & Provider Relations Coordinator** **Elvia Cabrera** **Contracts & Provider Relations Coordinator** **Payer Relations** **Ruby Paragas** **Payer Relations Specialist, Sr.**	 **858-927-5400** **858-927-5425** **858-927-5427** **858-927-5399** **858-927-5361**
Credentialing **Credentialing Fax Number**	**858-678-7939** **858-260-5843**
Customer Service	**844-337-3700**
Customer Service TTY (hearing impaired)	**888-515-4065**
Customer Service's Fax Number **Customer Service E-Mail**	**858-964-3102** **customerservice@scrippshealth.org**
Enrollment Inquiry	**844-337-3700**
Enrollment Fax Number	**858-964-3102**
Compliance **Appeals & Grievances Phone Number** **Appeals & Grievances (Routine) Fax** **Appeals & Grievances (Emergent) Fax** **Delegation Oversight Phone Number** **Delegation Oversight email** **Delegation Oversight Fax**	 **858-927-5907** **858-260-5879** **858-964-3100** **858-927-5887** **shpdelegationoversight@scrippshealth.org** **858-964-3139**

Privacy	**858-927-5461**
Utilization Management Referral Inquiry	**844-337-3700**
Utilization Management (Routine) Fax **Utilization Management (Emergent) Fax** **Utilization Management (Out of Area) Fax**	**858-260-5877** **858-964-3104** **858-260-5877**
Website	**www.scrippshealthplan.com**

Scripps Health Plan
Core Values, Mission, and Vision

Mission Vision & Value

- **Mission**

  Scripps strives 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.

- **Vision**

  Scripps Health 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.

- **Values**

  We provide the highest quality of service
  Scripps is committed to putting the patient first and quality is our passion. In the new world of health care, we want to anticipate the causes of illness and encourage healthy behavior for all who rely on us for service. We teach and encourage patients to participate in their care and to make well-informed decisions. We will be their advocate when they are most vulnerable. We measure our success by our patients' satisfaction, their return to health and well-being, and our compassionate care for dying patients, their families and friends.

  We demonstrate complete respect for the rights of every individual
  Scripps honors the dignity of all persons, and we show this by our actions toward one another and those we serve. We embrace the diversity that allows us to draw on the talents of one another. We respect and honor the cultural, ethnic and religious beliefs and practices of our patients in a manner consistent with the highest standards of care. All this is done in a compassionate setting. Our goal is to create a healing environment in partnership with all caregivers who are committed to serving our patients.

  We care for our patients every day in a responsible and efficient manner
  Scripps serves as a major community health care resource for San Diego County and, as such, we are accountable for the human, financial and ecological resources entrusted to our care as we promote healing and wholeness. We begin from a base of excellence and collaborate with co-workers, physicians, patients, and other providers to find new and creative ways to improve the delivery of health care services. All members of our community will have access to timely, affordable and appropriate care.

Customer Service

The Scripps Health Plan Customer Service Department provides assistance to Providers, Members and healthcare consumers. Customer Service can be reached toll-free at 844-337-3700 or by email at customerservice@scrippshealth.org.

Our Customer Service Department has friendly, well-informed, representatives available Monday through Friday from 8:00 a.m. to 5:00 p.m. PST. Customer Service Representatives assist callers by answering questions regarding an array of issues, ranging from:

- Health Plan policies and procedures
- Prior Authorization guidelines, inquiries and responsibilities
- Criteria used to make medically necessary determinations
- Claims and/or Provider Dispute Resolution inquiries, status, processes and procedures
- Financial responsibility for claims payment
- Provider claim and authorization status
- Member Eligibility verification
- Member benefit and copays
- Network and Plan Medical Group Affiliations
- Provider demographic changes
- Appeal and Grievance complaint intake

Language Assistance

California law (Section 1367.04 of the California Knox-Keene Act and Section 1300.67.04, Title 28, California Code of Regulations) requires that health plans establish a Language Assistance Program (LAP) for Limited English Proficient ("LEP") members. Under this law, contracted providers are required to assist members in accessing language services available at SHP. SHP contracts with a company specializing in *medical* interpreter and translation assistance with over 100 represented languages.

Interpreter Services

Providers may request interpreters for members whose primary language is not English by calling SHP at 844-337-3700. The Customer Service representative will require the following information:

- Member name, identification number, age, gender, language, and country of origin (to determine the appropriate dialect of the requested language).
- Provider information, including appointment date and time, office location, name, physician's phone number, and type of appointment (e.g., ob/gyn, well-care, etc.)

Face-to-face interpreting service requests must be submitted at least five (5) days prior to the appointment date. Please note: even with prior notice, interpreters for face-to-face services may not be available for all languages. Should an interpreter not be available for face-to-face services, SHP is able to make arrangements for telephone interpreting services. Please call Customer Service at 844-337-3700 to arrange for timely language assistance for our members.

As required by law, SHP shall establish and maintain an ongoing language assistance program to ensure LEP members have appropriate access to language assistance while accessing health care services. Providers shall cooperate and comply with the SHP's language assistance program. For assistance the provider may contact SHP's Customer Service at 844-337-3700 or 1-888-515-4065 TTY for the hearing and speech impaired.

Informational notices explaining how members can contact SHP, file a complaint with SHP, obtain assistance from the Department of Managed Health Care and seek an independent medical review are available in non-English languages through the department's Web site. The notice and translations can be downloaded and printed from www.hmohelp.ca.gov. In addition, hard copies may be requested by writing to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th St., Suite 500, Sacramento, CA 95814.

Member Rights and Responsibilities

Upon enrollment, members are given a member handbook which contains the list of member rights and responsibilities, also provided below.

MEMBERS' RIGHTS AND RESPONSIBILITIES

Scripps Health Plan is committed to treating members in a manner that respects their rights. Also, Scripps Health Plan has certain expectations of members' responsibilities. Both these commitments will be upheld at all times by all staff in all activities.

As a member, you have the **Right** to:

1. Receive considerate and courteous care, with respect for your right to personal privacy and dignity;
2. Receive information about all health services available to you, including a clear explanation of how to obtain them;
3. Receive information about your rights and responsibilities;
4. Receive information about your Scripps Health Plan, the services we offer you, the physicians and other practitioners available to care for you;
5. Select a PCP and expect his/ her team of health workers to provide or arrange for all the care that you need;
6. Have reasonable access to appropriate medical services;
7. Participate actively with your physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment;
8. A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage;
9. Receive from your physician an understanding of your medical condition and any proposed appropriate or medically necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment;
10. Receive preventive health services;
11. Know and understand your medical condition, treatment plan, expected outcome and the effects these have on your daily living;

12. Have confidential health records, except when disclosure is required by law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your PCP;
13. Communicate with and receive information from Customer Service in a language you can understand;
14. Know about any transfer to another hospital, including information as to why the transfer is necessary and any alternatives available;
15. Obtain a referral from your PCP for a second opinion;
16. Be fully informed about the Scripps Health Plan grievances procedure and understand how to use it without fear of interruption of health care;
17. Voice complaints about the Scripps Health Plan or the care provided to you;
18. Participate in establishing public policy of Scripps Health Plan, as outlined in your Evidence of Coverage and Disclosure Form or Health Service Agreement.
19. Make recommendations regarding Scripps Health Plan Member rights and responsibilities policy.

You, as a Scripps Health Plan Member, have the **Responsibility** to:

1. Carefully read all Scripps Health Plan materials immediately after you are enrolled so you understand how to use your benefits and how to minimize your out of pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Scripps Health Plan membership as explained in the Evidence of Coverage and Disclosure Form or Health Service Agreement;
2. Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed;
3. Provide, to the extent possible, information that your physician, and/or the Plan need to provide appropriate care for you;
4. Understand your health problems and take an active role in making health care decisions with your medical care provider, whenever possible.
5. Follow the treatment plans and instructions you and your physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations;
6. Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given;
7. Make and keep medical appointments and inform the Plan physician ahead of time when you must cancel;
8. Communicate openly with the PCP you choose so you can develop a strong partnership based on trust and cooperation;
9. Offer suggestions to improve the Scripps Health Plan;

10. Help Scripps Health Plan to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health plan coverage;
11. Notify Scripps Health Plan as soon as possible if you are billed inappropriately or if you have any complaints;
12. Select a PCP for your newborn before birth, when possible, and notify Scripps Health Plan as soon as you have made this selection;
13. Treat all Plan personnel respectfully and courteously as partners in good health care;
14. Pay your dues, copayments and charges for non-covered services on time;
15. For all mental health and substance abuse services, follow the treatment plans and instructions agreed to by you and the MHSA and obtain prior authorization for all nonemergency mental health and substance abuse services.

Primary Care Physician (PCP) Selection

SHP members are required to select a Primary Care Physician (PCP) to manage and coordinate their medical needs. Members in the same family may select the same or different PCPs in the following disciplines; Medical Doctor (MD) (an internist, family practitioner, pediatrician, or general practitioner), or a Doctor of Osteopathy (DO). Female members may select an Obstetrician/Gynecologist as their PCP.
If a member does not select a PCP at enrollment, SHP will assign a PCP based on the following factors:

- The member's residence
- The member's language preference
- The member's age
- The existence of established relationships and family linkages

Members are notified by mail of the SHP assigned PCP and of the right to select a different PCP by contacting SHP Customer Service. Assignment of a PCP becomes effective on the first day of the following month. For example, if the member calls to select a PCP on March 16th, the assignment to that PCP becomes effective on April 1. Exceptions may be made on a case-by-case basis.

The member is sent a health plan identification card upon enrollment and thereafter whenever a PCP change is made. The identification card includes the PCP, the PCP's telephone number, the assigned Plan Medical Group, copay and other important information.

- SHP encourages members to find a PCP they are comfortable with and stay with that PCP. This way the member and doctor can establish a relationship and the doctor will be familiar with the member's medical history. However, members can change PCPs at any time.
- PCP changes will be made based on the request from the member or the member's parent or guardian. PCP changes cannot be made by a Provider or the Provider's office staff without authorization from the member, but they can be made from the Provider's office if the member confirms the change by telephone.

Member Appeals & Grievances

SHP's Compliance Program includes oversight of the process through which members ask questions and resolve issues. Members will often address their questions or concerns directly with their provider, who may resolve the issue without SHP's intervention. If the provider is not able to resolve a question or problem, the member should be advised of their right to file a Grievance and instructed to contact SHP Customer Service at 844-337-3700.

A grievance is an indication that a member is dissatisfied with an aspect of his/her health care and/or the delivery of care.

An "appeal" is a request to re-evaluate an adverse decision or determination made by the Plan or any of its authorized Subcontractors (medical groups & delegated services). Sometimes a concern is not automatically classified as a "grievance" or an "appeal". If a member disagrees with a service denial or benefit policy, that's an appeal. If a member is dissatisfied with or concerned about the quality of the health care services he/she is receiving, that's a grievance. When it is not obvious our teams are trained to listen for clues. The member does not have to label their complaint as a formal grievance, please refer the member to our Customer Service team or follow the instructions listed below.

Appeals and Grievances received by SHP may include complaints about the quality of health care services received or an appeal of service denials. Members (or their designees) may call Customer Service or submit their Appeal or Grievance in writing, online or by fax:

Scripps Health Plan
Attention: Appeals & Grievances
Mail Drop: 4S-300
10790 Rancho Bernardo Road
San Diego, California 92127
www.scrippshealthplan.com
Phone: 844-337-3700
Fax: 858-260-5879

If the member prefers, he/she can complete the Grievance Form available on our website: www.scrippshealthplan.com. Providers are required to make Grievance Forms available to members upon request see Exhibit 4 Grievance Resolution Program. Forms are also available by contacting SHP at 844-337-3700.

SHP will make best efforts to facilitate the resolution of the member's concern. Members are encouraged to discuss their questions and concerns with the providers involved in their care. When the provider is unable resolve the concern, the matter will be transferred to the SHP's Appeals & Grievances Department.

SHP will acknowledge receipt of the Appeal or Grievance within five (5) calendar days, and will send the member a decision letter within thirty (30) calendar days. If the Appeal or Grievance involves an imminent and serious threat to the member's health, including but not limited to, severe pain, potential loss of life, limb, or major bodily function, SHP will provide a response within three (3) business days. In most cases, providers involved in the member's care will be contacted by SHP to request medical records or other information needed to research the member's Appeal or Grievance. It is important to respond promptly to such requests, in order to ensure that Appeals and Grievances are resolved within the timelines standards established by state regulations.

SHP understands that there may be many sides to every issue, so it is very important for providers to respond timely to inquiries about member Appeals or Grievances. SHP uses responses from providers to identify opportunities to educate members regarding realistic expectations of access, office wait times, appropriate patient–physician and patient–office staff interaction, etc. The responses also provide opportunities for SHP to work more closely with providers on interactions that are interpreted by members to be problematic and to develop ways to improve processes.

Grievances that are clinical in nature are reviewed by a physician or other appropriately licensed professional and the outcomes are forwarded to the Credentialing Review Panel. The Credentialing Review Panel reviews Grievances for appropriateness of the resolution and to identify any trends. The Credentialing Review Panel will determine if additional follow-up with the provider is needed. If the Committee determines patient care was impacted, the case is also reviewed during the re-credentialing process.

Independent Medical Review (IMR)

Care that is denied, delayed or modified by SHP or a delegated entity may be eligible for an Independent Medical Review (IMR). If the case is eligible for IMR, information about the case will be submitted to a medical specialist not affiliated with SHP who will review the information provided and make an independent determination. If the IMR specialist so determines, SHP will provide coverage for the previously denied or modified health care service.

The IMR process is in addition to any other procedures or remedies that may be available to the member. A decision not to participate in the IMR process may cause the member to forfeit any statutory right to pursue legal action against SHP regarding the care that was requested. Members pay no application or processing fees of any kind for IMR. Members have the right to provide information in support of the request for IMR. For cases that are not urgent, the IMR organization designated by the Department of Managed Health Care (DMHC) will provide its determination within thirty (30) days of receipt of the application and supporting documents. For urgent cases involving an imminent and serious threat to health, including but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of health, the IMR organization will provide its determination within seven (7) days. At the request of the IMR expert, the deadline can be extended by up to three (3) days if there is a delay in obtaining all necessary documentation.

Independent Medical Review is available in the following situations:

Denial of Experimental or Investigational Treatment for Life-Threatening or Seriously Debilitating Conditions

If a service is denied because it is deemed to be an investigational or experimental therapy, the member may be entitled to request an IMR of this decision. All of the following conditions must be true:

1. The member must have a life-threatening or seriously debilitating condition. “Seriously debilitating” means diseases or conditions that cause major irreversible morbidity. “Life-threatening” means either or both of the following:
    a. disease or conditions where the likelihood of death is high unless the course of the disease is interrupted
    b. disease or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival

2. The physician must certify that the member has a condition, as described in paragraph 1 above, for which standard therapies have not been effective, or for which standard therapies would not be medically appropriate, or for which there is no more beneficial standard therapy covered by SHP than the proposed therapy.
3. Either (a) the provider has recommended a drug, device, procedure or other therapy that he/she certifies in writing is likely to be more beneficial to the member than any available standard therapies, or (b) the member or a specialist physician (board eligible or certified) has requested a therapy that, based on documentation from the medical and scientific evidence, is likely to be more beneficial than any available standard therapy.
4. The member has been denied coverage by SHP for a drug, device, procedure, or other therapy recommended or requested as described in paragraph 3 above.
5. The specific drug, device, procedure, or other therapy recommended would be a covered service, except for SHP's determination that the therapy is experimental or investigational.

If there is potential that a member would qualify for IMR under this section, SHP will send the member an application within five days of the date services were denied. To request IMR, the member should return the application to the DMHC. The treating provider will be asked to submit the documentation described in paragraph 3 above. An expedited review will occur if the provider determines that the proposed therapy would be significantly less effective if not promptly initiated. In such cases the analyses and recommendations of the experts on the panel will be rendered within seven days of the request for IMR.

Denial of a Health Care Service as Not medically necessary

Members may request an IMR if the member believes that health care services have been improperly denied, modified, or delayed by SHP. A "disputed health care service" is any health care service eligible for coverage that has been denied, modified, or delayed, in whole or in part, because the service has been deemed not medically necessary.

SHP will provide the member with instructions on the IMR process with any appeal findings letter that denies, modifies, or delays health care services because the service is not medically necessary. To request an IMR, the member should return the application to the DMHC. The application for IMR will be reviewed by the DMHC to determine whether the case meets all of the following conditions:

1. The provider has recommended a health care service as medically necessary;
2. The member received an urgent or emergency service that a provider determined was medically necessary, or the member was seen by a provider for the diagnosis or treatment of the medical condition for which the IMR is requested;
3. The disputed health care service has been denied, modified, or delayed by SHP or a provider, based in whole or in part on a decision that the health care service is not medically necessary
4. The member filed an appeal with SHP and SHP's decision was upheld or the appeal remains unresolved after thirty (30) days. If the appeal requires expedited review, it may be brought immediately to the DMHC's attention. The DMHC may waive the requirement that the member follow SHP's Grievance process in extraordinary and compelling cases.

Additional Resources for members

HMO Help Center

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If a member has a Grievance against the Health Plan, the member should first telephone SHP toll-free at **844-337-3700 or TTY/TDD at 1-888-515-4065** to access SHP's Grievance process before contacting the DMHC. Utilizing this Grievance procedure does not negate any potential legal rights or remedies that may be available to the member. If the member needs help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by SHP, or a Grievance that has remained unresolved for more than 30 days, the member may call the department for assistance. Members may also be eligible for an Independent Medical Review (IMR). If eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(888-HMO-2219)** and a TDD line **(877-688-9891)** for the hearing and speech impaired. The department's website http://www.hmohelp.ca.gov has complaint forms, IMR application forms, and instructions.

Health Insurance Counseling and Advocacy Program

The Health Insurance Counseling and Advocacy Program (HICAP) provides free help to persons on Medicare to better understand their Medicare benefits (including prescription drug coverage), supplemental insurance, HMO options, and long-term care insurance. Members sometimes have questions about how to best coordinate their Medicare and SHP coverage. HICAP provides objective information, individual counseling, attorney services, and community education presentations. HICAP has offices at 3675 Ruffin Road, Suite 315, San Diego, CA 92123, and can be reached by calling toll-free 800-434-0222.

Provider Relations

Contracting/Provider Relations performs the following services for SHP:

- 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 SHP Departments
- Maintenance of Provider Directories and Provider demographics
- Provider Education

Utilization Management

The purpose of the Utilization Management (UM) Program is to maintain a comprehensive, coordinated process, which promotes and monitors the effective utilization of health care resources within the SHP health care delivery system. Activities of the UM Program include prospective (before), concurrent (during), and retrospective (after) review of healthcare services including coordination of appropriate discharge planning. SHP may delegate UM activities to qualified entities that meet specific regulatory requirements.

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 monitoring and trending of provider appeals and grievance determinations. The SHP Medical Director, or designee, chairs this committee.

Authorization review is performed by each Plan 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, or designee.

SHP and its delegated entities require all authorization requests to be screened by qualified health professionals using decision-making criteria that are objective and based on accepted medical evidence. Medical necessity criteria must be reviewed annually and updated as appropriate. Medical necessity criteria must be available to Providers and members upon request. Services not meeting standard medical necessity criteria are forwarded to the Medical Director or designee for review.

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

- Referral Management
- Prior Authorization
- Concurrent Review
- Retrospective Review
- Discharge Planning
- Second Clinical Opinions
- Emergent Care
- Out of Area coordination of care and repatriation
- Continuity of Care and transition of care when medically appropriate
- UM Key Service and Administrative Performance Indicators
- New Medical Technology review and determination
- Complex Case Management
- Disease Management

Please note that you may contact the Customer Service department if you have any general questions regarding UM criteria. For questions on a specific case, contact the physician listed on the denial letter or the Medical Director for the member's PMG:

SHP Authorization and Referral Responsibilities

SHP and its delegated entities are required to provide prompt and timely decisions on prior authorization requests appropriate for the nature of the Member's condition. In compliance with the Industry Collaborative Effort ("ICE") turn-around-time standards for commercial members, determinations for routine requests are not to exceed five business days from the receipt of all necessary medical information. Requests that are received as expedited are reviewed within 72 hours, and a response is communicated to the Provider and Member within 24 hours of the decision.

The UM authorization and referral decision making (inpatient and ambulatory services) turnaround time standards are:

CATEGORY	TIMEFRAMES (once all necessary information received)
Routine request and concurrent reviews	Within five (5) working days of receipt of all necessary information
Expedited	Within seventy-two (72) hours of receipt of request
Extension	Up to forty-five (45) calendar days when it is in the member's best interest to obtain additional information that would support the request.
Retrospective	Within thirty (30) calendar days of receipt of all necessary information
Routine Pharmacy	Within two (2) working days of receipt of request
Expedited Pharmacy	Within twenty-four (24) hours from the receipt of request

Clinical Guidelines/Review Criteria

SHP utilizes the following nationally developed clinical guidelines and criteria based on professionally recognized standards of practice reviewed by actively practicing physicians, and adopted and approved by the UMQIC in making referral and authorization decisions:

- Inpatient Services: Milliman Clinical Guidelines
- Outpatient Services: Milliman Clinical Guidelines
- Mental Health: Cigna Behavioral Medical Necessity Criteria

Mental Health Services

Mental health and chemical dependency benefits are administered through the Cigna Behavioral Health network of behavioral health providers. A referral from the member's primary care physician is not required. To locate a participating provider, please visit www.cignabehavioral.com > Member > Find a Therapist/Psychiatrist for a complete listing of providers or call (800) 866-6534.

Phone:
(800) 866-6534
TTY: 711

Address
Cigna Behavioral Health
Attention: Claims
P.O. Box 188022
Chattanooga, TN 37422

Hours of Operation
24 hours a day, 7 days a week

The development and/or review of clinical guidelines are an ongoing responsibility of the UMQIC, whose membership is composed of participating physicians. These criteria and guidelines are subject to annual review and revision, as applicable, by the UMQIC to ensure that they are

consistent with current literature and national guidelines as well as the outcomes and experience of SHP.

Contracted providers may request copies of any guidelines or review criteria used by SHP in the course of UM activities by calling the Customer Service Department at 844-337-3700.

Medical Necessity Determination Process

UM staff obtains and reviews any necessary clinical information and uses clinical guidelines and criteria approved by the UMQIC 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, the case is referred 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.

SHP strictly 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 reward practitioners or other individuals for issuing denials of coverage or service.
- Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization.

Denial Determination

A SHP 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 or requesting physician. Denials of service based on medical necessity will always be issued by a physician reviewer. Denial notifications to providers include the name and phone number of the physician responsible for the decision should you wish to discuss the specific SHP UM criteria used to render a determination.

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 applicable

Denial Determinations for emergent services will be given to the requesting physician, and member 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 SHP 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 on behalf of the member. Appeals should be submitted within sixty (60) days of the denial notice.

SHP is required to process an appeal within thirty (30) days of receipt. In some cases, an expedited three (3) business days 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. Physicians may request an expedited appeal orally or in writing, as provided for in the initial denial notice – appeal rights. Information for appeals is also available through SHP's Appeals & Grievance team, on our website at www.scrippshealthplan.com, through the Customer Service Department, or from the applicable Medical Director

Referrals and Authorizations Process

Prior Authorization requests for medical services, referrals and notifications to SHP should be submitted online via Cerecon the Plan's referral and eligibility portal. If you are not yet signed-up for this easy-to-use and secure Internet resource, please contact SHP's Customer Service Department at 844-337-3700 or via email at: customerservice@scrippshealth.org.

Prior Authorization requests may also be faxed to the numbers listed below. Urgent requests may be submitted via fax to 858-964-3104 or by calling Customer Service at 844-337-3700.

Referrals and Authorizations

Providers will receive a written authorization form that will specify the extent of the services authorized - providers may not exceed those authorization limits without an additional authorization form, except in the case of a medical emergency. Providers 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. For access to Cerecons/Aerial Care Coordination (ACC) you may fax the request for authorization to the SHP UM department at 858-260-5877. For additional information on ACC, contact Provider Relations at 858-927-5399. If you have any questions about an authorization, contact Customer Service at 844-337-3700 and request the Utilization Review Coordinator.

Pharmacy

SHP Prescription Drug Plan is managed by MedImpact. For inquiries related to your patient's pharmacy benefit, or prior authorization requirements, please call MedImpact customer contact center at 844-282-5343.

MedImpact
Phone: 844-282-5343
TTY: 711

Mailing Address
MedImpact
10181 Scripps Gateway Ct
San Diego, CA 92131

Hours of Operation
24 hours a day, 7 days a week

Online Help
Many questions regarding prescription drug benefits may be answered by accessing **www.MedImpact.com**.

Specialty Pharmacy

Specialty medications include, but are not limited to, many oral chemotherapeutic, multiple sclerosis and injectable agents. SHP uses US Bioservices for specialty drugs.

US Bioservices
Phone: 888-518-7246
Website: www.usbioservices.com

Prior Authorization

- Prior Authorization is the process of evaluating medical services prior to scheduling to determine Medical Necessity, appropriateness, and benefit coverage.
- Services requiring Prior Authorization should not be scheduled until a Provider receives approval from SHP or its delegated entity.
- SHP reserves the right to deny payment for authorized services if it is determined that inaccurate information was provided to support the Authorization request.
- Requests should be submitted by the requesting provider via the applicable referral management system.
- Requests must be accompanied by all pertinent medical records and supporting documents to avoid unnecessary delays.
- The following medical information should accompany all requests, as appropriate, to ensure that consulting physicians have clinical information prior to a patient visit:
  - Medical history related to the diagnosis
  - Results of any diagnostic tests previously performed (including lab and radiology reports)
  - Consultation reports related to the diagnosis from other physicians
  - Information on referrals pending for other Providers.

- Experimental/investigational services are not a Covered Benefit. Providers may submit a completed Prior Authorization Request to SHP to determine whether a requested service is considered experimental or investigational.
- SHP staff is available 8 a.m. to 5 p.m. Monday through Friday to answer questions from Providers and Members regarding Utilization Management issues.
- After office hours, Providers may call Customer Care at 844-337-3700 to be transferred to Scripps for Urgent medical requests or to MedImpact for Urgent prescription drug requests.
- Callers also have the option of leaving a voice mail message for return call by the next business day.
- Staff will identify themselves by name, title and organization name when making inbound or outbound calls about Utilization Management issues.
- The toll-free number 844-337-3700 is available 24 hours a day/ 7 days a week to accept collect calls regarding Utilization Management issues.
- Language Assistance is available through our toll-free Customer Care line.

Prior Authorization is NOT required for:

- Emergency services
- Family planning services
- Preventive care, like immunizations and annual physicals
- Basic prenatal care
- Sexually transmitted disease (STD) services
- Human immunodeficiency virus (HIV) testing

Provider Notification of UM Decision

The requesting Provider is informed as quickly as possible, via fax, telephone, or email of the final status of any Authorization request. When a requested service is approved, notification is sent to both the Provider and the Member. The notification of approval specifies the service authorized, number of treatments, valid from and to dates, and expected length of stay (if appropriate). Notification is also sent regarding any services that are denied or modified. A copy of the denial or modification letter is sent to the Member, facility (if applicable), PCP, and specialist. The denial or modification letter includes a clear and concise description of the criteria used to deny or modify the Authorization. All letters of denial or modification include an explanation of the reason for denial or modification as well as a description of how to file an Appeal. For questions regarding the status of a prior Authorization request, contact the appropriate delegated entity or SHP by phone at 844-337-3700, or online via the CERECON application.

Concurrent Hospitalization Review

All inpatient stays are reviewed to determine the appropriate level of care in accordance with written guidelines. Telephonic and/or on-site chart reviews are conducted at all contracted Hospitals and Skilled Nursing Facilities by licensed UM staff. An initial review of all hospitalizations will occur within one business day of the notification to SHP. Subsequent reviews are conducted as deemed necessary by the UM nurse to ensure that the length of stay and level of care meet clinical criteria. If the criteria have not been met or medical record documentation is inadequate to authorize continued stay, the nurse reviewer will consult with

the patient's attending physician, physician advisors, or other appropriate hospital staff to obtain additional information.

In the event that a Member is admitted to a facility outside the SHP's Service Area, the UM department will work with the Out-of-Area (OOA) facility and the member's PMG to assess when it is medically appropriate for the member to be safely transferred back into the service area assist in coordination of the transfer. The UM staff reviews admissions at Out-of-Network (OON) facilities telephonically. The UM staff facilitates transfer of the patient to a SHP contracted hospital as soon as medically appropriate.

Discharge Planning

Discharge planning is a process that begins prior to an inpatient admission with an assessment of each patient's potential discharge needs. Discharge planning activities are carried out by SHP or a delegated entity's UM staff in coordination with hospital staff, which may include discharge planners, social workers, or nurse case managers in conjunction with the treatment team.

Retrospective Authorization Review

Medical record review to determine appropriate utilization of services may be conducted in cases where there is a question regarding medical management, or for cases in which SHP was not notified before or during the provided service. Cases for retrospective review are often identified upon receipt of an unauthorized claim. Cases may also be identified through requests for retrospective authorization from OON or OOA Providers. Retrospective reviews will be processed within thirty (30) days of receipt.

Emergency Services

"Emergency services" means a medical and/or psychiatric screening, examination, and evaluation by a physician, or by other appropriate licensed persons, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

"Active labor" means a labor at a time at which either there is inadequate time to effect safe transfer to another hospital prior to delivery or a transfer may pose a threat to the health and safety of the patient or the unborn child.

A patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating physician, or other appropriate licensed persons, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient.

Emergency Services Providers may screen and stabilize a member without prior authorization in order to stabilize an emergency medical condition.

Second Medical Opinions

A second medical opinion by an appropriately qualified healthcare professional are available in accordance with AB12, and CA Health and Safety Code 1383.15.

A second medical opinion may be covered by SHP, if requested by the member or a participating health professional, for any of the following reasons:

- If member questions the reasonableness or necessity of the recommended surgical procedures.
- If the member questions their diagnosis or plan of care for a condition that threatens loss of life, limb, loss of bodily functions, or substantial impairment, including a serious chronic condition.
- If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating provider is unable to diagnose the condition.
- If the treatment plan in progress is not improving the medical condition within an appropriate period of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
- If the member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

Members or Providers may request a second opinion through SHP's UM Department or the member's PMG. Requests will be reviewed and facilitated through the authorization process.

A request for a second opinion about care provided by the member's PCP must be obtained by another qualified participating provider within the member's PMG and the PMG shall provide the second opinion.

A second opinion consult about care from a specialist, the member or provider may request authorization to receive the second opinion from a specialist of the same or equivalent specialty within any PMG in the SHP network.

When there is no qualified provider within the network, the member may request authorization for a second opinion consultation from an out-of-network provider. If authorization is received for an out-of-network provider, the authorization will be for a consult only and that provider should not perform, or provide care beyond the consult, as SHP does not provide reimbursement for such care. For questions about second opinions or a copy of the SHP's policy, please visit www.scrippshealthplan.com.

Complex Case Management Program

SHP's Complex Case Management Program uses a client/caregiver approach to promote availability of appropriate care and resources while maximizing the member's quality of life and health care benefits. Case Management is a collaborative process with the patient, family, physician, and other treating entities, designed to meet the individual's needs while promoting quality outcomes. Our Case Management nurses work closely with Plan Providers to develop and implement the most appropriate treatment plan for the member's needs. Providers interested in referring a member to the Complex Case Management Program, can call SHP Customer Service department at 844-337-3700. Any individual involved in the care of a member may make a referral to the Complex Case Management Program, including but not limited to:

- Primary Care Provider (PCP)

- Specialist
- Discharge planner
- Plan staff

Each case is considered on an individual basis. Cases not accepted into the Complex Case Management Program are kept on file for future reference.
Referrals to the Complex Case Management Program are screened for medical, psychosocial, financial, and related needs no later than thirty (30) calendar days from the date the member is eligible for Complex Case Management. The Case Manager assesses each referral through medical records and discussion with the PCP and other involved parties, as needed. Referrals for Case Management services include, but are not limited to, the following situations in which care coordination is needed to meet members' needs while promoting appropriate utilization of services and cost-effective outcomes:

- Transplants
- Chronic pain management
- Behavioral health issues
- Medication management
- Out-of-area/out-of-network services
- Care facilitation
- Second opinion coordination
- Social support issues

As appropriate, the Case Manager will facilitate care coordination for Members who have the following indicators:

- Three (3) or more acute hospital admissions per year
- Two (2) or more emergency department visits in a three (3)-month period
- Non-compliance with medical recommendations and care
- Complex medical needs that require close monitoring
- Home-health needs
- Life expectancy of six (6) months or less
- Inpatient hospital stay of greater than ten (10) days
- Complex psychosocial or functional requirements
- Quality issues related to clinical care

When a member is accepted into the Complex Case Management Program, the Case Manager performs the following functions:

- Serves as a liaison and resource for providers and members and their families
- Communicates information to caregivers to obtain consensus on a plan of care
- Develops and coordinates a plan of care with realistic and appropriate goals/outcomes
- Assists with the transfer of members from one facility to another
- Facilitates physician-to-physician communication and other communication when needed
- Manages all Authorizations for services for the assigned member
- Makes appropriate referrals to state and county waiver programs or other community resources

The Case Manager closes a case when one or more of the following endpoints have been established:

- Services are no longer needed due to resolution of the patient's illness or the patient's death
- Reasonable goals and objectives in the Plan of Care have been met and the member's condition is stabilized
- Family and other support systems are able to adequately provide needed services
- Care coordination is ongoing without the need for oversight by the Case Manager
- The member has moved out of the Service Area
- The member refuses Case Management services

Communication to Providers

SHP communicates changes or updates to policies, procedures, and regulatory requirements to providers via:

- The Provider Manual, which is provided upon initial contracting with SHP, and for which updates are posted online at www.scrippshealthplan.com.
- Directly via Mail, email or fax
- Via communication with the PMG to distribute information to their affiliated physicians.

SHP provides required notification to providers about:

- The policy requiring an appropriate physician advisor to be available to discuss all UM denial decisions.
- The contact information of the medical reviewer, as indicated in the provider denial letter.
- The opportunity to discuss a behavioral or non-behavioral health care UM denial decision with a physician or other appropriate reviewer.
- The method of obtaining UM Criteria, and updates or changes to UM criteria

Continuity of Care

Scripps Health plan (SHP) is in compliance with CA Health and Safety Code Sections 1300, 1367, 1373 and provides continuity of care for members currently receiving a course of treatment from a terminated provider and for new enrollees who are undergoing an Active Course of Treatment from a nonparticipating provider. Transitions of Care (TOC) include member notifications when an individual in a course of treatment enrolls in SHP and when a medical group or provider is terminated from the network. SHP also facilitates transitions of care when changes occur within the provider network as well as for new members and members with special needs and circumstances. When a member is actively receiving care and that care may be disrupted by the departure of a physician from the network, the member will be notified of the departure 60 days prior to the departure of the physician.

Member Enrollment Overview

SHP members select a Primary Care Physician (PCP) upon enrollment. Members who select a PCP affiliated with a clinic may be assigned to the clinic, not an individual physician within the clinic. In the event a PCP and PMG are not selected on the enrollment form, SHP will assist with selecting a PCP and PMG near the member's residence. SHP encourages selection of a PCP

within thirty (30) minutes or thirty (30) miles of a member's residence or work place. In the event SHP cannot reach a member, the Plan will assign a PCP based on the following factors:

- The member's home address and/or work address
- The member's documented language preference
- The member's age (pediatric or adult medicine)

Members will receive an ID card by mail that lists the PCP that has been assigned to them. They can contact Customer Services at 844-337-3700 to change their PCP. In most cases, members are effective with their PCP on the first day of the next month. For example, if the member calls to select a PCP on March 16th, the assignment to that PCP becomes effective on April 1. Exceptions may be made on a case-by-case basis.

Eligibility Verification

Providers are responsible for verifying every member's eligibility prior to rendering services, unless the services are emergent. All members should present their health plan identification card each time services are requested. The SHP Identification Cards identify the following information:

- Member name
- Gender
- Date of birth
- Member ID number
- Coverage effective date
- Plan Medical Group
- Group name and number
- Primary Care Physician (PCP) name
- PCP phone number
- Copayments/Deductible
- Claims mailing address
- Pharmacy Benefit Phone Number
- Behavioral Health Provider Phone Number
- Customer Service toll-free number
- American Specialty Health Plan Phone Number

It is the responsibility of each Provider to verify eligibility prior to providing services. Although the ID card is a primary method of identification, possession of the card does not guarantee eligibility, coverage, or benefits. Eligibility to receive services depends on verification from SHP. A new identification card is issued each time a member changes their PCP or PMG, but members may forget to present the most recent card when accessing services. Therefore, it is important to verify eligibility with each visit. Eligibility may be verified through the Cerecon web portal or by calling SHP Customer Service at 844-337-3700 Monday through Friday, 8:00 a.m. to 5:00 p.m.

Eligibility List

In order to ensure the proper management of care for members enrolled with SHP, our contracted PMGs have access to the SHP secured file transfer (FTP) site to obtain current eligibility files by PMG.
The electronic eligibility data files are updated regularly at mutually agreed-upon intervals. These lists contain information regarding the member's enrollment status for that particular month. It is

the responsibility of the PMG to share this information with its PCPs and other contracted Providers.

In the event of a reported discrepancy between the eligibility file and the member's current enrollment, please use the options listed above under Eligibility Verification to confirm the member's current status.

Provider Initiated Member Dismissal

Rarely, a Provider may provide care to a member who is disruptive or excessively difficult. In the event that the patient-physician relationship is irreparably damaged, the provider may submit a request to SHP to have the member assigned to a new PCP or to have care transferred to a new specialist. The provider is obligated to provide medically necessary care and access to services for as long as the member requires services, or until the relationship is terminated appropriately. A member may not be terminated or denied care due to diagnosis, health status/needs, or language barriers. Member dismissal will be considered under the following circumstances:

1. Member is non-compliant with recommended treatment plans to the extent that member's health is endangered.
2. Member demonstrates verbally abusive behavior toward the physician, ancillary or administrative office staff, or to other plan members.
3. Member physically assaults a provider, staff member, or plan member, or the member threatens any individual with any type of weapon on plan or provider premises, or verbalizes the intent to cause bodily harm. In such cases, appropriate charges should be brought against the member, and a copy of the police report submitted along with the request.
4. Member is disruptive to provider or plan operations with potential for limitations on access to care by other patients.
5. Member habitually uses non-contracted providers for non-emergency services without required authorization.
6. Member refuses to meet financial obligations such as copayments or coinsurance.
7. Member has a history of multiple missed appointments.
8. Member attempts to fraudulently obtain health care services, including allowing others to use the member's plan identification card to receive services.

The process for dismissal, if necessary, is as follows:

1. The Provider should discuss the conflict or problem with the member prior to requesting dismissal. Communication should include written documentation that conveys a clear set of instructions, the compliance requirements, and the consequences, if any, for not following the instructions, placing responsibility for compliance directly on the member.
2. The Provider requests authorization to dismiss the member from the panel by faxing a completed "Scripps Health Provider member Dismissal Form" Exhibit 1 to the attention of Performance Improvement at. 858-260-5879
3. The Dismissal Form should be completed in full and include supportive documentation detailing the situation. Supporting documentation may be in the form of copies of medical records, office notes, etc., and may include:
    a. Pertinent dates (missed appointments);
    b. Documentation of conversations (verbal abuse);
    c. Billing statements, including amount due, letters advising members to pay their bill (financial); and/or
    d. Documentation of previous attempts to educate member regarding noncompliance with recommended treatment plans or office practices.

4. SHP will request additional documentation from the Provider if necessary. Failure to provide documentation to support the dismissal request within five (5) working days of SHP's request will result in the request for dismissal being denied.
5. Requests for dismissal will be reviewed by the Chief Medical Officer.
6. If approved, the Provider will receive written authorization to dismiss the member within thirty (30) days of SHP's receipt of all supporting documentation.
7. After the Provider receives authorization from SHP to dismiss the member, the Provider has five (5) working days to provide the written notification to the member and to send a copy of such notice to SHP.
8. The notification must include the reason for the dismissal, and must not occur before authorization is received from SHP.

SHP will not contact the member for reassignment until SHP has received a copy of the dismissal letter sent to the member by the provider. If SHP does not receive a copy of the dismissal letter within ten (10) business days following SHP's approval to dismiss, the dismissal becomes invalid. The Provider is required to initiate the process again if they wish to pursue the dismissal. The provider is required to provide treatment and access to services until the member selects a new physician or a new physician is assigned. When a PCP dismisses a member, all referrals and authorizations for that member will be invalidated. The member must contact the new PCP to obtain new referrals and authorizations.

If a PMG wishes to dismiss a SHP member from all of their office locations, the PMG should contact the SHP Compliance Director. The request will be reviewed on a case-by-case basis.

Claims Adjudication

The Health Plan Matrix – Professional or Institutional assists provider in determining where to submit claims. The Health Plan Matrices are updated regularly and provide general guidelines. The Claims Department is responsible for accurately and promptly processing claims for which SHP is financially responsible. SHP utilizes a claim scrubbing software program that automatically applies Medicare Correct Coding Initiative ("CCI") edits along with other coding guidelines to ensure appropriate billing practices. This software provides auditing logic for all modifiers allowing payment modifications, if appropriate. SHP will process claims based on the industry standards, CPT guidelines, CCI edits and in compliance with State and Federal regulations.

Claims Submission Instructions: We currently accept claims submission via **Change Healthcare** (please contact your vendor to add payor ID 330099) or **Office Ally.** For Office Ally claims may be submitted electronically via 837-5010 format to our clearing house. SHP's Client ID number is: SHPM1. You may register to submit claims electronically to Office Ally calling 1-360-975-7000, option #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, option #1 for Existing Users. Please remember to follow the instructions below when submitting claims to ensure acceptance.

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: A Provider whose contract has the approval to use special billing or unique billing codes please follow there instructions:

- 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.

Timely Claims Submission

Claims that are the financial responsibility of SHP must be submitted within ninety (90) calendar days from the date of service.

- If SHP 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 SHP receives a claim that is not our financial responsibility, but the responsibility of the member's PMG, SHP will forward the claim to the member's PMG within ten (10) working days of the receipt of the claim that was incorrectly sent to SHP. 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 SHP: Claims for services provided to SHP Enrollees for whom SHP has financial responsibility must be sent to the following:

Scripps Heath Plan
Attention: Claims
P.O. Box 2579, 4S-300
La Jolla, CA 92038
Fax: 858-260-5852

Calling SHP Regarding Claims: For claim filing requirements or status inquiries, provider may contact Customer Service at 844-337-3700. 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 SHP:

- ICD -10 General Claims Submission Information, Effective October 1, 2015
- 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 SHP identification number
- Enrollee's date of birth
- Enrollee's gender

- Enrollee's SHP 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
- Skilled Nursing Facility UB04 requires level of care
- Inpatient stay UB04 requires DRG listed
- 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: Providers will receive an automatic claim receipt notification in the same format the original claim was submitted. For verification of claim receipt by SHP, contact Customer Service at 844-337-3700. Providers who have access to Cerecons/Aerial Care Coordination ("ACC") may view claims status online.

Reimbursement Timeliness

SHP 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.

SHP 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 SHP.

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 late payment interest rate. If SHP fails to include the interest amount in a payment to a provider a $10.00 fee will also be imposed on SHP. Late payments on complete claims for emergency service shall include $15.00.

Corrected Claims

Claims requiring corrections must be submitted with the Corrected Claim Form as attached in Exhibit 2. The information provided on the form will help us to assess the reason for the change, which will result in a faster turnaround time. We strive to make the claims process as efficient as possible, please adhere to the following when submitting a corrected claim:

- Attach a Corrected Claim Form for every corrected claim.
- Complete a separate form for each claim requiring correction
- Clearly describe the item or service to be reviewed. This is especially important with unlisted procedures, a modifier such as 22 or 59, and when more than one service was performed on the same date.
- Include the reason for the correction, as well as necessary legible notes and other documentation.

Providers Dispute Resolution

A Provider Dispute is a provider's written notice to SHP challenging, appealing or requesting reconsideration of a claim or a bundled group of substantially similar multiple claims that are individually numbered. The disputed claim(s) must meet at least one of the following conditions:

- Denied, Adjusted or Contested, or
- An adjudication error or other contract interpretation dispute, or
- Disputing a request for reimbursement of an overpayment of a claim, or
- Disputing a request of a refund letter from Scripps Health Plan.

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. 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 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)
- SHP claim number(s)
- Copy of the SHP 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 Provider Dispute involves a bundled group of substantially similar claims each claim must be individually numbered.

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

If the Provider Dispute represents a member or group of members the following written information must be provided:

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

SHP Provider Dispute Resolution Team shall process all provider disputes. If the Provider Dispute involves an issue of medical necessity or utilization review, the provider shall have an

unconditional right of appeal. Providers shall appeal the claim dispute for a de novo review and resolution for a period of sixty (60) working days from SHP's Date of Determination.

: Included in this Provider Manual is the Provider Dispute Resolution Form (Exhibit 3) which must be used to submit a Provider Dispute Resolution Request. This form is also available at www.scrippshealthplan.com

. All Provider Disputes must be sent to the attention of SHP Provider Disputes Department:

Scripps Health Plan
Attention: Provider Dispute Resolution
P.O. Box 1928
La Jolla, CA 92038
Fax: 858-260-5878

Time Period for Submission of Provider Disputes
Provider Disputes must be received by SHP within three hundred and sixty-five (365) calendar days from SHP's last date of action on the issue, or in the case of inaction, Provider Disputes must be received by SHP within three hundred and sixty-five (365) calendar days after the time for contesting or denying a claim has expired. Provider Disputes that do not include all required information set forth above may be returned to the submitter for completion. An amended Provider Dispute, which includes the missing information, must be submitted to SHP within thirty (30) working days of the receipt of a returned Provider Dispute.

Acknowledgement of Contracted Provider Disputes: SHP will acknowledge receipt of all Contracted Provider Disputes by sending an acknowledgment letter within fifteen (15) working days from the Date of Receipt by SHP.

Contacting SHP Regarding Contracted Provider Disputes: Contact Customer Service at **844-337-3700** for inquiries regarding the status of a Provider Dispute, or about filing a Provider Dispute.

SHP 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 Provider Dispute.

If the Provider Dispute is regarding an underpaid claim and it is determined in whole or in part in favor of the provider, SHP will pay any outstanding monies determined to be due, and applicable State interest and penalties required by law or regulation.

Claim Overpayments

Request for Provider to Reimburse SHP for an Overpayment of a Claim or Claims

Time Period for Request of an Overpayment: SHP 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 SHP determines a claim or claims have been overpaid, SHP will notify the Provider in writing through a separate notice. The notice will clearly identify the claim(s), the name of the member/patient, the Date of Service(s) and a clear explanation of

the basis upon which SHP 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(s).

Contested Notice: If the Provider contests SHP's 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 SHP. The notice must state the basis upon which the Provider believes that the claim was not overpaid. SHP will process the contested notice in accordance with SHP's Provider Dispute Resolution Process described in this Provider Operations Manual.

No Contest: If the Provider does not contest SHP's notice of overpayment of a claim, the Provider must reimburse SHP within thirty (30) working days of the Provider's receipt of the notice of overpayment of a claim. If a provider reimbursement is not received and posted at SHP within 45 working days of the initial letter, the claim will be offset from future monies owed to the provider.

Offsets to Payments: SHP may only offset an uncontested notice of overpayment of a claim against a Provider's current claim submission when the Provider fails to reimburse SHP 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, SHP will provide the Provider with a detailed written description. The specific overpayment or payments that have been offset against the specific current claim or claims will be identified in the initial overpayment notification letter.

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 DMHC. 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)

The purpose of the SHP 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 members within the SHP health care delivery system.

SHP' 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

SHP 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 Utilization Management Quality Improvement Committee ("UMQIC").

Appeals and Grievances

SHP will maintain a process for resolving member appeals and grievances. The Appeals and Grievances Department will have overall responsibility for:

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

Recommendations for appeal and grievance policy changes will be referred to the Policy and Procedure Committee 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, SHP 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, a delegated entity 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 SHP UMQIC reserves the right to terminate a Provider contract. SHP retains the right to make final decisions pertaining to a provider's participation in the SHP network.

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

Preventive Care Guidelines

SHP 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

Credentialing

Credentialing Program

Credentialing and re-credentialing is required for all contracted providers, practitioners and allied health care professionals, i.e. Physician Assistants ("PA") and Nurse Practitioners ("NP"), and health delivery organizations providing services to SHP members. The Quality Improvement (QI) staff, as part of the credentialing and re-credentialing process, may perform

Site Visits and Medical Record Review. Providers will be contacted in advance if a site visit or audit is needed.

Final credentialing approval is coordinated through SHP's Credentialing Review Panel, under the guidance of the Associate Medical Director of QI or designee. SHP retains the right to approve, suspend, and/or terminate individual practitioners, providers, and/or sites. The SHP process meets the California State and NCQA credentialing requirements.

Credentialing
SHP or a delegated entity credentials all contracted providers. Practitioners must meet the SHP criteria for acceptance as a provider and are required to maintain compliance with all standards as a condition for continued participation.

To begin the credentialing process, practitioners are required to submit a completed signed Application with the following attachments:

- Licensure to practice
- DEA certificate
- Proof of professional liability insurance
- An explanation of malpractice suits filed against the Practitioner to include case number; court number; a brief narrative case summary of the charge, facts, status, and outcome
- A signed release granting the SHP access to records of any medical society, medical board, college of medicine, hospital, or other institution, organization, or entity that does or may maintain records concerning the applicant
- A signed statement by the practitioner at the time of application regarding any physical or mental health problems, any history of chemical dependency/substance abuse, history of loss of license and/or felony convictions, and/or history of loss or limitation of privileges or disciplinary actions
- Work history with explanation of any gaps in employment that exceed 6 months

SHP will initiate the credentialing process and will complete the Primary Source Verification, based on NCQA standards and other pertinent information supplied or collected during the application process.

After medical staff office review, credentialing information is presented to the Credentialing Review Panel for review and approval. The Credentialing Review Panel meets quarterly. Providers are notified in writing of the Credentialing Review Panel's decision. Final credentialing approval is granted by the SHP Board of Directors, which also meets on a quarterly basis.

No applicant is automatically entitled to participate with the SHP via participation with a PMG or professional organization, via board certification or via staff membership or privileges for a particular health facility or practice setting.

Standards and Guidelines
At a minimum, the following requirements must be met for the SHP to consider acceptance of the applicant for participation in SHP's network:

- A participation agreement in the form prescribed by SHP and signed by the Provider.
- The physician applicant has not been rejected or terminated by SHP within the previous twelve (12) months.

- No felony, misdemeanor convictions nor evidence of committing other acts involving moral turpitude, dishonesty, fraud, deceit, or misrepresentation.
- Unrestricted license to practice in California.
- Use of SHP facilities for his/her regular practice and routinely makes rounds at participating facilities. If the physician does not have privileges at a SHP Hospital, he/she must have formal admitting arrangements with a Provider who does.
- Listing of office locations, names, and addresses of associates in the practice of medicine or osteopathy, and any physician or other practitioner who provides on-call services.

Additionally Primary Care Physicians (PCPs) and specialty physicians are required to meet the following standards to be considered for participation in SHP's network:

- Current unrestricted license to practice medicine or osteopathy in California.
- Current, valid federal Drug Enforcement Agency (DEA) certificate.
- Current staff membership, clinical privileges, and admitting privileges granted by a SHP Hospital within the service area or arrangements with a Provider who has such privileges.
- Graduation from medical school and completion of a residency for MDs and DOs. (An exception may be made for a Provider who has only completed a rotating internship, if the Provider agrees to be classified as a General Practitioner and practices in an underserved area of the county.)
- Documentation of board certification (if applicable). Practitioners will provide ongoing documentation of certification, at the time of application and at a minimum of every three (3) years thereafter, by the appropriate Board for physician specialty or of active and current involvement in the Board certification and examination process.
- Professional liability insurance policy of not less than $1,000,000 per incident and $3,000,000 per year.
- Twenty-four (24) hour-a-day coverage for all SHP members with another participating PCP or with another SHP physician who agrees to abide by the guidelines of SHP.
    - PCPs must be able to perform the following in the office setting:
    - EKG (pediatric offices as appropriate)
    - Office gynecology including routine pelvic and pap smears (pediatric office excepted)
    - Blood draws (not applicable if using national lab contract)
    - Minor surgery to include incision and drainage of abscess and suture of superficial lacerations
    - Availability and accessibility to include:
    - Minimum of twenty (20) hours each week of regularly scheduled office hours for treatment of patients for a one-physician practice and minimum of thirty (30) hours for a practice of two (2) or more physicians
    - During and after-hours response time to calls not greater than thirty (30) minutes after notification
    - Ability to accept a minimum of 250 new Members at time of application
    - No more than an average of five patients scheduled and seen each hour for routine office visits for adult medicine and six (6) patients per hour for pediatrics
- Compliance with Medical Board continuing education requirements.
- Absence of felony convictions, sound moral character, and in good professional standing in the community.
- Provision of quality, appropriate, and timely care.
- Supportive of the philosophy and concept of managed care and of SHP.
- Good standing with Centers for Medicare and Medicaid Services (CMS) in any state in where they have been licensed.

Delegated Credentialing/Re-Credentialing
Delegation status is granted only to entities that perform the credentialing/re-credentialing activities according to NCQA standards. Credentialing delegation oversight audits are conducted annually by SHP or by another NCQA-accredited health Plan in California via the Industry Collaborative Effort (ICE) shared delegation oversight credentialing audit process.

Credentialing appeals
To ensure Providers will be treated fairly and uniformly, Providers may appeal any adverse credentialing decision, including the right to discuss the decision and for any errors to be corrected.

Re-Credentialing
Re-review of Provider credentials for re-credentialing is performed no less than every three (3) years according to NCQA standards. Providers receive a re-credentialing application and release form approximately six (6) months before their current credentialing period is to expire. SHP utilizes a universal reapplication and only information that may have changed since the last credentialing will be requested.

Providers are responsible for producing adequate information for a complete evaluation of experience, background, training, and ability to perform as a clinician without limitations, including physical and mental health status as allowed by law. In order to keep the application on active status, Providers will be asked to supply the needed information within a specified time frame. Failure to provide the information within the required time frame will result in termination from the SHP network.

A complete copy of the SHP's Provider credentialing policy is available on our website at www.scrippshealthplan.com

Regulatory Compliance, Fraud, Waste and Abuse

The purpose of the Scripps Health Plan's Anti-Fraud Plan is to establish methods for objectively and systematically evaluating and investigating potential fraud and/or abuse of the Scripps Health Plan delivery system. Scripps Health Plan strives to continuously improve the structure, processes and outcomes of its anti-fraud activities.

Health care fraud is 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 representation. Fraud occurs when an individual knows or should know that something is false and takes deceptive actions that could result in some unauthorized benefit to themselves or another person.

Health care fraud is costly for everyone. It leads to higher premiums, more uninsured people and fewer dollars available for health care services.

Health care fraud comes in many forms, including:

- Submission of fraudulent claims (e.g., billing for services that were not provided or inappropriately coding claims to result in higher charges)
- Use of health plan ID cards by persons who are not entitled to benefits
- Falsification of drug prescriptions

Scripps Health Plan works closely with its affiliates and is committed to working to reduce fraudulent activity. If you suspect Fraud, Waste or Abuse, please notify us immediately:

Linda Pantovic, Plan Compliance Officer - 858-927-5360;
Pantovic.Linda@scrippshealth.org

You are protected
It is SHP's 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. No matter how you choose to report an issue or concern, so long as it is made in good faith, you are protected from retaliation by Scripps Health Plan policy, as well as Federal and State law.

The Compliance Department is responsible for the following activities:
- Ensure SHP is in compliance with the DMHC, Knox-Keene Health Care Service Act of 1975 as amended
- Monitoring and Oversight of the various functions within the Managed Care Division regarding all compliance and regulatory issues
- Develops and coordinates internal compliance review activities to assure timeliness, progress and improvement
- Facilitates communication between SHP and the Department of Managed Health Care (DMHC), as well as other regulators
- Ensures 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 Plan Compliance Officer for tracking, review, investigation, and reporting to the Compliance Committee, the Management Advisory Committee (MAC) and any regulatory agencies as necessary. Referrals are also made to the Credentialing Committee concerning misconduct of a credentialed provider. Reports of potential fraud or abuse cases may come from a variety of sources including:
- Enrollees
- UM Staff
- Claims Staff
- Providers
- Regulatory Agencies
- Customer Service Staff
- Case Management Staff

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

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

One of the primary goals of the Anti- Fraud Plan is to educate 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 SHP Compliance Program, Anti-Fraud Plan and training materials may be obtained by contacting the Plan Compliance Officer at 858-927-5360.

Reporting Compliance Issues and Concerns: SHP's policies and the *Standards of Conduct* require all contracted providers and employees of SHP to promptly report instances of non-compliance related to a managed care patient or impacting SHP operations or activities. Providers and employees are advised to report concerns to the Plan Compliance Officer, Linda Pantovic at 858-927-5360, via email at Pantovic.Linda@ScrippsHealth.org**.** 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 Plan Compliance Officer.

Privacy & Confidential Information

It is the responsibility of every health care provider that their employees ensure the confidentiality of records and related information for all patients. Each contracted provider is a Business Associate and 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 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**
- **Inforamtion from organizational or medical staff committees**
- **UR Committees**
- **Information received from non-SHP physicians and external agencies**

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

It is the policy of Scripps Health Plan to handle private information in a way that demonstrates our value and respect for the confidentiality of plan members and our partners. It is the responsibility of SHP employees, providers, business associates, contractors, volunteers and all others granted access to confidential information to be familiar with SHP privacy policies and comply with established practices for handling confidential information.

SHP informs members and their representatives of the privacy oversight program annually and upon enrollment by sending a *Notice of Privacy Practices*, which includes requisite disclosures as stipulated in the Privacy Rule. You can download a copy of SHP's Notice of Privacy Practices by visiting www.scrippshealthplan.com.

Providers are responsible for complying with SHP's policies regarding proper handling of Protected Health Information (PHI), including making their own Notice of Privacy Practices available publicly. Providers are also required to notify SHP of a potential or confirmed breach of a member's PHI. Examples of common privacy incidents in the provider office include:

- **Handing a bill, claim receipt or medical record to the wrong patient.**
- **Faxing medical records to the wrong provider or an incorrect fax number**
- **Mailing records or test results to the wrong patient**
- **Loss of a laptop or other digital storage device with PHI saved**

Report all suspected privacy breaches to SHPS Compliance Department via email at SHPSCompliance@scrippshealth.org or telephonically with Spencer Alexander, Privacy 858-927-5461.

PROVIDER'S ROLE AND RESPONSIBILITIES

Provider Responsibilities

This Provider Manual is an extension of your contract, as a SHP provider you agree to abide by the following:

- 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 the member is made aware of financial responsibility in advance and in writing of non-covered services and/or co-payments
- Provide all covered Hospital, Professional or Ancillary services to members enrolled through SHP 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 SHP when required. Failure to obtain prior authorization may result in non-payment of claims. In case of services already provided, it is the provider's responsibility to request retro-authorization
- Adhere to the SHP Formularies, clinical step-therapy protocols, and Mandatory Generic Prescription policies.
- Participate in the Quality Improvement and Utilization Management procedures defined by SHP.

- Comply with credentialing and re-credentialing requirements as stipulated.
- Ensure SHP has current Medical and DEA Licenses on file.
- Refer members and utilize SHP 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 SHP Fraud, Waste, and Abuse & *Privacy Programs – reporting potential misconduct or breach of privacy immediately to the Plan Compliance Officer*
- Retain records to support all Compliance Activities for at least ten (10) years or longer as required by law.

Verifying Eligibility

SHP members should present for services with their insurance identification card issued by SHP. Member ID cards contain pertinent information about the member's Primary Medical Group (PMG) and co-payments. Providers are responsible for verifying eligibility with the SHP prior to rendering authorized services.

Access to Care

Timely access to the appropriate level of health care services for members is essential. Providers are required to offer a sufficient number of available appointments and telephone capabilities to serve the needs of the members. Providers are prohibited from the unlawful discrimination against any member based on factors including, but not limited to, race, religion, color, national origin, gender, age, disability, marital status, sexual orientation, or source of payment.

Access-to-Care Standards

Access standards have been established to ensure that all health care services are available and delivered in a timely manner for all members. The Access Standards are required by law under California Health and Safety Code Section 1367.03 and Title 28 of the California Code of Regulations rule 1300.67.2.2.

SHP utilizes the access to care standard criteria to ensure that health care services are available and accessible to members at reasonable times. SHP will monitor compliance to the standards in various ways. Monitoring methods may include access surveys, wait-time studies and annual mystery caller audits. Providers will be monitored at least annually for access to health care, and monitoring results will be shared with the provider. Should any deficiencies be identified, providers will be required to submit a Corrective Action Plan (CAP) to ensure future compliance with the access standards. Access studies are conducted by the Compliance department no less than annually, based on the following standards:

Appointment Wait Times

Non-Urgent	
Primary Care Physician	Within 10 business days
Specialty and Ancillary Care	Within 15 business days
Urgent Care	
Authorization NOT required	Within 48 hours
Authorization required	Within 96 hours
Emergency Services	Immediately

Mental Health Care Services	
Non Urgent	Within 10 business days
Urgent	Within 48 hours
Emergent	Immediately
Follow-up Care – after inpatient stay	Within 7–30 days of discharge

Telephone Wait times	
During Normal Business Hours Answer by a Non-Recorded Voice	Within 10 minutes
After Normal Business Hours Response to After-Hours Calls	Within 30 minutes

Office Wait times	
PCP and Specialty	Within 30 minutes of check in

No Detrimental Impact Determination
The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice**,** has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member.

Preventive Follow-Up Care Services, and Standing Referrals
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.

The Primary Care Physician (PCP) must, in consultation with the specialist, determine the need for a standing referral. This determination must be made within **three (3) business** days from the date all appropriate medical records and other items of information necessary to the determination are provided. A treatment plan will be developed in coordination with PCP, Specialist, and Medical Director. In order to request a standing referral please consult with the member's PCP.

After-Hours Telephone Access
SHP requires PCP or designee to be available so that assigned members have access to urgent and emergency care 24 hours per day, 7 days per week. Providers must maintain 24 hour, 7 day per week telephone access capability to provide immediate response to emergency inquiries by members. Providers must maintain a procedure for triaging or screening member telephone calls which, at a minimum, incudes the employment, after business hours, of a telephone answering service, and/or answering machine, and/or office staff that will inform the caller:

- Regarding the wait time for a return call from the Provider, and
- How the caller may obtain urgent or emergency care, including how to contact another Provider who has agreed to be on call to triage by phone or, if needed, deliver urgent or emergency care.

- Every after-hours caller is expected to receive emergency instructions, whether a line is answered live or by recording. Callers with an emergency are expected to be told to:
    - Hang up and dial 911, or
    - Go to the nearest emergency room, or
    - Hang up and dial 911 or go to the nearest emergency room.

After receiving emergency instructions, callers with non-emergency situations who cannot wait until the next business day should receive one of the following options when speaking with a live person:

- **Stay on the line to be connected to the doctor on call.**
- **Leave a name and number and a physician or qualified health care professional will call back within 30 minutes.**
- **Reach the doctor at another number.**

When reaching a recording:

- Leave a message and the call is returned within 30 minutes.
- Call an alternate phone or pager number to contact the physician on call.

The waiting time for a member to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care, may not exceed 30 minutes.
All patient telephone calls should be documented on a phone message form, with the response given documented on the same form. Documentation of phone calls must be affixed to the progress notes and become a permanent part of the medical record. At minimum, documentation of the phone call must include:

- Patient name
- Date and time of call
- Patient's question/concern
- Advice/response provided
- Signature of individual who triaged the call

Behavioral Health (BH) Telephone Access

Behavioral Health practitioners will maintain access to BH screening and triage to ensure that callers reach a non-recorded voice within thirty (30) seconds. Telephone abandonment rates shall not exceed five percent (5%) at any time. Calls must be returned a by psychiatrist or qualified health care professional within thirty (30) minutes.

Failed Appointments

Failed appointments are those where a patient does not arrive for a scheduled medical appointment, either with or without prior notice from the patient. Failed appointments must be documented in the medical record according to the PMG's or Provider's written policy and procedure, with provisions for a case-by-case review of members with repeated failed appointments.

Some providers have established a missed-appointment fee for their patients. SHP shall reserve the right to review and approve such policies. Providers must demonstrate that members are notified in advance regarding any missed appointment fees. Policies must also include a provision for waiving the fee under extenuating circumstances. SHP does not reimburse providers for missed appointment fees.

Advanced Directives

The Omnibus Budget Reconciliation Act of 1990 provides individuals with information about their rights regarding advanced directives and encourages 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, Providers are required to inform patients about their rights to institute an Advance Directive:

- 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.

Member Billing

Providers agree contractually to look solely to SHP as the source of final payments for SHP members. It 4is a violation of law to bill HMO members directly except for co-payments, co-insurance or for benefits not covered by HMO insurance. For benefits not covered by HMO insurance, providers must obtain a written waiver from the patient prior to delivering the service to prevent misunderstandings.

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; 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..

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Revised

11/01/16

Exhibit 1
SHP PCP Member Dismissal Request Form

This form is to be used by a Provider's office to request dismissal of a current member assigned under a SHP policy.

PROVIDER INFORMATION

Provider Name: _____

Medical Group Name: _____

Telephone #: _____

Fax #: _____

Signature: _____

Dismissing from entire group? Yes / No (if applicable):

MEMBER INFORMATION

Member Name: _____

ID Number: _____

Date of Birth: _____

REASON FOR DISMISSAL

____ Irreparable damage to the physician–patient relationship
____ Financial
____ Fraud
____ Non-compliant
____ Abusive or threatening
____ Missed appointments
____ Other (Please specify below):_____
_____
_____

Please include details supporting dismissal and fax all supporting documentation with this request to Performance Improvement at 858-260-5879 or mail to:

Scripps Health Plan Services, 4S-300
Attention: Performance Improvement
10790 Rancho Bernardo Road
San Diego, California 92127

********** **FOR SCRIPPS HEALTH PLAN USE ONLY**********

Date dismissal request received: _____

Date all supporting documentation received:_____

Date review completed by SHP CMO:_____

Date SHP decision sent back to PCP:_____

Exhibit 2

Corrected Claim – Standard Cover Sheet

PMG:_____ **Product:** _____

Attention:_____

Send to: P.O. Box 2529 4S-300
La Jolla, CA 92038
Fax: 858-260-5852

◆This is NOT a DUPLICATE claim. Please forward to the appropriate area for reprocessing.
◆Be sure to Attach updated Claim form

Claim Identification Information:

I. Original Claim Number (from voucher): _____

Provider Office Contact Person:

Name: _____ Phone Number: _____

Other Information: _____

This claim is a corrected billing of a previous processed claim for the following reason(s):

- o Corrected diagnosis
- o Corrected date of service
- o Corrected charges
- o Corrected patient information
- o Corrected procedure code (CPT or CM)
- o Addition, or correction of modifier
- o Corrected provider information

II. Other: _____

III. **Any specific clarification/comment/instructions (e.g., the claim line that was corrected):**_____

_____

_____

_____

_____

IV. Supporting Documentation Attached? o **Yes** o **No**

Privacy Statement: This document contains confidential information. Any disclosure, copying or distribution is prohibited. If you have received this information in error, please notify the sender and destroy all copies.

Exhibit 3

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/PDR Department
  P.O. Box 1928
  La Jolla, CA 92038
  Fax: 858-260-5878

***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:**
*** Member ID Number:**	**Patient Account Number:**
DISPUTE TYPE ☐ Claim ☐ appeal of Medical Necessity / Utilization Management Decision ☐ Disputing Request For Reimbursement Of Overpayment	☐ Seeking Resolution Of A Billing Determination ☐ Contract Dispute ☐ Other:
***Service "From/To" Date:** (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	**Original Claim Amount Billed:** / **Original Claim Amount Paid:**
EXPECTED OUTCOME:	
*** DESCRIPTION OF DISPUTE:**	

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

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

	* Patient Name		*Date of Birth	* Member 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								

Exhibit 4

GRIEVANCE RESOLUTION PROGRAM

Scripps Health Plan staff will answer your questions and attempt to resolve any problem satisfactorily. We have a grievance program designed to resolve your concerns or complaints in a timely and effective manner.

If you have a question or concern, we encourage you to contact our Customer Service Department or Appeals and Grievances staff. This staff will assist you in filing your grievance and resolving your concern. The Scripps Health Plan Customer Service staff can be reached at the following number at **1-844-337-3700** or TTY at **1-888-515-4065** for the hearing and speech impaired.

If you wish to file a grievance in writing, please complete the attached form and mail or fax the details of your problem to:

Scripps Health Plan
Attention: **Appeals and Grievances**
Mail Drop: 4S-300
10790 Rancho Bernardo Rd
San Diego, CA 92127
Fax: **858-260-5879**

Upon receipt of your grievance, Scripps Health Plan will send you a written acknowledgement letter and the name of the person handling your concern. We will make every effort to promptly resolve your concern and will provide you with a written response as soon as possible. Occasionally, issues requiring extensive review may take longer to resolve. In such cases, we will provide a written response or status within thirty (30) working days of receipt of your concern.

Scripps Health Plan will assure that there is no discrimination against you solely on the grounds that you have filed a grievance or complaint. You, as the member, also have the right to request a conference as part of the grievance system. We would also like to inform you of the following information:

The California Department of Managed Health Care *is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at* ***1-844-337-3700*** *or TTY at* ***1-888-515-4065*** *for the hearing and speech impaired and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.*

Federal Employee Health Benefit Program (FEHBP) members:
The proceeding appeals information does not apply to participants of the FEHBP. If you are covered by the FEHBP, please refer to section 8, The Disputed Claims Process, or your Federal Brochure, which explains the FEHBP appeals process. Grievance/Complaint Report Form.

TODAY'S DATE:	**DATE OF SERVICE OR INCIDENT:**
NAME OF FACILITY, PROVIDER OR STAFF RELATED TO INCIDENT:	
SUBSCRIBER NAME:	**HEALTH PLAN MEMBER ID #:**
ADDRESS:	**HOME TELEPHONE:**
CITY, STATE, ZIP:	**WORK PHONE NUMBER:**
DATE OF BIRTH:	
***If a grievance is being filed by a Member other than the Subscriber, please provide the following information*:**	
MEMBER NAME:	**DAYTIME TELEPHONE:**
ADDRESS:	**RELATIONSHIP TO SUBSCRIBER:**
CITY, STATE, ZIP:	**DATE OF BIRTH:**

Does the Subscriber/Member reporting the Grievance have a Terminal illness?	☐ **Yes** ☐ **No**
	☐ **Yes** ☐ **No**
Is the Grievance related to treatment that is Experimental or Investigational?	☐ **Yes** ☐ **No**
Is this an Expedited Grievance? Check "Yes" if you feel that waiting for 30 days could seriously harm your health or ability to function for reasons including but not limited to severe pain or potential loss of life, limb or major bodily function.	

Please provide details related to the incident for which you are filing a Grievance including dates and times, names of individuals and locations. Please attach documentation if you need additional space.

SHPS USE ONLY	**DATE RECEIVED:**
EMPLOYEE (receiving grievance):	**PHONE**:
FOLLOW UP ACTION:	

RESULT/DECISION:	
DATE CLOSED:	**CSR TRACKING #**