Jade Health Care Medical Group

PROVIDER QUICK REFERENCE GUIDE

FOR JADE PROVIDERS USE ONLY

VERSION 1.2 – 07/2020

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SECTION 1 INTRODUCTION AND HOW TO CONTACT US

Section 1.1 Welcome to Jade Health Care Medical Group

Jade Health Care Medical Group is a medical group delivering culturally sensitive, bilingual managed health care in the San Francisco Bay Area. Our service area includes the City and County of San Francisco and Northern San Mateo County.

The Jade Health Care Medical Group (Jade) has been formed in response to the desire of interested community physicians to provide care to our community patients, utilizing our community hospital, Chinese Hospital, and the Chinese Community Health Plan (CCHP) network in San Francisco and Northern San Mateo County. The physician group will also assist its member physicians to meet the demands of the new practice environment, and provide physicians with the opportunity to work together with Chinese Hospital and its health plan to meet the needs of our community.

Section 1.2 Jade Health Care Medical Group's Mission

The mission of Jade Health Care Medical Group is to improve the health of our community by delivering high-quality, affordable healthcare through culturally competent and linguistically appropriate services.

Jade Health Care Medical Group is committed to serving our community and is devoted to delivering the highest quality health plan to the people and organizations we serve. We consider our health care providers as our customers and vital partners in serving our members.

For more Information:

445 Grant Ave, Suite 200
San Francisco, CA 94108
Website: www.JadeHCMG.com
General Email: Info@JadeHCMG.com
Phone Number: 1-415-677-2408

Section 1.3 Purpose of the Quick Reference Guide

This quick reference guide is intended to provide Jade Health Care Medical Group participating physicians, allied health care providers and facilities with the most frequently asked information to serve and coordinate the care of Jade Health Care Medical Group members.

The medical group's provider manual which includes all of Jade's initiatives and policies and procedures is available online on our website to view.

Section 1.4 Provider Network

Jade Health Care Medical Group providers are non-exclusive and may serve patients through many Health Care options. Jade's Provider Network includes our contracted providers, Health Care plans direct providers, and also available in a wide range of specialists and are accessible in accordance to Jade authorization guidelines.

Section 1.5 How to Contact Us - Helpful Resources

Jade contracts with the Chinese Community Health Plan (CCHP) as its MSO for many services and list the necessary forms on their website. To access support services please refer to the following matrix.

Jade Health Care Medical Group	**Additional Information**	**Phone/Fax**
Main Office	445 Grant Avenue, Ste. 200 San Francisco, CA 94108	1-415-677-2408
Website	**http://www.jadehcmg.com**	
Email	**info@jadehcmg.com**	
Hours of Operation:	Monday – Friday 9:30 a.m. - 5:00 p.m.	
Eligibility and Benefits		**Phone**
	Create an account on CCHP's Provider Portal: https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx (If you have any issues logging in, please contact Provider Network Management Department at 628-228-3281)	Or call Member Services seven days a week from 8:00 am to 8:00 pm. 1-888-775-7888 (toll free) 1-415-834-2118 (local)
	Create an account on SFHP's Provider Portal: https://sfhpprovider.healthtrioconnect.com/app/index.page? *If you have any issues logging in, please contact Provider Network Management Department by email at provider.relations@sfhp.org	1-415-547-7818 EXT 7084.
CCHP Provider Relations *		**Phone/Fax**
Provider Network Information	**CCHP:** Use the new web-based provider search function for CCHP at: www.cchphealthplan.com/doctors/search Please report any inaccuracies or changes to **Provider Network Management** via Provider Relations email: pr@cchphealthplan.com	
General Inquiries	Provider Network Management Provider.relations@cchphealthplan.com	1-628-228-3281
Request Username & Password for Website	Provider Relations Provider.relations@cchphealthplan.com	1-628-228-3281
Request Service Authorization Forms Request Referral Forms	Provider Relations Provider.relations@cchphealthplan.com	1-628-228-3214
Provider Contracting	Contact **Provider Contract Management**: CCHP.Contracting@cchphealthplan.com M-F 9:00 a.m. to 5:00 p.m.	1-628-228-3277

SFHP Provider Relations:		
	SFHP: **Email:** provider.relations@sfhp.org *Hours of Operation: **Monday through Friday**, **8:30am to 5:00pm** for any questions or concerns about provider issues, network and contracting, credentialing, and payment disputes, etc.*	1(415) 547-7818 ext. 7084
CCHP Provider Disputes *		**Phone/Fax**
Provider Dispute Forms & Instructions	www.cchphealthplan.com/cchp-providers-dispute-process	1-415-955-8800
Provider Relations Fax		1-415-955-8815
Submit a Provider Dispute Dispute must be submitted on Dispute Form	Disputes can be mailed to: Attention: Jade Health Care Medical Group Provider Dispute Resolution 445 Grant Avenue, Suite 700 San Francisco, CA 94108 M-F 9:00 a.m. to 5:00 p.m.	1-415-955-8815 (Fax)
SFHP Provider Disputes	**SFHP:** **Email:** provider.relations@sfhp.org *Hours of Operation: **Monday through Friday**, **8:30am to 5:00pm** for any questions or concerns about provider issues, network and contracting, credentialing, and payment disputes, etc.*	1(415) 547-7818 ext. 7084
CCHP Claims *		**Phone/Fax**
Check Claims Status	Create an account on CCHP's Provider Portal: https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx (If you have any issues logging in, please contact Provider Network Management Department at 628-228-3281)	1-628-228-3322
CCHP Claims General Inquiries	Member Services	1-415-834-2118
Submit Electronic Claims	For electronic submissions, the please direct them to CCHP's **Payer ID 94302**	
Submit Paper Claims	Paper claims can be mailed to: Attention: Jade Health Care Medical Group Claims Department 445 Grant Avenue, Suite 700 San Francisco, CA 94108	
CCHP Clinical Services*		**Phone/Fax**
CCHP UM Line		1-877-208-4959

Request Prior Authorization	Fax Service Authorization Form	1-415- 398-3669 (Fax)
View Authorizations Online	Create an account on CCHP's Provider Portal: https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx If you have issues logging in please contact Provider Network Management Department at 628-228-3281.	1-628-228-3281
SFHP UM Department		
SFHP UM Contact Information	**Email :** authorizations@sfhp.org	1(415) 547-7818 ext. 7080
CCHP Pharmacy*		
Request Prior Authorization for RX	CCHP Senior & Senior Select: CCHP Member Services CCHP Commercial Program: MedImpact Healthcare Systems	1-888-775-7888 1-800-788-2949
Formulary Questions	Pharmacy Manager	1-628-228-3334
Pharmacy Formulary	**Link to CCHP Formulary:** www.cchphealthplan.com/cchpproviders-formulary-pharmacy	1-628-228-3334 **1-888-989-0091**
SFHP Pharmacy		
Request Prior Authorization for RX	**SFHP:** PerformRx	1-888-989-0091
Pharmacy Formulary	**Link to SFHP Formulary:** https://www.sfhp.org/providers/pharmacy-services/sfhp-formulary/	
SFHP Pharmacy Directory:	**SFHP:** https://www.argushealth.com/enhanced/memberaccess-jsfweb/2.0/components/pharmacySearch/index.jsf	
CCHP Compliance*		**Phone/Fax**
Report Suspected Fraud, Waste or Abuse Report Privacy or Security Issue	Compliance Hotline – Confidential Email: Compliance@jadehcmg.com	1-415-955-8810 1-628-228- 3340
SFHP Customer Service Department		
Customer Service Department	The Customer Service Department is available to assist with any general questions about member benefits, eligibility, covered services, claims payments, etc.	1(415) 547-7800 or 1(800) 288-5555 or 1(415) 547-7830 TTY/TDD

	Hours of Operation: Monday through Friday, 8:30am to 5:30pm.	
* CCHP is the Management Services Organization (MSO) for Jade Health Care Medical Group		

Section 1.6 Notification of Provider Information Changes

Any change in your provider information must be reported to Jade Health Care Medical Group in writing as soon as possible. Some examples of these changes include practice location, phone number, tax identification number, claims payment address, hours of operation, status as open to newly assigned members (for Primary Care Physicians), affiliated or covering physicians, physician assistants and nurse practitioners. Please submit a written notice to the Jade Health Care Medical Group Contracts Department.

If terminating your participation, you must submit a termination notice to Jade Health Care Medical Group in the time frame stated in the Jade Health Care Medical Group Provider Agreement.

Providers with Jade Health Care Medical Group Contracts should notify us immediately.

Provider Contract Manager
Jade Health Care Medical Group
445 Grant Avenue, Suite 200
San Francisco, CA 94108

SECTION 2 VERIFYING MEMBER ELIGIBILITY

Section 2.1 Create Provider Portal User ID

Providers are required to create a CCHP Provider Portal Account with User ID so that you can easily check eligibility and claim status. This will also make communication between CCHP and providers more streamlined.

Chinese Community Health Plan's Provider Portal

Providers are required to create a CCHP Provider Portal Account with User ID so that you can easily check eligibility and claim status. This will also make communication between CCHP and providers more streamlined.

Main Account Set-Up

1. Go to website: https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx
2. Create new user account by "**Click here to create a new user**…"
3. Select "**Provider**" for providers or "**Office**" for offices. You will receive an email with your appropriate entity instructions.
4. The first account created will be the primary user and will be able to create other accounts. Create main account with the information in your email.
5. You will receive an activation email.
6. Click on the activation link to activate account.

Creating New User

1. After the "PrimaryWebAccount" is created, this user can go to "Manage Users" on the left sidebar and add new users.
2. Click "Add a User" and make sure to assign the "WebProvider" role to new users.
3. Complete user information.
4. An activation email will be sent to the user email.
5. Click the activation link to activate account.

***There are some functions on the new portal that require pop-ups. Go to your Privacy Settings and allow pop-ups from site: **portal.cchphealthplan.com**

San Francisco Health Plan's Provider Portal

San Francisco Health Plan also has a Provider Portal, SFHP ProviderLink, where providers and their staff can verify members' eligibility, download member rosters or primary care sites, and check authorizations status for their practices. The link to SFHP ProviderLink is https://sfhpprovider.healthtrioconnect.com/app/index.page? .

To gain access to the basic feature of SFHP ProviderLink:

1. Go to www.sfhp.org/providers
2. Select "Provider Secure Login"
3. Click on "Sign up here"
4. Fill in requested information for steps 1-6
5. Choose a USERNAME for step 7

6. Click Finish.

Your password will be sent to you via the e-mail that you submitted in the registration process. The Provider Relations department will activate your chosen username and password within 3 business days and notify you by email when this is complete.
For questions about SFHP ProviderLink, please contact SFHP's Provider Relations by email at provider.relations@sfhp.org or phone number at 1-415-547-7818 EXT 7084.

Section 2.2 Verifying Member Eligibility

Chinese Community Health Plan

Providers are responsible for verifying member eligibility before rendering services. Eligibility must be verified every time services are received. To verify eligibility for Jade members, please visit CCHP's website at: https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx , or you may call CCHP's Member Services Dept.

The websites contain real time information and can be accessed 24 hours a day. After checking member eligibility on the Website, if you still have questions, please contact Jade Health Care Medical Group Member Services at 415-834-2118.

If members are affiliated with other CCHP contracted medical groups, please use the appropriate eligibility verification process.

San Francisco Health Plan

For San Francisco Health Plan (SFHP) members, providers can check member eligibility through the following methods:

1. Accessing SFHP's provider portal, SFHP ProviderLink, via the SFHP website https://www.sfhp.org/providers/
2. Calling the SFHP Interactive Voice Response system (IVR) at 1-415-547-7810
3. Calling SFHP Customer Service Department at 1-415-547-7800, Monday – Friday, 8:30 am – 5:30 pm.

Questions regarding member's PCP assignment status can also be directed to Customer Services at (415) 547- 7800 or 1-800-288-5555 between the hours of 8:30 am and 5:30 pm, Monday through Friday.

Important Note: when calling SFHP IVR system, please provide the member's ID number from the front of the member's SFHP ID card. If SFHP ID card is not available, use the member's Social Security number or Medi-Cal Client Index Number (CIN).

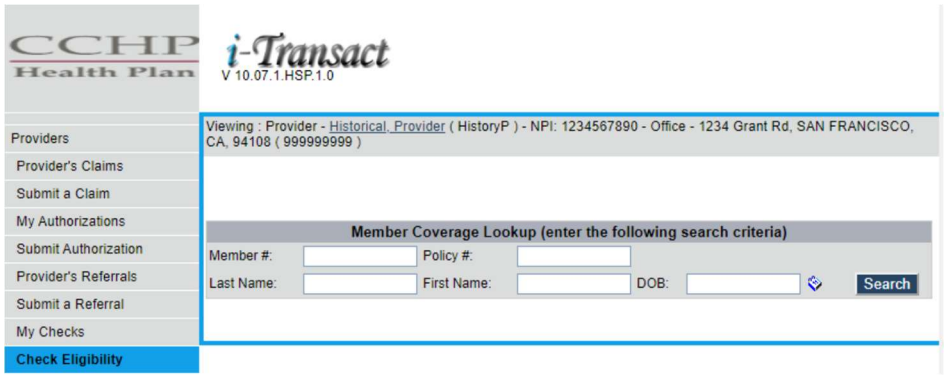
Section 2.3 Website Instructions for Verifying Eligibility

To use CCHP's Website to check CCHP member eligibility and benefits:

1. Go to https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx
2. Enter your username and password and click on "Logon".
3. For CCHP Member Eligibility Search, select the "**Check Eligibility**" option on the left side bar.
4. Enter the CCHP Member ID under "**Member #**" (Example: 0001234).

5. To search with the old CCHP Member ID, please enter the old CCHP Member ID without the asterisk under "**Policy #**" (Example: 00011122201).
6. You can also search by Last Name, First Name, and Date of Birth (DOB).
7. After you entered the member information, the coverage dates will be under the effective and expiration date.
8. For a summary of the member's benefits and copayments, please click on "**view**" under Benefits.
9. For member's PCP and Medical Group information, please click on "**view**" under Member Face Sheet.

See **"Eligibility search"** screenshot below:



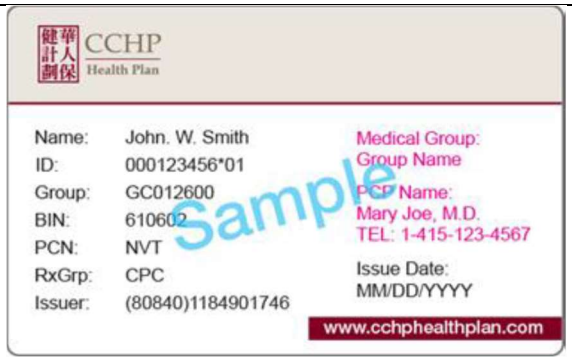
Note:
To verify eligibility and benefits for Medical Group's other health plan and program members, please use the applicable health plan website.

To check Member Eligibility for SFHP members:

1. Go to www.sfhp.org/providers
2. Select "Provider Secure Login"
3. Enter Username and Password
4. Click on "Login"
5. Click on "Verify Member Eligibility & PCP"
6. "Member Search" will open in a new window—please ensure that your browser is not
7. blocking pop ups
8. Enter last name, member ID, or Medi-Cal CIN, in addition to any other information to limit.
9. search by
10. Click on "Search"
11. Click on "View Details" next to member's name to view eligibility information

Section 2.4 Member ID Cards

Please ask patients to present their Jade Health Care Medical Group ID Card each time they present for services. The ID Card is not proof of eligibility. It is for identification purposes only, however it contains information to assist you in verifying eligibility on our website. If a member does not have an ID Card, you can still use the website to verify eligibility. Because member eligibility and benefits are subject to change, **providers are responsible for verifying eligibility each time services are received.** The following are samples of Jade Health Care Medical Group Member ID Cards for Chinese Community Health Plan and San Francisco Health Plan:

Chinese Community Health Plan Commercial (HMO) Program ID Card (Employer Group and Individual/Family Plan Members)	
Chinese Community Health Plan Commercial (PPO) Program ID Card (Employer Group and Individual/Family Plan Members)	
Chinese Community Health Plan Senior Program (HMO) ID Card (Medicare Advantage Members with Medicare Parts A + B)	

Chinese Community Health Plan Senior Select Program (HMO SNP) ID Card

(Medicare Advantage Members with Medi-Cal and Medicare Parts A + B)

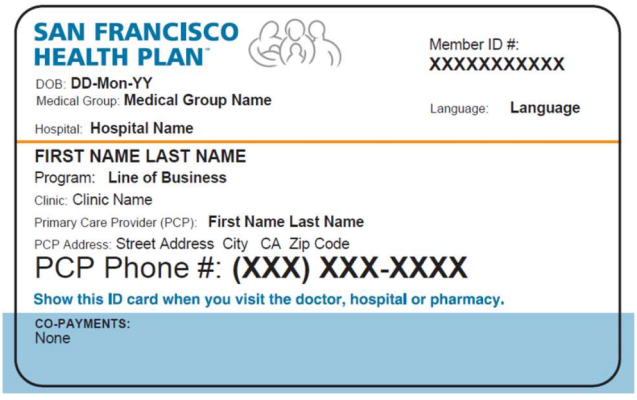
Please note that the service area for Jade Health Care Medical Group's Senior Select Program (HMO SNP) is the City and County of San Francisco. It does not include northern San Mateo County. Senior Select Program Members must obtain care within Jade Health Care Medical Group's San Francisco Provider Network.

Chinese Community Health Plan Covered California (HMO) Program ID Card

(Covered California Members)

San Francisco Health Plan ID Card

(SFHP Managed Medi-Cal and Healthy Kids Members)



SECTION 3 PRODUCTS AND BENEFITS

Section 3.1 Jade Health Care Medical Group Programs and Products

Jade Health Care Medical Group participates in a variety of commercial products for small and large group employers as well as products for individuals. Jade Health Care Medical Group participates in the following products:

- **Chinese Community Health Plan Commercial Products** for employer groups and individuals and families. Jade Health Care Medical Group offers several plans with different choices of copayments and optional dental, vision and chiropractic riders. These products include Covered California for which you are a contracted provider.
- **Chinese Community Health Plan Senior Program HMO** is a Medicare Advantage plan for people with Medicare Parts A and B. This plan includes a Medicare Part D drug benefit and offers an optional dental rider.
- **Chinese Community Health Plan Senior Select Program HMO Special Needs Plan (SNP)** is a Medicare Advantage plan for people with both Medicare Parts A and B *and* Medi-Cal. This plan includes a Medicare Part D drug benefit and a dental benefit.
- **Covered California Health Plan:** CCHP is one of only five in San Francisco and San Mateo counties to provide coverage through Covered California. All plans in Covered California are Qualified Health Plans, meaning, they meet or exceed quality standards set by state and federal guidelines. There are several CCHP plan options available through Covered California.
- **San Francisco Health Plan (SFHP):** is a Managed Medi-Cal health plan for San Francisco residents only. Jade is contracted to take care of the SFHP Managed Medi-Cal and Healthy Kids members only.

Section 3.2 Benefits Summary/Matrix

A summary of benefits can be found through the health plan's website at: https://www.cchphealthplan.com/family-member . Benefits are subject to change. Providers must verify a member's benefits and eligibility prior to rendering services as well has having prior authorization when required by Jade Health Care Medical Group. Refer to Section 2 for information on Web access to verify eligibility and benefits and Section 5 for services requiring prior authorization.

To access the SFHP's summary of benefits, please visit the SFHP website at the following links:

Medi-Cal: provides free and low-cost health care coverage services that are funded by State and Federal dollars. These services are available to individuals with low-income or limited resources. The Medi-Cal Program offers health services ranging from limited scope coverage to full scope coverage (inclusive of vision and dental for children). All SFHP members are enrolled in Managed Medi-Cal receiving full-coverage benefits at no cost. Managed Medi-Cal beneficiaries are required to choose a managed care health plan (Anthem Blue Cross or SFHP). Most Seniors and Persons with Disabilities, receiving services under Managed Medi-Cal are also required to choose a health plan. There are no premiums or co-pays for beneficiaries enrolled in Managed Medi-Cal. Eligibility is determined by the eligibility workers at the local Department of California Human Services Agency (HSA) or linked by other social services programs, such as CalWORKs, TANF, and SSI.
http://www.sfhp.org/members/programs/medi-cal/benefits_and_services.aspx

Healthy Kids HMO: is a health coverage program for low to moderate income children ages 0 to 18 (inclusive) living in San Francisco who are not eligible for Medi-Cal. Health Kids offers coverage regardless of immigration status and up to 300% of the Federal Poverty Level. The program provides comprehensive health, vision and dental care. SFHP is the only health plan in San Francisco administering the HK Program. To remain in the program, an annual premium must be paid to the program; premium assistance is available.
http://www.sfhp.org/members/programs/healthy_kids/benefits_and_services.aspx

Healthy Workers HMO: is a health coverage program partly administered by SFHP. It is offered to individuals providing In-Home Support Services (IHSS) and a select category of temporary, exempt as-needed employees of the City and County of San Francisco. HW members have access to medical services through the San Francisco Department of Public Health (DPH). Eligibility is determined through the IHSS Authority or the Department of Human Resources and is based on length of time employed and hours worked.
http://www.sfhp.org/members/programs/healthy_workers/benefits_and_services.aspx

Section 3.3 Service Area

Jade Health Care Medical Group's Service Area is the City and County of San Francisco and northern San Mateo County for all programs and products, except for the Jade Health Care Medical Group Senior Select Program. The Service Area for Jade Health Care Medical Group Senior Select Program members is the City and County of San Francisco only. For details go to:
https://www.cchphealthplan.com/family-member

Section 3.4 Primary Care Physicians

Jade Health Care Medical Group members must select a primary care physician to coordinate their care. The primary physician coordinates all care including referrals to specialists. The member must use plan physicians, providers and facilities except for emergencies. For services not available from the Jade Health Care Medical Group physician panel, prior authorization must be sought from the Utilization Management Department. (See Section 5)

Section 3.5 Member Copayments

Jade Health Care Medical Group members are responsible for certain copayments. The amount of the copayment varies by the plan to which they belong. Office visit copayment amounts are

listed on Jade Health Care Medical Group member ID cards. For copayment information specific to each patient, you can look it up on the Health Plan Website for Chinese Community Health Plan and the San Francisco Health Plan website, or you may view copayment information at their secure log in for contracted providers at:
https://secure.healthx.com/v3app/publicservice/loginv1/login.aspx?bc=250fdc7b-5144-44f4-88d9-d86b841d9ebf&serviceid=0ec2e499-26cd-4333-bb08-f97ffc1b75de

To access the most up-to- date co-payment information for San Francisco Health Plan, please visit the SFHP website at the following links:

Medi-Cal:
http://www.sfhp.org/members/programs/medi-cal/benefits_and_services.aspx

Healthy Kids HMO:
http://www.sfhp.org/members/programs/healthy_kids/benefits_and_services.aspx

Healthy Workers HMO:
http://www.sfhp.org/members/programs/healthy_workers/benefits_and_services.aspx

You can also call Chinese Community Health Plan Member Services department and San Francisco Health Plan Customer Services during office hours at:

CCHP Member Services
1-888-775-7888 (toll free)
1-415-834-2118 (local)
Monday to Saturday:
9:00 a.m. to 5:00 p.m.

SFHP Customer Services:
1-800-288-5555 (toll free)
1-415-547-7800 (local)

For people who are deaf, hard of hearing, or speech disabilities:
1-888-883-7347 (toll free)
1-415-547-7830 (local)
Monday to Friday:
8:30 am to 5:30 pm

Co-payments and co-insurance/deductibles should be collected from the patient at the time of service, and are deducted from the allowable amount. Depending upon the Health Plan type of plan and line of business, many Jade Health Care Medical Group members have a yearly maximum limit on the amount of copayments or out-of-pocket charges that they have to pay, before they reach what is called the Out-Of-Pocket-Maximum (OOP MAX). During each calendar year, once the member individually, (or if part of a couple or family) has met the respective OOP MAX, then for the remainder of the calendar year any copayment amount would not be due from the member, or as applicable, from other family members (if the couple, or family maximum has been reached).

Members will receive periodic updates of their copayments, deductibles, co-insurance and out of pocket maximums throughout the year. If your patient has a question, direct them to member services at the number listed above.

Section 3.6 Preventive Services Covered Without Copayments

Jade Health Care Medical Group's goal is to partner with providers to ensure that members receive preventive care services. Jade Health Care Medical Group provides most preventive services to members without any copayments or cost sharing. Over time, this is expected to significantly improve health and reduce incidence of preventable conditions. Providers are expected to review a patient's chart to determine if and when they need these important services and encourage patients to participate in their health by getting preventive services.

Section 3.7 Summary of Preventive Services Covered Without Copayments

The following preventive services are covered without member co-payments or cost sharing. A member's plan may include other preventive services not listed here that are at no cost to the member. Please consult the member's benefit plan description or contact Jade Health Care Medical Group Member Services with questions.

Service	USPSTF Grade	Adults		Special Population	
		Men	Women	Pregnant Woman	Children
Abdominal Aortic Aneurysm, Screening[1]	B	x			
Alcohol Misuse Screening and Behavioral Counseling Interventions by PCP	B	x	x	x	
Anemia, Prevention – Counseling by PCP[2]	B				x
Anemia, Screening[3]	B			x	
Anemia, Screening– Hemoglobin/Hematocrit in Chidhood[4]	B				x
Annual Well Visits for childrens[5]	-				x
Annual Women's Well Visits[6]	-		x		
Aspirin for the Prevention of Cardiovascular Disease, Counseling by PCP(Aspirin is Over the Counter and Not Covered)[7]	A	x	x		
Asymptomatic Bacteriuria in Adults, Screening[8]	A			x	
Breast Cancer, Screening[9]	B		x		
Chemoprevention for Breast Cancer for High Risk Women Discussion with PCP[35]	B		x		
Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment and BRCA MutationTesting[10]	B		x		
Breastfeeding, Counseling by PCP Regarding Behavioral Interventions[11]	B		X	x	
Cervical Cancer Screenig[12]	B		X		
Chlamydial Infection, Screening[13]	A		X	x	
Colorectal Cancer, Screeniogn[14]	A	x	X		

Congenital Hypothyroidism, Screenign[15]	A				x
Dental Caries in Preschool Children, Prevention and fluoride Prescription[16]	B				x
Depression (Adults), Screening[17]	B	x	x		
Diet, Behavioral Counseling By PCP to Promote a Healthy Diet[18]	B	x	x		
Folic Acid Supplementation, Generic Prescription Folic Acid (Brand Name and Over the counter are Not Covered) [19]	A			x	
Gonorrhea, Screening[20]	B		x	x	
Gonorrhea, Prophylactic Medication[21]	A				x
Hearing Loss in Newborns, Screening[15]	B				x
Hepatitis B Virus Infection, Screening[22]	A			x	
High Blood Pressure, Screening[34]	A	x	x		
HIV, Screening[23]	A	x	x	x	x
Service	**USPSTF Grade**	**Adults**		**Special Population**	
		Men	**Women**	**Pregnant Woman**	**Children**
Inmunizations[37]	-	x	x	x	x
Lead Screening up to Age 7[36]	I				x
Lipid Disorders in Adults, Screening[24]	A&B	x	x		
Major Depressive Disorder in Children and Adults, Screening[24]	B				x
Obesity in Adults, Screening[26]	B	x	x		
Osteoporosis in Postmenopausal Women, Screening[27]	B		x		
Phenylketonuria, Screening[15]	A				x
Rh (D) Incompatibility, Screening[28]	A			x	
Sexually Transmitted Infections, counseling By PCP or OB/GYN[29]	B	x	x		x
Sickle Cell Disease, Screening[15]	A				x
Syphilis Infection, Screening[30]	A	x	x	x	
TB Skin Test[38]	-				X
Tobacco Use and Caused Disease, Counseling by PCP and Generic Prescription Medications (Brand Name and Over the Counter Medications Not Covered)[31]	A	x	x	x	
Type 2 Diabetes Mellitus in Adults, Screening[32]	B	x	x		
Visual Impairment in Children Younger than Age 5 Years, Screening[33]	I				x

This document includes the evidence-based items or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual and AHRQ with respect to infants, children, and adolescents, evidence informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources Services Administration. In order for an office visit to be considered

"preventive", the service must have been provided or ordered by the PCP, or an OB/GYN who is a Jade Health Care Medical Group Physician. You should check this and also the rules about copay allocation.

Footnotes:

1. One-time screening by ultrasonography in men aged 65 to 75 who have ever smoked.
2. Counseling regarding routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia. Iron supplements are available over the counter and are not covered.
3. Routine screening in asymptomatic pregnant women.
4. Screening for anemia in children under age 18.
5. Children underage 18.
6. Women of all ages.
7. When the potential harm of an increase in gastrointestinal hemorrhage is outweighed by a potential benefit of a reduction in myocardial infarctions (men aged 45-79 years) or in ischemic strokes (women aged 55-79 years).
8. Pregnant women at 12-16 weeks gestation or at first prenatal visit, if later.
9. Mammography every 1-2 years for women 40 and older.
10. Referral for women whose family history is associated with an increased risk for deleterious mutations in BRCAI or BRCA2 genes for genetic counseling and evaluation for BRCA testing.
11. Interventions during pregnancy and after birth to promote and support breastfeeding.
12. Women aged 21-65 who have been sexually active and have a cervix.
13. Sexually active women 24 and younger and other asymptomatic women at increased risk for infection. Asymptomatic pregnant women 24 and younger and others at increased risk.
14. Adults aged 50-75 using fecal occult bold testing, sigmoidoscopy, or colonoscopy. Procedures to treat any abnormalities will require a co-payment, even if performed at the same time as the screening.
15. Newborns.
16. Prescription of oral fluoride supplementation at currently recommended doses to preschool children older than 6 months whose primary water source is deficient in fluoride.
17. In clinical practices with systems to assure accurate diagnoses, effective treatment, and follow-up.
18. Adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease.
19. Recommendation that women pregnant or planning on pregnancy have folic acid supplement.
20. Sexually active women, including pregnant women 25 and younger, or at increased risk for infection.
21. Prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.
22. Pregnant women at first prenatal visit.
23. All adolescents and adults at increased risk for HIV infection and all pregnant women.
24. Men aged 20-35 and women over age 20 that are at increased risk for coronary heart disease; all men aged 35 and older.
25. Adolescents (age 12-18) when systems are in place to ensure accurate diagnosis, psychotherapy, and follow-up.
26. Discussion/counseling about intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.
27. Women 65 and older and women 60 and older at increased risk for osteoporotic fractures.
28. Blood typing and antibody testing at first pregnancy-related visit. Repeated antibody testing for unsensitized Rh (D) –negative women at 24-28 weeks gestation unless biological father is known to be Rh (D) negative.
29. All sexually active adolescents and adults at increased risk for sexually transmitted infections.
30. Persons at increased risk and all pregnant women.
31. Discussion/counseling about tobacco cessation interventions for those who use tobacco. Augmented pregnancy-tailored counseling to pregnant women who smoke. Generic prescription medications are covered.
32. Asymptomatic adults with sustained blood pressure greater that 135/80 mg Hg.
33. To detect amblyopia, strabismus, and defects in visual acuity; part of well-child.
34. Screening for high bold pressure in adults ages 18 and older without known hypertension.
35. Discussion/counseling about chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.

36. Children ages 1-5 at increased risk for lead poisoning.
37. Refer to recommendations made by the CDC and ACIP for immunization of children and adults,
38. Refer to CDC guidelines.

Section 3.8 Member Entitlement to Copayment Parity for Services Not Available at Chinese Hospital

Jade Health Care Medical Group has some benefit plans where the copayment for services rendered at Chinese Hospital is lower than the copayment rendered at other hospitals. It is the policy of Jade Health Care Medical Group that in the event a member's benefit plan has a lower copayment for services rendered at Chinese Hospital, and the member requires and is authorized for healthcare services at a facility other than Chinese Hospital, the member's copayment for the services rendered at a facility other than Chinese Hospital will not exceed that which would have been applicable. This policy also applies to its outpatient facilities if for reasons beyond the member's control care must be obtained at an outside facility, the member's copayment for the services rendered at a facility other than Chinese Hospital will not exceed that which would have been applicable. In addition, this policy is also applicable if Chinese Hospital is not within the required mandated standards of being within 15 miles from the member's residence, as long as the member obtains prior authorization for services from a contracted Jade Health Care Medical Group facility.

In regard to specialty services not provided by Chinese Hospital (such as Inpatient Mental Health, Substance Abuse, or OB-Labor & Delivery), members will be responsible for copayments that are no more than would be required for similar treatment or stays at Chinese Hospital for commensurate care for inpatient or outpatient services.

POLICY:

1. It is the policy of Jade Health Care Medical Group that in the event a commercial member requires and is authorized for health care services, other than at CH for reasons beyond the member's control and must be obtained at an outside facility, and/or if CH is not within the required California mandated standard of being 15 miles or less from the member's official residence, and so long as member obtains services from preauthorized and contracted Jade Health Care Medical Group facility that is within the 15 mile standard, the member's copayment amount due and payable for the services will not exceed that which would have been applicable, if the services could have been or might have been obtainable at CH.

2. In specific regard to Mental Health Services and or Substance Abuse benefits, since CH does not offer specialized inpatient, partial hospitalization or day treatment programs for substance abuse, that the member's copayment amount due and payable for the services will not exceed that which would have been applicable if the services could have been or might have been obtained at CH. Due to legal requirements for parity between categories of service and reimbursement between 'medical physical health' and 'mental health' and 'substance abuse', the member shall not be charged the lower of the near 'equivalent' for the 'medical' benefits and copayments whether at CH or a non-CH facility.

3. In regard to Obstetrical, Pediatric, or other inpatient services not provided by CH, or the intensity or specialty of which has been determined by Jade Health Care Medical Group's Medical Director to be medically necessary to be obtained from a facility other than CH; or in the event that CH does not have available capacity or cannot accommodate member in a timely manner; the member's copayment amount due and payable for the services will not exceed that which would have been applicable if the services could have been or might have been obtainable at CH.

4. Other reasons the member's copayment amount due and payable for the services will not exceed that which would have been applicable if the services could have been or might have been obtainable at CH, if as preauthorized by the Jade Health Care Medical Group Medical Management as being medically necessary, prudent, and or required by law or regulation in order to assist the member to obtain crucial and specialized treatment.

5. This policy and procedure does not apply to emergency or emergent services for which no authorization is required and before medical stabilization has been achieved.

PROCEDURE:

1. Jade Health Care Medical Group's Utilization Management department shall provide the member receiving any authorization to a non CH facility that appears to fit within the guidelines of this Policy and Procedure, with a letter confirming that the authorized services apply to the benefit, and that the member's copayment shall be at parity to CH level, and they shall update the file to indicate the Member's reduced copayment.

2. Until and unless CH inaugurates a newly licensed and operating Psychiatric, Substance Abuse-Detoxification or Rehabilitation, Pediatric Unit, and or an Obstetrical-Labor & Delivery Units, then UM shall notify all members of the applicability of the Jade Health Care Medical Group Parity Benefit and shall inform them in writing as to the applicable CH copayments that will apply to their required non-CH services and/or stay. They shall then update the members billing file to indicate the applicable copayment that shall apply and be collected from the member.

3. In the event that the Utilization Management department has made a determination, that the request and authorized services to a non-CH facility have been voluntary; or do not apply to a service related to Mental Health, Substance Abuse, or Obstetrical Labor & Delivery Services; or do not result from the closure, full census, or inability to accommodate a specific member due to a unique disability or individually unique treatment requirement, then it may determine this policy does not apply. In this case, they shall inform the member by mail and include the reason it does not apply, as well as provide Jade Health Care Medical Group appeal, grievance and DMHC rights and notification letters to the member.

SECTION 4 PHARMACY INFORMATION

Section 4.1 Pharmacy Benefit Manager

Most Jade Health Care Medical Group members have prescription drug coverage. Jade Health Care Medical Group (Jade) members contracts with MedImpact Healthcare Systems and San Francisco Health Plan contracts with PerformRX, a pharmacy benefit management (PBM) company to administer its prescription drug benefit.

When you have a question about coverage for a particular drug or require assistance on behalf of a Jade Health Care Medical Group member regarding a prior authorization or non-formulary request, please contact the appropriate office:

For your Medicare patients: 1-866-270-3877

For your Commercial patients: 1-866-333-2757

For your SFHP patients: 1-888-989-0091

In addition, Jade has a pharmacist available to discuss concerns regarding drugs that are not on the formulary or to assist you in finding an alternative drug that is on the formulary. Both Jade and SFHP have a Pharmacy and Therapeutics Committee that reviews new drugs as well as requests for additions to the formulary. If you have concerns or suggestions about particular drugs that are not on the Jade formulary, please contact the Jade Pharmacist at the number listed in Section 1. For questions or concerns about the SFHP formulary, you may also contact the SFHP Pharmacy Department at 1-415-547-7818 EXT 7085.

Section 4.2 Drug Formulary

Jade Health Care Medical Group uses a drug formulary (list of covered drugs). Please refer to the applicable Jade Health Care Medical Group Formulary, available at https://cchphealthplan.com/provider, under “CCHP Drug List” for drugs covered by Jade Health Care Medical Group.

The Jade formulary is based on a multiple tier incentive design. The formulary lists preferred generic drugs, which have a first tier copayment and preferred brand name drugs with a second tier copayment. Depending on their pharmacy benefit, some members also have a third tier copayment for covered specialty drugs and injectables.

The formulary for SFHP members, with the exception of the Kaiser group, is managed by the SFHP pharmacy services department with oversight from the SFHP Pharmacy and Therapeutics Committee, a sub-committee of the SFHP Quality Improvement Committee. You can access the

SFHP Formulary on SFHP's website at: https://www.sfhp.org/providers/pharmacy-services/sfhp-formulary/

Section 4.3 Prior Authorization

When a drug on the formulary indicates that prior authorization is required, or when a physician wants to prescribe a drug that is not listed on the formulary, you should first determine if an alternative drug that is on the formulary is an option for your patient. If an alternative drug is not an option, you can request a prior authorization by submitting the Prescription Drug Prior Authorization Request Form or calling at the following**:**

- **For your Jade Health Care Medical Group Medicare patients: 1-866-270-3877, 24 hours a day, seven days a week**
- **For your Jade Health Care Medical Group Commercial patients: 1-800-788-2949, 24 hours a day, seven days a week**
- **For your Jade Health Care Medical Group SFHP patients: 1-888-989-0091 or 1-415-547-7818 EXT 7085**

For SFHP members, the prescriber or pharmacist may submit also prior authorizations to SFHP in the following ways:

1. Download and fax prior authorization request forms to 1(855) 811-9330 for standard requests or 1(855) 811-9331 for urgent requests.
2. Submit request online using the Online Pharmacy Prior Authorization Request Form available at http://www.sfhp.org/providers/formulary/prior-authorization-requests/ .

All pharmacy prior authorization requests will be responded to within 24 hours or one business day of receipt made by telephone or other telecommunication device. SFHP will also provide at least a 72-hour supply of a covered outpatient drug in an emergency situation.

For further information on the pharmacy prior authorization process, visit www.sfhp.org or contact the SFHP Pharmacy Department at 1(415) 547-7818 x 7085.

SECTION 5 UTLIZATION MANAGEMENT PROGRAM

Section 5.1 Utilization Management Program

The Utilization Management Department at Jade is responsible for the concurrent review and prior authorization process, which includes monitoring inpatient hospitalizations and patients in skilled nursing facilities as well as working with physicians for those patients in need of case management services.

Jade Health Care Medical Group uses evidence-based clinical guidelines developed by Milliman Care Guidelines (MCG), LLC. MCG identify benchmark patient care and recovery stages to enhance health care services delivery, resource management and patient outcomes. This approach can reduce unnecessary variation in health care delivery and health care disparities in our community. MCG provide health care professionals with evidence-based clinical guidelines at the point of care. They also support prospective, concurrent, and retrospective reviews; proactive care management; discharge planning; patient education, and quality initiatives.

For those members you serve as a Participating Provider under Jade, the following UM program components will apply to you; for other affiliated Medical Groups, please refer to the respective Medical Group Utilization Management Programs.

Section 5.2 Notice of Utilization Management Decision-Making

Utilization Management (UM) decision-making is based on medical necessity and appropriateness of service in conjunction with eligibility and covered benefits. Jade Health Care Medical Group does not reward practitioners or other individuals for issuing denials of coverage or services. There are no financial incentives for UM decision makers to encourage decisions that result in denial of care.

Section 5.3 Determination of Medical Necessity

Objective criteria are used in making utilization decisions and are reviewed and updated as necessary, but no less than yearly. The sources of criteria are:

- Milliman Care Guidelines
- Hayes Medical Technology Directory
- Federal Medicare Guidelines
- National standards reflecting best practice
- Online searches for national and community best practices
- Other sources as appropriate and available

Sufficient member specific medical information is required to make a determination of medical necessity. Physicians from appropriate specialty areas of medicine and surgery, either board certified or equivalent, are available to review cases pertaining to their specialty. The UR/Case Managers and physician advisors perform interrater reliability studies at least annually to assure the consistent application of the criteria.

Section 5.4 Primary Care Physician Referral Process

Members of Jade Health Care Medical Group have selected a primary physician (PCP) from the Jade Health Care Medical Group Provider Directory. The directory can be found at http://jadehealthcaremedicalgroup.com/doctors/search . Family members may select different primary care physicians. The primary care physician is responsible for:

1. Assuring reasonable access and availability to primary care services,
2. Making referrals to specialists and other plan providers,
3. Providing 24 hour coverage for advice and access to care, and
4. Communicating authorization decisions to the health plan member.

Jade Health Care Medical Group members may require services that go beyond the scope of their primary care physician (PCP). When this occurs, the PCP refers the member to an appropriate participating specialist using the Specialty Consultation Referral process.

In the event the Jade Health Care Medical Group does not have a needed provider or consultant, the member's primary physician or attending physician or Jade Health Care Medical Group specialist must request prior authorization from the Utilization Management Department to use a non-contracted, out-of-network specialist.

A. Jade Health Care Medical Group delegates the responsibility for providing general medical care for Members to Primary Care Physicians (PCPs).

B. PCPs are responsible for requesting specialty care, diagnostic tests, and other medically necessary services through their Delegated entity's referral process.

PROCEDURES:

1. Referrals to specialists, second opinions, elective hospital admissions, or any service which require prior authorization are initiated by PCPs or specialists through the Jade Health Care Medical Group UM Department. Prior authorization for proposed services, referrals, or hospitalizations involve the following:

    a. Verification of Member eligibility;
    b. Written documentation by the PCP or specialist of medical necessity for service, procedure, or referral;
    c. Verification of the place of service, referred to practitioner, or specialist is within the Jade Health Care Medical Group network; and

d. Assessment of medical necessity and appropriateness of level of care with determination of approval or denial for the proposed service or referral.

2. PCPs shall maintain a Referral Tracking Log for all referrals submitted for approval. The prior authorization/referral process shall meet all standards, including timeliness.

3. For expedited referrals, Member should receive notice of decision within seventy-two (72) hours of receipt of request. For routine referrals, Medicare and Commercial Members should receive notice of decision within fourteen (14) calendar days and five (5) business days, respectively.

4. The PCP informs Members that if the referral is denied or modified, they can file an appeal or grievance with Jade Health Care Medical Group. A written notice of denial shall be provided through Jade Health Care Medical Group that includes the appeal and grievance process.

5. Referrals to specialists or out-of-network practitioners require documentation of medical necessity, rationale for the requested referral and prior authorization. Once the prior authorization has been obtained, the PCP shall continue to monitor the Member's progress to ensure appropriate intervention and assess the anticipated return of the Member to the Jade Health Care Medical Group network.

6. Members requiring special tests/procedures or referral to a specialist may have to obtain prior authorization.

   a. Each specialist provides written documentation of findings and care provided or recommended to the PCP within two (2) weeks of the Member encounter.
   b. The PCP evaluates the report information, initials and dates the report once reviewed, and formulates a follow-up care plan for the Member. This follow-up plan shall be documented in the Member's medical record.
   c. The presence of specialist reports on the PCP's medical records is assessed during periodic chart audits by Jade Health Care Medical Group.

7. Denial logs and letters for in-network and out-of-network denials and modifications shall be maintained by Jade Health Care Medical Group shall on a monthly basis for monitoring purposes. Information on the denial logs shall include at a minimum: Member name, Jade Health Care Medical Group number, requesting physician name, date of referral or request, the specifics of referral or request, diagnosis, decision by Jade Health Care Medical Group [approval, denial, or partial approval (modification) specifics], alternatives offered and date of decision.

8. Jade Health Care Medical Group reserves the right to perform site audits or to

verify accuracy of information on referral logs by examining source information.

9. Referrals for behavioral health services for Members are initiated by the PCP through Jade Health Care Medical Group as outlined in Jade Health Care Medical Group Policy.

Section 5.5 Consultation Referral Forms and Procedure

The Consultation Referral Form is to be used for referring patients to participating Jade Health Care Medical Group physicians or participating behavioral health specialists only. It cannot be used for referring to non-Jade Health Care Medical Group physicians or providers, nor can it be used to request services that require prior authorization; for these services, the Service Authorization Form (SAF) must be used.

To refer a patient to a Jade Health Care Medical Group specialist physician or Jade Health Care Medical Group behavioral health specialist:

Complete a Jade Health Care Medical Group Consultation Referral Form.

1. The primary or referring physician should complete all pertinent information on the top half of the Consultation Referral Form, including the reason for consultation. If the referring physician is not the primary physician, the referring physician should obtain consent from the primary physician and check mark the box "If referring MD is not the PCP, has PCP consent". The referring physician shall keep the white copy for his/her records.

2. After completing the Referral Form, the referring physician should keep the white copy for his/her records and give the remaining copies to the patient who should be told to bring the Referral Form to the Jade Health Care Medical Group specialist physician or Jade Health Care Medical Group behavioral health specialist .

3. **Following consultation, the specialist will fill out the bottom half of the Consultation Referral Form and send a copy of the form/report to the referring physician and primary physician**. Consulting physicians and behavioral health specialists must send a written communication to the referring physician.

4. The specialist physician shall keep a copy of the form for his/her records.

5. For electronic claims, the Jade Health Care Medical Group specialist physician or behavioral health specialist (consultant) must indicate the name of the referring Jade Health Care Medical Group physician on the electronic claim. For paper claims, the specialist (consultant) physician or behavioral health specialist must submit a copy of the Jade Health Care Medical Group Referral Form with the claim.

6. If the specialist physician determines the patient needs a procedure that is an office procedure and the procedure does not require prior authorization, the treating specialist may perform the procedure after consultation with the primary physician.

7. If the procedure requires authorization based on criteria from Section 5.16 then the specialist must request prior authorization from the Utilization Management Department by completing and submitting a Service Authorization Form (SAF) by fax. If the request is urgent, mark "URGENT" at the top of the SAF.

Section 5.6 Primary Care Physician (PCP) Referrals - Referral Tracking Log

All Primary Care Physicians (PCPs) are required to maintain a system for tracking all referrals submitted to Jade Health Care Medical Group.

PROCEDURES:

1. All PCPs shall maintain a referral log that contains all of the information noted below:
   a. Date referral sent for review;
   b. Member Name;
   c. Member Jade Health Care Medical Group ID number;
   d. Acuity of referral (Emergent, Urgent, or Routine);
   e. Reason for Referral or Diagnosis;
   f. Service/Activity Requested;
   g. Date referral returned;
   h. Referral Decision (Approved, Partially Approved (Modified), Denied);
   i. Date Patient Notified;
   j. Date of Appointment or Service; and
   k. Date Consultation or other Report Received.

2. PCPs may either use the Jade Health Care Medical Group Referral Tracking Log (See Attachment, "Referral Tracking Log") or another system that contains all of the above-required information.

3. PCPs shall utilize the referral log to coordinate care for the Member, to obtain assistance from Jade Health Care Medical Group if specialty appointments are delayed, or consultation notes are not received

4. Referral logs, or equivalent system, shall be available at all times at the PCP site.

5. Copies of referrals and any received consultation and/or service reports shall be filed timely in the Member's medical record.

Section 5.7 Referral from PCP to Participating Specialists

The Specialty Consultation Referral Process enables a Primary Care Physician (PCP) to coordinate the process by which their patients receive care from Jade Health Care Medical Group specialist physicians, behavioral health specialists and other Jade Health Care Medical Group participating health care providers. When a Jade Health Care Medical Group primary care physician identifies the need for a referral, the PCP may refer patients to a Jade Health Care Medical Group specialist physician, including behavioral health specialists as medically appropriate by completing a Jade Health Care Medical Group Consultation Referral Form.

- A referral is good for 4 visits in a calendar year for the **same diagnosis** to the same specialist. Referrals submitted in December are also valid for the following year up to a maximum of four visits.
- Jade Health Care Medical Group specialist visits for a different diagnosis require a new and separate Consultation Referral Form from the PCP with the new specific diagnosis.
- Additional visits beyond 4 for the same diagnosis range require prior authorization.
- Specialty Services exceeding $500 (of Medicare allowable) also require prior authorization. If a patient self-refers to a Jade Health Care Medical Group OB/GYN specialist for women's health services a referral is not required.
- The Consultation Referral Form cannot be used for non-Jade Health Care Medical Group physicians or non-Jade Health Care Medical Group behavioral health specialists. All services from non-Jade Health Care Medical Group physicians and non-Jade Health Care Medical Group behavioral health specialists require prior authorization by the Jade Health Care Medical Group Utilization Management Department.

Section 5.8 Referral from Participating Specialist to Participating Specialist

With PCP concurrence, for those services or providers not requiring prior authorization, a Jade specialist physician may refer to another Jade Health Care Medical Group specialist as medically appropriate by completing a Jade Health Care Medical Group Consultation Referral Form.

Section 5.9 Additional Care by a Participating Specialist

(For more than 4 visits in a Calendar Year)
The specialist, in consultation with the primary physician, may need to see a patient beyond the primary physician's referral (**valid for 4 office visits per calendar year for the same diagnosis**; prior approval is required for further visits). The specialist is required to submit a Service Authorization Form (SAF) to the Utilization Management Department to request additional office visits. The SAF must include the diagnosis, medical justification for additional visits, and treatment plan (i.e., frequency and duration of visits). **The boxes on the top of the SAF "services provided by" and "has primary physician approval" MUST also be filled out.**

Section 5.10 Referral from PCP to Mental Health Specialists, Substance Abuse Specialists or Detoxification or Mental Health Facilities

Jade requires a referral from the member's primary care physician (PCP) for all services rendered by Jade specialists, including referrals to Jade specialists and specialty facilities contracted to provide mental health care, psychological or psychiatric or mental or substance abuse assessments, interventions or treatments. Prior authorization is not required for nonemergency admissions to detoxification or mental health facilities.

The PCP may refer a patient to a Jade contracted outpatient mental health or mental health specialist for up to four visits for the same diagnosis in a calendar year. Additional visits require prior authorization from the Utilization Management (UM) Department.

The Jade contracted mental health provider (after consulting and with the PCP for ongoing coordination of care) may request prior authorization from the UM Department for the 5th and subsequent visits by submitting a completed Service Authorization Form (SAF) along with clinical documentation and a treatment plan.

Requests for authorization for additional treatment or specialty visits will be handled in an equivalent manner to what may be needed for any non-mental health services.

Section 5.11 Mental Health Coordination of Care

Jade Health Care Medical Group requires coordination of care between mental health specialist and the primary care physicians to achieve optimal health for each member. Effective coordination of care is dependent upon clear and timely communication among practitioners and facilities. In sharing members' mental health information, including the diagnosis, progress and current medications, the PCP and mental health specialist can effectively and confidentially coordinate care with appropriate treatment for individuals that have coexisting medical and mental diagnoses. The communication can also reduce complications or adverse outcomes from medication interactions, duplicate medications and tests resulting from the lack of communication.

Primary Care Physicians are expected to exchange any relevant information with the mental health specialist such as medical history, diagnosis, current medications, test results, and hospital admission/discharge information. All efforts to coordinate care on behalf of the member should be documented in the member's medical record. The PCP must document and initial in the patient's medical chart signifying review of information received from a mental health specialist who is treating the member.

Mental health providers are expected to consult with the PCP and communicate with the PCP in writing or verbally regarding the patient's progress including the diagnosis, treatment plan and current medications. The mental health specialist must document in the patient's chart communication with the patient's PCP.

Section 5.12 Documentation Requirements and Communication Methods

Documentation of communication between the primary care physician and the mental health specialist is required for all Jade patients. The Jade Consultation Report Form may be used for communicating with a patient's PCP, or other methods of written communication may include a letter, a reply documenting clinical findings and recommendations on the Jade Consultation Referral Form as well as copies of test results and hospital reports. For urgent matters, verbal communication via telephone is often appropriate. For verbal communications, the following must be documented in the patient's progress notes: date, time, content of the phone call and treatment/outcome.

Section 5.13 Review Procedures - Standing Referral/Extended Access to Specialty Care

A. Jade Health Care Medical Group are required to establish and implement procedures for Primary Care Physicians (PCPs) to request a standing referral to a specialist for a Member who, as a component of ongoing ambulatory care, requires continuing specialty care over a prolonged period of time, or extended access to a specialist for a Member who has a life threatening, degenerative, or disabling condition that requires coordination of care by a specialist.

B. Members with a life-threatening, degenerative or disabling condition or disease shall receive a referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist or specialty care center coordinate the Member's care.

C. Practitioners that are Board Certified in appropriate specialties, e.g., Infectious Disease, are able to treat conditions or diseases that involve a complicated treatment regimen that requires ongoing monitoring. Board certification is verified during the Provider credentialing process. Members may obtain a list of practitioners who have demonstrated expertise in treating a condition or disease involving a complicated treatment regimen that requires ongoing monitoring by contacting Jade Health Care Medical Group at (415) 677-2408.

D. PCPs are responsible for coordinating the care of the Member in consultation with the specialist, and Member.

PROCEDURES:

1. Jade Health Care Medical Group shall develop and implement a procedure for standing referrals or extended access to a specialist at the Member or PCP request. The PCP and/or Member determines, in consultation with the specialist and the Medical Director or designee, within three (3) business days if a Member needs continuing care from a specialist.

2. After consultation with the specialist as needed, and the Medical Director, the PCP shall submit his/her request for a standing specialty referral or extended access to Jade Health Care Medical Group using the designated form (See Attachment, "Standing Referral/Extended Access to Specialty Care"). Appropriate medical records shall be attached to the request.

3. Standing referrals are processed according to turnaround timeframes as outlined in Jade Health Care Medical Group Policy.

4. If Jade Health Care Medical Group determines that the standing referral should be limited in terms of number of visits or timeframe, Jade Health Care Medical Group, in consultation with the PCP and specialist, shall develop a treatment plan specifying the limits. The treatment plan shall be approved by Jade Health Care Medical Group.

5. Treatment plans shall be submitted to Jade Health Care Medical Group Medical Director by fax at (415)398-3669. Jade Health Care Medical Group shall make its determination regarding the treatment plan within three (3) business days.

6. Standing referrals or extended access to specialty care approved without limitations do not require a treatment plan.

7. After approval of the standing referral or extended access to specialty care with or without a treatment plan, the PCP, specialist, and Member shall be notified in writing of the specifics of the determination within two (2) business days of the determination.

8. Potential conditions necessitating a standing referral and/or treatment plan include but are not limited to the following:

    a. Significant cardiovascular disease;
    b. Asthma requiring specialty management;
    c. Diabetes requiring Endocrinologist management;
    d. Chronic obstructive pulmonary disease;
    e. Chronic wound care;
    f. Rehab for major trauma;
    g. Neurological conditions such as multiple sclerosis, uncontrollable seizures among others;
    h. GI conditions such as severe peptic ulcer and chronic pancreatitis among others.; And
    i. Members with a combination of conditions that require complex including but not limited for example to diabetes mellitus, COPD and congestive heart failure.

9. Potential conditions necessitating extended access to a specialist or specialty care center and/or treatment plan include but are not limited to the following:

   a. Hepatitis C;
   b. Lupus;
   c. HIV;
   d. AIDS;
   e. Cancer;
   f. Potential transplant candidates;
   g. Severe and progressive neurological conditions;
   h. Renal failure; and
   i. Cystic fibrosis.

10. When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine the Member shall be referred to an HIV/AIDS specialist. An HIV/AIDS specialist is a physician who holds a valid, un-revoked and unsuspended license to practice medicine in the state of California who meet any one of the following four criteria:

    a. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine (AAHIVM); or
    b. Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a certificate of Added Qualification in the field of HIV medicine; or
    c. Is board certified in the field of infectious diseases and meets the following qualifications:

        i. In the preceding twelve (12) months has clinically managed medical care to a minimum of twenty-five (25) patients who are infected with HIV; and
        ii. In the preceding twelve (12) months has successfully completed a minimum of fifteen (15) hours of Category 1 Continuing Medical Education (CME), (as directed by the Medical Board of California), in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-positive patients, including a minimum of five (5) hours related to antiretroviral therapy per year; or

    d. Meets the following qualifications:
        i. In the preceding twenty-four (24) months has clinically managed medical care to a minimum of twenty (20) patients who are HIV-positive; and

ii. Has completed any of the following;

1. In the preceding twelve (12) months has obtained board certification or recertification in the field of infectious diseases; or
2. In the preceding twelve (12) months has successfully completed a minimum thirty (30) hours of Category 1 CME in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-positive patients; or
3. In the preceding twelve (12) months has successfully completed a minimum of fifteen (15) hours of Category 1 CME in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-positive patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the AAHIVM.

11. The HIV/AIDS specialist may utilize the services of a nurse practitioner or physician assistant if:

a. The nurse practitioner or physician assistant is under the supervision of an HIV/AIDS specialist; and
b. The nurse practitioner or physician assistant meets the qualifications specified in this policy; and
c. The nurse practitioner or physician assistant and the supervising HIV/AIDS specialist have the capacity to see an additional patient.

12. The Member may be referred to a non-network provider if there is no HIV/AIDS specialist, or appropriately qualified nurse practitioner or physician assistant under the supervision of an HIV/AIDS specialist within the network appropriate to provide care to the Member, as determined by the Medical Director and/or PCP in consultation with Jade Health Care Medical Group's Medical Director, when warranted.

13. Any medical condition requiring frequent or repeat visits to a specialist should be considered by the PCP for submission of a standing referral or extended access to a specialty care referral.

a. Upon Member request for a standing referral, the PCP shall make a determination within three (3) business days regarding submission of a standing referral to Jade Health Care Medical Group. This determination should be made after consulting with the Member's Specialist.
b. Once a decision is made that a standing referral is needed, the PCP shall submit a request for standing specialty referral to Jade Health Care Medical Group within four (4) business days, using the designated form (See

Attachment, "Standing Referral/Extended Access to Specialty Care"). Appropriate medical records shall be attached to the request. A determination will be rendered by Jade Health Care Medical Group's Medical Director (or designee) after referral and medical documentation is received.

14. After approval of the standing specialty or extended access to specialty care with or without a treatment plan, Jade Health Care Medical Group are required to notify the PCP, specialist, and Member in writing of the specifics of the determination within two (2) business days of the determination.

15. All denials of standing specialty referral requests or extended access to specialty care shall be forwarded to Jade Health Care Medical Group within three (3) business days of the denial. Delegates shall also inform the PCP, specialist, and Member of the denial in writing according to prescribed formats for denials.

16. Jade Health Care Medical Group can require specialists to provide to the PCP and Jade Health Care Medical Group written reports of care provided under a standing referral.

Out of Network

17. Members can be referred to out-of-network practitioners when appropriate specialty care is not available within the network.

18. All services for out-of-network providers shall be coordinated adequately and timely.

19. Jade Health Care Medical Group shall coordinate payment with out-of-network providers and ensure that cost to the Member is not greater than it would be if the services were furnished within the network.

20. Members can be referred to an out-of-network HIV/AIDS specialist when an appropriate HIV/AIDS specialist, or qualified nurse practitioner, or physician assistant under the supervision of an HIV/AIDS specialist is not available within the network, as determined by PCP in conjunction with the Jade Health Care Medical Group's Medical Director, as warranted.

Section 5.14 Referral to Non-Participating Specialists

Prior Authorization is required to refer members to non-participating specialists. Non-participating specialists are physicians who are not contracted with Jade Health Care Medical Group. Prior Authorization is to be obtained by the process outlined below.

Section 5.15 Prior Authorization

Prior Authorization is intended to ensure that the requested service is covered by the member's benefit, that the provider of the service is participating, and that the services are medically necessary. Services will also be reviewed to ensure that the most appropriate setting is being utilized and to identify those members who may benefit from our case management programs. Prior Authorization is subject to a member's eligibility and covered benefits at the time of service. For SFHP's Prior Authorization process, please visit SFHP's website at: https://www.sfhp.org/providers/authorizations/pre-authorizations/

Section 5.16 Services Requiring Prior Authorization

The following contains a summary of services requiring prior authorization**.** Physicians should consult the Jade Health Care Medical Group Physician Handbook for more detailed information. Please refer to the Covered Services and Exclusions section of a member's Evidence of Coverage for more information on services that require a prior authorization. **Please note that our prior authorization requirements are subject to change**. If you have questions about services requiring prior authorization, contact the Utilization Management Department.

Service (in alphabetical order)*

- All services from Non-Participating Providers
- Acupuncture services
- Acute Rehabilitation Facilities
- Ambulatory surgery
- Amniocentesis
- Durable Medical Equipment
- Epidural blocks for pain management
- Fetal testing, stress and non-stress **after the first test** (No authorization needed for the first test)
- Home Health Care Services
- Hospitalizations (Elective)
- Mammograms **for 2nd or more in a year**. (No authorization required for first mammogram in year)
- Nuclear cardiograms, cardiac imaging
- Nuclear Medicine Studies: Bone, Heart, Liver/spleen, Lung, Thyroid
- Occupational Therapy
- Out-of-Plan Providers (also referred to as non-plan or non-contracted or out-of-network providers)
- Outpatient Services from Non-Preferred Providers (as indicated on the Outpatient Services List in this Section)
- PCP referrals in excess of four visits to specialist physicians in a calendar year
- Physical Therapy **after initial consultation visit**
- Radiology Scans: CAT, MRI, PET

- Services, procedures or supplies over $500 allowable (according to the Medicare Fee Schedule)
- Skilled Nursing Facility (SNF)
- Speech Therapy
- Transportation (Non-emergency medically necessary ambulance, wheelchair, medi-van, air ambulance)
- Ultrasound for pregnancy and Gyn studies **after the first two tests** (No approval needed for the first two tests, except for Gyn studies for infertility)

**All outpatient services performed at Chinese Hospital (excluding MRIs) will not require prior authorization*

For San Francisco Health Plan (SFHP) members, the SFHP website link below outlines services that require prior authorization for San Francisco Health Plan members enrolled in Medi-Cal Managed Care or Healthy Workers Program through UC San Francisco (UCSF) or Community Health Network (CHN) medical groups. Failure to obtain Prior Authorization will result in a denial of coverage. Below are the Prior Authorization requirements for In-Medical Group services only. Although not listed, Prior Authorization is required for all out-of-medical group services except for emergency services, urgent care services, sensitive services (for Medi-Cal members), emergent transportation and non-emergent transportation from facility to facility. This table can be found on SFHP's website at:
https://www.sfhp.org/files/providers/forms/Services_Requiring_Prior_Auth.pdf

Section 5.17 Outpatient Services

Outpatient services, including ambulatory services, diagnostic studies and specialty referrals are authorized based upon medical necessity by the UR/Case Manager. Referrals to medical group specialists for up to four visits per calendar year do not require authorization. If the medical group cannot provide a needed specialty service, authorization for a non-contracted provider shall be given.

Section 5.18 Emergency Services

Prior authorization is not required for provision of emergency services. Emergency services, including emergency ambulance transportation, are authorized without medical review.

A. Providers shall render services to Members who present themselves to an Emergency Department (ED) for treatment of an emergent or urgent condition. Per federal law, at a minimum, services shall include a Medical Screening Exam (MSE).

B. Per regulatory requirements, Jade Health Care Medical Group has adopted the "prudent layperson" definition of an emergency medical condition, as follows:

   a. Emergency Medical Condition means a medical condition which is manifested

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

i. Placing the health of the individual (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
ii. Serious impairment to bodily function; or
iii. Serious dysfunction of any bodily organ or part.

C. If it is determined that the Member's condition was not emergent, Jade Health Care Medical Group is responsible for the MSE, at a minimum based on individual contracts. The Member does not need to be notified of an ED denial. The Member is not financially responsible and shall not be billed for any difference between the amount billed by the Hospital and amount paid.

D. Emergency services can be subject to retrospective review. Jade Health Care Medical Group may retrospectively review claims and adjust payment if services provided were beyond the scope of the authorization and were not medically necessary. A retrospective billing adjustment of an Emergency Department visit does not require Member notification because the Member is not financially impacted by the decision, and payment shall be made for the MSE.

a. Hospitals can forward to Jade Health Care Medical Group any facility costs associated with a visit to an ED that was authorized by a Primary Care Physician (PCP), and judged non-emergent after medical review by a hospital staff physician.
b. If medical review of the claim by Jade Health Care Medical Group determines that the authorized visit was for a Member with a non-emergency medical condition, then Jade Health Care Medical Group is financially responsible for the facility and technical components of the visit.
c. Where conflict regarding payment decisions cannot be resolved between Hospital and Delegate, claims can be submitted to Jade Health Care Medical Group for final adjudication.

PROCEDURES:

1. Final determination of whether or not an emergency medical condition existed can be subject to medical review by a physician; however, the prudent layperson definition shall be utilized in the review.

a. Medical decision criteria and diagnosis codes may be utilized in the review process; however, under the prudent layperson definition, the review shall

also take into account emergency medical conditions that present acutely but result in benign diagnoses. Examples include and are not limited to:

i. 2 year old with 103° fever, listless, less responsive, vomiting - Otitis Media;
ii. 38 year old with acute, severe chest pain - Costochondritis;
iii. 17 year old female with severe lower abdominal pain, vaginal bleeding - Spontaneous Abortion - complete;
iv. 12 year old with severe shortness of breath, cough - Asthma;
v. 60 year old with fever to 104°, severe cough, acute shortness of breath - Bronchitis;
vi. 23 year old pregnant woman with lower abdominal pain, fever, perceived decreased fetal movement - Urinary Tract Infection;
vii. 12 year old with severe abdominal pain, vomiting fever - Adenitis, Mesenteric; or
viii. Sudden onset of behavioral changes or an exacerbation of a known psychiatric diagnosis - Adjustment Disorder.

b. A physician shall perform review of retrospective billing adjustments or reduction of payments of claims.

2. Prior authorization is not required for the MSE (or COBRA exam) performed at an ED, to the extent necessary to determine the presence or absence of an emergency medical condition, or for services necessary to treat and stabilize an emergency medical condition. If the MSE demonstrates that an emergency medical condition is not present, ED personnel shall contact the PCP or designee for authorization of services or treatment beyond the MSE.

3. Jade Health Care Medical Group's payment for associated services shall be based on the Member's presentation and the complexity of the medical decision-making as outlined in the American Medical Association (AMA) CPT Guide under 'Emergency Department Services.'

4. In the event that the ED is unable to reach the responsible PCP or designee, the call time and phone number shall be documented in the ED record and the ED shall provide medically necessary care.

5. Authorized ED visits can be subject to review by Jade Health Care Medical Group to determine if an emergency medical condition was present. If medical review determines that an emergency medical condition was not present, the facility and technical components of the claim will be reviewed for payment. The Hospital can appeal adverse payment decisions for Jade Health Care Medical Group review.

6. Examples of non-emergent ED visits could include:

   a. Possible fractures (sprain – rule out fracture);
   b. Simple lacerations;
   c. Mild asthma exacerbation;
   d. Small animal bites; or
   e. High fever without systemic symptoms.

Section 5.19 How to Request Prior Authorization

Jade Health Care Medical Group has transitioned to ICD-10 diagnosis and procedure coding as mandated by the Centers for Medicare and Medicaid Services (CMS).

To ensure timely access to specialty care for Jade Health Care Medical Group Members, Jade Health Care Medical Group has adopted mandated turnaround timeframes for specialty referrals.

PCPs are responsible for providing general medical care for Members and requesting specialty care, diagnostic tests, and other medically necessary services either through Jade Health Care Medical Group's referral authorization process.

The PCP shall review any referral from an affiliated mid-level practitioner, i.e. Nurse Practitioner (NP) or Physician Assistant (PA), prior to the submission of the referral. If there are questions about the need for treatment or referral, the PCP shall see the Member.

Jade Health Care Medical Group shall have a process in place to allow a specialist to directly request authorization from Jade Health Care Medical Group for additional specialty consultation, diagnostic, or therapeutic services.

Jade Health Care Medical Group shall have a process in place when decisions to deny or modify (authorize an amount, duration, or scope that is less than requested) are made by a qualified health care professional with appropriate clinical expertise in the condition and disease.

Jade Health Care Medical Group should evaluate PCP and specialist referral patterns for over and under-utilization.

PROCEDURES:

A. The Nurse Practitioner or the Physician Assistant can sign and date the referral form but shall document on the form the name of the PCP or specialist.

B. Referral forms from the PCP or specialist shall include the following information:

1. Designation of the referral request as either routine or expedited to define the priority of the response. Referrals that are not prioritized are handled as "routine." Referrals that are designated as expedited shall include the supporting documentation regarding the reason the standard timeframe for issuing a determination could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function;
2. The diagnosis (ICD-10) and procedure (CPT) codes;
3. Pertinent clinical information supporting the request; and
4. Signature of referring physician and date. This may consist of handwritten signature, handwritten initials, unique electronic identifier, or electronic signatures that shall be able to demonstrate appropriate controls to ensure that only the individual indicated may enter a signature.

C. Upon receipt of the referral, Jade Health Care Medical Group is responsible for verification of Member eligibility and plan benefits.

D. Jade Health Care Medical Group shall have a process that facilitates the Member's access to needed specialty care by prior authorizing at a minimum a consult and follow up visit (a total of two visits) for medically necessary specialty care (See Attachment, "Specialty Office Service Authorization Sets").

E. Prior authorization for medically necessary procedures or other services that can be performed in the office, beyond the initial consultation and follow up visit, should be authorized as a set or unit. For example, when approving an ENT consultation for hearing loss, an audiogram should be approved.

1. **Exceptions -** Prior Authorization is not required and Member may self-refer for the following services. All other services require prior authorization:

    a. Family Planning;
    b. Abortion Services;
    c. Sexually transmitted infection (STI) treatment;
    d. Sensitive and Confidential Services;
    e. HIV Testing and counseling at the Local Health Department;
    f. Immunizations at the Local Health Department;
    g. Routine OB/GYN Services, (including prenatal care by Family Care Practitioner (credentialed for obstetrics) within Jade Health Care Medical Group Network;
    h. Urgent Care;
    i. Preventative services within Jade Health Care Medical Group Network;
    j. Urgent support for home and community service-based recipients; and
    k. Other services as specified by the Centers for Medicare and Medicaid Services (CMS).

F. Referrals to out-of-network practitioners require documentation of medical necessity, rationale for the requested out-of-network referral, and prior authorization from Jade Health Care Medical Group. Once the prior authorization has been obtained, the PCP's office should assist the Member with making the appointment, continue to monitor the Member's progress to ensure appropriate intervention, and assess the anticipated return of the Member into the network.

G. Decisions for referrals shall be made in a timely fashion not to exceed regulatory turnaround timeframes for determination and notification of Members and practitioners (See Attachment, "UM Timeliness Standards –". All timeframes shall meet regulatory requirements as outlined in Title 42 of the Code of Federal Regulations Sections 438.210, 422.568, 422.570, and 422.572.

H. Jade Health Care Medical Group should monitor the PCP's rates of referrals to specialists to:

1. Monitor for potential over or under utilization of specialists; and
2. Identify referral requests that are within the scope of practice of the PCP.

I. When Jade Health Care Medical Group identifies a potential problem with the PCP's referrals to specialists, interventions need to be implemented that address the specific circumstances that were identified during the monitoring process. Interventions, such as written correspondence to the PCP that addresses the identified concern with supporting policy or contract attached, or the Medical Director contacting the PCP to discuss the concern, should be attempted to help educate the PCP.

J. There shall be documented evidence of the corrective action taken by Jade Health Care Medical Group, including the PCP's response to the intervention. The PCP's referral pattern shall be re-evaluated after a sufficient amount of time (at least sixty (60) days) has elapsed to monitor effectiveness.

K. Specialists are required to forward consultation notes to the PCP within two (2) weeks of the visit.

To request Prior Authorization for San Francisco Health Plan (SFHP) members, the provider must complete the Pre-Authorization Request Form

Section 5.20 Urgent Authorizations

Urgent requests receive special attention. The UM Department makes every effort to return authorization determinations in a timely manner. Urgent or emergent care should never be delayed while awaiting prior authorization. Please do not hesitate to ask to speak directly to the

UM Manager if you have concerns that the process may interfere with the care your patient requires.

During Business Hours: Monday – Friday, 9:00 am to 5:00 pm

a. Outpatient: If a situation is urgent, submit an SAF marked "URGENT" at the top and it will be given priority processing.
b. Inpatient: For urgent inpatient authorization, call the UM Manager at 1-628-228-3252.

Weekends, After Hours, Holidays

On weekends, after hours or holidays, the primary physician or the Jade Health Care Medical Group attending physician has the authority to authorize treatment for services that the physician considers urgent/emergent. The attending physician should then submit a timely SAF to the Utilization Management Department the next business day.

Section 5.21 Authorization Process Turnaround Standards

Outpatient Review

Utilization decisions are made in a timely manner depending on the urgency of the request. For routine authorizations, decisions are made within seven calendar days of obtaining all necessary information. Urgent decisions are made within one business day. A tracking system for identifying the status of all authorization requests is established. The provider is notified within one working day of the decision. If denied, the member and practitioner are given written or electronic conformation of the denial within two working days of making the decision. If an urgent case is denied, the member and practitioner are notified as to how to initiate an expedited appeal at the time they are notified of the denial.

Concurrent Review

For concurrent review, decisions are made within one working day of obtaining all information and providers are notified by telephone within one working day of the decision.

Retrospective Review

Medical necessity decisions in retrospective situations are resolved within 30 working days of obtaining all necessary information. Members and providers are informed of retrospective denials within five days of making the decision.

Section 5.22 Utilization Management Timeliness Standards

Jade Health Care Medical Group requires that all participating providers, including those who are participating in affiliated medical group, are aware of and compliant with the Utilization Management Timeliness Standards for the type of programs in which Jade members are enrolled. Below are reference tables by program type

Table 8.22.1 Utilization Management Timeliness Standards (Commercial HMO - California)			
Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
Urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition **not to exceed 72 hours after receipt of the request.**	Practitioner: Within 24 hours of the decision, not to exceed 72 hours of receipt of the request (for approvals and denials). Member: Within 72 hours of receipt of the request (for approval decisions). Document date and time of oral notifications.	Within 72 hours of receipt of the request. Note: If oral notification is given within 72 hours of receipt of the request, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
Urgent Pre-Service - Extension Needed • Additional clinical information required	Additional clinical information required: Notify member and practitioner within 24 hours of receipt of request & provide 48 hours for submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made within 48 hours of receipt of information. Note:	Additional information received or incomplete Practitioner: Within 24 hours of the decision, not to exceed 48 hours after receipt of information (for	Additional information received or incomplete Within 48 hours after receipt of information. Note: If oral notification is given, written or electronic notification

Table 8.22.1 Utilization Management Timeliness Standards (Commercial HMO - California)			
Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 48 hours after receipt of information.	approvals and denials). Member: Within 48 hours after receipt of information (for approval decisions). Document date and time of oral notifications.	must be given no later than 3 calendar days after the initial oral notification.
	Additional information not received: If no additional information is received within the 48 hours given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 48 hours. Note: Decision must be made in a timely fashion appropriate for the member's condition not to exceed 48 hours after the deadline for extension has ended.	Additional information not received Practitioner: Within 24 hours of the decision, not to exceed 48 hours after the timeframe given to the practitioner & member to supply the information (for approvals & denials). Member: Within 48 hours after the timeframe given to the practitioner and member to supply the information (for approval decisions). Document date and time of oral notifications.	Additional information not received Within 48 hours after the timeframe given to the practitioner & member to supply the information. Note: If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.

Table 8.22.1 Utilization Management Timeliness Standards (Commercial HMO - California)			
Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
Urgent Concurrent - (i.e., inpatient, ongoing/ambulatory services) Request involving both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved and the request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments. Exceptions: • If the request is not made at least 24 hours prior to the expiration of prescribed period of time or number of treatments, and request is urgent, default to *Urgent Pre-service* category. • If the request to extend a course of treatment beyond the period of time, or number of treatments previously approved by the Health Plan/PMG/IPA does not involve urgent care, default to *Non –urgent*	Within 24 hours of receipt of the request.	Practitioner: Within 24 hours of receipt of the request (for approvals and denials). Member: Within 24 hours of receipt of the request (for approval decisions).	Within 24 hours of receipt of the request. Note: If oral notification is given within 24 hours of request, written or electronic notification must be given no later than 3 calendar days after the oral notification.

Table 8.22.1 Utilization Management Timeliness Standards (Commercial HMO - California)			
Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
Pre-service category.			
Standing Referrals to Specialists / Specialty Care Centers - All information necessary to make a determination is received	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 3 business days of receipt of request. **NOTE:** Once the determination is made, the referral must be made within 4 business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or designee.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.
Non-urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 5 business days of receipt of request.	Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the	Within 2 business days of making the decision.

Table 8.22.1 Utilization Management Timeliness Standards (Commercial HMO - California)			
Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
		decision (for approval decisions).	
Non-urgent Pre-Service - Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer	Additional clinical information required: Notify member and practitioner within 5 business days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made in a timely fashion as appropriate for member's condition not to exceed 5 business days of receipt of information.	Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	Within 2 business days of making the decision.
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available in a timely fashion as appropriate for member's condition not to exceed an additional 5 business days.		
	Require consultation by an Expert Reviewer:		

Table 8.22.1 Utilization Management Timeliness Standards (Commercial HMO - California)			
Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
	Upon the expiration of the 5 business days or as soon as you become aware that you will not meet the 5 business day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		
	Require consultation by an Expert Reviewer: Decision must be made in a timely fashion as appropriate for the member's condition within 5 business days of obtaining expert review, not to exceed 15 calendar days from the date of the delay notice to the practitioner and member.	Require consultation by an Expert Reviewer: Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	Require consultation by an Expert Reviewer: Within 2 business days of making the decision.
Post-Service - All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days of receipt of request.	Practitioner: Within 30 calendar days of receipt of request (for approvals). Member: Within 30 calendar days of receipt of request (for approvals).	Within 30 calendar days of receipt of request.
Post-Service - Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer	Additional clinical information required: Notify member and practitioner within 30 calendar days of receipt of request & provide at least 45 calendar days for		

Table 8.22.1 Utilization Management Timeliness Standards (Commercial HMO - California)			
Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
	submission of requested information.		
	Additional information received or incomplete If additional information is received, complete or not, decision must be made within 15 calendar days of receipt of information.	Additional information received or incomplete Practitioner: Within 15 calendar days of receipt of information (for approvals). Member: Within 15 calendar days of receipt of information (for approvals).	Additional information received or incomplete Within 15 calendar days of receipt of information.
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 15 calendar days.	**Additional information not received** Practitioner: Within 15 calendar days after the timeframe given to the practitioner & member to supply the information (for approvals). Member: Within 15 calendar days after the timeframe given to the practitioner and member to supply the information (for approval decisions).	Additional information not received ***Within 15 calendar days after the timeframe given to the practitioner & member to supply the information.***

Table 8.22.1 Utilization Management Timeliness Standards (Commercial HMO - California)			
Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
	Require consultation by an Expert Reviewer: Upon the expiration of the 30 calendar days or as soon as you become aware that you will not meet the 30 calendar day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		
	Require consultation by an Expert Reviewer: Within 15 calendar days from the date of the delay notice.	Require consultation by an Expert Reviewer: Practitioner: Within 15 calendar days from the date of the delay notice (for approvals). Member: Within 15 calendar days from the date of the delay notice (for approval decisions).	Require consultation by an Expert Reviewer: Within 15 calendar days from the date of the delay notice.
Translation Requests for Non-Standard Vital Documents 1. Urgent (e.g., pre-service pend or denial notifications with immediate medical necessity)	LAP Services Not Delegated: All requests are forwarded to the contracted health plan. 1. Request forwarded within one (1) business day of member's request		LAP Services Delegated/Health Plan: All requested Non-Standard Vital Documents are translated and returned to member within 21 calendar days.

Table 8.22.1 Utilization Management Timeliness Standards (Commercial HMO - California)			
Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
2. Non-Urgent (e.g., post-service pend or denial notifications)	2. Request forwarded within two (2) business days of member's request		

Table 8.22.2 A Utilization Management Timeliness Standards Centers for Medicare and Medicaid Services (CMS)		
Type of Request	Decision	Notification Timeframes
Standard Initial Organization Determination (Pre-Service) - If No Extension Requested or Needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Within 14 calendar days after receipt of request. ▪ Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
Standard Initial Organization Determination (Pre-Service) - If Extension Requested or Needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	Use the MA-Extension: Standard & Expedited to notify member and provider of an extension. Extension Notice: ▪ Give notice **in writing** within 14 calendar days of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The Health Plan must respond to an expedited grievance within 24 hours of receipt. Decision Notification After an Extension: ▪ Must occur no later than expiration of extension. Use NDMC template for written notification of denial decision.
Expedited Initial Organization Determination **-** If Expedited Criteria are not met	Promptly decide whether to expedite – determine if: 1) Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or	If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice. ▪ Use the MA Expedited Criteria Not Met template to provide written

Table 8.22.2 A Utilization Management Timeliness Standards Centers for Medicare and Medicaid Services (CMS)		
Type of Request	Decision	Notification Timeframes
	2) If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision. If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. ▪ The 14 day period begins with the day the request was received for an expedited determination.	notice. The written notice must include: 1) Explain that the Health Plan will automatically transfer and process the request using the 14-day timeframe for standard determinations; 2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination; 3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically; and 4) Provide instructions about the expedited grievance process and its timeframes.
Expedited Initial Organization Determination - If No Extension Requested or Needed	As soon as medically necessary, within 72 hours after receipt of request (includes weekends & holidays).	Within 72 hours after receipt of request. ▪ Approvals – Oral or written notice must be given to member and provider within 72 hours of receipt of request. – Document date and time oral notice is given. – If written notice **only** is given, it must be **received** by member and provider within 72 hours of receipt of request.

Table 8.22.2 A Utilization Management Timeliness Standards Centers for Medicare and Medicaid Services (CMS)		
Type of Request	Decision	Notification Timeframes
(See footnote)[2]		▪ Denials – When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be **received** by member and provider within 72 hours of receipt of request. – Use NDMC template for written notification of a denial decision.
Expedited Initial Organization Determination - If Extension Requested or Needed	May extend up to 14 calendar days. **Note:** Extension allowed ***only*** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers. When requesting additional information from non-contracted providers, the organization must	Use the MA-Extension: Standard & Expedited template to notify member and provider of an extension. Extension Notice: ▪ Give notice **in writing,** within 72 hours of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. **Note:** The Health Plan must respond to an expedited grievance within 24 hours of receipt. Decision Notification After an Extension: ▪ Approvals – Oral or written notice must be given to member and provider no

2 Note: Health Plans may have referral requirements that may impact timelines. When processing expedited requests, groups must factor in the time it may take to refer the request to the health plan in the total 72 hours to ensure that expedited requests are handled timely.

Table 8.22.2 A Utilization Management Timeliness Standards Centers for Medicare and Medicaid Services (CMS)		
Type of Request	Decision	Notification Timeframes
	make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request). Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	later than upon expiration of extension. – Document date and time oral notice is given. – If written notice **only** is given, it must be **received** by member and provider no later than upon expiration of the extension. ▪ Denials – When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be **received** by member and provider no later than upon expiration of extension. – Use NDMC template for written notification of a denial decision.

Table 8.22.2 B Utilization Management Timeliness Standards Centers for Medicare and Medicaid Services (CMS) - Hospital Discharge Appeal Notices			
Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
Hospital Discharge Appeal Notices (Concurrent)	Attending physician must concur with discharge decision from inpatient hospital to any other level of care or care setting. Continue coverage of inpatient care until physician concurrence obtained. Hospitals are responsible for valid delivery of the revised Important Message from Medicare (IM): 1) Within 2 calendar days of admission to a hospital inpatient setting. 2) Not more than 2 calendar days prior to discharge from a hospital inpatient setting. Health Plans or delegates are responsible for delivery of the Detailed Notice of Discharge (DND) when a member appeals a discharge	Hospitals must issue the IM within 2 calendar days of admission, obtain the signature of the member or representative and provide a copy of the IM at that time. Hospitals must issue a follow up IM not more than 2 calendar days prior to discharge from an inpatient hospital. ▪ NOTE: Follow up copy of IM is not required: ▪ If initial delivery and signing of the IM took place within 2 calendar days of discharge. ▪ When member is being transferred from inpatient to inpatient hospital setting. ▪ For exhaustion of Part A days, when applicable. If IM is given on day of discharge due to unexpected physician order for discharge, member must be given adequate time (at least several hours) to consider their right to request a QIO review.	Upon notification by the QIO that a member or representative has requested an appeal, the Health Plan or delegate must issue the DND to both the member and QIO as soon as possible but no later than noon of the day after notification by the QIO. The DND must include: ▪ A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered. ▪ A description of any applicable Medicare coverage rules, instructions, or other Medicare policy, including information about how the member may obtain a copy of the Medicare policy from the MA organization.

Table 8.22.2 B Utilization Management Timeliness Standards Centers for Medicare and Medicaid Services (CMS) - Hospital Discharge Appeal Notices			
Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
	decision. DND must be delivered as soon as possible but no later than noon of the day after notification by the QIO (Quality Improvement Organization).		▪ Any applicable Medicare health plan policy, contract provision, or rationale upon which the discharge determination was based. ▪ Facts specific to the member and relevant to the coverage determination sufficient to advise the member of the applicability of the coverage rule or policy to the member's case. ▪ Any other information required by CMS.

Table 8.22.2 C Utilization Management Timeliness Standards Centers for Medicare and Medicaid Services (CMS) - Termination of Provider Services			
Type of Request	Decision	Notice of Medicare Non-Coverage (NOMNC) Notification	Detailed Explanation of Non-Coverage (DENC) Notification
Termination of Provider Services: ▪ Skilled Nursing Facility (SNF) ▪ Home Health Agency (HHA) ▪ Comprehensive Outpatient Rehabilitation Facility (CORF) NOTE: This process does not apply to SNF Exhaustion of Benefits (100 day limit).	The Health Plan or delegate is responsible for making the decision to end services no later than two (2) calendar days or 2 visits before coverage ends: ▪ Discharge from SNF, HHA or CORF services OR ▪ A determination that such services are no longer medically necessary	The SNF, HHA or CORF is responsible for delivery of the NOMNC to the member or authorized representative ▪ The NOMNC must be delivered no later than 2 calendar days or 2 visits prior to the proposed termination of services and must include: member name, delivery date, date that coverage of services ends, and QIO contact information. ▪ The NOMNC may be delivered earlier if the date that coverage will end is known. ▪ If expected length of stay or service is 2 days or less, give notice on admission. **Note**: Check with Health Plan or delegate for delegated responsibility, as a Health Plan or delegate may choose to deliver the NOMNC instead of the provider.	Upon notification by the Quality Improvement Organization (QIO) that a member or authorized representative has requested an appeal: ▪ The Health Plan or delegate must issue the DENC to both the QIO and member no later than close of business of the day the QIO notifies the Health Plan of the appeal.

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Revised & Approved 6/5/03, 5/17/04, 7/14/04, 4/26/06, 9/13/07, 6/10/11

Table 8.22.3 Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)		Notification Timeframe	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
Routine (Non-urgent) Pre-Service • All necessary information received at time of initial request	Within 5 working days of receipt of all information reasonably necessary to render a decision	Practitioner: Within 24 hours of the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service
Routine (Non-urgent) Pre-Service – Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer • Additional examination or tests to be performed (AKA: Deferral)	Within 5 working days from receipt of the information reasonably necessary to render a decision but no longer than 14 calendar days from the receipt of the request • The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Health Plan/ Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest • Notify member and practitioner of decision to defer, in writing, within 5 working days of receipt of request & provide 14 calendar days from the		

Table 8.22.3 Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)		Notification Timeframe	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
	date of receipt of the original request for submission of requested information. Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered	Practitioner: Within 24 hours of making the decision Member: None Specified	
	Additional information received • If requested information is received, decision must be made within 5 working days of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service	Practitioner: Within 24 hours of making the decision Member: None Specified	
	Additional information incomplete or not received • If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial		Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 28 calendar days

Table 8.22.3 Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)		Notification Timeframe	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
			from the receipt of the request for service Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service
Expedited Authorization (Pre-Service) • Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life	Within 72 hours of receipt of the request	Practitioner: Within 24 hours of making the decision Member: None specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 3 working days from the receipt of the request for service

Table 8.22.3 Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)		Notification Timeframe	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
or health or ability to attain, maintain or regain maximum function. • All necessary information received at time of initial request			
Expedited Authorization (Pre-Service) - Extension Needed • Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain	Additional clinical information required: Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify practitioner and member using the "delay" form, and insert specifics about what has not been received, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered • Note: The time limit may be extended by up to 14 calendar days if the Member requests an extension, or if the Provider Group / Health Plan can provide justification upon request		

Table 8.22.3 Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)		Notification Timeframe	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
maximum function. • Additional clinical information required	by the State for the need for additional information and how it is in the Member's interest Additional information received • If requested information is received, decision must be made within 1 working day of receipt of information. Additional information incomplete or not received • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.	Practitioner: Within 24 hours of making the decision Member: None specified Practitioner: Within 24 hours of making the decision Member: None specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision

Table 8.22.3 Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)		Notification Timeframe	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulatory services) In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. CA H&SC 1367.01 (h)(3)	Within 5 working days or less, consistent with urgency of Member's medical condition **NOTE:** When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process… would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination CA H&SC 1367.01 (h)(2)	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision

Table 8.22.3 Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)		Notification Timeframe	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulatory services) **OPTIONAL:** Health Plans that are NCQA accredited for Medi-Cal may choose to adhere to the more stringent NCQA standard for concurrent review as outlined.	Within 24 hours of receipt of the request	Practitioner: Within 24 hours of receipt of the request (for approvals and denials) Member: Within 24 hours of receipt of the request (for approval decisions)	Member & Practitioner: Within 24 hours of receipt of the request Note: If oral notification is given within 24 hour of request, then written/electronic notification must be given no later than 3 calendar days after the oral notification
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days from receipt or request	Member & Practitioner: None specified	Member & Practitioner: Within 30 calendar days of receipt of the request

Table 8.22.3 Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)		Notification Timeframe	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of <u>Denial and Modification</u> to Practitioner and Member
Post-Service - Extension Needed • Additional clinical information required	Additional clinical information required (AKA: deferral) • Decision to defer must be made as soon as the Plan is aware that additional information is required to render a decision but no more than 30 days from the receipt of the request Additional information received • If requested information <u>is received</u>, decision must be made within 30 calendar days of receipt of information Example: Total of X + 30 where X = number of days it takes to receive requested information Additional information incomplete or not received • If information requested is incomplete or not received, decision must be made with the information that is available by the end of the 30th calendar day given to provide the information	Member & Practitioner: None specified Member & Practitioner: None Required	<u>Member & Practitioner</u>: Within 30 calendar days from receipt of the information necessary to make the determination <u>Member & Practitioner</u>: Within 30 calendar days from receipt of the information necessary to make the determination

Table 8.22.3 Utilization Management Timeliness Standards (Medi-Cal Managed Care - California)		Notification Timeframe	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
Hospice - Inpatient Care	Within 24 hours of receipt of request	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision

Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s).

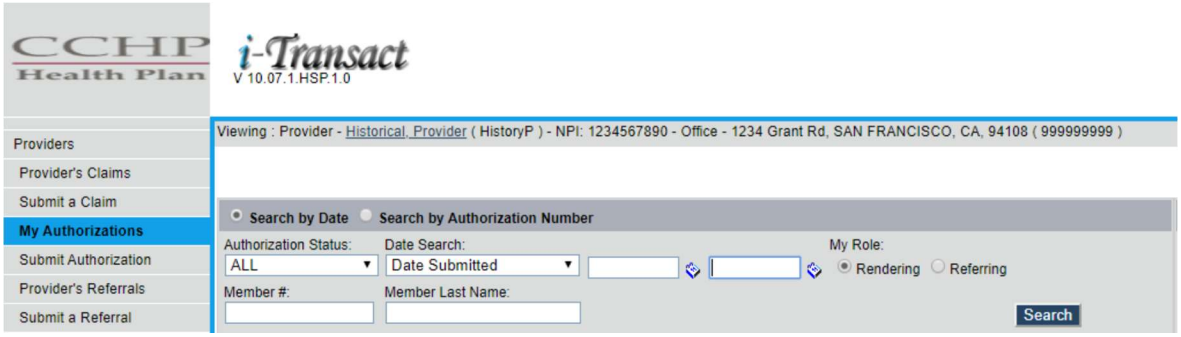
Section 5.23 Instructions for Checking the Status of Authorizations Online

Requests for Prior Authorization must be submitted by FAX to the Utilization Management Department using a Jade Service Authorization Form (SAF). We are not currently able to accept requests for authorization via the Website.

You can view the status of authorization requests that have been received by the UM Department on the Website. Please note that the term "Referral" as used on the Website means "Authorizations." To check the status of authorizations:

1. Go to website: https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx
2. Enter your username and password and click on "Logon".
3. Click "**My Authorizations**" option on the left side bar.
4. You can search by date or by authorization number.
5. Enter "**Member #**", and select the appropriate authorization status and date search.
6. Click on the "Search" button and the "Search by Date" page will list applicable Authorizations (SAF) requests received. Click on the left side of the screen authorization number in blue and a detail explanation of the authorization will be display.

See **"Authorizations"** screenshot below:



To view authorizations on SFHP ProviderLink:

1. Go to www.sfhp.org/providers
2. Select "Provider Secure Login"
3. Enter Username and Password
4. Click on "Login"
5. Click on "Search for Authorization"
6. "Authorizations Search" will open in a new window—please ensure that your browser is
7. not blocking pop ups
8. Enter required date fields in addition to any other information to limit search by

Click "Search"

Section 5.24 Inpatient/Outpatient Case Management

Case management is a comprehensive, multidisciplinary process that coordinates timely, medically appropriate, quality care in the most appropriate setting. Case management maximizes benefit and community resources by providing assessment, problem identification, planning, outcome monitoring, and re-evaluation to meet the needs of a specific, targeted population with complex health care needs. The case manager is the link between the individual, the provider, the payer and the community. Jade Health Care Medical Group contracts with the Chinese Community Health Plan to provide Case Management on behalf of their enrolled members. The Provider relies on the Case Manager to coordinate care for the assigned patients.

Section 5.25 Inpatient Review

Admissions are reviewed on the first working day following admission, using MCG. If admission or continued stay does not meet criteria outlined in the guidelines and the individual member circumstance, the Nurse Reviewer will refer the case to the Medical Director.

Medical information is requested before admission, on admission or concurrently and, in some cases, retrospectively to authorize inpatient care. Authorized lengths of stay are determined by medical necessity. Continued stay may not be denied without concurrent review except in the case when a facility fails to provide timely medical information on which to base the review.

- Inpatient review is the process to determine the medical necessity of inpatient services.
- Concurrent Review is a process designed to monitor appropriateness and quality of healthcare in the institutional setting at the time the services are rendered.

Additional Instructions for Medicare Advantage Patients:

A. The facility is responsible for notifying the Medicare Member of their right to a Quality Improvement Organization (QIO) review of discharge decisions by delivering the "Important Message From Medicare About Your Rights" (IM) notice.

B. The IM notice should be given to Medicare Members at the acute inpatient level, this includes acute and rehabilitation facilities, long term acute care hospitals and psychiatric hospitals.

C. Members in facility swing beds or custodial care beds do not receive these notices when receiving services at a lower level of care.

D. The Member shall be notified of decisions to terminate Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services no less than two (2) days before the proposed end of the services.

E. Members do not need a three (3) days acute facility stay prior to admission to a SNF.

PROCEDURES (Inpatient Acute):

1. Acute facility shall notify Members who are inpatient about their acute stay discharge appeal rights. Facilities shall issue the IM notice.
    a. A follow up copy shall be delivered as far in advance of discharge as possible, but no less than two (2) calendar days before the planned date of discharge.
    b. When discharge cannot be predicted in advance, the follow-up copy may be delivered as late as the day of discharge giving the beneficiary at least four (4) hours to consider their right to request a QIO review.
    c. If delivery of the original IM is within two (2) calendar days of the date of discharge, no follow up notice is required.
        i. Discharge, no follow up notice is required.
        ii. (Example: The Member is admitted on a Monday, the IM is delivered on Wednesday, and the Member is discharged on Friday, no follow up notice is required.)
2. A Member has the right to request an expedited review by the QIO, when it has

been determined, and the physician concurs that inpatient care is no longer necessary.

a. Members who fail to make a timely request for an expedited review and are no longer an inpatient, can still request a QIO review within thirty (30) calendar days of the date of discharge, or at any time for good cause.

b. Upon the QIO notification to an acute facility and/or Jade Health Care Medical Group of the request for expedited review, the facility shall deliver the Detailed Notice of Discharge to the Member.

c. The Detailed Notice of Discharge shall be completed with all necessary information requests on form instructions.

d. If the Member requests, the facility or Jade Health Care Medical Group shall furnish the Member with a copy of, or access to, any documentation that is sent to the QIO, including written records or any information provided by telephone.

   i. The facility or Jade Health Care Medical Group shall accommodate the request by no later than the first day after the material is requested.
   ii. Jade Health Care Medical Group's UM Nurse will coordinate the continued care and discharge plans with the facility's Case Manager.
   iii. Skilled Nursing Facility (SNF), Long Term Acute Care Hospital (LTACH), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) services:

3. Practitioners and Members are given written or electronic notification of the decision of non-coverage of further SNF, HHA, or CORF care no later than two (2) calendar days or two (2) visits prior to the proposed termination of services. The Notice of Medicare Non- Coverage (NOMNC) letter may be delivered earlier if the date that coverage will end is known. If the expected length of stay or service is two (2) days or less, the NOMNC letter shall be given on admission. The NOMNC letter shall include:

   a. Member name;
   b. Delivery date;
   c. Date that coverage of services will end;
   d. QIO contact information for a fast track appeal;
   e. Member's right to submit evidence to the QIO; and
   f. Alternative appeal mechanisms if the Member fails to meet the deadline for a fast track appeal.

4. If the Provider is unable to personally deliver the NOMNC to a person legally acting on behalf of a Member, then the Provider should telephone the representative to advise him or her of the proposed terminated services, appeal rights, and

document the call and send written notice via mail.

5. When direct phone contact cannot be made, the notice is sent to the Member's representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt for the NOMNC letter.

6. Once the NOMNC is completed, a copy should be faxed as follows:

    i. Skilled Nursing Facilities (SNF) and Home Health (HH) authorized by Jade Health Care Medical Group, please fax to (415) 398-3669

7. Upon notification by the QIO that a Member has filed a request for a fast track appeal, the Detailed Explanation of Non-Coverage (DENC) notice shall be sent to the Member by the close of business on the day the QIO notification is received with all the necessary information explaining why services are no longer necessary or no longer covered.

Section 5.26 Discharge Planning

Discharge planning begins on admission when goals and treatment plans are identified. Based upon the member's needs, post hospital services are arranged when the patient is medically stable for discharge.

Section 5.27 Retrospective Review

When inpatient services have been provided without prior authorization, medical information shall be obtained from the provider to determine whether the services were medically necessary. The determination shall be made within 30 days of receipt of all information.

Section 5.28 Denial/Appeal Process

Physician reviewers from the appropriate specialty conduct and document medical appropriateness reviews on any denial file. A psychiatrist, doctoral-level clinical psychologist, or certified addiction medicine specialist reviews any behavioral health care denials that are based on medical necessity. A description of the reason that the service is denied is documented clearly and the criteria on which the denial is based are available to the practitioner and member on request.

Section 5.29 Conflict of Interest

No person may participate in the review, evaluation or final disposition of any case in which he/she has been professionally involved or where judgment may be compromised. If it is necessary to seek outside physician reviewers in order to eliminate conflict of interest and assure an objective determination, such will be done.

Section 5.30 Coordination of Care Audits

The Jade Quality Improvement Department conducts medical chart audits to verify documentation of effective communication and coordination of care between the PCP and mental health specialist. Prior to the onsite audit, as a means to monitor the communication between PCP's and mental health specialists, the Quality Improvement nurse reviewer will identify and request charts of patients who have received mental health care services based on paid claims. The nurse reviewer will review and score the chart for proof of documentation of clinical information shared between the mental health specialists and PCP's as mandated by current Department of Managed Health Care regulations.

Section 5.31 Second Opinions

In certain situations, it is appropriate for an additional medical or surgical opinion ("second opinion") to be provided when a treating physician, or Jade Health Care Medical Group feels this would be helpful in determining a diagnosis or course of treatment.

A. Primary Care Physicians (PCPs), Specialists, and Members (if the practitioner refuses), have the right to request a second opinion from Jade Health Care Medical Group, regarding proposed medically necessary medical or surgical treatments from an appropriately qualified in network healthcare professional acting within their scope of practice who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition, or conditions associated with the request for a second opinion.

B. Second opinions are authorized when medically necessary and are arranged through Jade Health Care Medical Group.

C. The mandated timeframes for decisions of a request for a second opinion and subsequent notification to the Member and practitioner are available in the Member's Evidence of Coverage (EOC) and are available to the public, upon request.

PROCEDURES:

1. The Member's request for a second opinion is processed through Jade Health Care Medical Group prior authorization system. Members should request a second opinion through their PCP or specialist. If the PCP or specialist refuses to submit a request for a second opinion, the Member can submit a request for assistance through Jade Health Care Medical Group Member Services at (415) 834-2118. Jade Health Care Medical Group's Member Services staff directs the request to the Jade Health Care Medical Group Utilization Management Department to be processed.

2. The PCP or specialist submits the request for a second opinion to Jade Health Care Medical Group including documentation regarding the Member's condition and proposed treatment.

3. If the referral for a second opinion is approved, Jade Health Care Medical Group will help arrange for the Member to see a practitioner in the appropriate specialty. Agreements with any network or out-of-network practitioner for second opinions shall include the requirement that the consultation report for the second opinion be submitted within three (3) working days of the visit to the Practitioner.

4. If the referral is denied or modified, Jade Health Care Medical Group provides written notification to the Member, including the rationale for the denial or modification, alternative care recommendations, and information on how to appeal this decision. Request may be denied if the Member insists on an out-of-network practitioner when there is an appropriately qualified practitioner in-network.

5. If there is no physician within the Jade Health Care Medical Group network that meets the qualifications for a second opinion, Jade Health Care Medical Group may shall authorize a second opinion by a qualified physician outside Jade Health Care Medical Group's network and ensure that cost to the Member is not greater than it would be if the services were furnished within the network.

6. Jade Health Care Medical Group shall provide and coordinate any out-of-network services adequately and timely.

7. Members disagreeing with Jade Health Care Medical Group's denial of a second opinion may appeal through the Jade Health Care Medical Group grievance process. In cases where the Member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb or other major bodily function, or lack of timeliness that would be detrimental to the Member's ability to regain maximum function, decisions and notification of decisions to practitioners are completed in a timely fashion not to exceed seventy-two (72) hours after receipt of request, whenever possible.

8. In situations where the Member believes that the need for a second opinion is urgent, they can request facilitation by Jade Health Care Medical Group by contacting Jade Health Care Medical Group Member Services. Jade Health Care Medical Group Medical Services reviews such requests, and if determined to be urgent, facilitates the process by working directly with the PCP and the Utilization Management team. If determined by Jade Health Care Medical Group Medical Services to be not urgent, the Member is referred back to his/her PCP to continue the process.

9. Reasons for providing or authorizing a second opinion include, but are not limited to,

the following:

a. The Member questions the reasonableness or medical necessity of recommended surgical procedures;
b. The Member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment including but not limited to a serious chronic condition;
c. Clinical indications are not clear or are complex and confusing, a diagnosis is questionable due to conflicting test results, or the treating PCP/specialist is unable to diagnose the condition and the Member requests an additional diagnostic opinion;
d. The treatment plan in progress is not improving the medical condition of the Member within an appropriate time period given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment; and
e. The Member has attempted to follow the plan of care or consulted with the initial physician concerning serious concerns about the diagnosis or plan of care.

10. If the Member is requesting a second opinion about care from his or her PCP, the second opinion shall be provided by an appropriately qualified physician of the Member's choice within Jade Health Care Medical Group network.

11. If the Member is requesting a second opinion about care from a specialist, the second opinion shall be provided by any physician of the same or equivalent specialty of the Member's choice within Jade Health Care Medical Group network. Jade Health Care Medical Group. If not authorized, additional medical opinions obtained from a physician not within Jade Health Care Medical Group network are the responsibility of the Member.

12. The notification to the practitioner that is performing the second opinion shall include the timeframe for completion of the consultation and requirements for submission of the consultation report.

13. The second opinion practitioner is responsible for submitting consultation reports to the Member, requesting practitioner and PCP within three (3) working days of the visit. If the second opinion is deemed urgent, the submission of the consultation report shall be within twenty-four (24) hours of the visit.

14. The PCP is responsible for documenting second opinions and monitoring receipt of consultation reports on the PCP Referral Tracking Log (See Attachment, "Referral Tracking Log").

15. Mandated timeframes for decision including approval, denial or modification of a

non- urgent or urgent or concurrent request for a second opinion and subsequent notification to the Member and practitioner shall follow the regulatory timeframes.

16. If the referral is denied or modified, Jade Health Care Medical Group provides written notification to the Member including rationale for the denial or modification, alternative care recommendations, and information on how to appeal this decision. Member, Member's Representatives, or practitioners appealing on behalf of the Member, disagreeing with a denial of a second opinion, may appeal through the Jade Health Care Medical Group grievance process.

17. Jade Health Care Medical Group's Medical Director or physician designee may request a second opinion at any time it is felt to be necessary to support a proposed method of treatment or to provide recommendations for an alternative method of treatment.

Section 5.32 Retroactive Authorizations

For services requiring authorization, the request must be submitted prior to rendering the service, to:

1. Verify medical necessity,
2. Verify the service requested is a covered benefit,
3. Verify member eligibility and enrollment, and
4. Verify the provider and location of service is in network.

Requests for retroactive authorizations will not be approved for any elective and non-emergent services.

NOTE: Claims received for elective and non-emergent services without the required prior authorization by the Utilization Management Department will be denied.

SECTION 6 CLAIMS PROCEDURES

Section 6.1 Timely Filing

For authorized claims, when Jade Health Care Medical Group is primary, claims must be submitted to Jade Health Care Medical Group by the deadline specified in your contract. Typically, this requires submission of claims no later than 90 days from date of service. Claims submitted after the deadline specified in the provider contract will be denied event if previously authorized and must be written off by the provider.

Secondary claims submission must include a copy of the primary EOB and must be submitted within 90 calendar days of the receipt of the primary payer's EOB.

Claims will not be paid beyond submission deadlines unless there is a special circumstance in which the provider can demonstrate good cause. At no time is the patient responsible for payment of claims submitted after the timeliness deadline.

Section 6.2 Claims Submission

Jade is contracted with Independent Physician Associations and with providers directly. If you are submitting a claim for services provided under your IPA contract, you must submit them to the IPA who will in turn file them on your behalf. Jade also has direct contracted providers who submit their claims directly to Jade for payment.

Section 6.3 Electronic Claims

Jade Health Care Medical Group prefers that claims be submitted electronically. If you already submit claims electronically to other payers, please contact your clearinghouse vendor and tell them to forward your claims for Jade Health Care Medical Group members to the Emdeon clearinghouse. The Jade Health Care Medical Group Emdeon Payer ID Number is **94302**.

Section 6.4 Paper Claims

All paper claims must be submitted on a CMS 1500 or UB04 Form to:

Jade Health Care Medical Group
Claims Department
445 Grant Ave Suite 700
San Francisco, CA 94108

Section 6.5 Claims for Referred Services

For electronic claims, the Jade Health Care Medical Group specialist physician or behavioral health specialist (consultant) must indicate the name of the referring Jade Health Care Medical Group physician on the electronic claim.

For paper claims, the Jade Health Care Medical Group specialist physician or behavioral health specialist must indicate the name of the referring Jade Health Care Medical Group physician on the claim and submit a copy of the Jade Health Care Medical Group Consultation Referral Form with the claim.

Section 6.6 Claims for Authorized Services

Be sure that a claim for authorized services includes the following:

1. The procedure code(s) that was authorized on the Service Authorization Form (SAF) matches the code on the claim form,
2. The reference number for the authorization, and
3. When submitting a paper claim, attach a copy of the approved SAF.

Section 6.7 Claims Information for San Francisco Health Plan:

SFHP Claims Department maintains a full manual of all relevant claims submission, coordination of benefit, and dispute resolution and appeal procedures in the San Francisco Health Plan Claims Operations Manual. Please reference the claims manual at: http://www.sfhp.org/files/PDF/providers/Claims_Ops_Provider_Manual.pdf .

Any questions regarding claims should be directed to the SFHP Claims Department at 1-415-547-7818 EXT 7115 or claims@sfhp.org.

Section 6.8 Clinical Documentation

If a PCP or Specialist bills the following CPT codes: 99205 and 99215, a copy of the PCP notes or consultation report must be sent with the claim. Specialists must send a copy of their consultation report to the PCP who made the referral.

Section 6.9 Claims Resubmission Policy

To avoid duplicate claims, please first check the status of your claims either on our Website or by calling the phone number listed in Section 1 to confirm receipt. Resubmission of a claim should be no earlier than 60 days following the original claims.

Jade Health Care Medical Group contracted health care professionals and facilities can check the status of their claims using the Jade Health Care Medical Group Provider Portal. Please click on the above Provider Portal link to log-in with your UserID and Password. After checking online, if you have a question about a claim, please call Member Services Center at 1-415-834-2118.

If you need assistance with web access, please call Provider Relations at 1-628-228-3214, Monday through Friday, 9:00 AM to 5:00 PM.

If you are not a contracted provider with Jade Health Care Medical Group or do not have web access and would like to check claims status, please call Member Services Center at 1-415-834-2118.

Section 6.10 Refunds

When submitting a refund, please include a copy of the remittance advice, an explanation why you believe there is an overpayment, a check in the amount of the refund, and a copy of the primary payer's remittance advice (if applicable). Section 6.11 Processing Timeliness Standards

Section 6.11 Processing Timeliness Standards

Jade Health Care Medical Group processes claims according to the following State and Federal regulatory claims payment standards:

- Commercial claims – 95% of all claims – complete claims, contested claims and denials will be processed within 45 working days.
- Medicare Advantage 30-day claims – at least 95% of clean MA claims from unaffiliated (non-contracting) providers will be processed within 30 calendar days from date of receipt.
- Medicare Advantage 60-day claims – at least 95% of all other MA claims (unclean claims, member liability denials and claims for affiliated, contracted providers) will be processed within 60 calendar days from date of receipt.
- Jade Health Care Medical Group processes also comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.39 shall be subject to any Provider remedies, including interest payments provided for in California statute and/or provider agreements, if it fails to meet the standards specified in these policies and procedures.

Section 6.12 Checking the Status of Claims

Claims status can be checked 24 hours a day online at https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx.. Refer to Section 6.13 for Web access instructions. To inquire about claims by telephone, refer to Section 1, Key Contacts and Resources. Jade Health Care Medical Group maintains sufficient claims processing/tracking/payment systems capability to: comply with applicable State and federal law, regulations and Contract requirements, determine the status of received claims, and calculate the estimate for incurred and unreported claims, as specified by Title 28, CCR, Sections 1300.77.1 and 1300.77.2.

Section 6.13 Website Instructions for Checking the Status of Claims

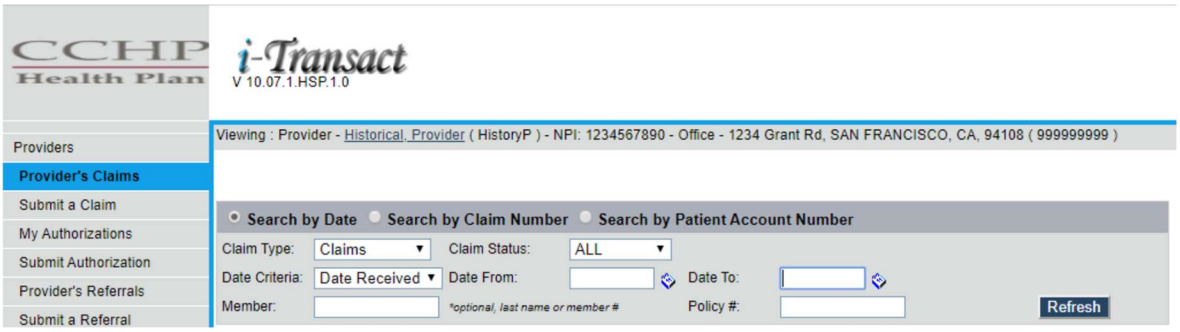
Contracted providers with Internet access can use the Web to check the status of any previous month's claims paid by Jade Health Care Medical Group, and Chinese Hospital. To check the status of claims:

1. Go to https://portal.cchphealthplan.com/iTransact/Logon/Logon.aspx
2. Enter your username and password and click on "Logon".
3. Click "Provider's Claims" (naming will depend on the type of account) option on the left

side bar.
4. You may search by date or claim number.
5. Enter the CCHP Member ID under "**Member #**" or enter the old CCHP Member ID without the asterisk under the "Policy #" (Example: 00011122201).
6. On the "search by date" page, you have the option to narrow the information being searched by the claim status and date criteria.

5.

See "Claims search" screenshot below:



7. Click on the "Refresh" button and the "Search by Date" page will list applicable claims.
8. For more details, click on the claim number in blue and you will see the entire claim summary.
9. Please click on "view" in next to the claim number for the Evidence of Payment (EOP).

To check the claim status on SFHP ProviderLink:

1. Go to www.sfhp.org/providers
2. Select "Provider Secure Login"
3. Enter Username and Password
4. Click on "Login"
5. Click on "Search for Claim"
6. "Claim Search will open in a new window—please ensure that your browser is not blocking pop ups
7. Enter required fields in addition to any other information to limit search by
8. Click "Search"

Section 6.14 Provider Dispute Resolution Procedure

Jade Health Care Medical Group has a Provider Dispute Resolution (PDR) process that ensures provider disputes are handled in a fast, fair and cost effective manner. A provider dispute is a written notice from a provider that

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

Providers have 365 days from the date of the Jade Health Care Medical Group's action or inaction to submit a provider dispute. If a provider disputes the failure to take action on a claim, the provider has 365 days from the last date on which the Plan could have either paid, denied or contested the claim (consistent with claims payment timeliness rules) to submit the dispute. Jade Health Care Medical Group will respond to the dispute in a timely manner in accordance with State and Federal Guidelines.
Jade Health Care Medical Group will resolve each provider dispute within 45 business days following receipt of the dispute, and will provide the provider with a written determination stating the reasons for the determination.

Non-Contracted Provider Dispute Resolution Process for CMS Medicare Advantage Plan Members

A non-contract provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the non-contract provider completes a waiver of liability statement, which provides that the non-contract provider will not bill the Medicare member regardless of the outcome of the appeal. The health plan cannot undertake a review until or unless such form/documentation is obtained.

Section 6.15 How to Submit Provider Disputes

Provider Dispute Form
Providers must use a Provider Dispute Resolution Request Form. You may download the PDR Request Form and Instructions for Submitting Provider Disputes at https://cchphealthplan.com/provider, under "CCHP Provider Dispute Process." You may also contact Provider Relations at telephone number listed in Section 1.

Disputes may be mailed to:

Jade Health Care Medical Group
Attention: Provider Dispute Resolution Area
445 Grant Avenue, Suite 700
San Francisco, CA 94108

Acknowledgement of Provider Disputes
Jade Health Care Medical Group will acknowledge receipt of a provider dispute within 15 business days of receipt. Provider disputes received electronically must be acknowledged within 2 working days from the date of receipt.

Resolution Timeframe

Jade Health Care Medical Group will resolve each provider dispute within 45 business days following receipt of the dispute, and will provide the provider with a written determination stating the reasons for the determination.

Download the CMS Non-Contracted Provider Dispute Process at:
https://cchphealthplan.com/provider (under “CCHP Provider Dispute Process”)

Download the Waiver of Liability Statement at:
https://cchphealthplan.com/provider (under “CCHP Provider Dispute Process”)