COMMUNITY HEALTH CENTER NETWORK

Provider Manual

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Section 1

CHCN Introduction

Purpose of the Provider Manual

The Community Health Center Network (CHCN) Provider Manual is a reference tool designed to guide both CHCN contracted providers and member health centers in implementing the benefit programs offered by CHCN. If the terms of your service agreement differ from the information contained in this Manual, then this Manual rules. This is a combined manual for Medi-Cal and Group Care programs managed by CHCN. Although most sections of the manual apply to all programs, sections that apply only to particular programs are noted.

Introduction to Community Health Center Network

CHCN is a partnership between eight health service organizations to provide a comprehensive range of professional health care and social services in a manner respectful of the community's values and traditions. Incorporated in 1996, CHCN's purpose was to introduce the managed care business to its member health centers by serving as a network of management services.

Current health centers of CHCN are:
Asian Health Services
Axis Community Health
Bay Area Community Health
La Clinica De La Raza
LifeLong Medical Care
Native American Health Center
Tiburcio Vasquez Health Center
West Oakland Health Council

These health centers provide services in over 40 primary care health center sites in the Bay Area and contain approximately 450 primary care providers and mid-level practitioners. Language capacity exceeds 25 spoken and 8 written. Our health centers are located in cities throughout Alameda County.

Community Health Center Network Responsibilities

1. Implement standards and protocols for the coordination of managed care business.

2. Review health plan contracts and act as the communicating body to the CHCN member health centers.

3. Coordinate professional services of a managed care member including specialty, radiology, laboratory, and certain minor ancillary services.

4. Process and pay claims for managed care members.

5. Coordinate authorizations.

6. Review utilization of specialty services.

7. Ensure quality of care through quality improvement programs and quality assurance reviews.

8. Coordinate membership and eligibility services.

9. Review provider and member concerns.

10. Implement formal processes for the purpose of recommending and approving policies and procedures.

Non-Discrimination Notice

Discrimination is against the law. CHCN follows Federal civil rights laws. CHCN does not discriminate, exclude people, or treat them differently because of race, color, national origin, religion, ancestry, ethnic group identification, mental or physical disability, medical condition, genetic information, marital status, gender or gender identity, sexual orientation, age, or sex.

If you believe that CHCN has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Alameda Alliance for Health. You can file a grievance by phone, in writing, in person, or electronically:

Alameda Alliance for Health

- By phone: 1-877-932-2738; CRS for hearing impaired at 711 or 1-800-735-2929
- In writing: Fill out a complaint form or write a letter and send it to:

  Alameda Alliance for Health
  G & A Unit
  1240 South Loop Road
  Alameda, CA 94502
  Fax 1-855-891-7258

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call 1-800-368-1019. If you cannot speak or hear well, please call TTY/TDD 1-800-537-7697.
- In writing: Fill out a complaint form or send a letter to:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Section 2

Services and Contacts

Community Health Center Network

101 Callan Avenue, Suite 300 San Leandro, CA 94577
Phone: 510-297-0200 Fax: 510-297-0209
Website: https://chcnetwork.org/
Web Portal: https://connect.chcnetwork.org

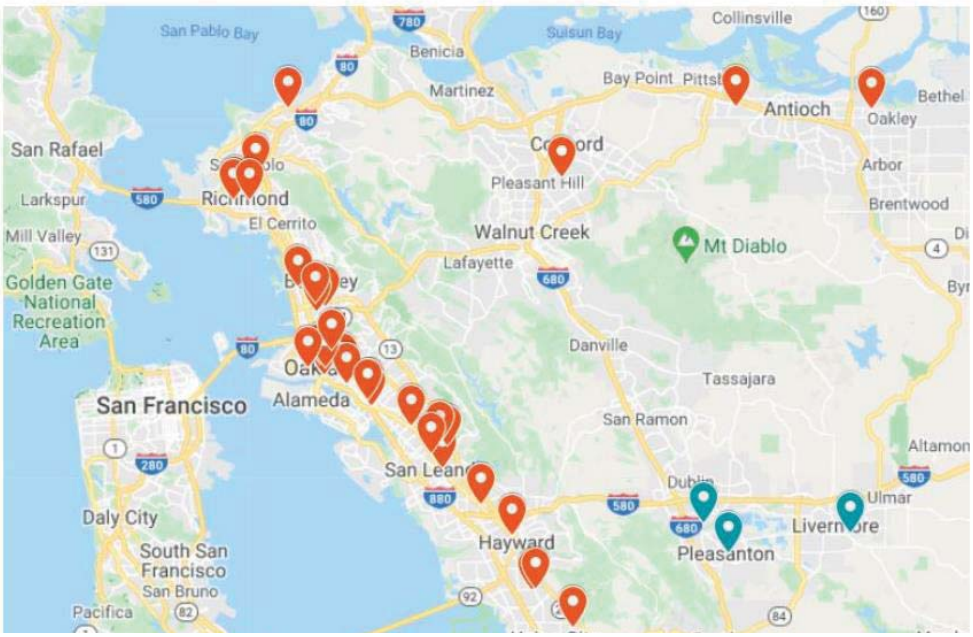
Contact Information

Executive Management		
Andie Martinez Patterson, Chief Executive Officer	510-297-0266	amartinezpatterson@alamedahealthconsortium.org
Tri Do, M.D., Chief Medical Officer	510-297-0435	tdo@chcnetwork.org
Steve Blake, Chief Operations Officer	510-297-0240	sblake@chcnetwork.org
Chief Information Officer	510-297-0474	
Michael Ibarra de Perea, Human Resources Director	510-297-0244	mibarradeperea@chcnetwork.org
Teresa Ercole, Compliance Officer	510-297-0290	tercole@chcnetwork.org
Finance		
Rogers Moody, Director of Finance	510-297-0257	rmoody@chcnetwork.org
Information Systems		
Mark Delgado, EDI Specialist	510-297-0298	mdelgado@chcnetwork.org
Reporting & Analytics		
Sharon Lee, Data Analyst Manager	510-297-0289	slee@chcnetwork.org
Yin-Yu Chen, Data Analyst Manager	510-297-0427	ychen@chcnetwork.org
Operations		
Sepi Azari, Director of Operations	510-297-0485	sazari@chcnetwork.org
Credentialing Support	510-297-0271	credentialing@chcnetwork.org
Provider Services	510-297-0299	providerservices@chcnetwork.org
Claims Department	510-297-0210	
Care Management		
Melissa Rosel, Utilization Management Director	510-297-0415	mrosel@chcnetwork.org
Outpatient UM Supervisor	510-297-0295	
Richmond Santos, RN Inpatient Care Supervisor	510-297-0418	rsantos@chcnetwork.org
Layla Castillon, Outpatient Case Management Nurse Supervisor	510-297-0419	lcastillon@chcnetwork.org
Utilization Management Intake Coordinators	510-297-0222	umcod@chcnetwork.org
General Information		
Customer Care	510-297-0200	customercare@chcnetwork.org

AXIS COMMUNITY HEALTH http://www.axishealth.org/						
SITE	**HOURS (Bolded if After Hours)**	**ADDRESS**	**CITY**	**ZIP**	**PHONE**	**FAX**
LIVERMORE	**M W 8:30am-9pm** Tu Th F 8:30am-5pm **Sat (1st & 3rd) 8:45am-1pm**	3311 PACIFIC AVE	LIVERMORE	94550	(925) 462-1755	(925) 449-7157
PLEASANTON	**M-Th 8:30am- 9pm** F 8:30am- 5pm	4361 RAILROAD AVE	PLEASANTON	94566	(925) 462-1755	(925) 462-1650
HACIENDA	**M-Th 8:30am-9pm** F 8:30am-5pm **Sat (1st, 3rd, 4th) 8:45am-1pm**	5925 W LAS POSITAS BLVD STE 100	PLEASANTON	94588	(925) 462-1755	(925) 462-1650
ASIAN HEALTH SERVICES https://asianhealthservices.org/						
SITE	**HOURS (Bolded if After Hours)**	**ADDRESS**	**CITY**	**ZIP**	**PHONE**	**FAX**
ROLLAND & KATHRYN LOWE MEDICAL CENTER	M-F 9am-5pm Closed daily 12:30-1:30pm	835 WEBSTER ST	OAKLAND	94607	(510) 318-5800	(510) 986-8681
CHENMING & MARGARET HU MEDICAL CENTER	M-F 9am-5pm **Sat 8:45am-1pm** **Teen Clinic Tu 5-7pm**	818 WEBSTER ST	OAKLAND	94607	(510) 986-6800	(510) 986-6896
ASIAN HEALTH SERVICES PEDIATRICS SAN LEANDRO	M Th F 9am-12:30pm, 1:30-5pm Tu 9am- 12:30pm W 1:30- 5pm	101 CALLAN AVE STE 105	SAN LEANDRO	94577	(510) 357-7077	(510) 357-4363
FRANK KIANG MEDICAL CENTER	M-F 9am-5pm Closed daily 12:30-1:30pm	250 E 18TH ST 2ND FLR	OAKLAND	94606	(510) 735-3888	(510) 628-0568
BAY AREA COMMUNITY HEALTH https://bach.health/						
SITE	**HOURS (Bolded if After Hours)**	**ADDRESS**	**CITY**	**ZIP**	**PHONE**	**FAX**
LIBERTY	**M-Th 8am-7pm** **F-Sat 8am-5pm**	39500 LIBERTY ST	FREMONT	94538	(510) 770-8040	(510) 770-8145
MOWRY I	**M-Th 8am-7pm** F 8am-5pm	2299 MOWRY AVE STE 3B	FREMONT	94538	(510) 770-8040	(510) 456-4390
MOWRY II	**M-F 8am-8pm**	1999 MOWRY AVE STE F & N	FREMONT	94538	(510) 770-8040	(510) 657-8954
MAIN ST VILLAGE	M-F 8am -5pm	3607 MAIN ST STE B	FREMONT	94538	(510) 770-8040	(510) 933-0598
IRVINGTON DAVE	**M-F 8am-7pm**	40910 FREMONT BLVD	FREMONT	94538	(510) 770-8040	(510) 623-8926
LA CLINICA DE LA RAZA http://www.laclinica.org/						
SITE	**HOURS (Bolded if After Hours)**	**ADDRESS**	**CITY**	**ZIP**	**PHONE**	**FAX**
ALTA VISTA	M-F 8:30am-5:30 pm Wed (3rd) 9:30am-5:30pm	1515 FRUITVALE AVE	OAKLAND	94601	(510) 535-6300	(510) 535-4019
TRANSIT VILLAGE	M-F 8:15am-5:30pm **Sat 8:45am-12:15pm**	3451 E 12TH ST	OAKLAND	94601	(510) 535-3319	(510) 535-4225
SAN ANTONIO NEIGHBORHOOD HEALTH CENTER	M-F 8:30am-5:30pm **Sat 8:30-5:30pm**	1030 INTERNATIONAL BLVD	OAKLAND	94606	(510) 238-5400	(510) 238-5437
95TH AVENUE	M-F 8:30am-5:30 pm	9475 INTERNATIONAL BLVD	OAKLAND	94603	510-434-5770	510-434-5790
DAVIS PEDIATRICS	M-F 9am-12pm, 1:30-5pm	5461 FOOTHILL BLVD	OAKLAND	94601	(510) 532-0918	(510) 532-0956
LIFELONG MEDICAL CARE https://www.lifelongmedical.org/						
SITE	**HOURS (Bolded if After Hours)**	**ADDRESS**	**CITY**	**ZIP**	**PHONE**	**FAX**
ASHBY HEALTH CENTER	M W F 8:15am-5pm **Tu 8:15am-8:15pm** Th 8:15am-12:45pm, 2-5pm F 8:15am-5pm	3075 ADELINE ST STE 280	BERKELEY	94703	(510) 981-4100	(510) 553-2171
EAST OAKLAND	M-F 8am-5pm **Sat 8am-12pm**	10700 MACARTHUR BLVD	OAKLAND	94605	(510) 981-4100	(510) 563-4360
OVER 60 HEALTH CENTER	M-F 8am-5pm Closed 1st W 12:30-1:30pm Closed 3rd W 12:30-2:30pm	3260 SACRAMENTO ST	BERKELEY	94702	(510) 981-4100	(510) 428-4594
WEST BERKELEY FAMILY PRACTICE (WBFP)	M W 1pm-5pm Tu Th 8am-5pm	837 ADDISON ST	BERKELEY	94710	(510) 981-4100	(510) 981-4294
DOWNTOWN OAKLAND	M T W F 8am-5pm Th 9:30am-5pm	616 16TH ST	OAKLAND	94612	(510) 981-4100	(510) 451-4285
HOWARD DANIEL CLINIC	M-F 8am-5pm 1st Tu 10:30am-5pm	9933 MACARTHUR BLVD	OAKLAND	94605	(510) 981-4100	(510) 553-2172
TRUST	M W Th F 8:30am-4:30pm Tu 1pm-4:30pm	386 14TH ST	OAKLAND	94612	(510) 210-5050	(510) 444-4424
LENOIR	M-Th 9am-5pm Closed M-Th 12:30-2pm F 9am-12:30pm	2940 SUMMIT ST STE 1B	OAKLAND	94609	(510) 834-4897	(510) 834-4799

SITE	HOURS (Bolded if After Hours)	ADDRESS	CITY	ZIP	PHONE	FAX
NATIVE AMERICAN HEALTH CENTER http://www.nativehealth.org/						
SITE	**HOURS (Bolded if After Hours)**	**ADDRESS**	**CITY**	**ZIP**	**PHONE**	**FAX**
NATIVE AMERICAN HEALTH CENTER	M-F 8am-5:30pm	2950 INTERNATIONAL BLVD	OAKLAND	94601	(510) 535-4410	(510 535-4449
TIBURCIO VASQUEZ HEALTH CENTER https://www.tvhc.org						
HEALTH CENTER SITE	**HOURS (Bolded if After Hours)**	**ADDRESS**	**CITY**	**ZIP**	**PHONE**	**FAX**
HAYWARD	M-Sat 8am-5pm	22331 MISSION BLVD	HAYWARD	94541	(510) 471-5880	(510) 690-0703
UNION CITY	M-Sat 8am-5pm	33255 9TH ST	UNION CITY	94587	(510) 471-5880	(510) 471-9051
SILVA PEDIATRIC CLINIC	M-Sat 8am-5pm	680 W TENNYSON RD	HAYWARD	94544	(510) 471-5880	(510) 782-4756
SAN LEANDRO	M-F 8am-5pm	16110 E 14TH ST	SAN LEANDRO	94578	(510) 471-5880	(510) 476-0404
FIREHOUSE CLINIC	**M-F 8am-8pm**	28300 HUNTWOOD AVE	HAYWARD	94544	(510) 471-5880	(510) 293-1288
HESPERIAN CLINIC	M-F 8am-5pm	19682 HESPERIAN BLVD	HAYWARD	94541	(510) 471-5880	(510) 690-0717
WEST OAKLAND HEALTH https://www.westoaklandhealth.org/						
SITE	**HOURS (Bolded if After Hours)**	**ADDRESS**	**CITY**	**ZIP**	**PHONE**	**FAX**
WEST OAKLAND HEALTH CENTER	M-F 8:15am-5pm **Tu,Th 8:15am-8pm** **Sat 9am-1pm**	700 ADELINE ST	OAKLAND	94607	(510) 835-9610	(510) 893-4333
EAST OAKLAND HEALTH CENTER	M-F 8:15am-5pm	7450 INTERNATIONAL BLVD	OAKLAND	94621	(510) 835-9610	(510) 893-4333
WILLIAM BYRON RUMFORD MEDICAL CLINIC	M-F 8:15am- 5pm	2960 SACRAMENTO ST	BERKELEY	94702	(510) 835-9610	(510) 893-4333
ALBERT J THOMAS MEDICAL CLINIC	M-F 8:15am- 5pm	10615 INTERNATIONAL BLVD	OAKLAND	94603	(510) 835-9610	(510) 893-4333

Community Health Center Network
Health Center Site Map



Section 3

Grievances and Appeals

Member Rights and Responsibilities

CHCN members have these rights:

- Delegate/Vendor, will not differentiate, or discriminate against any Member as a result of his/her enrollment in a Health Benefit Plan, or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for Health Services, status as a litigant, status as a Medicare or Medicaid beneficiary, sexual orientation, gender identity, or any other basis prohibited by law.
- To be treated with respect, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about the plan and its services, including Covered Services.
- To be able to choose a primary care provider within the Contractor's network.
- To participate in decision making regarding your own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care received.
- To make recommendations about the member rights and responsibilities.
- To receive care coordination.
- To request an appeal of decisions to deny, defer, or limit services or benefits.
- To receive oral interpretation services for their language.
- To receive free legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To receive care from out-of-network providers when medically necessary and approved through Utilization Management at no cost.
- To receive emergency services at no cost.
- To have access to family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and Emergency Services outside the Contractor's network pursuant to the federal law.
- To request a State Hearing, including information on the circumstances under which an expedited hearing is possible.
- To disenroll upon request. Beneficiaries that can request expedited disenrollment include, but are not limited to, beneficiaries receiving services under the Foster Care, or Adoption Assistance Programs; and members with special health care needs.
- To access Minor Consent Services.
- To receive written member informing materials in alternative formats (including braille, large-size print, and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with W & I Code Section 14182 (b)(12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand.
- To receive a copy of your medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by the Contractor, providers, or the State.

CHCN members have these responsibilities:

- Tell the CHCN and your doctors what we need to know (to the extent possible) so we can provide care.
- Follow care plans and advice for care that you have agreed to with your doctors.
- Learn about your health problems and help to set treatment goals that you agree with, to the degree possible.
- Work with your doctor.
- Always present your health plan Member ID Card when getting services.
- Ask questions about any medical condition and make certain you understand your doctor's explanations and instructions.
- Give your doctors and CHCN correct information.
- Help CHCN maintain accurate and current records by providing timely information regarding changes in address, family status, and other health care coverage.
- Make and keep medical appointments and inform your doctor at least 24 hours in advance when an appointment must be cancelled.
- Treat all CHCN staff and health care staff with respect and courtesy.
- To have access to, and where legally appropriate, receive copies of, amend or correct your Medical Record.
- Use the emergency room only in case of an emergency or as directed by your doctor.

Grievances and Appeals

Purpose:
To aid the health plan, Alameda Alliance for Health, in meeting the turn-around time requirements for member grievances. CHCN is not delegated to resolve grievances however we do work with the health plan to gather information related to the grievance from our UM Department, specialists and health centers based on the grievance type.

Definitions:

Grievance
Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by the health plan to make an authorization decision.

Complaint
Is the same as a Grievance. Where the health plan is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.

Inquiry
Is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other health plan processes.

Appeal
Under new federal regulations, an "Appeal" is defined as a review by the health plan of an Adverse Benefit Determination. While state regulations do not explicitly define the term "Appeal", they do delineate specific requirements for types of Grievances that would fall under the new federal definition of Appeal. These types of Grievances involve the delay, modification, or denial of services based on medical necessity, or a determination that the requested service was not a covered benefit. The health plan shall treat these Grievances as Appeals under federal regulations.

Adverse Benefit Determination

This is defined to mean any of the following actions taken by the health plan.

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of a payment for a service.
- The failure to provide services in a timely manner.
- The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
- For a resident of a rural area with only one health plan, the denial of the beneficiary's request to obtain services outside the network.
- The denial of a beneficiary's request to dispute financial liability.

Policy:

Customer Care (CC) staff shall log all member grievance information received from the health plan into the Customer Care Incident Module in EZ-Cap. Member appeals filed based on an adverse determination by CHCN are handled by the CHCN Customer Care staff for review. Grievances filed based on the standard of care provided by one of our clinics or specialists are routed to that provider for a response to the complaint by Customer Care staff. CHCN members are permitted to file a grievance or appeal either verbally or in writing.

CHCN Customer Care Procedure:

1. Incoming grievances are received by fax.
    a. Turn Around Time for grievances received from health plan is indicated on the packet.
    b. Turn Around Time for grievance received from member; info will be routed to health plan within 24 hours
    c. Turn Around Time for Adverse Benefit Determination is 48 hours with an acknowledgment.
    d. For expedited appeals, records will be sent within 24 hours.

2. CC staff logs the grievance or appeal in the Customer Service Incident Module within EZ-Cap.
    a. Grievance
    Grievances are routed to the provider of service to issue a response.
        i. Once CHCN receive the completed packet from the provider, CC staff closes out the incident and forwards information provided the member's health plan.
    b. Appeal
    The packet is routed to one of the Customer Care staff for completion.
        i. The Customer Care Associate prepares a response to the request for information and attaches a copy of the appeal to the authorization in EZ-CAP.
        ii. The completed packet is sent back to the health plan.
        iii. Customer Service Incident is closed upon submission of the packet to the health plan.

Member Grievance Form

At Alameda Alliance for Health (Alliance) your satisfaction is important to us! If you have a problem with the Alliance, you have the right to make a complaint. This is also called filing a grievance.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below. You can attach extra pages if needed.
2. Please submit the completed form by mail or in person:
   a. Mail: Alameda Alliance For Health, Attn: Member Services, PO Box 2818, Alameda, CA 94501-0818
   b. In person: 1240 South Loop Road, Alameda, CA 94502
      (Lobby Hours: Tuesday, Wednesday, and Thursday, 9 am – 11 am and 2 pm – 4 pm)

If you have questions, or if you need help with this form, please contact:

Alliance Member Services Department, Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567** · Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**
www.alamedaalliance.org

SECTION 1: MEMBER INFORMATION

Last Name: _____ First Name: _____

Date of Birth (MM/DD/YYYY): _____ Alliance Member ID #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

If another person is filling out this form:

Name of Person Filing Grievance: _____ Phone Number: _____

Where Incident Occurred: _____ Date Incident Occurred: _____

Please describe the problem you had:

_____

How have you tried to resolve this problem?

_____

What do you think is a good solution to your problem?

_____

SECTION 2: SIGNATURE

Full Name (Print): _____

Signature: _____ Date: _____

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-510-747-4567** and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

Section 4

Provider Services

Health Center Medical Provider Credentialing

All medical providers working in CHCN health centers must be credentialed by Alameda Alliance for Health including volunteers, on-call, and specialty providers. Please notify CHCN immediately upon hire and submit all required credentialing materials to CHCN for new hires within 30 days. CHCN collects and submits credentialing materials for the following types of medical providers.

Physicians*:

- Medical Doctor (MD)
- Doctor of Osteopath (DO)

*Including volunteer, on-call, or specialty providers

Advanced Practice Professionals (APPs)*:

- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Certified Nurse Midwife (CNM)

*Contact CHCN about other providers, such as registered dieticians or chiropractors that are not credentialed with the health plan already.

Please submit all required credentialing materials and include a completed checklist for new hires within 30 days.

Submit the following forms for all PROVIDERS:

- CV
- CAQH Authorization and Release of Information to Designated Contacts
- Standard Authorization, Attestation and Release
- Disclosure and Attestation
- Proof of board certification
- Unlimited and full schedule DEA

Submit the following forms for all PHYSICIANS (DO and MD)

- Admitting Arrangement Form (for physicians without hospital privileges) OR Admitting Physician Verification Form (for physicians with hospital privileges)

Submit the following forms for all APPs (CNM, NP, and PA)

- Non-Physician Agreement to Standardized Procedures & Protocols
- Supervising Practitioner Verification Form

Health Center Behavioral Health Provider Credentialing

All behavioral health providers, including interns, must be credentialed by Alameda Alliance for Health. CHCN does not facilitate credentialing of behavioral health providers for the health centers. Please submit credentialing applications for behavioral health providers directly to the health plan.

If you have any questions regarding initial or re-credentialing for our health center providers with our health plan, please contact:

Email: credentialing@chcnetwork.org or
Call: 510-297-0271

You can find all forms and more information on CHCN Connect at:

https://connect.chcnetwork.org/Provider-Library/Credentialing

Termination Process for Contracted Specialists

If either party wishes to terminate the contracted agreement, the following terms must be met:

(a) a written notice given 90 calendar days prior to desired termination date, with or without cause.

(b) Forthwith by notice in writing to the other party if the other party materially breaches this Agreement in any manner and such material breach continues for a period of 15 business days after written notice is given to the breaching party specifying the nature of the breach and requesting that it be cured. As used herein "material breach" includes, without limitation, Physician's failure to fully comply with applicable laws and requirements, policies and procedures of CHCN and each HMO, and/or the failure to provide Specialist Services at agreed upon levels acceptable levels, as determined by CHCN in its sole discretion, of quality and accessibility.

(c) Immediately by CHCN upon written notice to Physician, if Physician's or Physician entity's: (i) license to practice medicine in any state is suspended or revoked; or, (ii) staff privileges at any hospital are revoked, suspended significantly (in the judgment of CHCN) reduced for any medical disciplinary cause or reason; or (iii) professional or general liability coverage as required under this Agreement is no longer in effect; or if Physician: (iv) is criminally charged with any act involving moral turpitude; or (v) no longer satisfies the credentialing standards of CHCN and each HMO; or (vi) is no longer eligible to participate in the Medi-Cal Program; or (vii) dies or suffers a disability that renders Physician unable to perform his/her responsibilities hereunder; or (viii) the credentialing information provided to CHCN or HMOs by Physician was materially false.

Primary Care Providers (PCPs) within the member health centers may not be subject to the terms above.

Member Access

Policy
The Community Health Center Network (CHCN) provides comprehensive medical care to eligible managed care patients within its provider network. Accessing primary and specialty care is clearly explained to new members in the Welcome Packet to new members.

Scope
All CHCN managed care patients and providers.

Procedure
Each health center within CHCN receives membership reports on a monthly basis listing all eligible managed care members for the current month. Health Centers identify patients who are new to their health center and to CHCN. These patients receive a health center welcome packet within 60 days. Welcome packets are particular to each clinic site and include the following information:

- Health Center's location and telephone number
- Hours of operation
- How to contact the health center after hours
- How to make an appointment
- Services available at the health center
- How referrals to specialists are made
- What to do in case of an emergency
- How to submit complaints

In addition, managed care patients new to the health center are sent cards requesting that they schedule an appointment for a new patient exam within 120 days or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.

Procedure: Access Oversight

Access Standards
CHCN supports the health plan with activities to monitor appointment availability using the Department of Managed Health Care Provider Appointment Availability survey tool for primary and specialty care providers. Providers must meet the following state standards:

- Access to PCP or designee 24 hours a day, 7 days a week
- Non-urgent primary care appointments available within 10 business days of request
- Non-urgent specialty care appointments available within 15 business days of request
- Urgent primary and specialty care appointments available within 48 hours of request

In addition, primary care providers are required to meet the following access standards even though they are not captured on the survey tool:

After Hours Care

- After hours care – all CHCN health centers are required to have an after-hours call system whereby members have 24 hour physician access
- After hour call answering services inform members how the caller may obtain urgent or emergency care including, how to contact another provider who has agreed to be on-call to triage or screen by phone or if needed, to deliver urgent or emergency care.

Interpretive Services

Medi-Cal managed care interpretive services are provided at no cost to the patient and available 24 hours a day, 7 days a week.

Alameda Alliance for Health:

Face-to-Face Interpreter Services

Call the Alliance Member Services department at **510-747-4567** or fax the Request for Interpreters Form to Alliance Member Services at **1-855-891-7172.**

The Alliance asks for **72 hours advance notice**. Same day requests may be possible for urgent situations.

Telephonic Interpreter Services

Call the Alliance's interpreter vendor, International Effectiveness Centers (IEC), at **1-866-948-4149.**

2020 Interpreter Services Provider Update

At Alameda Alliance for Health (Alliance), we appreciate our provider-plan partnership to ensure that your Alliance patients have access to quality interpreters for all health care services. This packet contains important updates to Alliance interpreter services. We are rolling these changes out in three (3) phases.

THIS PACKET INCLUDES:

- Letter from Scott Coffin, Alliance CEO
- Provider Alert regarding our new telephonic interpreter services vendor, CyraCom
- Interpreter Services Provider Guide
- Interpreter Services Request Form
- Point to Your Language Card
- I Speak Cards

PHASE	DESCRIPTION	LAUNCH DATE
1	**For all Alliance Providers –** Launch of new telephonic interpreter services vendor, CyraCom.	June 1, 2020
2	**First group** of Alliance clinics/providers will begin to follow the new guidelines for in-person interpreter services. - Community Health Center Network (CHCN) clinics - Beacon Health Options providers **All Alliance providers** will need to submit requests for in-person interpreters Services five (5) business days in advance.	July 1, 2020
3	**Second group** of Alliance providers will follow the new guidelines for in-person interpreter services. - Children's First Medical Group - Alameda Health System - All other directly contracted clinics and providers	October 1, 2020

Questions? Below are ways that you can contact us for questions related to Alliance interpreter services:

- Contact the Health Education Manager:
  Linda Ayala
  Phone Number: **1.510.747.6038**
  Email: **layala@alamedaalliance.org**
- Call our Provider Call Center:
  Monday – Friday, 7:30 am – 5 pm
  Phone Number: **1.510.747.4510**
- Visit the provider section of our website:
  www.alamedaalliance.org/providers/provider-resources/language-access

June 22, 2020

Re: Interpreter Services for Alameda Alliance for Health Members

Dear Alliance Provider Partner,

At Alameda Alliance for Health (Alliance), we appreciate our dedicated provider community and the quality health care that you provide to our members. We understand that interpreter services are key to helping provide excellent care to our diverse membership. Almost 40% of our members prefer to communicate in a language other than English, and at many of our partner clinics, that percentage is significantly higher.

Over the next year, we will be moving most of our interpreter services from in-person to on-demand telephonic interpreting. We anticipate that increasing on-demand telephonic services will lift a significant administrative burden for you and your office staff. Telephonic interpreting services has the advantage of immediate access, and in most cases, there is no need to preschedule or confirm appointments.

To support this change, we will have a new vendor for telephonic interpreter services – CyraCom. They have specialized in health care interpretation for more than 25 years and provide on-demand services in over **230** languages.

Our planned on-demand telephonic interpreter services rollout date for Community Health Center Network (CHCN) and Beacon Health Options is Wednesday, July 1, 2020. For Children First Medical Group (CFMG), Alameda Health System (AHS) and all directly contract providers, the effective date is Thursday, October 1, 2020. In-person interpreter services will still be available for American Sign Language (ASL) and sensitive or complex health care visits. For in-person interpreters, providers will still need to complete an *Interpreter Services Appointment Request Form*, and fax it directly to the Alliance at least **five (5) business days** before the appointment.

In this packet you will find our updated instructions for accessing interpreter services. Please note the implementation date. If you have any questions, please contact our project lead:

Linda Ayala, MPH, Health Education Manager
Phone Number: **1.510.747.6038**
Email: **layala@alamedaalliance.org**

We remain committed to ensuring that our members have access to quality interpreter services at each health care encounter, and look forward to our continued partnership.

Sincerely,

Scott Coffin
Chief Executive Officer
Alameda Alliance for Health

Important Update Starting Monday, June 1, 2020: New Alliance On-Demand Telephonic Interpreter Services Vendor CyraCom

At Alameda Alliance for Health (Alliance), we value our dedicated provider partners and appreciate all of the hard work you do to protect the health and wellbeing in our community. We are excited to announce our new on-demand vendor for interpreter services, CyraCom.

Starting Monday, June 1, 2020, the Alliance will partner with CyraCom to provide on-demand telephonic interpreter services for our members. CyraCom has specialized in health care interpretation for more than 25 years and provides services in over 230 languages.

Telephonic interpreter services is the fastest and most efficient way to obtain an interpreter. To access services, please call **1.510.809.3986** and follow the prompts. This is the same phone number that we have always had for telephonic interpreter services.

The automated system will request the following:

1. **The PIN number for the network you are contracted with:**
    - If you are a **CHCN** provider – **1001**
    - If you are a **CFMG** provider – **1002**
    - If you are a **Beacon** provider – **1003**
    - If you are an **Alliance** provider – **1004**
2. **A number to request the language you need:**
    - For Spanish – press **1**
    - For Cantonese – press **2**
    - For Mandarin – press **3**
    - For Vietnamese – press **4**
    - For all other languages – press **0**
3. **The member's 9-digit Alliance Member ID number.**

Requesting an interpreter for Telehealth: CyraCom also offers interpretation for telehealth visits! When you are ready to connect to an interpreter, please call **1.510.809.3986**. Follow steps 1-3 above, and provide the telehealth phone number and log in information. The interpreter will then call in to join your telehealth visit.

For more information on interpreter services, including how to schedule American Sign Language (ASL), telephonic interpretation for less common languages, or in-person services, please contact:

Alliance Provider Services Department Phone Number:
1.510.747.4510
www.alamedaalliance.org/providers/provider-forms

At Alameda Alliance for Health (Alliance), we are committed to continuously improve our provider and member customer satisfaction. The Alliance provides no-cost interpreter services including American Sign Language (ASL) for all Alliance covered services, 24 hours a day, 7 days a week.

Effective Monday, June 1, 2020, please use this guide to better assist Alliance members with language services. Please confirm your patient's eligibility before requesting services.

TELEPHONIC INTERPRETER SERVICES

Common uses for telephonic interpreter services:

- Routine office and clinic visits.
- Pharmacy services.
- Free standing radiology, mammography, and lab services.
- Allied health services such as physical occupational or respiratory therapy.

To access telephonic interpreters:

1. Please call **1.510.809.3986**, available 24 hours a day and 7 days a week.
2. Provide the nine-digit Alliance member ID number.
3. For communication with a patient who is deaf, hearing or speech impaired, please call the California Relay Service (CRS) at **7-1-1.**

IN-PERSON INTERPRETER SERVICES

Members can receive in-person interpreter services for the following:

- Sign language for the deaf and hard of hearing
- Complex courses of therapy or procedures, including life-threatening diagnosis (Examples: cancer, chemotherapy, transplants, etc.)
- Highly sensitive issues (Examples: sexual assault or end of life)
- Other conditions by exception. Please include your reason in the request.

To request in-person interpreters:

1. You must schedule in-person interpreter services at least **five (5) business days** in advance. For ASL, **five (5) days** is recommended, but not required.
2. Please complete and fax the **Interpreter Services Appointment Request Form** to the Alliance at **1.855.891.9167**. To view and download the form, please visit **www.alamedaalliance.org/providers/provider-forms**.
3. The Alliance will notify providers by fax or phone if for any reason we *cannot* schedule an in-person interpreter.
4. If needed, please cancel interpreter services at least **48 hours** prior to the appointment by calling the Alliance Provider Services Department at **1.510.747.4510**.

PLEASE NOTE:
The Alliance discourages the use of adult family or friends as interpreters. Children should not interpret unless there is a life-threatening emergency and no qualified interpreter is available. If a patient declines interpreter services, please document the refusal in the medical record.

Questions? Please call Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone number: **1. 510.747.4510**

Interpreter Services Request Form

At Alameda Alliance for Health (Alliance), we provide no-cost interpreter services including American Sign Language (ASL) for all Alliance covered services, 24 hours a day, 7 days a week. Please confirm your patient's eligibility before requesting services. Please complete this form to request interpreter services.

INSTRUCTIONS

1. Please print clearly, or type in the fields below.
2. Forms must be submitted by fax at least **five (5) working days** prior to the appointment date. For ASL, **five (5) working days** is recommended, but not required.
3. Please return form by fax to the Alliance at **1.855.891.9167**.

For questions, please call the Alliance Provider Services Department at **1.510.747.4510**.

SECTION 1: PATIENT INFORMATION

Full Name: _____ Alliance Member ID #: _____

Date of Birth (MM/DD/YYYY):_____ Phone Number: _____

SECTION 2: INTERPRETER SERVICE TYPE (CHECK ONLY ONE TYPE OF SERVICE)

☐ Telephone Interpreting by Appointment ☐ In-Person Interpreting

☐ Video Interpreting by Appointment *(if available at clinic location)*

Language: _____ Special Requests (optional): _____

SECTION 3: APPOINTMENT DETAILS

For in-person appointments, please include address information.
For prescheduled video or telephonic appointments, please provide call-in information and/or link.

Date (MM/DD/YYYY): _____ Start Time: _____ Duration: _____ Provider

Name: _____ Provider Specialty: _____ Address

(*include dept./floor/suite)*: _____ City:

State: _____ Zip Code: _____

Call-In Information/Link: _____

Please complete if requesting an in-person interpreter: What is the nature of the request?

☐ Complex course of therapy or procedure including life-threatening diagnosis *(Examples: cancer, chemotherapy, transplants, etc.)*

☐ Highly sensitive issues (*Examples: sexual assault, abuse, end-of life, etc.*)

☐ Other condition *(please include justification)*:

SECTION 4: REQUESTOR INFORMATION

Name: _____ Phone

Number: _____ Date (MM/DD/YYYY): _____

Telephonic interpreter services are available for Alliance members at anytime, 24 hours a day, 7 days a week without an appointment by calling **1.510.809.3986**. To view and download this form, please visit **www.alamedaalliance.org/providers/provider-forms**.

"I SPEAK" CARDS

FOR ALLIANCE MEMBERS

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We are committed to continuously improving our provider and member customer satisfaction.

The Alliance has created "I Speak" cards as a resource for our provider partners and members to use during doctor visits. This resource includes information to help Alliance members get an interpreter for their health care visits. Alliance members can show the card to your office staff to let them know what language they speak. It also has instructions on how your office can contact the Alliance to get an interpreter.

Furthermore, you can help your patients if you are sending them to receive other services such as laboratory or radiology. The "I Speak" card will let the medical office staff know how to call an interpreter for your patient. Alliance telephonic interpreters are available 24 hours a day, 7 days a week at **1.510.809.3986**.

INSTRUCTIONS

1. Please fill in the member's preferred language.
2. Ask the patient to show the card to the health care provider for help in their language.

Please see back to view samples of the "I Speak" card.

To request a supply of "I Speak" cards, please email Alliance Health Programs at **livehealthy@alamedaalliance.org**. Please provide your name, clinic, mailing address, phone number, and quantity needed for each language. I speak cards are available in English, Spanish/English, Chinese/English and Vietnamese/English.

Thank you for partnering with us to ensure that our members are receiving care in their language!

ALAMEDA Alliance FOR HEALTH

Questions? Please call Alliance Health Programs
Monday - Friday, 8 am - 5 pm
Phone Number: **1.510.747.4577**
www.alamedaalliance.org

SAMPLES OF "I SPEAK" CARDS*

ENGLISH CARD - USE FOR ANY LANGUAGE

Front

ALAMEDA Alliance FOR HEALTH

I Speak: _____

PLEASE CALL AN INTERPRETER.
Thank You.

Back

Providers: To request a phone interpreter on demand, please call **1.510.809.3986**.

Alameda Alliance for Health (Alliance) members can receive interpreter services for covered health care services.

Please have the member ID ready.

Members: For any questions, please call the Alliance Member Services Department at **1.510.747.4567**.

BILINGUAL CARD - AVAILABLE IN SPANISH, CHINESE AND VIETNAMESE

Front

ALAMEDA Alliance FOR HEALTH

I speak Spanish

PLEASE CALL AN INTERPRETER.
Thank you

Back

Providers: To request a phone interpreter on demand, please call **1.510.809.3986**.

Alameda Alliance for Health (Alliance) members can receive interpreter services for covered health care services.

Please have the member ID ready.

Members: For any questions, please call the Alliance Member Services Department at **1.510.747.4567**.

Inside

ALAMEDA Alliance FOR HEALTH

Yo hablo español

LLAME A UN INTÉRPRETE.
Gracias.

Proveedores: Para solicitar el servicio de interpretación por teléfono por encargo, llame al **1.510.809.3986**.

Los miembros de Alameda Alliance for Health (Alliance) pueden recibir servicios de interpretación para los servicios de cuidado de la salud cubiertos.

Tenga a la mano su número de identificación del miembro.

Miembros: Si tiene alguna pregunta, llame al Departamento de Servicios al Miembro de Alliance al **1.510.747.4567**.

*Actual "I Speak" Cards are standard business card size.

Point to your language. We will get you an interpreter.

Arabic ةيبرعلا ةغللا كنغل بلا رشأ لاح مجرتملا بدانتسو	Laotian
Cambodian ភាសាខ្មែរ sUmcgðúúlPasarbs´Gñk eylgnWgehAGñkbkERbmkCUn	Mam Mam Yectz tyola. K,o co jel yolon tejun xal toj tell tyola.
Cantonese 廣東話 請指認您的語言 以便為您請翻譯	Mandarin 國語 請指認您的語言 以便為您請翻譯
Dari یرد ؟ببنز یم پگ نابز مادک هب امش دیآ یم نامجرت کي.	Mien Mienh Nuqv meih nyei waac mbuox yie liuz, yie heuc faan waac mienh bun meih oc.
Eritrean	Pashto وټښپ هنیپ هبژ هلچخ. رکو یربخ هرسرد نامجرت هب رژ.
Ethiopian	Punjabi pMjwbI ApxI bolI ieSwry nwl dso [quhwfy vwsqy pMjwbI bolx vwlw bulwieAw jweygw [
Farsi یسراف بنک هراشا بنک یم تبحص هک ینابز هب، میروآ یم مجرتم امش یارب.	Russian Русский Язык Укажите, на каком языке Вы говорите. Сейчас Вам вызовут переводчика.
Hindi ihNdI ApnI BwSw eSwry sy idKweXy [Awpky iIE duBwiSXw bulwXw jwEygw [	Spanish Español Señale su idioma. Se llamará a un intérprete.
Hmong Hmoob Thov taw tes rau koj yam lus. Peb yuav hu ib tug neeg txhais lus rau koj.	Tagalog Tagalog Ituro mo ang iyong wika. Matatawagan ang tagapag-salin.
Indonesian Bahasa Indonesia Tunjukkan bahasamu. Jurubahasa akan disediakan.	Thai ภาษาไทย ช่วยชี้ให้เราดูหน่อยว่า ภาษาไหนเป็นภาษาที่ท่านพูด แล้วเราจะจัดหาล่ามให้ท่าน
Japanese 日本語 あなたの話す言語を指で、示してください。 通訳をお呼びします。	Urdu ودرا نوک پآ یس ؟یگنیرک دنسپ انرک ٹاب نیم نابز اگ ےیاج ایلاب وک نامجرت یک یہپآ ےلیک ددم یک پآ.
Korean 한국어 당신이 쓰는 말을 지적하세요. 통역관을 불러 드리겠어요.	Vietnamese Tiếng Việt Chỉ rõ tiếng bạn nói. Sẽ có một thông dịch viên nói chuyện với bạn ngay.

ALAMEDA Alliance FOR HEALTH

Transportation Services

Medi-Cal transportation services are provided when medically necessary at no cost to the patient. Transportation benefits are managed by the Medi-Cal health plan, Alameda Alliance for Health (AAH).

Medical transportation is allowed to transport members to medically necessary services, including to pick-up prescription drugs that cannot be mailed and other medical supplies, prosthetics, orthotics, and equipment. There are two types of transportation services: non-medical transportation (NMT) and non-emergency medical transportation (NEMT). Both are described below.

Effective October 1, 2017, transportation is also allowed for any medically necessary Medi-Cal benefits, including services not covered directly by the managed care plan, such as specialty behavioral health and dental services.

Additional information can be found in the All Plan Letter from Department of Health Care Services at http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

Non-Medical Transportation (NMT)

Modalities:

- Taxi, public transit, East Bay Paratransit, private vehicle mileage reimbursement
- The least costly method of transportation that meets the member's needs will be provided.
- NMT is available to members using a wheelchair so long as the member can ambulate without assistance from the driver.

NMT does not require provider certification. Members may request NMT by contacting LogistiCare directly for Alameda Alliance for Health. If a provider wishes to request NMT on behalf of the member, they may do so using the Physician Certification Statement (PCS) Form, attached.

- AAH LogistiCare 866-791-4158

Non-Emergency Medical Transportation (NEMT)

NEMT is covered only when a recipient's medical and physical condition does not allow that recipient to travel by bus, passenger car, taxicab, or another form of public or private conveyance. Criteria are as follows:

- NEMT is provided to members who cannot reasonably ambulate, stand, or walk without assistance, including those using a walker or crutches for medically necessary covered services.
- NEMT is required when the member cannot take ordinary public or private means due to medical and physical condition and when transportation is required for obtaining medically necessary services.
- Plans must ensure door-to-door assistance for members receiving NEMT services, and plans must provide transportation for a parent or guardian if the member is a minor.

Modalities:

1. **Ambulance Services**
    - Transfers between facilities for members who require continuous intravenous medication, medical monitoring, or observation.

- Transfers from an acute care facility to another acute care facility except when member is transferred immediately following an inpatient stay to a skilled nursing facility or intermediate care facility.
- Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
- Transport for members with chronic conditions who require oxygen if monitoring is required.

2. **Litter Van Services**
    - Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport.
    - Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs, or other forms of public conveyance.
3. **Wheelchair Van Services**
    - Renders the member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport.
    - Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle, and place of treatment because of a disabling physical or mental limitation.
    - Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs, or other forms of public conveyance.

    Members with the following conditions may qualify with a Physician Certification Statement:

    - Members who suffer from severe mental confusion
    - Members with paraplegia
    - Dialysis recipients
    - Members with chronic conditions who require oxygen but do not require monitoring.
4. **Air** – only when ground transport is not feasible.

How to Request NEMT

Effective July 1, 2017, both health plans require a Physician Certification Statement (PCS) Form to request NEMT services.

- A physician, advanced practice professional, dentist, or mental health provider may request NEMT services using the health plan's Physician Certification Statement (PCS)
- For AAH members, submit the PCS request form directly to LogistiCare

Attachments

AAH PCS Form

Physician Certification Form – Request for Non-Emergency Medical Transportation (NEMT)

Please complete the Alameda Alliance for Health (Alliance) Physician Certification Form – Request for Non-Emergency Medical Transportation (NEMT) Form to request NEMT services for Alliance members. NEMT includes transportation by ambulance, wheelchair, and gurney vans for medically necessary covered services, specifically when the patient is non-ambulatory. All NEMT trips include door-to-door service.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below.
2. Please complete the form and fax or email it to:

   Alameda Alliance for Health
   ATTN: Case and Disease Management Department – Request for Transportation
   Fax Number: **1.510.747.4130**
   Email: **DeptCMDM@AlamedaAlliance.org**

Questions? Please call Alliance Case Management Department at **1.510.747.4512.**

PLEASE NOTE: A PCS form is only required to request NEMT services. A PCS form is not required for non-medical transportation (NMT) level services such as a bus, taxi or car. To request and schedule NMT services, Alliance members can call Alliance Transportation Services toll-free at **1.866.791.4158.**

SECTION 1: MEMBER INFORMATION

Last Name: _____ First Name: _____

Date of Birth (MM/DD/YYYY): _____ Alliance Member ID #: _____

Phone Number: _____ ☐ Home ☐ Cell

SECTION 2: TRANSPORTATION NEEDS

Non-emergency medical transportation (NEMT) request *(please select only one (1) level of service):*

- ☐ Air transport (additional verification information needed for approval)
- ☐ Ambulance (including basic life support (BLS), advanced life support (ALS), critical care transport (CCT), specialty care transport (SCT), bariatric patients, and patients who require oxygen not self-administered or regulated)
- ☐ Litter van/gurney van (for bedbound patients, including bariatric patients)
- ☐ Wheelchair van (including bariatric patients)

SECTION 2: TRANSPORTATION NEEDS (cont.)

Duration *(from date of signature below)*:

- ☐ 3 months
- ☐ 6 months
- ☐ 9 months
- ☐ **12 months (max duration)**
- ☐ Other: _____

SECTION 3: FUNCTION LIMITATIONS JUSTIFICATION

Please describe the member's specific physical and medical limitations that prevent the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles *(please select only one (1)*:

- ☐ Member is a dialysis recipient
- ☐ Member has leg weakness, mobility limitations or fall risk
- ☐ Member has severe mental confusion
- ☐ Other, please describe:

SECTION 4: CERTIFICATION FOR NON-EMERGENCY MEDICAL TRANSPORTATION

The provider who is responsible for providing care for the member is responsible for determining the medical necessity for transportation. This certificate can be completed and signed by an MD, DO, PA, NP, CNM, physical therapist, speech therapist, occupational therapist, or mental health or substance use disorder provider who is employed or supervised by a hospital, facility, or physician's office where the patient is being treated and who has knowledge of the patient's condition at the time of completion of this certificate, except for requests relating to hospice or home health services, which must be signed by an MD or DO.

Provider Last Name: _____ Provider First Name: _____

Provider Credential:_____ Phone Number: _____

Signature: _____ Date: _____

Electronic Consults for CHCN Health Center Providers

What is RubiconMD?

Community Health Center Network (CHCN) contracted with RubiconMD to provide electronic consults to all primary care providers (PCP) in CHCN's network. RubiconMD offers a **secure, web-based platform and smartphone application** for PCPs to submit specialty consultations prior to referring a patient for a specialty visit, much like a curbside consult. PCPs use RubiconMD as a tool for informal **peer-to-peer** discussion with specialists in order to **improve specialty referrals**. Providers can easily upload documents, labs, tests, clinical notes, and images from the electronic health record to RubiconMD's platform for quick and efficient consultation.

How does Econsult improve member care and save time and money?

Each CHCN provider has **unlimited** access to specialty consults and use of the platform. RubiconMD offers more than **105 specialty types**, including high-demand specialties such as dermatology, cardiology, and a variety of pediatric sub-specialties. Consulting with specialists from RubiconMD's network *prior* to referring the patient to a local specialist **reduces unnecessary referrals** and allows providers to manage the member's care. The average specialist **response time is between 2.5 and 4 business hours** on RubiconMD, a significant improvement from specialty appointments wait times of 2 weeks or more.

Partnership with Alameda Health System

Beginning in September 2016, CHCN partnered with **specialists from Alameda Health System** (AHS) to provide electronic consults in the following specialty areas, depending on provider availability:

Cardiology	Endocrinology	Gastroenterology	Neurology
Pulmonology	Rheumatology	Urogynecology	Urology

Opportunities for a "virtual curbside" with an AHS specialist will enhance CHCN and member health centers' relationships with **mission-aligned** colleagues at AHS. If an in-person consult is needed, providers may refer to AHS specialists or another provider of their choice in the network.

For more information about CHCN's electronic consult program, please contact Provider Services at providerservices@chcnetwork.org

CHCN Connect Provider Portal

Community Health Center Network's (CHCN) Connect is a secure online portal to access CHCN managed care information and various services. You must be a registered and authorized user to gain access. CHCN partners can use Connect to securely access the following information:

- Download remittance advice (RA, EOB)
- CHCN member eligibility
- Claims and payment status
- Prior authorization submissions and status
- Contracted specialty provider look up
- CHCN resources

As of **November 2023**, CHCN no longer accepts free-mail for account registrations. User would need to create an account using a business email domain. It is encouraged that management registers as the local admin since there can only be one local admin per group.

CHCN Connect Web Address is: https://connect.chcnetwork.org/

To register a new account as a local admin, please ensure to provide the following information:

- First Name
- Last Name
- Phone Number
- Group Name
- Tax ID
- Organization NPI

CHCN will notify the local admin via email when the account is set up.

For any questions, contact CHCN Customer Care department at 510-297-0480 or by email at portalsupport@chcnetwork.org.

For additional resources, including training on CHCN Connect at:
https://connect.chcnetwork.org/Connect-HowTo

Section 5

Care & Utilization Management

Overview

CHCN's Care Management department includes Utilization Management (UM) and Case Management (CM) systems which ensure the delivery of efficient, high quality, cost effective health care and services to our members. Our UM department reviews and processes requests for both prior and concurrent authorizations for both outpatient and inpatient services. CHCN collaborates with both contracted and non-contracted providers to authorize timely, appropriate, care and services. CHCN serves as a delegate to Alameda Alliance for Health. We ensure that all members are treated equally and that the same standards of care are met for all members assigned by the Health Plan.

The CHCN Utilization Management department personnel consists of peer reviewers, licensed health care professionals, and unlicensed support staff, qualified to make decisions on provider requests for service authorizations. Authorization decisions are based on member eligibility, benefit coverage, and medical necessity. CHCN only allows a licensed physician to deny, or modify requests for authorization of health care services for reasons of medical necessity.

CHCN uses the following references to make requested authorization determinations, as applicable to the member's insurance coverage:

- Medi-Cal policy guidelines
- Alameda Alliance medical coverage polices
- MCG® Care Guidelines (nationally recognized evidence-based guidelines)

Inter-rater Reliability (IRR) Testing and UM file review is conducted at least annually to assess determinations made by UM staff, including Medical Directors and physician reviewers, to evaluate the consistency in applying medical criteria. If the report findings indicate there is inconsistency in criteria application, corrective education and/or individual action plans are implemented in an effort to improve consistency.

Providers may contact the CHCN UM department to request a copy of the medical coverage policy criteria used to make an authorization decision.

CHCN has an appropriate practitioner reviewer available to discuss all UM denial decisions with the requesting provider. Providers may contact the UM department to discuss non-behavioral health UM denial decisions with a physician, or other appropriate reviewer. UM staff is available at least eight (8) hours a day during normal business hours **(Monday – Friday, 8:30 a.m. – 5:00 p.m.)**, on normal business days (**work days, excluding weekends and holidays)**, to receive inbound communications regarding UM issues. Communications from members and providers can be received via mail, fax, electronic and telephone communications, including voicemail. You may reach the UM department by calling (510) 297-0242 and request to speak to the Medical Director and/or Chief Medical Officer.

UM Fax: (510) 297-0222 UM email: umcod@chcnetwork.org

After business hours, you may leave a message at (510) 297-0242 and a UM staff member will call you the next business day.

The CHCN UM department notifies providers and members of all UM decisions. Members and providers receive notification regarding authorization decisions to deny, delay (defer) or modify a request for care or services. Providers are notified via portal, fax, and letter notification within one (1) to two (2) business days of the authorization decision. Members who have questions about their letter notification may call our Customer Care department at (510) 297-0200 for assistance. Members who are deaf or have other hearing impairments may call 7-1-1 or toll free 1-800-735-2929 for hearing and language assistance.

Affirmative Statement

CHCN does not make decisions regarding hiring, promoting or terminating its provider/practitioners or, other individuals based upon the likelihood or perceived likelihood that the individual will support or, tend to support the denial of benefits. Utilization Management decisions are based solely on appropriateness of care and service and the existence of coverage. There are no rewards or incentives for providers/practitioners or other individuals for issuing denials of coverage, service or care. There are no financial incentives for utilization management decision-makers to encourage decisions that would result in underutilization of care or services. Our providers/practitioners are ensured independence and impartiality in making authorization decisions that will not influence:

- Hiring
- Compensation
- Termination
- Promotion
- Any other similar matters

COMMUNITY HEALTH CENTER NETWORK

Please Don't Handwrite!
Type in the data and fax from your system. You can save the PDF file. All **bolded fields** are required.

Authorizations are contingent upon member's eligibility, medical necessity, and covered services, and are not a guarantee of payment. The provider is responsible for verifying member's eligibility on the date of service. Procedure must be a covered benefit. REMAINING BALANCE MAY NOT BE BILLED TO THE PATIENT.

Please verify eligibility using either: Web: https://connect.chcnetwork.org or CHCN Customer Services: (510) 297-0220.

TYPE OF REQUEST (please select only one):

- ☐ **Routine** Approval based on CHCN clinical review. CHCN has up to 5 business days to process routine requests.
- ☐ **Urgent** Inappropriate use will be monitored. CHCN has up to 72 hours to process urgent requests for all lines of business.
- ☐ **Retro** Please provide the date of service(s) (DOS) rendered. Submission timeframe from DOS: Elevance Health (ABC) 30 calendar days and 90 calendar days for AAH. CHCN has up to 30 calendar days from the date of receipt of the request to process the request.
- ☐ **Modification** Request for existing authorized services. Please enter the CHCN Auth Number and the Member information below. Use a separate sheet to specify your changes or to attach additional supporting documentation.

If Mod, CHCN AUTH #:

REQUESTING PROVIDER

Name:	
Address:	
City: State: Zip:	
NPI #:	TIN #:
Office Contact:	
Phone:	**Fax:**
Email:	

MEMBER (For newborn services provide mother's information and check newborn fields below)

First Name:	**Health Plan ID#:**
Last Name:	☐ Newborn? DOB:
Date of Birth:	Phone:
Address:	Other Insurance (i.e. Commercial, Medicare A, B):
City: State: Zip:	

PLACE OF SERVICE: (Must check only one box)

☐ **Inpatient** ☐ **Outpatient** ☐ **Doctor's Office** ☐ **Ambulatory Surgical Center** ☐ **DME** ☐ **HHA**

AUTHORIZE TO

Name/Facility:		Phone:
Specialty/Dept:		Fax:
NPI #:	TIN #:	Address:
Anticipated Date of Service:		City: State: Zip:

☐ Non-Contracted. Please **do not enter general comments** here. Only give reason for out of network provider request.

DIAGNOSES / SERVICE CODES **Only enter the code, modifier, and quantity. Do not enter text.**

ICD Code(s):									

CPT/HCPCS	Mod	**Qty**	CPT/HCPCS	Mod	Qty	CPT/HCPCS	Mod	Qty	CPT/HCPCS	Mod	Qty

COMMUNITY HEALTH CENTER NETWORK

CHCN Prior Authorization Request form is now a fillable PDF form that you can use to type in your information and then print. All fields that are marked in **"Bold"** are mandatory. Please submit an electronically completed form with all the required information to help us service your request faster. The following table provides information regarding expected information in some of the key fields.	
Request Type	Please check only one of the four boxes provided. CHCN follows the turnaround times for authorization processing as establish by regulations and the health plans. **NOTE:** 'Modification' requests are considered as 'Routine' requests.
Requesting Provider	Please enter information for your practice. For convenience you can type in your information once and then save the file for future use.
Name	Please enter provider name (First name Last name).
NPI#	Please enter the NPI number of the provider.
Office Contact	Please enter name of the office contact (First Name Last Name). CHCN staff will communicate with this person if needed.
If Mod, CHCN Auth #	If you are requesting modification for an existing authorization please enter the authorization number provided to you so that we can uniquely identify your record. Please specify member information in the form as well. Include your modification request on a separate sheet of paper.
Member	Please enter CHCN member information. **NOTE:** If the requested service is for a newborn please enter mother's member information below. Newborn care is covered under mothers' benefit plan during the birth month and one month after that.
First Name	Please enter CHCN member's first name.
Last Name	Please enter CHCN member's last name.
Date of Birth	Please enter member's date of birth in MM/DD/YYYY format.
Health Plan ID #	Please enter member's Health Plan ID #.
Newborn	Please check this if the authorization request is for a newborn child.
DOB	Please enter new born child's date of birth in MM/DD/YYYY format.
Other Insurance	If the member has other insurance coverage please mention insurance id.
Place of Service	For all future elective procedures please check 'Inpatient'. For other services check appropriately. For home health services please check 'HHA'.
Authorize To	Please enter information about the provider (or facility) that you are requesting authorization for.
Name / Facility	Please enter name (First Name Last Name) of the provider you are authorizing in the request. If you do not know the name please enter the facility information (e.g. UCSF).
Specialty / Dept	Please enter Specialty of the provider or the department if you have entered a facility name above.
NPI #	Please enter the NPI number of the requested provider if available.
Anticipated Date of Service	Please enter the date of service if known. This will help CHCN to verify if the patient is eligible for that service on this date.
Non-contracted	Please check if the provider is not within CHCN contracted provider network
Reason	If you have selected non-contracted provider please enter the reason for requesting an out of network provider. (The reason could be unavailability of the particular specialty within CHCN network).

Diagnoses / Service Code	Please enter ICD-10 codes for diagnoses and CPT/HCPCS codes for request service / equipment / supplies
Diagnoses	Please enter ICD-10 codes to describe diagnoses. At least one code is required for us to process your request. You can enter up to nine diagnoses codes on the form. If you need to enter more than nine please enter your first nine codes and then attach a separate sheet with the rest of the codes.
CPT / HCPCS code	Please enter CPT (or HCPCS) codes for procedures (or equipment/supplies) that you are requesting authorization for. At least one code is required. You can enter up to twelve codes on this form. If you need to enter more than 12 codes please enter your first twelve codes on this form and then attach a separate sheet with the rest of the codes.
Mod	Please enter modifier for the CPT code if applicable. If you have multiple modifiers for one CPT / HCPCS code please enter each modifier in a separate line.
Qty	Please enter number of units of service (or equipment / supplies) requested. For every CPT /HCPCS code you enter you are required to provide associated quantity.

Authorization Requirements

Benefit coverage requirements are applicable to all members and all lines of business. Providers must verify a member's health plan/CHCN eligibility.

Prior Authorization Grid
https://portal.chcnetwork.org/UM-Authorizations-Resources

If a rendering provider (the provider who rendered care to a patient) does not receive an authorization approval number from CHCN, claims may not be reimbursed.

CHCN will only accept prior authorization requests from the treating physician who determined medical necessity for the services or procedure. The "treating physician" is defined as the primary care or specialty clinician who is currently providing care to the member. CHCN does not accept prior authorization requests from rendering providers who are not primary care or specialty clinicians. CHCN will cancel and return any prior authorization request from a submitting provider who is not the treating clinician.

Authorization of Prescription Drugs

All providers must use the new universal Prescription Drug Prior Authorization Request (PAR) Form when requesting authorization for prescription injectable/infusion drugs which require prior authorization.

Prescription Drug Prior Authorization Form:
https://portal.chcnetwork.org/Portals/9/PA-AUTH-Form.pdf

RETRO-Authorizations

All required authorizations for care and services should be submitted to CHCN prior to services being rendered. CHCN accepts authorizations submitted less than 30 days after the date(s) of service(s) on a case by case basis. Generally, retrospective reviews will be considered when:

1. Member eligibility was not accurately identified at time of service
2. Medically necessary service was rendered in an emergent or urgent situation

To initiate the retrospective review process, providers are requested to submit a CHCN Authorization Request form and mark the request as "Retro." CHCN will review the request within the 30 calendar day allowable timeframe and issue a formal Notice of Action following the review. Should the provider not agree with our decision, they may request a formal appeal with the health plan Grievance and Appeals department for reconsideration.

Retrospective Review Prior Authorization Policy:
https://portal.chcnetwork.org/Portals/9/RetrospectiveReviewPriorAuthPolicy.pdf

Authorization of Gender Confirmation Surgical Services

CHCN requires documentation of a behavioral health (BH) evaluation in order to prior authorize gender confirmation surgical services. Gender confirmation services are defined as surgical procedures that changes a person's physical appearance and function from his/her existing sex

characteristics, including secondary sex characteristics, to resemble that of the opposite sex in order to affirm his/her gender identity. In order to make it easier to document the BH evaluation, providers may utilize CHCN's standard form, which can be found on the portal. Behavioral health providers may submit this form or a narrative statement documenting responses to all items on the attached form. CHCN will not authorize gender confirmation surgical services without documentation of a behavioral health evaluation.

The behavioral health evaluation must be performed by a provider with appropriate training:

- Master's degree or its equivalent in a clinical behavioral science field by an accredited institution; or
- Doctor of medicine or osteopathy, specializing in psychiatry and/or PhD in clinical behavioral science field by an accredited institution; or
- Licensed Psychiatrist; and
- Up-to-date clinical license; and
- Training, continuing education, and experience working with the diagnosis and treatment of Gender Dysphoria

- Nationally recognized medical/clinical guidelines will be used to review requested services from transgender members and those standards are applied consistently across the population.

CHCN requires documentation of a behavioral health (BH) evaluation in order to prior authorize gender confirmation surgical services. Gender confirmation services are defined as surgical procedures that changes a person's physical appearance and function from his/her existing sex characteristics, including secondary sex characteristics, to resemble that of the opposite sex in order to affirm his/her gender identity. In order to make it easier to document the BH evaluation, providers may utilize CHCN's standard form, which can be found on the portal. Behavioral health providers may submit this form or a narrative statement documenting responses to all items on the attached form. CHCN will not authorize gender confirmation surgical services without documentation of a behavioral health evaluation.

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- Doctor of medicine or osteopathy, specializing in psychiatry and/or PhD in clinical behavioral science field by an accredited institution; or
- Licensed Psychiatrist; and
- Up-to-date clinical license; and
- Training, continuing education, and experience working with the diagnosis and treatment of Gender Dysphoria

Therapist Documentation Form for Evaluation of Transgender Surgery

Client's name:
Legal name:
Date of Birth:

Clinician's name:

Clinician's title and license:

Please describe your experience completing assessments for gender related surgeries:

For which surgery or surgeries are you referring your client? (Please select all that apply)

Orchiectomy	Penectomy	Vaginoplasty
Hysterectomy/Oophorectomy	Phalloplasty	Metoidioplasty
Feminizing mammoplasty (breast augmentation)		Subcutaneous mastectomy
A surgery not listed here. Please describe:		

Please list the dates you evaluated this client for readiness and appropriateness for surgical intervention:

Which current or previous medical and/or mental health providers did you speak with in your evaluation?

Please give a description of this client, identifying characteristics, their history of gender dysphoria, and their attempts to address their gender dysphoria.

Please indicate the length of time your client has taken hormones and their response to hormones.

For patients considering gender conforming surgery, the standards of care state that the patient must have at least 12 continuous months of living in a gender role that is congruent with their gender identity. Please describe how the client has met this standard.

Does this client have the capacity to give informed consent for the requested surgery? If no, please explain.

Are there any issues the surgeons need to know about regarding communication? These could include English fluency, hearing impairments, an autism spectrum disorder, literacy level, learning differences, etc.

Please document the specific impairment that will be addressed by the proposed procedure. How will this particular surgery improve your client's functioning? How will it make their life better? Please include the client's words if applicable.

Do you have any hesitation or concern that the client may regret or not benefit from this surgical intervention?

Please give a brief description of your client's mental health history, including suicidality, homicidality, a history of violence towards healthcare workers, any psychiatric hospitalizations, and residential treatment for mental health or substance abuse.

Please list all current and past DSM Diagnoses:

Please list all medications that the client is currently taking related to psychological concerns, sleep, or emotional problems. (This should include supplements, such as St. John's Wort and medical marijuana).
Please list the prescriber's name next to the medication.

Does your client have a mental health problem that the stress of surgery, anesthesia, or recovery may cause your client to decompensate? For instance, PTSD, anxiety disorders, schizophrenia, substance abuse, etc.

Yes No
Comments:

If answer to previous question is yes, please describe how you have prepared your client for this possibility and how this will be addressed.

Please list the result of the CAGE or other substance abuse screening tool.

Please describe current and past substance use, including nicotine. Please list any concerns you have or that your client has regarding their substance use or their sobriety and pain medication.

Please describe medical problems your client may have.

What is your client's function, including their ability to satisfactorily complete ADLs and IDLs?

Describe your client support system, relationships, family support, and work.

Do you believe your client is capable of carrying out their aftercare plan? (including providing for their own self-care following surgery, e.g. Dilation 3x per day, hygiene issues, monitoring for infection, getting adequate nutrition, staying housed, etc.) Yes No

Comments:

What additional care will your client need and how will that be arranged? Who will provide needed case management?

Please explain your rationale for the referral for this surgery.

Please indicate that you discussed these issues to your client's satisfaction:

- Potential alterations in sexual functioning
- Risks and benefits, alternatives to surgery
- The impact of drugs and/or alcohol on surgery and outcomes
- The importance of aftercare related to post-operative complications and aesthetic outcomes
- The mandatory education/preparation program (Vaginoplasty, metoidioplasty, and phalloplasty only)
- Sterilization and reproductive choices (Genital surgeries only)

Is your client's gender identity stable and consolidated?

Yes No

Do you believe your client has realistic expectations about what the surgery can and cannot do?

Yes No

Is there anything you would like to add?

Signature: _____ Date: _____

Please fax completed form to 510-297-0222

For questions, please contact CHCN Utilization Management department at 510-297-0481 or umcod@chcnetwork.org.

Continuity of Care (CoC)

Department of Health Care Services All Plan Letter (APL) 18-007, states Medi-Cal members assigned a mandatory aid code and who are transitioning from Medi-Cal fee-for-service (FFS) into a Medi-Cal managed care health plan (MCP) have the right to request continuity of care in accordance with state law and the MCP contracts, with some exceptions. All MCP members with pre-existing provider relationships who make a continuity of care request to an MCP must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require continuity of care for services they have been receiving through Medi-Cal FFS or through another MCP.
CHCN will provide continuity of care with an out-of-network provider when:

1. CHCN is able to determine that the member has an existing relationship with the out-of-network provider (self-attestation is not sufficient to provide proof of a relationship with a provider);

    a. An existing relationship means the member has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment for a non-emergency visit, unless otherwise specified.

2. The provider is willing to accept the higher of the MCP's contract rates or Medi-Cal FFS rates;

3. The provider meets the MCP's applicable professional standards and has no disqualifying quality of care issues (for the purposes of CoC, a quality of care issue means CHCN can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other CHCN members);

4. The provider is a California State Plan approved provider; and

5. The provider supplies CHCN with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

CHCN is not required to provide continuity of care for services not covered by Medi-Cal. In addition, provider continuity of care protections do not extend to the following providers: durable medical equipment, transportation, other ancillary services, and carved-out services.

Inpatient Admissions Requirements

- For Alameda Alliance members, all inpatient facilities must notify CHCN within 24 hours, but no later than the end of the next business day of all inpatient admissions.
- Admission ***face sheet notifications*** should be faxed to our Inpatient Care Transition (ICT) unit at 510-297-0444.
- Notifications not received by our ICT unit within the noted timeframe may result in a facility denial of the inpatient authorization for service and payment.
- For obtaining authorization for inpatient services, a hospital must inform CHCN of the member's stay within 24 hours, but no later than the end of the next business day. If the member is admitted on a Friday and the facility notifies CHCN on Monday, the grace period should be honored and therefore Monday would be considered the next business day. If notification is received by the end of the day on Monday, the authorization will be denied for untimely notification. The member would be reviewed for medical necessity from the day of notification while member is still in the hospital.

Timely Concurrent Review

- CHCN uses MCG and health plan appropriate evidenced-based guidelines to perform initial and concurrent review of all inpatient admissions.
- Upon request, facilities should fax concurrent ***clinical information*** to the ICT unit via fax at 510-297-0449, by the end of the next business day from the time of the request.
- Clinical information insufficient to render a medically necessary determination, or clinical information not received within this timeframe, may result in a facility denial of the inpatient authorization for the service and payment.

Denial of Inpatient Services

- CHCN may deny any inpatient admission by contracted facilities if notification of the admission is not received by the end of the next business day.
- CHCN may deny any admission or days of inpatient care if sufficient clinical information for concurrent review is not received by the end of the next business day.
- CHCN may deny inpatient days should clinical information submitted not support MCG CARE GUIDELINES criteria for continued stay.
- CHCN will issue a notice of denial for inpatient services to the facilities clinical representative or department by the end of the day in which the denial is effective.
- Upon notification of a denial of inpatient services, the facility's clinical representative may initiate an appeal of the denial to CHCN and/or the health plan.

Notification of Stays for Observation

CHCN requires all facilities to submit immediate notification when a member is admitted for a hospital or observation stay. Additionally, separate notification to CHCN is requested when an observation stay converts to an inpatient admission. Please send all Inpatient Admission and Observation Stay notifications to our ICT unit via fax at 510-297-0444.

In addition to notification methods described above, CHCN provides a written notice of the authorization decision to the provider within two (2) business days of the date of decision. Member, member's representative and providers will receive notification of the authorization

decisions within two (2) business days if the decision is to deny, delay or modify the requested service. The notification letter includes the scope of services approved, the amount of services and the duration of service.

When there is insufficient information and a decision cannot be reached within the initial designated timeframe, the request will be deferred while medical information is gathered from the requesting physician. If CHCN cannot make a decision to approve, modify, or deny the request for authorization, within the timeframes specified above CHCN will notify the provider and the member in writing and specify the clinical information necessary to render a decision. The written notification will also notify the member and provider of the anticipated date on which a decision may be rendered.

Outpatient Basic Case Management

The CHCN Basic Case Management (BCM) program is part of a comprehensive health care management suite of services. CHCN offers a continuum of services, including care transitions, care coordination, as well as, case and utilization management.

Since many of CHCN's members have complex needs, gaps may occur in the healthcare delivery system serving these members. These gaps can create barriers to members receiving optimal care. Our Basic Case Management program helps reduce these barriers by identifying the basic unmet needs of members and assisting them with finding solutions. Solutions may include coordination of care and services, assisting members in accessing community-based resources, and/or providing health education. Should a member have complex case management needs, the member should be referred to the appropriate health plan for evaluation.

Simply complete and submit the Case Management Referral Form along with any clinical information to*:* lcastillon@chcnetwork.org or call 510.297.0440.

Case Management Referral Form:
https://portal.chcnetwork.org/UM-Authorizations-Resources

Outpatient Case Management Referral Form

Please complete and submit along with any clinical information to: DKipp@chcnetwork.org and PVang@chcnetwork.org

Date:	Member Name:		
Date of Birth:	Clinic Name:	Health Plan/LOB:	PCP/Provider:
Referred by:	Referral Contact Email:		

Reason for Referral:

☐ Coordination of Care needs

☐ Upcoming transition from CCS to full Medi-Cal (21yrs of age)

☐ No PCP visits in the past 12 months

☐ Frequent ER Visits (3 or more visits within the past 3 months)

Please refer members with the following needs to assigned clinic SPOC's/PCP:

Palliative Care/Hospice needs Multiple unstable chronic conditions Significant impairment of ADLs/IADL's Home Safety Concerns

Behavior/Mental Health

Referral summary--SBAR (Situation/Background/Assessment/Recommendation)**:**

Other Referral Requirements and Services

Community Based Adult Services (CBAS)

Refer directly to the appropriate health plan when medically necessary CBAS services are needed for a member. Health Plans follow the eligibility guidelines issued by the California Department on Aging: https://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/ under the "Forms" section, you will be able to find CBAS eligibility criteria.

Once a member has selected a CBAS center, the CBAS center will submit an authorization request to the health plan for further review.

Experimental and Investigational Therapies

All CHCN members may request experimental and/or investigational treatment for a medical problem. These types of authorizations will be directed to the CHCN's Medical Director and/or to the respective health plan for medical review and decision making.

Hospice Services

CHCN will not deny hospice care to members who are certified as terminally ill by a physician and who directly, or through their representative, voluntarily elect to receive such care in lieu of curative treatment related to the terminal condition.

A member who elects to receive Hospice Care must file an election statement with the hospice providing the care. The election statement must include:

- Identification of the hospice
- The member's or representative's acknowledgement that:
  - He or she has full understanding that the hospice care given as it relates to the member's terminal illness will be palliative rather that curative in nature.
- The effective date of the election;
- The signature of the member or representative.

A member's voluntary election may be revoked or modified at any time. The member must file a signed statement with the hospice agency revoking the member's election for the remainder of the election period. A member or representative may:

- Execute a new election for any remaining entitled election period at any time after revocation;
- Change the designation of a hospice provider once each election period; this is not a revocation of the hospice benefit.

CHCN responds to requests for prior authorization of inpatient hospice care within 24 hours of receipt.

Behavioral Health Services

Refer directly to the appropriate health plan for outpatient behavioral health services that are needed for the treatment of mild to moderate behavioral health conditions. Also refer directly to the appropriate health plan for the treatment of autism and development delays, including Behavioral Health Treatment (BHT) and Applied Behavioral Analysis (ABA) services.

- Refer Alameda Alliance for Health members contact BEACON Health Strategies at 1-855-856-0577.
- Submit prior authorization requests for Pre-Bariatric surgery Psych Evaluations to CHCN.

Autism Spectrum Disorder services

CHCN is not currently delegated for Behavioral Health services.

Behavioral Health Treatment (BHT) services are a Medi-Cal covered benefit for members under 21 years of age after a diagnosis of autism spectrum disorder (ASD).

BHT services teach skills through the use of behavioral observation and reinforcement or through prompting to teach each step of targeted behavior. BHT services are designed to be delivered primarily in the home and in other community settings.

California Children Services (CCS)

Regardless of the line of business to which a member is assigned, the California Children Services, (CCS) authorizes services for CCS-eligible conditions for members younger than 21 years of age. Providers who are aware that a member has a CCS eligible condition and/or an open case should obtain authorization for that condition directly from CCS. CHCN may also refer a request to CCS for program eligibility and coverage determination. You may contact CCS directly:

Alameda County (510) 208-5970
Contra Costa County (925) 957-2680

CCS website: http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx

Early Start – Early Intervention Program

SUMMARY:

The Early Start (ES) program is a component of an Early Intervention (EI) program, enacted by the California Department of Developmental Services (DDS). Note that this is not the Department of Health Care Services (DHCS).

SOURCE:

https://www.dds.ca.gov/services/early-start/what-is-early-start/

ABOUT:

The Early Intervention Program for Infants and Toddlers with Disabilities was enacted in 1986 under the Individuals with Disabilities Education Act (IDEA; 20; U.S.C., Section 1431 et seq.). This program is California's response to federal legislation ensuring that early intervention services for infants and toddler with disabilities and their families are provided in a coordinated, family-centered system of services that are available statewide.

ELIGIBILITY:

Infants and toddlers from birth to age 36 months may be eligible for early intervention services through Early Start if, through documented evaluation and assessment, they meet one of the criteria listed below:

- have a developmental delay of at least 33% in one or more areas of cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing; or
- have an established risk condition of known etiology, with a high probability of resulting in delayed development; or
- be considered at high risk of having a substantial developmental disability due to a combination of biomedical risk factors of which are diagnosed by qualified personnel

California Government Code: Section 95014(a)

California Code of Regulations: Title 17, Chapter 2, Section 52022

AVAILABLE SERVICES:

Based on the child's assessed developmental needs and the families concerns and priorities as determined by each child's Individualized Family Service Plan (IFSP) team, early intervention services may include:

- assistive technology
- audiology
- family training, counseling, and home visits
- health services
- medical services for diagnostic/evaluation purposes only
- nursing services
- nutrition services

- occupational therapy
- physical therapy
- psychological services
- service coordination (case management)
- sign language and cued language services
- social work services
- special instruction
- speech and language services
- transportation and related costs
- vision services

REFERRALS:

Anyone can make a referral, including parents, medical care providers, neighbors, family members, foster parents, and day care providers.

The first step that parents may take is to discuss their concerns with their health care provider/doctor. You can also call the local regional center or school district to request an evaluation for the child.

If the child has a visual impairment, hearing impairment, or severe orthopedic impairment, or any combination of these, contact the school district for evaluation and early intervention services.

After contacting the regional center or local education agency, a service coordinator will be assigned to help the child's parents through the process to determine eligibility.

Parent-to-parent support and resource information is also available through Early Start Family Resource Centers.

AFTER REFERRAL:

Within 45-days the regional center or local education area shall:

- Assign a service coordinator to assist the family through evaluation and assessment procedures.
- Parental consent for evaluation is obtained.
- Schedule and complete evaluations and assessments of the child's development.
- If an infant or toddler is eligible for early intervention services, an Individual Family Service Plan (IFSP) will be developed that addresses the strengths, and needs of the infant or toddler, parental concerns, and early intervention services.
- Identify early intervention services that are provided in the family home or other community settings.

WHO PROVIDES SERVICES:

Early intervention services that are needed for each eligible infant or toddler are purchased or arranged by a regional center or a local education agency.

Family Resource Centers provide family support services.

COST:

There is no cost for evaluation, assessment and service coordination. Public or private insurance is accessed for medically necessary therapy services including speech, physical and occupational therapies. Services that are not covered by insurance will be purchased or provided by regional centers or local education agencies.

An Annual Family Program Fee may be assessed in some circumstances.

ADDITIONAL INFO:

Call your local regional center, local educational agency, or family resource center for resource information or a referral to Early Start services.
If you need additional information about how to get Early Start services call (800) 515-BABY or e-mail us at earlystart@dds.ca.gov.

Submission of an Authorization Request

Confirm member eligibility

1. Select a CHCN participating provider
2. Complete all items on the Prior Authorization Request form
3. Submit the Prior Authorization Request form via the Connect Provider Portal or fax to (510) 297-0222.

Prior Authorization Form:
https://connect.chcnetwork.org/UM-Authorizations-Resources

Provider offices may request an authorization verbally by directly calling the UM department at (510) 297-0481.

CHCN processes authorization requests in a timely manner and in accordance with State and Federal requirements. To ensure accurate processing, indicate on the Prior Authorization form whether the requested service is "Routine/Standard, Urgent, Retro, or a Modification". Inappropriate use of the "Urgent" category will be monitored and downgraded/reclassified to Routine category when "Urgent" authorization criteria are not met.

A prior authorization request for a future elective (non-urgent) surgery or treatment submitted as "Urgent" is not considered to be urgent. A Prior Authorization Request form should only be submitted as "Urgent" when care is needed within 24-72 hours or the member is at risk for serious harm should care be delayed.

"Urgent" prior authorization requests submitted with complete information are processed with a final determination/decision within 72 hours of receipt. "Routine" authorization requests submitted with complete information are processed with a determination/decision within 5 business days from receipt. Requests may be deferred for up to 14 days if medical information necessary to make a final determination/decision is missing.

Utilization Management Timeliness Standards

Request Type (as marked on PAR form)	Method of Provider Submission	CHCN Response Timeframe	Method of Notification
Urgent	Portal, Fax, telephone	Within 72 hours of receipt request	Portal, Fax, or telephone
Routine	Portal, Fax, telephone or mail (received at least 5 days prior to requested date of service)	Within five (5) working days of receipt of request with all clinical information needed to make a decision May defer up to fourteen (14) calendar days if additional information is needed	Portal, Fax, telephone
Concurrent	Fax	Within the next business after receipt of notification and clinical information	Fax

CHCN UM staff may call you to discuss the authorization request, or request additional clinical information, suggest modifications or redirection of the request to an in-network provider. Decisions to modify or deny authorization requests are made by CHCN Medical Director.

An authorization number, along with any visit, dates, or service limits, will be given for all authorizations consistent with evidence-based clinical guidelines.

Utilization Management department staff are available by telephone every business day at (510) 297-0481, from 8:30 a.m. - 5:00 p.m., Monday – Friday. Messages left on voicemail will receive a call back from a department associate within one business day.

Providers (in-network and out-of-network) may contact the CHCN UM department by calling (510) 297-0481 or faxing (510) 297-0222 to request a copy of the medical criteria used to make an authorization determination/decision.

California Lead Poisoning Prevention Branch (CLPPB) Guidelines

State regulations impose specific responsibilities on doctors, nurse practitioners, and physician assistants doing periodic health care assessments on children between the ages of 6 months and 6 years.

These regulations apply to all physicians, nurse practitioners, and physician assistants, not just Medi-Cal or Child Health and Disability Prevention (CHDP) providers.

CHCN providers please refer to the below resource for lead screening standard of care.

Standard of Care on Screening for Childhood Lead Poisoning

End of Life Services

Terminally ill members, age 18 or older with the capacity to make medical decisions are permitted to request & receive prescriptions for aid-in-dying medications if certain conditions are met. Provision of these services by health care providers is voluntary and refusal to provide these services will not place any physician at risk for civil, criminal or professional penalties.

End of Life Services include consultations and the prescription of an aid-in-dying drug. EOL services are a carve out for Medi-Cal Managed Care Health Plans (MCPs). Members are responsible for finding a Medi-Cal FFS Physician for all aspects of the EOL+benefit. Policy & Procedure describes:

1). During a visit with a CHCN provider, a member may provide an oral request for EOL services. If the CHCN provider is also enrolled with the Department of Health Care Services (DHCS) as a Medi-Cal FFS provider, that provider may elect to become the member's attending physician as he or she proceeds through the steps in obtaining EOL services.

2). Alternatively, if the CHCN provider is not a Medi-Cal FFS provider, the provider may document the oral request in his or her medical records as part of the visit.

3). The CHCN provider should advise the member that following the initial visit he or she must select a Medi-Cal FFS physician in order for all of the remaining requirements to be satisfied.

Access to Services without Authorization or Referral

Family Planning Services
Medi-Cal Members are entitled to timely, convenient, and confidential access to the full range of family planning services, as defined in Title 22. In accordance with federal regulations, Medi-Cal members are allowed freedom of choice in selecting a family planning Provider. Therefore, Medi-Cal members may receive such services from a PCP, non-PCP, or an out-of-plan provider, without prior authorization. Members enrolled in other CHCN product lines may see CHCN contracted providers for family planning services.

Scope of Family Planning Services

The following family planning services (for Medi-Cal members only) are covered for both in-network and out-of-plan providers:

- Abortions
- Contraceptive drugs and items, including Emergency Contraceptive. A 12 month supply of contraceptive treatment (pills, transdermal patches, vaginal rings) will be dispensed at one time when requested without utilization management control.
- Diagnosis and treatment of STDs if medically indicated
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider, if provided in an ambulatory setting
- Health education and counseling necessary to make informed choices and understand contraceptive methods
- Laboratory tests if medically indicated as part of decision making process for choice of contraceptive methods
- Limited history and physical examination
- Pregnancy testing and counseling
- Provision of contraceptive pills/devices/supplies
- Screening, testing and counseling of members at risk for HIV; referral for treatment
- Tubal ligation
- Vasectomies

Abortion Services

CHCN provides members with timely access to first and second trimester abortion services. The following guidelines apply to CHCN abortion services:

- In-network abortion services are available to all members without a referral or prior authorization.
- CHCN Medi-Cal members have the right to abortion services within and outside of the CHCN provider network without a referral or prior authorization.
- CHCN will NOT reimburse for abortions provided by out-of-plan providers for CHCN Group Care members without prior authorization.
- Every effort shall be made to assist the member seeking abortion services with access to a first trimester abortion. This includes providing timely and appropriate counseling, education, information, and referral.
- Providers shall assist members in identifying abortion service providers. Providers should refer to the Provider Directory, or encourage the member to contact the Member Services department.

Minor Consent Services

Minor Consent Services means those Covered Services of a sensitive nature which minors do not need parental consent to access, related to:

- Sexual assault, including rape.
- Drug or alcohol abuse for children 12 years of age or older.
- Pregnancy.
- Family planning.
- Sexually transmitted diseases (STDs), designated by the Director, in children 12 years of age or older.
- Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either
  (1) there is a danger of serious physical or mental harm to the minor or others or
  (2) the children are the alleged victims of incest or child abuse.

Immunizations

Prior authorization is not required for medically necessary immunizations administered by contracted primary and specialty care providers.

Providers must ensure timely provision of immunizations to members in accordance with the most recent schedule and recommendations published by Advisory Committee on Immunization Practices (ACIP), regardless of a member's age, sex, or medical condition, including pregnancy.

Providers to document each member's need for ACIP recommended immunizations as part of all regular health visits.

Providers must report member-specific immunization information to immunization registry(ies), such as Statewide Immunization Information System (CAIR). Reports must be made following a member's IHA and after all other health care visits that result in an immunization. Providers should report immunization information within 14 days of administering an immunization.

Sterilization Services

Written informed consent must be obtained from all members seeking sterilization procedures in accordance with State law. This applies to all members regardless of the product line in which they are enrolled and includes services for tubal ligations, sterilization, vasectomies and hysterectomies. Interpreter services must be provided if there is evidence that the patient does not understand the language and/or the text of the informed consent process. The provider must complete, sign and date the PM 330 consent form. In addition, a copy of the DHCS Booklet on Sterilization is provided to the patient by either a physician or by the physician's designee, as part of the Informed Consent process for Sterilization prior to the member signing the PM 330 Consent form.

A copy of the signed sterilization consent form must be maintained in the member's medical records. For Medi-Cal members, a copy of the consent must also be submitted to CHCN in order to be reimbursed (see below). Consent submission to CHCN only applies to Medi-Cal members. Providers do not need to submit a copy of the consent to CHCN for members in other product lines.

Prior authorization is not required for tubal ligations or vasectomies. Prior authorization is required for hysterectomies.

Requirements Regarding Sterilization Consent

The legal requirements listed below apply to the provision of sterilization services. Sterilization is covered only if all applicable requirements are met at the time the procedure is performed. If the member obtains retroactive coverage, previously provided sterilization services for tubal ligations and vasectomies are not covered unless all applicable requirements, including the timely signing of an approved sterilization consent form, have been met.

Providers must comply with the following sections of California Law:

- Informed consent procedure for hysterectomies – Health and Safety Code Section 1690, 22 CCR Section 70707.5, 51305.6
- Criteria for the performance of sterilization of Medi-Cal patients – 22 CCR Section 51305.1, 22 CCR Section 70707.1
- Informed consent process for sterilization – 22 CCR Section 51305.3, 70707.3
- Certification of informed consent for sterilization – 22 CCR 51305.4, 70707.4
- Noncompliance with California Law– 22 CCR 51305.7
- Additional requirements for Informed Consent When Specified Federal Funds Are Used Medi-Cal – 22 CCR Section 70707.6

Medi-Cal Managed Care Sterilization Requirements

CHCN members enrolled in Medi-Cal Managed Care must meet the requirements of the law specific to Medi-Cal funded members. This means that a member cannot waive the thirty-day waiting period between date of written consent and the actual performance of the procedure unless an emergency situation is documented in accordance with Title 22 CCR 51305.1.

When submitting claims for Medi-Cal members, a copy of an appropriately completed PM330 must be submitted with claim for vasectomies and tubal ligations. Failure to submit the PM 330 will result in denial of payment to all providers involved in the delivery of the service until a properly completed PM330 is submitted. If the PM330 has not been properly completed in accordance with Medi-Cal guidelines, payment may be denied.

For hysterectomies, any consent form that meets the intent of the regulations for Medi-Cal members will be accepted. Failure to submit a consent form will result in denial of payment to all providers involved in the delivery of the service until the consent form is received by CHCN. If the consent has not been properly completed in accordance with Medi-Cal guidelines, payment may be denied.

California Perinatal Services Program (CPSP)

Policy:

The Comprehensive Perinatal Services Program (CPSP) is a state funded, voluntary participation program run by the California Department of Public Health that provides services to all pregnant women from conception to 60 calendar days postpartum. Servers covered by CPSP include but, are not limited to; standard obstetric, nutrition, psychosocial, as well as, health education. This multidisciplinary approach to the delivery of prenatal care is based on the recognition that providing these services contributes significantly to improved pregnancy outcomes.
CHCN clinics are certified to provide CPSP services and make them available to all prenatal patients as soon after pregnancy is determined as possible.

Scope:

CHCN has certified CPSP providers within all health centers that offer pregnant women CPSP services and refer high-risk pregnancies to the appropriate specialists including perinatologists. When referred, all pregnant members have access to genetic screening.

Procedure:

CPSP providers will develop an individualized plan of care for each pregnant member that includes the following interventions when indicated by identified risk factors:

- Obstetrics
- Nutrition
- Psychosocial
- Health Education

CPSP is entirely voluntary for the patient. Pregnant women who decline the CPSP services sign an ***Acknowledgement Form*** stating that they were offered the services and declined. The most current CPSP information and tools may be found on the CPSP website:
https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx

All CHCH health center providers, regardless of CPSP certification, use CPSP tools, including a comprehensive risk assessment that is comparable to ACOG and CPSP Standards to document Prenatal and Postpartum Care.

CHCN Oversight of CPSP Process

CHCN maintains a data warehouse with 100% of CHCN's health center encounters contained within. Using a dashboard tool, CPSP services rendered at a clinic/clinic site/member level may be assessed on a quarterly basis. Utilization patterns will be evaluated semi-annually and where warranted, more detailed investigation will be conducted by CHCN UM/QI staff to ensure appropriate rendering of CPSP services by the health centers.

Child Health and Disability Prevention (CHDP)

Purpose
The Child Health and Disability Prevention (CHDP) is a preventative program that delivers periodic health assessments and services to low income children and youth in California. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment.

Eligibility
All Medi-Cal recipients from birth to age 20 are eligible for CHDP scheduled periodic health assessments and services. CHDP provides a schedule of periodic health services to non-Medi-Cal children and youth from birth to age 19 years whose family income is equal to or less than 200 percent of the federal income guidelines. All children and youth are eligible for health assessments based on the same schedule or periodicity used for Medi-Cal children and youth.

Access to CHDP Providers
All primary care providers that see children at Community Health Center Network member health centers are also CHDP providers. Members may select a provider through the health plan provider directory. Provider directories are available online on the health plan website and may be requested in print as well.

Standards
CHDP bases assessment standards on the American Academy of Pediatrics Periodicity Schedule and can be accessed at the following link:
http://www.dhcs.ca.gov/services/chdp/Pages/HAG.aspx

Additional Information and Resources
To find out more about CHDP services please contact your county CHDP office.

Alameda County: http://www.acphd.org/chdp.aspx

Contra Costa County: http://cchealth.org/chdp/

Department of Health Care Services CHDP Overview can be accessed at the following link:
http://www.dhcs.ca.gov/services/chdp/Pages/default.aspx

CHDP Training and Resource Material for Health Centers can be accessed at the following link:
http://www.dhcs.ca.gov/services/chdp/Pages/Training.aspx

Initial Health Assessments (IHA)

CHCN member health centers are required to administer the Staying Healthy Assessment (SHA) to all Medi-Cal members as part of the Initial Health Assessment (IHA) and periodically re-administer. Individual Health Education Behavioral Assessment (IHEBA) is a generic term for the SHA. An IHEBA enables a provider of primary care services to comprehensively assess the member's current acute, chronic, and preventive health needs as well as identify those members whose health needs require coordination with appropriate community resources.

The goals of the SHA are to assist providers with:

- Identifying and tracking high risk behaviors of members.
- Prioritizing each member's need for health education related to lifestyle, behavior, environment, and cultural and linguistic needs.
- Initiating discussion and counseling regarding high risk behaviors.
- Providing tailored health education counseling, interventions, referral, and follow-up.

Primary care providers (PCPs) are responsible for reviewing each member's SHA in combination with the following relevant information:

- Medical history, conditions, problems, medical/testing results, and member concerns.
- Social history, including member's demographic data, personal circumstances, family composition, member resources, and social support.
- Local demographic and epidemiologic factors that influence risk status.

Periodicity

CHCN member health centers must ensure that each member completes a SHA in accordance with the following guidelines and timeframes below. A member's refusal to complete the SHA must be documented on the appropriate age-specific form and kept in the member's medical record.

New Members:

New members must complete the SHA within 120 days of the effective date of enrollment as part of the IHA.

Current Members:

Current members who have not completed an updated SHA must complete it during the next preventive care office visit.

Pediatric Members:

Members 0–17 years of age must complete the SHA during the first scheduled preventive care office visit upon reaching a new SHA age group. PCPs must review the SHA annually with the patient (parent/guardian or adolescent) in the intervening years before the patient reaches the next age group.

Adolescents (12–17 years) should complete the SHA without parental/guardian assistance beginning at 12 years of age, or at the earliest age possible to increase the likelihood of obtaining accurate responses to sensitive questions. The PCP will determine the most appropriate age, based on discussion with the parent/guardian and the family's ethnic/cultural background.

Adult and Senior Members:
There are no designated age ranges for the adult and senior assessments, although the adult assessment is intended for use by 18 to 55 year olds. The age at which the PCP should begin administering the senior assessment to a member should be based on the patient's health and medical status, and not exclusively on the patient's age. The adult or senior assessment must be re-administered every 3 to 5 years, at a minimum. The PCP must review previously completed SHA questionnaires with the patient every year, except years when the assessment is re-administered.

Assessment Components
The SHA consists of seven age-specific pediatric questionnaires and two adult questionnaires available in threshold languages at the links below:
http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx

The IHA must be conducted in a culturally and linguistically appropriate manner for all patients, including those with disabilities.

If the patient answers YES to any alcohol question on the SHA, then the provider must offer an expanded screening questionnaire, New Screening, Brief Intervention and Referral for Treatment (SBIRT). SBIRT identifies patients with potential alcohol use disorders who need referral for further evaluation and treatment. If indicated, the provider should provide up to 3 brief interventions.

PCP Responsibility
The PCP must review the completed SHA with the member and initiate a discussion with the member regarding behavioral risks the member identified in the assessment. Clinic staff members, as appropriate, may assist a PCP in providing counseling and following up if the PCP supervises the clinical staff members and directly addresses medical issues.

The PCP must prioritize each member's health education needs and initiate discussion and counseling regarding high-risk behaviors.

Based on the member's behavioral risks and willingness to make lifestyle changes, the PCP should provide tailored health education counseling, intervention, referral, and follow-up. Whenever possible, the PCP and the member should develop a mutually agreed-upon risk reduction plan.

The PCP must review the SHA with the member during the years between re-administration of a new SHA assessment. The review should include discussion, appropriate patient counseling, and regular follow-up regarding risk reduction plans.

STAYING HEALTHY ASSESSMENT (SHA)

Instruction Sheet for the Provider Office

SHA PERIODICITY TABLE

	Administer	Administer /Re-Administer		Review
Questionnaire Age Groups	Within 120 Days of Enrollment	1st Scheduled Exam (after entering new age group)	Every 3-5 Years	Annually (Intervening Years)
0 - 6 Mo	√			
7 - 12 Mo	√	√		
1 - 2 Yrs	√	√		√
3 - 4 Yrs	√	√		√
5 - 8 Yrs	√	√		√
9 -11 Yrs	√	√		√
12 - 17 Yrs	√	√		√
Adult	√		√	√
Senior	√		√	√

SHA COMPLETION BY MEMBER

- Explain the SHA's purpose and how it will be used by the PCP.
- Offer SHA translation, interpretation, and accommodation for any disability if needed.
- Assure patient that SHA responses will be kept confidential in patient's medical record, and that patient's has the right to skip any question.
- A parent/guardian must complete the SHA for children under 12.
- Self-completion is the preferred method of administering the SHA because it increases the likely hood of obtaining accurate responses to sensitive or embarrassing questions.
- If preferred by the patients or PCP, the PCP or other clinic staff may verbally asked questions and record responses on the questionnaire or electronic format.

PATIENT REFUSAL TO COMPLETE THE SHA

- How to document the refusal on the SHA:
  1) Enter the patient's name and "date of refusal" on first page
  2) Check the box "SHA Declined by Patient" (last page page)
  3) PCP must sign, print name and date the back page
- Patients who previously refused/declined to complete the SHA should be encouraged to complete an age appropriate SHA questionnaire each subsequent year during scheduled exams.
- PCP must sign, print name and date an age appropriate SHA each subsequent year verifying the patient's continued refusal to complete the SHA.

SHA RECOMMENDATIONS

Adolescents (12-17 Years)

- Annual re-administration is highly recommended for adolescents due to frequently changing behavioral risk factors for this age group.
- Adolescents should begin completing the SHA on their own at the age of 12 (without parent/guardian assistance) or at the earliest age possible. The PCP will determine the most appropriate age, based on discussion with the family and the family's ethnic/cultural/community background.

Adults and Seniors

- The PCP should select the assessment (Adult or Senior) best suited for the patient's health & medical status, e.g., biological age, existing chronic conditions, mobility limitations, etc.
- Annual re-administration is highly recommended for seniors due to frequently changing risk factors that occur in the senior years.

PCP RESPONSIBILITIES TO PROVIDE ASSISTANCE AND FOLLOW-UP

- PCP must review and discuss newly completed SHA with patient. Other clinic staff may assist if under supervision of the PCP, and if medical issues are referred to the PCP.
- If responses indicate risk factor(s) (boxes checked in the middle column), the PCP should prioritize patient's health education needs and willingness to make life style changes, provide tailored health education counseling, interventions, referral and follow-up.
- Annually, PCP must review & discuss previously completed SHA with patient (intervening years) and provide appropriate counseling and follow-up on patient's risk reduction plans, as needed.

REQUIRED PCP DOCUMENTATION

- PCP must sign, print name and date the newly administered SHA to verify it was reviewed with patient and assistance/follow-up was provided as needed.
- PCP must check appropriate boxes in "Clinical Use Only" section to indicate topics and type of assistance provided to patient (last page).
- For subsequent annual reviews, PCP must sign, print name and date "SHA Annual Review" section (last page) to verify the annual review was conducted and discussed with the patient.
- Signed SHA must be kept in patient's medical record.

OPTIONAL CLINIC USE DOCUMENTATION

- Shaded "Clinic Use Only" sections (right column next to questions) and "Comments" section (last page) may be used by PCP/clinic staff for notation of patient discussion and recommendations.

Adult Clinical Preventive Services

CHCN PCPs should implement uniform guidelines for adult periodic health examinations in accordance with the most current edition of the "Guide to Clinical Preventive Services," a report of the US Preventive Services Task Force. Preventive health services should be provided to adult members by the member's assigned PCP.

Documentation for Clinical Preventive Services

Documentation of all clinical preventive service encounters must be included in the member's medical record. For more information on adult preventive health services, providers can access www.ahcpr.gov/clinic/uspstfix.htm.

Section 6

Quality Improvement

Quality Improvement Program

Community Health Center Network (CHCN) is committed to achieving and maintaining excellence in health outcomes for its members by systematically and continuously monitoring care and services through a formally adopted Quality Improvement Program (QIP). The QIP is based on planned systematic activities that are organized and implemented by CHCN to monitor, assess, and improve its quality of health care provided to members.

Quality oversight activities monitor the delivery of care, and include observations and review of documentation as it pertains to continuity, safety, efficiency, and member satisfaction; as well as evaluating performance on established sets of clinical metrics reflective of industry and regulatory standards.

The Quality Improvement Program activities and processes are established in accordance with CHCN's organizational vision, values and strategic initiatives; with the integration of Contracted Full Service Health Plan standards and requirements. The Quality Improvement Department contributes to oversight.

Important Aspects of Care and Service:

Monitoring and evaluation includes high-volume, high-risk services, and the care of acute and chronic conditions. All of these are monitored through studies, indicators, and the continuous quality improvement process used within CHCN.

Access to Care and Service:

The health plan conducts an annual appointment availability survey. Additionally, CHCN has incorporated access to care questions into the annual Patient Satisfaction Survey. Access questions on the patient satisfaction survey include:

- Ease of being seen & hours clinic is opened
- Ability to get through on the phone during and after clinic hours
- Wait times in the waiting room and exam room
- Have you gone to the ER or Urgent Care Center because you could not get a same day appointment at the clinic?

Section 7

Billing and Claims

Billing for Services

All claims are subject to NCCI bundling edits.

Cost of supplies is included in the overall contracted rate unless specifically outlined in the provider contract. Supplies are not reimbursed separately.

To Submit a Claim

Once services have been rendered, the claims form (electronic 837 file, CMS 1500) can be submitted to:

Mailing address for paper claims submission:

Community Health Center Network
101 Callan Avenue, Suite 300
San Leandro, CA 94577

CHCN strongly encourages electronic claims submission. We partner with the clearing house Office Ally to receive claims. Paper claims are only to be submitted if they have supporting documentation, e.g. primary RA/EOB, medical docs/reports, invoices). For assistance, please contact: Mark Delgado, EDI Specialist, at (510) 297-0200.

You may view claims status via CHCN's secure web portal, CHCN Connect. If you do not have access to CHCN Connect, you may request it from your local administrator. If your group does not have a local administrator or you do not know who it is, please submit a Technical Request Form to CHCN Portal Support for further assistance.

If you cannot find the information you need in the portal, you may contact CHCN Customer Care department at (510) 297-0480.

Claims Requiring Notes/Attachments

The following is a list of claims types and/or services that require the identified attachments when submitting claims to Community Health Center Network. These documents are reviewed to determine payment responsibility and process claims timely and appropriately.

In addition to the items listed below, CHCN may request information or documentation for other services or procedures billed to CHCN.

Type of Claim/Service	CPT Codes	Notes/Attachment
Coordination of Benefits (COB)	All	Other Carrier/payer Explanation of Benefits (EOB)
Hysterectomy	See attached list	Hysterectomy- Informed Consent
Sterilization	See attached list	Consent Form (PM 330)
Unlisted Procedures	"By report" codes	Op/Procedure Report
Unusual Procedure or Multiple Modifiers	All	Op/Procedure Report
Unusual Services	All	Op/Procedure Report
Vaginal Deliveries	01967	Anesthesia Report or Time in Attendance (TIA)

Radiology Billing Requirements

Effective June 1, 2019, providers will be required to identify professional and technical component using appropriate modifiers ("26" or "TC") on radiology services. Radiology services include but are not limited to procedure codes ranging from 70000 through 79999. CHCN requires this information in order to process claims in accordance with contracted health plans' Division of Financial Responsibility (DOFR). After June 1 2019, radiology procedures billed without a modifier will be adjusted "UDM9" instructing providers to bill with the appropriate modifier.

Also effective June 1, 2019, Alameda Alliance for Health is the appropriate pay or for technical component of radiology services in all places of service (POS), including office setting (POS 11). After June 1, 2019, technical component of radiology procedures will be adjusted "UDB7" and providers will be instructed to bill the health plan. CHCN will forward claims received with technical component to the health plan.

For exact CPT codes reference the Medi-Cal table at: http://files.medi-cal.ca.gov/pubsdoco/Rates/rates_range_display.asp.

Pharmaceutical Radiology Billing Guidelines

Effective for services rendered on or after April 1, 2021, the following codes will be reimbursed at 100% of current Medi-Cal rates when billed to CHCN. Standard Medi-Cal billing guidelines apply.

Diagnostic Radiopharmaceutical Agents

Per Study Dose" Agents
Reimbursement is limited to one unit (one study dose):

A4642	A9521	A9557
A9500 thru A9504	A9526	A9559 thru A9562
A9507	A9536 thru A9542	A9566 thru A9572
A9510	A9546	A9580
A9515	A9550 thru A9555	A9582

Other Agents
Reimbursement is allowed as per their descriptors:

A4641	A9520*	A9547
A9505	A9524	A9548
A9508	A9528	A9556
A9509	A9529	A9558
A9512	A9531	A9587
A9516	A9532	A9588*

**Code A9520 requires an invoice for reimbursement.*
**Code A9588 requires an invoice and the acquisition cost when billing.*

"Not Otherwise Classified" Agents
HCPCS diagnostic radiopharmaceutical agent codes **A9597** (tumor identification) and **A9598** (non-tumor identification) require "By Report" billing along with an invoice.

Diagnostic radiopharmaceutical agent codes are not split-billable and must not be billed with any modifier.

An invoice with the acquisition cost of the substance(s) must be attached to the claim.
HCPCS codes A9515, A9587, A9588, A9597 and A9598 may be billed with modifiers U7 or 99**.**

Paramagnetic Contrast Material
A9575 through A9579, A9581, A9583, A9585, Q9953 and Q9954
These codes are not split-billable and must not be billed with any modifier, with the exception of HCPCS code A9579, which may be billed with modifier UD.
An invoice is required when billing for codes A9575 through A9579.

High Osmolar Radiographic Contrast Media
Q9958 thru Q9964 are not split-billable. These codes may be billed with modifier UD. Only one code in the range is reimbursable, per date of service, any provider, unless medical justification is attached.

Any zero priced code requires an invoice submitted with claim.

Hysterectomy

This section is to assist providers in billing for hysterectomy services.

Hysterectomy Consent Form

The *Hysterectomy – Informed Consent* form in this section is included as a sample. A hysterectomy consent form may be a hospital form, a physician-designed form or a written statement by the person who secures authorization. To be acceptable, however, the form must include the following:

- A statement that the procedure will render the patient permanently sterile and
- The patient's signature and date of signing. The date of signing must be on or before the date of surgery.

  For the purposes of Medi-Cal reimbursement, patients undergoing therapy that is not for, but results in, sterilization (formerly referred to as secondary sterilization) are not required to complete the Department of Health Care Services sterilization *Consent Form* (PM 330).

TAR Requirement

All hysterectomy services require a *Treatment Authorization Request* (TAR)

No Waiting Period

There is no waiting period for a hysterectomy

Hysterectomy: Consent Form Required

A hysterectomy informed consent form is required for claims submitted for hysterectomy services. Claims submitted with any of the following CPT-4, HCPCS or ICD-10-CM procedure codes that are not accompanied by a hysterectomy informed consent form will be denied.

Medical Services and Outpatient Services

CPT-4 Code	Description
51597	Pelvic exenteration, complete, for vesical, prostatic or urethral malignancy, with removal of bladder and ureteral transplantations, with or without hysterectomy
51925	Closure of vesicouterine fistula; with hysterectomy

Medical Services and Outpatient Services

CPT-4 Code	Description
58150	Total abdominal hysterectomy, (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58152	Total abdominal hysterectomy with colpo-urethrocystopexy
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58200	Total abdominal hysterectomy, including partial vaginectomy, with lymph node sampling
58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling
58240	Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy
58260	Vaginal hysterectomy, for uterus 250 grams or less
58262	Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)
58263	Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s), with repair of enterocele
58267	Vaginal hysterectomy, for uterus 250 grams or less; with colpo-urethrocystopexy
58270	Vaginal hysterectomy, for uterus 250 grams or less; with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy
58280	Vaginal hysterectomy, with repair of enterocele
58285	Vaginal hysterectomy, radical
58290	Vaginal hysterectomy, for uterus greater than 250 grams
58291	Vaginal hysterectomy, **for uterus greater than 250 grams;** with removal of tube(s) and/or ovary(s)
58292	Vaginal hysterectomy, **for uterus greater than 250 grams;** with removal of tube(s) and/or ovary(s), with repair of enterocele
58293	Vaginal hysterectomy, **for uterus greater than 250 grams**; with colpo-urethrocystopexy with or without endoscopic control
58294	Vaginal hysterectomy, **for uterus greater than 250 grams**; with repair of enterocele
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 grams or less
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)

Medical Services and Outpatient Services

CPT-4 Code	Description
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 grams
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)
58548	Laparoscopy, surgical, with radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with removal of tube(s) and ovary(s), if performed
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less
58552	Laparoscopy, surgical, **with vaginal hysterectomy, for uterus 250 grams or less;** with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams
58554	Laparoscopy, surgical, **with vaginal hysterectomy, for uterus greater than 250 grams;** with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 grams or less
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 grams
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)
58951	Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy
58953	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking
58954	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy
58956	Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy
59135	Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy requiring total hysterectomy
59525	Subtotal or total hysterectomy after cesarean delivery

Inpatient Services

Hospitals submitting claims for rooms in connection with hysterectomy services must include at least one of the following ICD-10-PCS codes in the *Principal Diagnosis Code* field (Box 67) to support the revenue code being billed:

0UT20ZZ	**0UT57ZZ**	**0UT7FZZ**
0UT24ZZ	**0UT58ZZ**	**0UT90ZZ**
0UT27ZZ	**0UT5FZZ**	**0UT94ZZ**
0UT28ZZ	**0UT60ZZ**	**0UT97ZZ**
0UT2FZZ	**0UT64ZZ**	**0UT98ZZ**
0UT40ZZ	**0UT67ZZ**	**0UT9FZZ**
0UT44ZZ	**0UT68ZZ**	**0UTC0ZZ**
0UT47ZZ	**0UT6FZZ**	**0UTC4ZZ**
0UT48ZZ	**0UT70ZZ**	**0UTC7ZZ**
0UT4FZZ	**0UT74ZZ**	**0UTC8ZZ**
0UT50ZZ	**0UT77ZZ**	**0UTCFZZ**
0UT54ZZ	**0UT78ZZ**	

Such inpatient claims must be submitted with a *Hysterectomy – Informed Consent* form.

Exceptions for Hysterectomy Consent Form Attachment
A hysterectomy consent form is not required to be attached to the claim under the following circumstances.

Previously Sterilized Individuals

A sterilization consent form is not required if an individual has previously been sterilized as the result of a prior surgery, menopause, prior tubal ligation, pituitary or ovarian dysfunction, pelvic inflammatory disease, endometriosis or congenital sterility. When submitting a claim for a Medi-Cal patient who is sterile for one of these reasons, the provider must state the cause of sterility in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim form or on an attachment. This statement must be handwritten and signed by a physician. All assistant surgeon, anesthesiology and Inpatient provider claims must include a copy of the primary physician's statement.

Emergency Circumstances

A hysterectomy consent form is not required if a hysterectomy is performed in a life-threatening emergency in which the physician determines prior acknowledgment was not possible. In this case, a handwritten statement, signed by the physician certifying the nature of the emergency must accompany the claim. The certification of emergency must appear in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim form or on an attachment. All assistant

surgeon, anesthesiology and Inpatient provider claims must include a copy of the primary physician's statement. A diagnosis alone will not justify this service as an emergency.

Refer to the *Sterilization* section in this manual for additional information.

Hysterectomy consent form claim attachments are required with all CPT-4 procedure codes that result in sterilization except as previously noted.

Guidelines for Hysterectomies:

1. A physician may perform or arrange for a hysterectomy only if:

    - The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representative if any, orally and in writing that the hysterectomy will render the individual permanently sterile. Note the exceptions to this guideline under the "Exceptions for Hysterectomy Consent Form Attachment" entry in this section.
    - The written information may be transmitted to the patient on a hospital form, a physician-designed form, or merely a written statement by the person who secures authorization.
    - The individual or the individual's representative, if any has signed a written acknowledgement of the receipt of the proceeding information. The consent must be dated prior to the date of surgery. This acknowledgment may be a hospital's form, a physician-designed form or a written statement by the patient. (A sample informed consent form is included in this section, refer to *Figure 1*).
    - Although the consent from for sterilization, PM330 (refer to the *Sterilization* section in this manual) and the federal forms are not ideal for hysterectomy patients because the age and waiting period restrictions are inapplicable, these forms are adequate so long as the name of the operation is clearly denoted as "hysterectomy". A consent form signed previously for a tubal ligation is not acceptable. (A sample informed consent form is included in this section, refer to *Figure 1*.)
    - The individual has been informed of the rights to consultation by a second physician.

2. A copy of the written acknowledgment signed by the patient must be:

    - Provided to the patient,
    - Retained by the physician and the hospital in the patient's medical records, and
    - Attached to claims submitted by physicians, assistant surgeons, anesthesiologists, and hospitals.

3. The claim must include documentation stating the hysterectomy is not being performed for sterilization. Include a diagnosis code or an explanation in the *Remarks* area/*Additional claim Information* field (Box 19) of the claim.

4. A hysterectomy will not be covered if:

- Performed solely for the purpose of rendering an individual permanently sterile.
- There is more than one purpose for the procedure and the hysterectomy would not be performed except for the purpose of rendering the individual permanently sterile.

  For Medicare/Medi-Cal crossover patients, the hysterectomy consent form should be completed and a copy attached to the Medicare claim form.

Anesthesia Time

Refer to the *Anesthesia* section in the appropriate Part 2 manual for instructions to bill anesthesia time associated with a hysterectomy.

Hysterectomy Inquiries

Questions concerning hysterectomy services covered by Medi-Cal should be directed to:

Benefits Branch
Department of Health Care Services
MS 4601
1501 Capitol Avenue, Suite 71.4001
P.O. Box 997417
Sacramento, CA 95899-7417
(916) 552-9797

HYSTERECTOMY – INFORMED CONSENT

This is to certify that I, _____ have been
(name of patient)

advised by my physician or his/her designee _____
name of physician or designee)

that the hysterectomy which will be performed on me will render me

permanently sterile and incapable of having children.

I have been informed of my rights to consultation by a second physician prior to having this operation.

_____ _____
Patient Signature Date

_____ _____
Patient Representative (if any) Date

Figure 1. Sample Informed Consent Form for Hysterectomy.

CONSENT FORM
PM 330

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from

_____ . When I first asked for
(doctor or clinic)

the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a

_____ .
(Name of procedure)

The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on ____/____/____ .
Mo Day Yr

I, _____
Last

_____ _____
First *M. I.*

hereby consent of my own free will to be sterilized by

_____ by a
(Doctor's name)

method called _____ .
(Name of procedure)

My consent expires **180 days** from the date of my **signature below**.

I also consent to the release of this form and other medical records about the operation to:

- **Representatives of the Department of Health and Human Services.**
- **Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.**

I have received a copy of this form.

_____ *Date:* ____/____/____
Signature of individual to be sterilized *Mo Day Yr*

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent

form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ *Date:* ____/____/____
Signature of Interpreter *Mo Day Yr*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the
(Name of Individual to be sterilized)

consent form, I explained to him/her the nature of the sterilization

operation _____, the fact that it
(Name of procedure)

is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at anytime and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ *Date:* ____/____/____
Signature of person obtaining consent *Mo Day Yr*

_____
Name of Facility where patient was counseled

_____
Address of Facility where patient was counseled *City* *State* *Zip Code*

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon

_____ on
(Name of individual to be sterilized)

____/____/____ *(Date of Sterilization),* I explained to him/her the nature of the
Mo Day Yr

sterilization operation _____ ,
(Name of procedure)

the fact that it is intended to be final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of Alternative Final Paragraphs**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery when the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. **Cross out the paragraph below which is not used.**

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (**check applicable box below and fill in information requested**.)

A ☐ Premature delivery date: ____/____/____ Individual's **expected date**
Mo Day Yr

of delivery: ____/____/____ (Must be 30 days from date of patient's signature).
Mo Day Yr

B ☐ Emergency abdominal surgery; describe circumstances: _____

_____

_____ *Date:* ____/____/____
Signature of Physician performing surgery *Mo Day Yr*

NOTA: NINGUNO DE LOS BENEFICIOS QUE RECIBO DE LOS PROGRAMAS O PROYECTOS SUBSIDIADOS CON FONDOS FEDERALES SE ME CANCELARÁ O SUSPENDERÁ EN CASO DE QUE YO DECIDA NO ESTERILIZARME.

■ CONSENTIMIENTO PARA ESTERILIZACIÓN ■

Declaro que he solicitado y obtenido información sobre esterilización de _____ (doctor o clinica). Al solicitar información se me dijo que yo soy la única persona que puede decidir esterilizarme o no y que estoy en mi derecho a negarme a ser esterilizado. Mi decisión de no esterilizarme no afectará mi derecho a recibir atención o tratamiento médico en el futuro, y tampoco dejaré de recibir ningún tipo de asistencia o beneficios que recibo actualmente de los programas subsidiados con fondos federales, tales como A.F.D.C. o Medicaid o de aquellos a los que pudiera tener derecho en el futuro.

ENTIENDO QUE LA ESTERILIZACIÓN DEBE SER CONSIDERADA **PERMANENTE** E **IRREVERSIBLE**. DECLARO QUE ES MI DECISIÓN EL NO QUERER VOLVER A EMBARAZARME, DAR A LUZ O SER PADRE NUEVAMENTE.

Declaro que se me ha informado acerca de la existencia de otros métodos anticonceptivos temporales que están a mi disposición y que me permitirían en un futuro tener hijos o ser padre nuevamente. Sin embargo, he rehusado estos metodos alternativos y he decidido esterilizarme.

Entiendo que se me va a esterilizar mediante un método conocido como:

_____ (Nombre del procedimiento)

Declaro que se me explicaron los malestares, riesgos y beneficios asociados con la operación, y que se respondió a todas mis preguntas satisfactoriamente.

Entiendo que la operación no se llevará a cabo hasta por lo menos treinta (30) días después de que firme este formulario, y que puedo cambiar de parecer en cualquier momento y decidir no esterilizarme. Si decido no esterilizarme, no dejaré de recibir ninguno de los beneficios o servicios médicios ofrecidos por los programas subsidiados con fondos federales.

Declaro tener al menos 21 años de edad y que nací en ____/____/____. Mes Día Año

Apellido

Nombre I.

por medio de la presente doy mi consentimiento libre y voluntario para ser esterilizado/a por _____ (Nombre del Doctor)

utilizando un método conocido como _____ (Nombre del procedimiento)

Mi consentimiento es válido sólo por un plazo de **180 días** a partir de la fecha en que firme este formulario como se muestra **abajo**.

Asimismo, doy mi consentimiento para que este formulario y otros expedientes médicos sobre la operación se den a conocer a:

- **Representantes del Departamento de Salud y Servicios Humanos.**
- **Empleados de los programas o proyectos que reciben fondos de dicho Departamento, pero únicamente para determinar si se cumplieron las leyes federales.**

He recibido copia de este formulario.

_____ *Fecha:* ____/____/____

Firma de la persona a se esterilizada *Mes Día Año*

■ DECLARACIÓN DEL INTÉRPRETE ■

Si se requiere de un intérprete para asistir a la persona que va a ser esterilizada: Declaro que he traducido la información y los consejos verbales que la persona que recibe este consentimiento le ha dado a la persona que va a ser esterilizada. También le he leído a la persona el contenido de este formulario de consentimiento en idioma _____ y le he explicado su contenido. A mi mejor saber y entender dicha persona ha comprendido las explicaciones que se le dieron.

_____ *Fecha:* ____/____/____

Firma del intérprete *Mes Día Año*

■ DECLARACION DE LA PERSONA QUE RECIBE EL CONSENTIMIENTO ■

Declaro que antes de que _____ (Nombre de la persona a ser esterilizada) firmara el formulario de consentimiento, le expliqué la naturaleza del método de esterilización conocido como _____ (Nombre del procedimiento). También le expliqué que dicha operación es final e irreversible, y le informe sobre los malestares, riesgos y beneficios asociados con dicho procedimiento.

Declaro que le he explicado a la persona a ser esterilizada acerca de la existencia de otros métodos anticonceptivos temporales y que a diferencia de estos, el método de esterilización es irreversible.

Declaro que le he informado a la persona a ser esterilizada que puede desistir en cualquier momento a este consentimiento y que esto no traerá como consecuencia la péridida de ningún servicio médico o beneficio subsidiado con fondos federales

Declaro que, a mi mejor saber y entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece estar en su sano juicio. Dicha persona, de forma voluntaria y con conocimiento de causa, ha solicitado ser esterilizada y parece entender la naturaleza y las consecuencias del procedimiento.

_____ *Fecha:* ____/____/____

Firma de quien recibe el consentimiento *Mes Día Año*

Nombre del lugar donde el paciente recibió la información

Dirección del lugar donde el paciente recibió la información Ciudad Estado Código Postal

■ DECLARACIÓN DEL MÉDICO ■

Declaro que poco aqntes de operar a _____ (Nombre de la persona a ser esterilizada) en ____/____/____ (Fecha de esterilización), le explique la naturaleza del metodo de esterilizacion conocido como _____ (Nombre del procedimiento), también le expliqué que este método es final e irreversible y le informé de los malestares, riegos y beneficios asociados con este procedimiento.

Declaro que le he explicado a la persona a ser esterilizada acerca de la existencia de otros métodos anticonceptivos temporales y que ha diferencia de estos, el método de esterilización es irreversible.

Declaro que le he informado a la persona a ser esterilizada que puede desistir en cualquier momento a este consentimiento y que esto no traerá como consecuencia la pérdida de ningún servicio médico o beneficios subsidado con fondos federales.

Declaro que, a mi mejor saber y entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece estar en su sano juicio. Dicha persona, de forma voluntaria y con conocimiento de causa, ha solicitado ser esterilizada y parece entender la naturaleza y las consecuencias del procedimiento.

(**Instrucciones para el Uso Alternativo de los Párrafos Finales:** Use el primer párrafo de abajo excepto en caso de parto prematuro o cirugía del abdomen de emergencia cuando la esterilización se lleve a cabo antes de que se cumplan treinta (30) días desde que la persona firmó este consentimiento. En dichos casos se debe usar el segundo párrafo. **Tachar el párrafo de abajo que no es usado.**

(1) Han pasado por lo menos trienta (30) días desde que la persona firmó este consentimiento y la fecha en que se realizó la esterilización.

(2) La esterilización se realizó en menos de 30 días, pero después de 72 horas desde que la persona firmó este consentimiento debido a lo siguiente: (**Marque la casilla correspondiente de abajo y escriba la información que se solicita.**)

A ☐ Fecha de parto prematuro: ____/____/____ **Fecha anticipada** del parto: ____/____/____ (Debe ser 30 dias a partir de la firma de la persona).
Mes Día Año *Mes Día Año*

B ☐ Cirugía del abdomen de emergencia; describa las circunstancias: ____

_____ *Fecha:* ____/____/____

Firma del Doctor a cargo de la cirugía *Mes Día Año*

CONSENT FORM - PM 330

NOTA: NINGUNO DE LOS BENEFICIOS QUE RECIBO DE LOS PROGRAMAS O PROYECTOS SUBSIDIADOS CON FONDOS FEDERALES SE ME CANCELARÁ O SUSPENDERÁ EN CASO DE QUE YO DECIDA NO ESTERILIZARME.

CONSENTIMIENTO PARA ESTERILIZACIÓN

Declaro que he solicitado y obtenido información sobre esterilización de ________________ (doctor o clinica). Al solicitar información se me dijo que yo soy la única persona que puede decidir esterilizarme o no y que estoy en mi derecho a negarme a ser esterilizado. Mi decisión de no esterilizarme no afectará mi derecho a recibir atención o tratamiento médico en el futuro, y tampoco dejaré de recibir ningún tipo de asistencia o beneficios que recibo actualmente de los programas subsidiados con fondos federales, tales como A.F.D.C. o Medicaid o de aquellos a los que pudiera tener derecho en el futuro.

ENTIENDO QUE LA ESTERILIZACIÓN DEBE SER CONSIDERADA **PERMANENTE** E **IRREVERSIBLE**. DECLARO QUE ES MI DECISIÓN EL NO QUERER VOLVER A EMBARAZARME, DAR A LUZ O SER PADRE NUEVAMENTE.

Declaro que se me ha informado acerca de la existencia de otros métodos anticonceptivos temporales que están a mi disposición y que me permitirían en un futuro tener hijos o ser padre nuevamente. Sin embargo, he rehusado estos metodos alternativos y he decidido esterilizarme.

Entiendo que se me va a esterilizar mediante un método conocido como:

____
(Nombre del procedimiento)

Declaro que se me explicaron los malestares, riesgos y beneficios asociados con la operación, y que se respondió a todas mis preguntas satisfactoriamente.

Entiendo que la operación no se llevará a cabo hasta por lo menos treinta (30) días después de que firme este formulario, y que puedo cambiar de parecer en cualquier momento y decidir no esterilizarme. Si decido no esterilizarme, no dejaré de recibir ninguno de los beneficios o servicios médicios ofrecidos por los programas subsidiados con fondos federales.

Declaro tener al menos 21 años de edad y que nací en ____/____/____.
Mes Día Año

Apellido ________________

Nombre ________________ I. ____

por medio de la presente doy mi consentimiento libre y voluntario para ser esterilizado/a por ________________
(Nombre del Doctor)

utilizando un método conocido como ________________
(Nombre del procedimiento)

Mi consentimiento es válido sólo por un plazo de **180 días** a partir de la fecha en que firme este formulario como se muestra **abajo**.

Asimismo, doy mi consentimiento para que este formulario y otros expedientes médicos sobre la operación se den a conocer a:

- **Representantes del Departamento de Salud y Servicios Humanos.**
- **Empleados de los programas o proyectos que reciben fondos de dicho Departamento, pero únicamente para determinar si se cumplieron las leyes federales.**

He recibido copia de este formulario.

________________ Fecha: ____/____/____
Firma de la persona a se esterilizada Mes Día Año

DECLARACIÓN DEL INTÉRPRETE

Si se requiere de un intérprete para asistir a la persona que va a ser esterilizada: Declaro que he traducido la información y los consejos verbales que la persona que recibe este consentimiento le ha dado a la persona que va a ser esterilizada. También le he leído a la persona el contenido de este formulario de consentimiento en idioma ________________ y le he explicado su contenido. A mi mejor saber y entender dicha persona ha comprendido las explicaciones que se le dieron.

________________ Fecha: ____/____/____
Firma del intérprete Mes Día Año

DECLARACION DE LA PERSONA QUE RECIBE EL CONSENTIMIENTO

Declaro que antes de que ________________ (Nombre de la persona a ser esterilizada) firmara el formulario de consentimiento, le expliqué la naturaleza del método de esterilización conocido como ________________ (Nombre del procedimiento).
También le expliqué que dicha operación es final e irreversible, y le informe sobre los malestares, riesgos y beneficios asociados con dicho procedimiento.

Declaro que le he explicado a la persona a ser esterilizada acerca de la existencia de otros métodos anticonceptivos temporales y que a diferencia de estos, el método de esterilización es irreversible.

Declaro que le he informado a la persona a ser esterilizada que puede desistir en cualquier momento a este consentimiento y que esto no traerá como consecuencia la péridida de ningún servicio médico o beneficio subsidiado con fondos federales

Declaro que, a mi mejor saber y entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece estar en su sano juicio. Dicha persona, de forma voluntaria y con conocimiento de causa, ha solicitado ser esterilizada y parece entender la naturaleza y las consecuencias del procedimiento.

________________ Fecha: ____/____/____
Firma de quien recibe el consentimiento Mes Día Año

____
Nombre del lugar donde el paciente recibió la información

____
Dirección del lugar donde el paciente recibió la información Ciudad Estado Código Postal

DECLARACIÓN DEL MÉDICO

Declaro que poco aqntes de operar a ________________ (Nombre de la persona a ser esterilizada) en ____/____/____ (Mes Día Año) (Fecha de esterilización), le explique la naturaleza del metodo de esterilizacion conocido como ________________ (Nombre del procedimiento), también le expliqué que este método es final e irreversible y le informé de los malestares, riegos y beneficios asociados con este procedimiento.

Declaro que le he explicado a la persona a ser esterilizada acerca de la existencia de otros métodos anticonceptivos temporales y que ha diferencia de estos, el método de esterilización es irreversible.

Declaro que le he informado a la persona a ser esterilizada que puede desistir en cualquier momento a este consentimiento y que esto no traerá como consecuencia la pérdida de ningún servicio médico o beneficios subsidado con fondos federales.

Declaro que, a mi mejor saber y entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece estar en su sano juicio. Dicha persona, de forma voluntaria y con conocimiento de causa, ha solicitado ser esterilizada y parece entender la naturaleza y las consecuencias del procedimiento.

(**Instrucciones para el Uso Alternativo de los Párrafos Finales:** Use el primer párrafo de abajo excepto en caso de parto prematuro o cirugía del abdomen de emergencia cuando la esterilización se lleve a cabo antes de que se cumplan treinta (30) días desde que la persona firmó este consentimiento. En dichos casos se debe usar el segundo párrafo. **Tachar el párrafo de abajo que no es usado.**

(1) Han pasado por lo menos trienta (30) días desde que la persona firmó este consentimiento y la fecha en que se realizó la esterilización.

(2) La esterilización se realizó en menos de 30 días, pero desputés de 72 horas desde que la persona firmó este consentimiento debido a lo siguiente: (**Marque la casilla correspondiente de abajo y escriba la información que se solicita.**)

A Fecha de parto prematuro: ____/____/____ (Mes Día Año) **Fecha anticipada** del parto: ____/____/____ (Mes Día Año) (Debe ser 30 dias a partir de la firma de la persona).

B Cirugía del abdomen de emergencia; describa las circunstancias: ____

____

________________ Fecha: ____/____/____
Firma del Doctor a cargo de la cirugía Mes Día Año

Example of PM-330 Sterilization Consent Form

State of California -- Health and Human Services Agency

CONSENT FORM
PM 330

Department of Health Services

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from (1) _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from A.F.D.C. or Medicaid that I am now g

I UNDER BE CONSIDERED **PERMANENT** D THAT I DO NOT WANT TO BEC THER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a (2) _____ (Name of procedu

Fields 2, 6, 13, & 20
Bilateral Tubal Ligation

Bilateral Tubal Ligation

The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

Fields 4, 7, 12, & 18
Penny L. Sillen

not be done until at least thirty days after I change my mind at any time and that my I will not result in the withholding of any b federally funded programs.

I am at least 21 years of age and was born on (3) ___/___/___ Mo Day Yr.

I, (4) _____ Last First M. I.

hereby consent of my own free will to be sterilized by (5) _____ (Doctor's na by a method called (6) _____ (Name of procedure).

Bilateral Tubal Ligation

My consent expires **180 days** from the date of my **signature below.**

I also consent to the release of this form and other medical records about the operation to:

- **Representatives of the Department of Health and Human Services.**
- **Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.**

I have received a copy of this form.

(7) Penny L. Sillen, _____ Date: (8) ___/___/___
Signature of individual to be sterilized Mo Day Yr

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in (9) _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(10) _____ Date: (11) ___/___/___
Signature of Interpreter Mo Day Yr

PM 330 (1/99)

■ STATEMENT OF PERS NSENT ■

Before (12) Penny L. Sillen, _____ (Name of individual to be sterilized) signed the consent form, I explained to ization operation (13) Bilateral Tubal Ligation _____ (Name of procedure) t that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at anytime and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ Date: (15) ___/___/___
Signature of person obtaining consent Mo Day Yr

(16) _____
Name of Facility where patient was counseled

(17) _____
Address of Facility where patient was counseled City State Zip Code

■ PHYSICIAN'S STATEMENT ■

Shortly b n operation upon (18) Penny L. Sillen, _____ (Name of individual to be sterilized) on (19) ___/___/___ (Date of Sterilization), I explained to him/her the nature of the sterilization operation (20) Bilateral Tubal Ligation _____ (Name of procedure), the fact that it is intended to be final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/sh y Federal funds.

To the best of my at least 21 years old and d voluntarily requested to b d consequences of the proc

Fields 21 & 22
Cross off the Paragraph which DOES NOT APPLY

(**Instructions for use of Alternative Final Paragraphs**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery when the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. **Cross out the paragraph below which is not used.**

(21) (1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(22) (2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (**check applicable box below and fill in information requested**.)

Fields 27 & 28
Physician Signature & Date must be ON or AFTER Sterilization DATE

idual's **expected date**

of patient's signature).

mstances: _____

(27) Marcus J. Welby M.D. _____ Date: (28) ___/___/___
Signature of Physician performing surgery Mo Day Yr

PM-330 Sterilization Consent Form
Tips & Reminders for Successful Billing

☑ Name of procedure. Fields 2, 6, 13 and 20 require the name of the procedure. The name of the procedure must be present and must be consistent throughout the form and must match name of procedure on the claim.

☑ Patient's name. Fields 4, 7, 12 and 18 require the name of the patient to be consistent throughout the form.

Tip: Use the name as reflected on the BIC or the name used when determining Family PACT eligibility.

☑ Interpreter's statement. Fields 9, 10 and 11 require the language type, signature of the interpreter and date.

☑ Field 21 and 22 (Alternative Final Paragraphs). The paragraph that does not apply must be crossed out (an 'X' through the paragraph that does not apply is required).

(21) Paragraph one. Donot cross off paragraph one if the minimum waiting period of 30 days has been met.

(22) Paragraph two. Donot cross off paragraph two if the minimum waiting period of 30 days hasnot been met.

☑ Physician's signature. Field 27 requires full signature of the Physician who has verified consent and who actually performed the operation.

☑ Date. Field 28 must be present (month/day/year). Date must be on or after the sterilization date.

Note: These instructions must be followed exactly or the *Consent Form* will be returned and reimbursement delayed.

A completed PM 330 Sterilization Consent Form must accompany all claims directly related to the sterilization surgery. This requirement extends to all providers, attending physicians, surgeons, assistant surgeons, anesthesiologists and facilities.

Obstetric (OB) Care includes care delivered to a pregnant woman to diagnose and manage the pregnancy and related conditions, the health of the woman and the fetus, the delivery and the postpartum course.

The primary care provider is responsible for assessing the pregnant woman's needs and providing routine OB care. If a patient needs specialty services or is considered high risk, the patient should be referred to an OB contracted specialist.

A referral is not required if "Total OB Care" is provided by a CHCN PCP or contracted specialty provider. However, a referral is required if the contracted OB provider is providing co-management services.

Non-contracted providers are required to obtain prior authorization before rendering services. If prior authorization is not obtained, claim will be denied as "authorization required".

Billing for Total OB Care

CHCN reimburses providers for "Total OB Care" on a Fee-For-Service (FFS) basis, with a limit of 13 ante-partum visits per member/per pregnancy. Provider should submit a HCFA-1500 claim form for each ante-partum visit using the appropriate E & M codes. Refer to **Attachment A for OB FFS Payment Schedule.**

- CHCN will reimburse provider for one postpartum visit per member/per pregnancy period. Additional postpartum visits billed will be denied as "unit exceeds authorized number per pregnancy period".

- Providers are required to provide CPSP services (Ante-partum & Postpartum Health Education, Nutrition, and Psychosocial services) to all prenatal patients. However, CPSP visits are included in Total OB Care reimbursement and will not be reimbursed separately.

- Provider must indicate the member's LMP date in box 14 on the HCFA-1500 claim form when billing for initial visit. The Alameda Alliance for Health (AAH) Prenatal Reporting Form is also required when billing for CHCN/AAH members. If the pregnant woman chooses to see another provider in the middle of her prenatal care, provider should indicate "transfer out" in box 19 on the HCFA-1500 claim form when billing for the last ante-partum visit. If for any reasons, the member's prenatal care is terminated; i.e. TAB, SAB, lost to care, lost eligibility, etc, please specify this information on the claim form when billing for the last visit.

- If a pregnant woman became CHCN eligible while reaching her second or third trimester or being diagnosed as high risk pregnancy, and was being managed by a non-panel provider, CHCN will consider this as continuity of care, and honor payment to this provider. Provider needs to contact the CHCN U/M Department to obtain retro authorization for Total OB Care.

Delivery

- The delivery charge is reimbursed by CPT code to the delivery provider and should be billed on a HCFA-1500 claim form. For high risk delivery not previously identified, the change in risk level should be indicated on the claim form with the appropriate high risk diagnosis codes.

Separate Payment for OB Related Services

- Sonograms/ultrasound, fetal non-stress tests, and amniocentesis are separately payable for CHCN contracted providers - referral is required
- Genetic consultation is separately payable – referral from patient's PCP is required
- Supplies are included with the procedure
- All services must be billed within 90 days of the date of services

NOTE: All claims are subject to NCCI bundling edits
ALL CPT & DIAGNOSTIC CODES ARE SUBJECT TO CHANGE BASED ON MEDI-CAL GUIDELINES

Attachment A

FEE-FOR-SERVICE SCHEDULE

The lower of the following fees or actual charges, minus the member's co-payments if applicable.
Consistent with 1375.4.1(b) of California Health and Safety Code, detailed payment policies, rules, non-standard coding methodology, and fee schedule for contracted providers is available in electronic format.

CHCN Obstetrical (OB) Fee-For Service Payment Schedule	
Service Provided	CPT-4 Code
Initial Visit	
Initial Visit	99205
Initial Visit if patient is transferred in	99204
Antepartum Care	
Established Patient, minimal (5 minutes)	99211
Established Patient, moderate (10minutes)	99212
Established Patient, low-moderate (15 minutes)	99213
Established Patient, moderate-severe (25 minutes)	99214
Established Patient, moderate-high (40 minutes)	99215
Delivery Only (Does not include Antepartum or Postpartum Care)	
Vaginal Delivery	59409
Cesarean Delivery	59514
VBAC Delivery	59612
Cesarean Delivery after VBAC Attempt	59620
Postpartum Office Visit	
Postpartum Office Visit between 21-56 days (One visit may be billed/paid)	Z1038

The following CLIA-waived laboratory services are reimbursable at the following rates when performed in the provider's office. All other laboratory services not listed must be referred to Quest/Unilab, Community Health Center Network's contracted lab.

Laboratory Reimbursement Schedule				
Description	CPT Codes		Description	CPT Codes
UA dips w/ or w/out micro	81000		Glucose Blood Test	82962
Urinalysis, non-auto w/o scope	81002		Assay of Lead	83655
Urinalysis, auto, w/o scope	81003		Natriuretic Peptide	83880
Urinalysis; qual or semi-quan	81005		Spun, Microhematocrit	85013
Urine Screen for Bacteria	81007		Hematocrit	85014
UA micro only	81015		Hemoglobin, Colorimetric	85018
Urine Pregnancy Test	81025		INR, finger stick	85610
Test for Blood, Feces	82270		Wet mount (provider only)	87210
Glucose, finger stick	82947		Strep screen	87430
Glucose Test	82950		Automated Hemogram	85025
Glucose Tolerance Test (GTT)	82951		TB Test	86580

MEMORANDUM

TO: CHCN Contracted Specialty Providers

FROM: Karen Matsuoka, Provider Services and Contracts Manager

SUBJECT: Immunizations

DATE: September 15, 2017

Please read this important notice regarding immunizations.

Effective July 1, 2017, CHCN is responsible for payment of immunization claims from both health center and specialty care providers for Medi-Cal and IHSS lines of business. The claim should include procedure codes for vaccine(s) and administration. Please do not use HCPC codes to bill vaccines.

Childhood Immunization

The federal Vaccines for Children (VFC) program supplies free vaccines to CHCN health center providers for Medi-Cal members aged 0 to 19. All claims for VFC vaccines require the appropriate modifiers such as SK and SL. If billing more than one modifier on an electronic claim submission, please use modifier 99 as well as the multiple modifiers. Please refer to the Medi-Cal Provider Manual for the most current VFC procedure codes and billing guidance.

CHCN may reimburse for vaccines not available through VFC. Specialists and CHCN health centers may bill CHCN fee for service.

Adult Immunization

Specialists may bill CHCN fee for service.

When billed by CHCN health centers, certain adult immunizations are paid fee for service by CHCN and others are included in capitation rates. Please refer to the PCP Cap Exception list in the CHCN Provider Manual for a list of vaccines reimbursed fee for service.

PCP Cap Exceptions, Service Code Designations

Primary care services are reimbursed by a monthly capitation with the exception of some services that are not considered to be standard primary care services across all clinics. Services falling outside of the capitated service list are paid fee-for-service (FFS). This policy distinguishes services across three levels as defined below:

- **Level 2**: Services not required, but strongly encouraged to be provided by clinics and payable FFS when billed by clinics' primary care providers
- **Level 3**: Services requiring requisite experience when provided by clinics' PCPs and payable FFS when billed by clinics' primary care providers
- **Level 4: S**ervices that should be provided by a provider with specialty training

LEVEL 2: Services not required, but strongly encouraged to be provided by clinics and payable FFS when billed by clinics' primary care providers				
CPT CODE	**SERVICE DESCRIPTION**	**EFFECTIVE DATE**	**COMMENTS**	**CROSS WALK FROM**
0064A	ADM SARSCOV2 50MCG/0.25ML	01/24/2022	AAH Group Care Members	
10021	FINE NEEDLE ASPIRATION; W/O IMAGING GUIDANCE	08/01/2008		
10080	DRAINAGE OF PILONIDAL CYST	01/01/2014		
10140	DRAINAGE OF HEMATOMA/FLUID	06/01/2013		
11300	SHAVE SKIN LESION 0.5 CM/<	01/01/2014		
11301	SHAVE SKIN LESION 0.6-1.0 CM	10/15/2015		
11305	SHAVE SKIN LESION 0.5 CM/<	07/01/2014		
11306	SHAVE SKIN LESION 3.6-1.0 CM	10/01/2015		
11307	SHAVE SKIN LESION 1.1-2.0 CM	10/01/2015		
11308	SHAVE SKIN LESION >2.0 CM	07/01/2014		
11311	SHAVE SKIN LESION 0.6-1.0 CM	07/01/2014		
11400	EXC TR-EXT B9+MARG < 0.5 CM	11/01/2001		
11401	EXC TR-EXT B9+MARG 0.6-1 CM	11/01/2001		
11402	EXC TR-EXT B9+MARG 1.1-2 CM	11/01/2001		
11403	EXC TR-EXT B9+MARG 2.1-3 CM	11/01/2001		
11404	EXC TR-EXT B9+MARG 3.1-4 CM	11/01/2001		
11406	EXC TR-EXT B9+MARG > 4.0 CM	11/01/2001		
11420	EXC H-F-NK-SP B9+MARG 0.5<	11/01/2001		
11421	EXC H-F-NK-SP B9+MARG 0.6-1	11/01/2001		
11422	EXC H-F-NK-SP B9+MARG 1.1-2	11/01/2001		
11423	EXC H-F-NK-SP B9+MARG 2.1-3	07/01/2014		
11426	EXC H-F—NK-SP B9+MARG> 4CM	11/01/2001		
11440	EXC FACE-MM B9+MARG 0.5 < CM	11/01/2001		
11441	EXC FACE-MM B9+MARG 0.6-1 CM	11/01/2001		
11442	EXC FACE-MM B9+MARG 1.1-2 CM	11/01/2001		
11443	EXC FACE-MM B9+MARG 2.1-3 CM	11/01/2001		
11444	EXC FACE-MM B9+MARG 3.1-4 CM	11/01/2001		
11446	EXC FACE-MM B9+MARG >4 CM	11/01/2001		
11730	REMOVAL OF NAIL PLATE, SINGLE	11/01/2001		
11732	REMOVE NAIL PLATE, ADD-ON	11/01/2001		
11740	DRAIN BLOOD FROM UNDER NAIL	11/01/2001		
11750	REMOVAL OF NAIL BED	11/01/2001		

LEVEL 2: Services not required, but strongly encouraged to be provided by clinics and payable FFS when billed by clinics' primary care providers				
CPT CODE	**SERVICE DESCRIPTION**	**EFFECTIVE DATE**	**COMMENTS**	**CROSS WALK FROM**
11900	INTRALESIONAL INJECTION(NOT LOCAL ANE OR CHEMO)	01/01/2007		
11901	ADDED SKIN LESION IN	11/01/2011		
11981	INSERT DRUG IMPLANT DEVISE	01/01/2012		
11982	REMOVE DRUG IMPLANT DEVICE	07/01/2012		
11983	REMOVE/INSERT DRUG IMPLANT	01/01/2012		
12004	REPAIR SUPERFICIAL WOUND(S)	11/01/2001		
12020	CLOSURE OF SPLIT WOUND	11/01/2001		
12021	CLOSURE OF SPLIT WOUND W/ PACKING	11/01/2001		
12031	INTMD RPR S/A/T/EXT 2.5 CM/<	07/01/2014		
12034	INTMD RPR S/TR/EXT 7.6-12.5	01/01/2014		
12041	INTMD RPR N-HF/GENIT 2.5C	09/01/2013		
12042	INTMD RPR N-HF/GENIT2.6-7.5	01/01/2014		
16030	DRESS/DEBRID P-THINK BURN L	11/01/2001		
17000	DESTROY BENIGN/PREMLG LESION	11/01/2001		
17003	DESTROY LESIONS, 2-14	11/01/2001		
17004	DESTROY LESIONS, 15 OR MORE	11/01/2001		
17110	DESTRUCT LESION, 1-14	11/01/2001		
17111	DESTRUCT LESION, 15 OR MORE	11/01/2001		
17250	CHEMICAL CAUTERY OF WOUND	09/01/2010		
17340	CRYOTHERAPY OF SKIN	11/01/2001		
19100	BX BREAST PERCUT W/O IMAGE	11/01/2001		
19101	BIOPSY OF BREAST, OPEN	11/01/2001		
20520	REMOVEAL OF FOREIGN BODY	11/01/2001		
20525	REMOVE MUSCLE FOREIGN BODY	11/01/2001		
20526	THER INJECTION CARP TUNNEL	10/01/2016		
20550	INJ TENDON SHEATH/LIGAMENT, APONEUROSIS	11/01/2001		
20551	INJ TENDON ORIGIN/INSERTION	12/02/2002		
20552	INJ TRIGGER POINT 1/2 MUSCL	12/02/2002		
20600	DRAIN/INJECT, JOINT/BURSA, SML JOINT/ BURSA	11/01/2001		
20605	DRAIN/INJECT, JOINT/BURSA	11/01/2001		
20610	DRAIN/INJECT, JOINT/BURSA, MAJOR JOINT/BURSA	11/01/2001		
20612	ASPIRATE/INJ GANGLION CYST	01/01/2014		
24201	REMOVAL OF ARM FOREIGN BODY	11/01/2001		
25111	REMOVE WRIST TENDON LESION	11/01/2001		
27086	REMOVE HIP FOREIGN BODY	11/01/2001		
27087	REMOVE HIP FOREIGN BODY	11/01/2001		
28190	REMOVAL OF FOOT FOREIGN BODY	11/01/2001		
28192	REMOVAL OF FOOT FOREIGN BODY	11/01/2001		
28193	REMOVAL OF FOOT FOREIGN BODY	11/01/2001		
29085	APPLY HAND/WRIST CAST	07/01/2008		

LEVEL 2: Services not required, but strongly encouraged to be provided by clinics and payable FFS when billed by clinics' primary care providers				
CPT CODE	**SERVICE DESCRIPTION**	**EFFECTIVE DATE**	**COMMENTS**	**CROSS WALK FROM**
29405	APPLY SHORT LEG CAST	11/01/2001		
29515	APPLICATION LOWER LEG SPLINT	06/01/2015		
29580	APPLICATION OF PASTE BOOT	11/01/2001		
30300	REMOVE NASAL FOREIGN BODY	01/01/2012		
30903	CONTROL NASAL HEMORRAGE COMPL	11/01/2001		
31000	IRRIGATION, MAXILLARY SINUS	11/01/2001		
36400	BL DRAW < 3 YRS REM/JUGULALR	11/01/2001		
36405	BL DRAW < 3 YRS SCALP VEIN	11/01/2001		
36406	BL DRAW <3 OTHER VEIN	11/01/2001		
40808	BIOPSY OF MOUTH LESION	11/01/2001		
45300	PROCTOSIGMOIDOSCOPY DX	11/01/2001		
45305	PROCTOSIGMOIDOSCOPY W/ BX	11/01/2001		
45330	DIAGNOSTIC SIGMOIDOSCOPY	11/01/2001		
45331	SIGMOIDOSCOPY AND BIOPSY	11/01/2001		
46600	DIAGNOSTIC ANOSCOPY	11/01/2001		
46606	ANOSCOPY AND BIOPSY	11/01/2001		
46608	ANOSCOPY REMOVE THE BODY	11/01/2001		
46611	ANOSCOPY	09/01/2013		
46900	DESTRUCTION ANAL LESION(S)	11/01/2001		
46916	CRYOSURGERY, ANAL LESION	01/01/2011		
51701	INSERT BLADDER CATHETER	09/22/2003		
51702	INSERT TEMP BLADDER CATHETER	01/01/2011		
56405	I & D OF VULVA/PER	11/01/2001		
56420	INCIS DRAIN OF BARTH	01/01/2007		
56501	DESTROY, VULVA LESION	01/01/2008		
56740	REMOVE VAGINA GLAND	11/01/2001		
57160	INSERT PESSARY OTHER DEVICE	04/01/2011		
58100	ENDOMET SAMPL,W/WO ENDOCERVICA	11/01/2001		
58300	INSERT INTRAUTERINE DEVICE	11/01/2001		
58301	REMOVE INTRAUTERINE DEVICE	11/01/2001		
76805	OB US >/= 14 WKS SNGL FETUS	06/01/2001		
76810	OB US >/= 14 WKS ADDL FETUS	06/01/2001		
76815	OB US, LIMITED	06/01/2001		
76816	OB US FOLLOW-UP PER FETUS	06/01/2001		
76817	TRANSVAGINAL US OBSTETRIC	01/01/2007		
76856	US EXAM, PELVIC, COM	06/01/2001		
76857	US EXAM PELVIC LIMITED	06/01/2001		
86480	TB TEST CELL IMMUN MEASURE	07/01/2015		
87430	INFECT AGT ANT DET BY ENZYME I	11/01/2001		
88720	BILIRUBIN TOTAL TRANSCUT	09/01/2010		
90384	99RH IG, FULL-DOSE	01/01/2012		J2790
90385	RH IG, MINIDOSE, IM	01/01/2012		J2790

LEVEL 2: Services not required, but strongly encouraged to be provided by clinics and payable FFS when billed by clinics' primary care providers				
CPT CODE	**SERVICE DESCRIPTION**	**EFFECTIVE DATE**	**COMMENTS**	**CROSS WALK FROM**
90389	TETANUS IG IM	09/23/2003		
90586	BCG VACCINE, INTRAVE	01/01/2008		
90620	MENB RP W/OMV VACINE IM (AGE 19 AND OLDER)	10/01/2015		
90630	NON-VFC FLU VACC IIV4 NO PRESERV ID	10/01/2015		
90649	NON-VFC GARDASIL	12/01/2006		
90651	9VHPV VACINE 3 DOSE IM (AGE 19 AND OLDER)	10/01/2016		
90660	FLU VACCINE NASAL	01/01/2007		
90662	FLUXONE HIGH-DOSE (AGE 65 AND OLDER)	11/01/2010		
90670	PCV 13 VACCINE IM (AGE 19 AND OLDER)	04/01/2016		
90675	RABIES VACCINE, IM	01/01/2008		
90680	NON-VFC ROTOVIRUS VACC 3 DOSE, ORAL	11/01/2006		
90690	TYPHOID VACCINE, ORAL	09/22/2003		
90691	TYPHOID VACCINE, IM	09/22/2003		
90693	TYPHOID VACCINE AKD SC	09/22/2003		
90698	NON-VFC DTAP-HIB-IP	08/15/2008		
90717	YELLOW FEVER VACCINE, SC	09/22/2003		
90725	CHOLERA VACCINE, INJECTAB	09/22/2003		
90736	ZOSTERSHINGLES VACCINE (AGE 60 AND OLDER "ONCE IN A LIFETIME")	01/01/2008		
90739	HEP B VACC 2 DOSE ADULT I	01/12/2022		
90746	HEPATITS B VACCINE, ADULT DOSAGE, FOR INTRAMUSCULAR USE (AGE 19 AND OLDER)	11/01/2001		
92557	COMPREHENSIVE HEARING TEST	11/01/2001		
95004	PERCUT ALLERGY SKIN TESTS	11/01/2001		
95052	PHOTO PATCH TEST(S)	11/01/2001		
95070	BRONCHIAL ALLERGY TESTS	11/01/2001		
95071	BRONCHIAL ALLERGY TESTS	11/01/2001		
97597	RMVL DEVITAL TIS 20 CM/<	07/01/2012		
99204	NURSING FACILITY CARE, INITIAL	01/05/2004		
99221	HOSPITAL CARE, INITIAL LEVEL I	11/01/2001		
99222	HOSPITAL CARE, INITIAL LEVEL II	11/01/2001		
99223	HOSPITAL CARE, INITIAL LEVEL III	11/01/2001		
99231	HOSPITAL CARE, SUBSEQUENT, LEVEL I	11/01/2001		
99232	HOSPITAL CARE, SUBSEQUENT, LEVEL II	11/01/2001		
99233	HOSPITAL CARE, SUBSEQUENT, LEVEL III	11/01/2001		
99238	HOSPITAL DISCHARGE DAY MGMT; 30 MIN	11/01/2001		
99239	HOSPITAL DISCHARGE DAY MGMT; > 30 MIN	11/01/2001		

LEVEL 2: Services not required, but strongly encouraged to be provided by clinics and payable FFS when billed by clinics' primary care providers				
CPT CODE	**SERVICE DESCRIPTION**	**EFFECTIVE DATE**	**COMMENTS**	**CROSS WALK FROM**
99251	INPATIENT CONSULTATION, INITIAL, LEVEL I	11/01/2001		
99252	INPATIENT CONSULTATION, INITIAL, LEVEL II	11/01/2001		
99253	INPATIENT CONSULTATION, INITIAL, LEVEL IIII	11/01/2001		
99254	INPATIENT CONSULTATION, INITIAL, LEVEL IV	11/01/2001		
99255	INPATIENT CONSULTATION, INITIAL	11/01/2001		
99283	EMERGENCY DEPT VISIT	09/01/2014		
99284	EMERGENCY DEPT VISIT	07/01/2015		
99285	EMERGENCY DEPT VISIT	01/01/2012		
99304	NURSING FACILITY CARE INIT	09/01/2013		
99305	NURSING FACILITY CARE, INITIAL	09/01/2011		
99306	NURSING FACILITY CARE, INITIAL	01/01/2011		
99307	NURSING FAC CARE SUBSEQ	10/01/2012		
99308	NURSING FAC CARE, SUBSEQ	01/01/2006		
99309	NURSING FAC CARE, SUBSEQ	01/01/2011		
99310	NURSING FAC CARE, SUBSEQ	01/01/2011		
99315	NURSING FAC DISCHARGE DAY	11/01/2001		
99316	NURSING FAC DISCHARGE DAY	11/01/2001		
99341	HOME VISIT NEW PATIENT	09/01/2013		
99342	HOME VISIT NEW PATIENT	09/01/2013		
99343	HOME VISIT NEW PATIENT	09/01/2013		
99344	HOME VISIT NEW PATIENT	09/01/2013		
99347	HOME VISIT-E&M OF ESTABLISHED PATIENT	07/01/2008		
99348	HOME VISIT-E&M OF ESTABLISHED PATIENT	01/01/2009		
99349	HOME VISIT-E&M OF ESTABLISHED PATIENT	01/01/2009		
99350	HOME VISIT-E&M OF ESTABLISHED PATIENT	09/01/2009		
99356	PROLONGED PHYSICIAN SERVICE, INPATIENT	01/01/2009		
99357	PROLONGED PHYSICIAN SERVICE; EACH ADDL 30 MINS	01/01/2009		
99460	INIT NB EM PER DAY HOSP	01/01/2009		
99461	INIT NB EM PER DAY, NON-F	09/01/2009		
99462	SBSQ NB EM PER DAY, HOSP	09/01/2009		
99XXX	ALL PREGNANCY RELATED E&M CODES	11/01/2001		
D1206	TOPICAL APPLICATION OF FLORIDE	07/01/2014		D1203
G9919	SCRN ND POS ND PROV OF RE	01/01/2020		
G9920	SCRNING PERF AND NEGATIVE	01/01/2020		
J0171	ADRENALIN EPINEPHRINE INJ	01/01/2014		
J0456	AZITHROMYCIN	04/01/2014		
J0690	CEFAZOLIN SOCIUM INJECTION	01/01/2014		
J0696	CEFTRIAXONE SODIUM INJECTION	10/01/2008		X2024

LEVEL 2: Services not required, but strongly encouraged to be provided by clinics and payable FFS when billed by clinics' primary care providers				
CPT CODE	**SERVICE DESCRIPTION**	**EFFECTIVE DATE**	**COMMENTS**	**CROSS WALK FROM**
J0696	SODIUM CEFTRIAXONE 250MGM	10/01/2008		
J1020	METHYLPREDNISOLONE 20MG INJECTION	01/01/2014		
J1030	METHYLPREDNISOLONE 40MG INJECTION	11/01/2001		
J1040	METHYLPREDNISOLONE 80MG INJECTION	11/01/2001		
J1050	MEDROXYPROGESTERONE ACETATE	01/01/2016		
J1100	DEXAMETHASONE SODIUM PHOS	01/01/2013		
J1200	DIPHENHYDRAMINE HCL INJECTION	11/01/2001		
J1725	HYDROXYPROGESTERONE CAPROATE	09/01/2013		
J1815	INSULIN INJECTION	09/01/2013		
J1885	KETOROLAC TROMETHAMINE INJECTION	11/01/2001		
J1940	FUROSEMIDE INJECTION	07/14/2015		
J1950	INJECTION LEUPROLIDE ACETATE PER 3	01/01/2010		
J1950	LUPRON INJECTION 3.75MG	06/01/2009		X7422
J2001	LIDOCAINE INJECTION	01/01/2013		
J2060	LORAZEPAM INJECTION	01/01/2013		
J2405	ODANSETRON HYDROCHLORIDE INJECTION	07152015		
J2540	PENICILLIN G POTASSIUM INJ	07/01/2013		
J2675	PROGESTERONE PER 50MG	10/01/2008		X6812
J2792	RHO (D) IMMUNE GLOBULIN H, SD	01/01/2014		
J2930	METHYLPREDNISOLONE INJECTION	11/01/2001		
J3301	TRIAMCINOLONE ACETONIDE INJECTION	11/01/2001		
J3303	TRIAMCINOLONE HEXACETONL INJ	10/01/2016		
J3420	VITAMIN B12 INJECTION	11/01/2001		
J3430	INJECTION, VITAMIN K, PHY	01/01/2014		
J3490	MEDROXYPROGESTERONE INJ	12/01/2014		
J7297	LEVONORGESTREL IU 52MG 3 YR	10/01/2016		J7302
J7298	LEVONORGESTREL IU 52MG 5 YR	10/01/2016		J7302
J7300	PARAGARD IUD DEVICE	11/01/2001		X1522
J7301	SKYLA 13.5MG	07/01/2014		
J7307	ETONOGESTREL IMPLANT SYSTEM	01/01/2008		
J9260	METHOTREXATE SODIUM, 50MG	01/01/2011		
LEVEL 3: Services requiring requisite experience when provided by clinics' PCPs and payable FFS when billed by clinics' primary care providers				
CPT CODE	**SERVICE DESCRIPTION**	**EFFECTIVE DATE**	**COMMENTS**	**CROSS WALK FROM**
Z1038	POSTPARTUM FOLLOW-UP OFFICE VISIT	01/01/2017		59430
10180	COMPLEX DRAINAGE WOUND	01/01/2012		
11424	EXC H-F-NK-SP-B9+MARG 3.1-4	07/01/2014		
11765	EXCISION OF NAIL FOLD TOE	01/01/2014		

LEVEL 3: Services requiring requisite experience when provided by clinics' PCPs and payable FFS when billed by clinics' primary care providers				
CPT CODE	**SERVICE DESCRIPTION**	**EFFECTIVE DATE**	**COMMENTS**	**CROSS WALK FROM**
12002	RPR S/N/AX/GEN/TRUNK2.6-7.5CM	11/01/2001		
12011	REPAIR SUPERFICIAL 2.5CM OR LESS	11/01/2001		
12013	REPAIR SUPERFICIAL WOUND(S)	11/01/2001		
12014	REPAIR SUPERFICIAL WOUND(S)	11/01/2001		
12015	REPAIR SUPERFICIAL WOUND(S)	11/01/2001		
12016	REPAIR SUPERFICIAL WOUND(S)	11/01/2001		
12017	REPAIR SUPERFICIAL WOUND(S)	11/01/2001		
12018	REPAIR SUPERFICIAL WOUND(S)	11/01/2001		
12051	INTMD RPR FACE/MM 2.5 CM/<	07/01/2014		
12052	INTMD RPR FACE/MM 2.6-5.0 CM	10/01/2015		
20612	ASPIRATE/INJ GANGLIN CYST	01/01/2014		
24640	TREAT ELBOW DISLOCATION	07/01/2014		
29075	APPLICATION OF FOREARM CAST	09/01/2013		
29240	STRAPPING OF SHOULDER	01/01/2015		
46083	INCISE EXTERNAL HEMORRHOID	07/01/2015		
54056	CRYOSURGERY PENIS LESION(S)	01/01/2011		
54115	TREATMENT OF PENIS LESION	11/01/2001		
56515	DESTROY VULVA LESION/S COMPL	07/01/2014		
56605	BX OF VULVA	11/01/2001		
57061	DESTROY VAGINAL LESION	11/01/2001		
57100	BIOPSY OF VAGINA	04/01/2011		
57410	PELVIC EXAMINATION UNDER ANESTHESIA	10/01/2015		
57452	EXAM OF CERVIX W/SCOPE	11/01/2001		
57454	BX/CURETT OF CERVIX W/SCOPE W/ENDOCERV CURRET	11/01/2001		
57455	BX/CURETT OF CERVIX W/SCOPE	11/01/2001		
57456	COLOPOSCOPY W ENDOCERVICAL CURRETTAGE	05/01/2007		
57460	BX OF CERVIX W/SCOPE, LEEP	11/01/2001		
57500	BIOPSY OF CERVIX	11/01/2001		
57510	CAUTERIZATION OF CERVIX	11/01/2001		
57511	CRYOCAUTERY OF CERVIX	11/01/2001		
58605	DIVISION OF FALLOPIAN TUBE	11/01/2001		
58611	LIGATE OVIDUCT(S0 ADD-ON	11/01/2001		
58661	LAPAROSCOPY, REMOVE ADNEXA	11/01/2001		
58662	LAPAROSCOPY EXISE LESIONS	01/01/2016		
58671	LAPAROSCOPY, TUBAL BLOCK	11/01/2001		
58925	REMOVAL OF OVARIAN CYSTS(S)	11/01/2001		
59025	FETAL NON-STRESS TEST	11/01/2001		
59300	EPISIOTOMY OR VAGINAL REPAIR	11/01/2001		
59320	REVISION CERVIX	11/01/2001		
59409	VAG DELIVERY ONLY (WITH OR W/O)	11/01/2001		

LEVEL 3: Services requiring requisite experience when provided by clinics' PCPs and payable FFS when billed by clinics' primary care providers				
CPT CODE	**SERVICE DESCRIPTION**	**EFFECTIVE DATE**	**COMMENTS**	**CROSS WALK FROM**
59414	DELIVER PLACENTA	07/14/2015		
59514	CAESAREAN DELIVERY ONLY	01/01/2002		
59612	VAG DEL ONLY AFTER PREV C-SEC	11/01/2001		
59620	C-SECT ONLY FOLL. ATTEMP. VAG	01/01/2002		
59820	CARE OF MISCARRIAGE	11/01/2001		
59870	EVACUATE MOLE OF UTERUS	01/01/2016		
60100	BIOPSY THYROID,PERCUTANEOUS CO	11/01/2001		
65205	REMOVE FOREIGN BODY FROM EYE	11/01/2001		
65210	REMOVE FOREIGN BODY FROM EYE	11/01/2001		
65220	REMOVE FOREIGN BODY FROM EYE	11/01/2001		
65222	REMOVE FOREIGN BODY FROM EYE	11/01/2001		
65235	REMOVE FOREIGN BODY FROM EYE	11/01/2001		
65260	REMOVE FOREIGN BODY FROM EYE	11/01/2001		
65265	REMOVE FOREIGN BODY FROM EYE	11/01/2001		
67413	EXPLORE/TREAT EE SOCKET	11/01/2001		
68840	EXPLORE/IRRIGATE TEAR DUCTS	11/01/2001		
76801	OB US <14 WKS, SINGLE FETUS	11/01/2001		
92551	PURE TONE HEARING TEST, AIR	11/01/2001		
92552	PURE TONE AUDIOMETRY, AIR	11/01/2001		
92553	AUDIOMETRY, AIR & BONE	11/01/2001		
92561	BEKESY AUDIOMETRY, DIAGNOSTIC	11/01/2001		
94010	BREATHING CAPACITY TEST	11/01/2001		
94150	VITAL CAPACITY TEST	11/01/2001		
96360	HYDRATION IV INFUSION, INIT	01/01/2010		

LEVEL 4: Services that should be provided by a provider with specialty training				
CPT CODE	**SERVICE DESCRIPTION**	**EFFECTIVE DATE**	**COMMENTS**	**CROSS WALK FROM**
19000	BARINAGE OF BREAST LESION	11/01/2001		
24500	TREAT HUMERUS FRACTURE	01/01/2015		
36420	VEIN ACCESS CUTDOWN <1YR	11/01/2001		
36425	VEIN ACCESS CUTDOWN >1YR	11/01/2001		
38500	BIOPSY/REMOVAL LYMPH NODES	11/01/2001		
38505	NEEDLE BIOPSY LYMPH NODES	01/01/2015		
42809	REMOVE PHARYNX FOREIGN BODY	11/01/2001		
49000	EXPLORATION OF ABDOMEN	01/01/2013		
49320	DIAG LAPARO SEPARATE PROC	11/01/2001		
49322	LAPAROSCOPY ASPIRATION	01/01/2008		
51729	CYSTOMETROGRAM W/VP&UP	09/01/2011		
51741	ELECTRO-UROFLOWMETRY	12/31/2011		
51784	ELECTROMYOGRAPHY STUDY	12/31/2011		
51797	INTRAABDOMINAL PRESS	12/31/2011		

LEVEL 4: Services that should be provided by a provider with specialty training				
CPT CODE	**SERVICE DESCRIPTION**	**EFFECTIVE DATE**	**COMMENTS**	**CROSS WALK FROM**
51798	US URINE CAPACITY MEASURE	01/01/2012		
52000	CYSTOSCOPY	01/012007		
56700	PARTIAL REMOVAL OF HYMEN	07/01/2014		
57230	REPAIR OF URETHRAL LESION	09/01/2013		
57240	REPAIR BLADDER & VAGINA	01/01/2007		
57250	REPAIR RECTUM & VAGINA	01/01/2007		
57268	REPAIR OF BOWEL BULGE	01/01/2013		
57283	COLPOPEXY INTRAPERITONEAL	07/01/2014		
57288	REPAIR BLADDER DEFECT	07/01/2007		
57505	ENDOCERVICAL CURETTAGE	01/01/2007		
57520	CONIZATION OF CERVIX	01/01/2007		
57522	CONIZATION OF CERVIX W/O FULGURATION	01/01/2014		
57720	REVISION OF CERVIX	11/01/2011		
57800	DILATION OF CERVICAL CANAL	07/01/2015		
58120	DILATION AND CURETTAGE	01/01/2011		
58140	MYOMECTOMY ABDOM MET	01/01/2011		
58150	TOTAL HYSTERECTOMY	01/01/2008		
58180	PARTIAL HYSTERECTOMY	01/01/2016		
58260	VAGINAL HYSTERECTOMY	01/01/2008		
58270	VAG HYST W/ENTEROCELE REPAIR	07/01/2014		
58350	REOPEN FALLOPIAN TUBE	09/01/2014		
58541	LSH, UTERUS 250 G OR LESS	01/01/2011		
58550	LAPARO-ASST VAG HYSTERECTOMY	01/01/2015		
58553	LAPARO-VAG HYST COMPLEX	10/01/2015		
58554	LAPARO-VAG HYST W/T/O COMPL	06/01/2014		
58555	HYSTEROSCOPY, DX, SEP PROC	11/01/2001		
58558	HYSTREOSCOPY, BIOPSY	01/01/2010		
58561	HYSTEROSCOPY REMOVE MYOMA	01/01/2012		
58562	HYSTEROSCOPY REMOVE FB (POS 21)	10/01/2015		
58563	HYSTOROSCOPY, ABLATION	01/01/2011		
58565	HYSTEROSCOPY STERILIZATION	01/01/2011		
58573	TLH W/T/O UTERUS OVER 250 G	10/01/2016		
58700	REMOVAL OF FALOPIAN TUBE	01/01/2013		
58720	REMOVAL OF OVARY/TUBE(S)	01/01/2016		
58740	ABHESIOLYSIS TUBE OVARY	01/01/2013		
58940	REMOVAL OF OVARY(S)	01/01/2013		
59150	TREAT ECTPIC PREGNANCY	01/01/2011		
59151	TREAT ECTOPIC PREGNANCY	01/01/2008		
59160	D & C AFTER DELIVERY	07/01/2013		
59812	TREATMENT OF MISCARRIAGE	01/01/2009		
64435	N BLOCK INJ PARACERVICAL	01/01/2015		

HISTORY – DELETED CODES

DELETED PCP Cap Exceptions, Service Code Designations

LEVEL 2: Services not required, but strongly encouraged to be provided by clinics and payable FFS when billed by clinics' primary care providers

CPT CODE	SERVICE DESCRIPTION	DELETE DATE	CROSS WALK TO
D1203	TOPICAL APPLICATION OF FLORIDE – TERMED CODE	06/30/2014	D1206
J0540	PENICILLIN G BENZATHINE INJECTION – MOVED TO CAP	11/01/2010	
J0550	PENICILLIN G BENZATHINE INJECTION – MOVED TO CAP	11/01/2010	
J0560	PENICILLIN G BENZATHINE INJECTION – MOVED TO CAP	11/01/2010	
J0570	PENICILLIN G BENZATHINE INJECTION – MOVED TO CAP	11/01/2010	
J0580	PENICILLIN G BENZATHINE INJECTION – MOVED TO CAP	11/01/2010	
J0715	CEFTIZOXIME SODIUM 500MG	07/01/2014	
J0780	PROCHLORPERAZINE, UP TO 10MG, INJECTION	01/01/2015	
J1055	MEDRXYPROGESTER ACETATE INJECTION	08/31/2013	
J1080	INJECTION, TESTOSTERONE CYPIONATE MOVED TO CAP	10/31/2015	
J2790	RHO D IMMUNE GLOBULIN INJECTION – TERMED CODE	12/31/2011	90384 90385
J7040	NORMAL SALINE SOLUTION INFUSION	07/01/2014	
J7302	LEVONORGESTREL IU CONTRACEPT	12/31/2016	J7297 J7298
J7611	ALBUTEROL, 1MG, CONCENTRATE	09/30/2008	
J7612	LEVALBUTEROL, 0.5MG, CONCENTRATE	09/30/2008	
J7613	ALBUTEROL, 1MG UNIT DOSE – MOVED TO CAP	07/01/2014	
J7614	LEVALBUTEROL, 0.5MG, UNIT DOSE	09/30/2008	
J7616	ALBUTEROL, UP TO 5MG	09/30/2008	
J7619	ALBUTEROL INH SOL UNIT DOSE	09/30/2008	
J7621	(LEVO) ALBUTEROL/IPRA-BROMIDE	09/30/2008	
J7626	BUDESONIDE INHALATION SOL	07/01/2014	
J7644	IPRATROPIUM BROM INH SOL UNIT DOSE – TERMED CODE	07/01/2014	
J7645	07IPRATROPIUM BROMIDE CO	07/01/2014	
Q0090	LEVONORGESTREL INTRAUTERI – TERMED CODE	06/30/2014	J7301
X1522	PARAGARD IUD DEVICE	07/01/2014	J7300
X1532	MIRENA INTRAUTERINE SYSTEM	07/01/2014	J7302
X5280	PHYSICAL THERAPY VISIT	07/01/2014	
X5862	SODIUM CEFTRIAXONE 500MGM – TERMED CODE	09/30/2008	J0715
X5864	SODIUM CERFTRAIAXONE 250MGM – TERMED CODE	09/30/2008	J0696
X5974	HYDROXYPROGESTERONE 250MG/CC	09/30/2008	
X6046	MEDROXYPROGES 400MG/ML	09/30/2008	
X6051	DEPO-PROVERA 150MGM – TERMED CODED	10/31/2010	J1055
X6052	TESTOSTERONE CYPIONATE-50	07/01/2014	
X6812	PROGESTERONE PER 50MG – TERMED CODE	09/30/2008	J2675
X7422	LUPRON INJECTION 3.75MG – TERMED CODE	05/31/2009	J1950
X7430	LUPRON DEPOT-PED 11.	08/31/2009	
X7490	LUNELLE 5-25MG/0.5ML	10/01/2002	
11975	INSERT CONTACEPTIVE CAP – MOVED TO CAP	07/01/2014	

LEVEL 2: Services not required, but strongly encouraged to be provided by clinics and payable FFS when billed by clinics' primary care providers			
CPT CODE	**SERVICE DESCRIPTION**	**DELETE DATE**	**CROSS WALK TO**
11976	REMOVAL OF CONTRACEPTIVE CAP – MOVED TO CAP	06/01/2015	
11977	REMOVAL/REINSERT CONTRA CAP – MOVED TO CAP	07/01/2014	
16010	TREATMENT OF BURN(S)	07/01/2014	
16015	TREATMENT OF BURN(S)	07/01/2014	
17100	12DESTRUCTION OF SKIN LESION	09/30/2008	
30905	CONTROL OF NOSEBLEED – MOVED TO CAP	06/01/2015	
30906	REPEAT CONTROL OF NOSEBLEED – MOVED TO CAP	06/01/2015	
41115	EXCISION OF TONGUE FOLD	07/01/2014	
81002	URINALYSIS, NONAUTO W/O SCOPE	06/01/2013	
81003	URINALYSIS, AUTO, W/O SCOPE	06/01/2013	
81005	URINALYSIS; QUAL OR SEMI-QUAN – MOVED TO CAP	07/01/2018	
81007	URINE SCREEN FOR BACTERIA – MOVED TO CAP	07/01/2018	
81015	MICROSCOPIC EXAM OF URINE – MOVED TO CAP	07/01/2018	
82270	TEST FOR BLOOD, FECES – MOVED TO CAP	07/01/2018	
82274	ASSAY TEST FOR BLOOD, FEC – MOVED TO CAP	07/01/2018	
82947	ASSAY, GLUCOSE, BLOOD QUANT – MOVED TO CAP	07/01/2018	
82950	GLUCOSE TEST – MOVED TO CAP	07/01/2018	
82951	GLUCOSE TOLERANCE TEST (GTT) – MOVED TO CAP	07/01/2018	
82962	GLUCOSE BLOOD TEST – MOVED TO CAP	07/01/2018	
83036	GLYCATED HEMOGLOBIN	04/01/2013	
83655	ASSAY OF LEAD – MOVED TO CAP	07/01/2018	
85013	SPUN, MICROHEMATOCRIT – MOVED TO CAP	07/01/2018	
85014	HEMATOCRIT – MOVED TO CAP	07/01/2018	
85018	HEMOGLOBIN, COLORIMETRIC	06/01/2013	
85610	PROTHROMBIN TIME – MOVED TO CAP	07/01/2018	
87210	SMEAR, WET MOUNT, SALINE/INK – MOVED TO CAP	07/01/2018	
90656	FLU VACCINE NO PRESERV 3 & > - MOVED TO CAP	06/01/2015	
90665	LYME DISEASE VACCINE, IM	07/01/2014	
90692	TYPHOID VACCINE H-P SC/ID	12/31/2016	
90727	PLAGUE VACCINE IM	12/31/2016	
90742	SPECIAL PASSIVE IMMUNIZATION	07/01/2014	
97802	MEDICAL NUTRITION, INDIV	01/31/2014	
97803	MED NUTRITION, INDIV, SUBSEQUENT	01/31/2014	
99217	OBSERV CARE DISCHARGE DAY	07/01/2014	
99234	OBSERV/HOSP SAME DATE	07/01/2014	
99235	OBSERV/HOSP SAME DATE	07/01/2014	
99236	OBSERV/HOSP SAME DATE	07/01/2014	
99261	INPT. CONSULT, FOLLOW-UP	09/30/2008	
99262	INPATIENT CONSULTATION, FOLLOW	09/30/2008	
99263	INPT. CONSULT, FOLLOW-UP	09/30/2008	
99301	NURSING FACILITY ASMT., ANNUAL	09/30/2008	
99302	NURSING FACILITY ASSMT.	09/30/2008	

LEVEL 2: Services not required, but strongly encouraged to be provided by clinics and payable FFS when billed by clinics' primary care providers			
CPT CODE	**SERVICE_DESCRIPTION**	**DELETE DATE**	**CROSS WALK TO**
99303	NURSING FACILITY ASSMT., INITIAL	09/30/2008	
99313	NURSING FAC CARE, SUBSEQ	07/01/2014	
99431	NEWBORN, HISTORY AND EXAM	06/30/2014	
99433	NORMAL NEWBORN CARE/HOSPITAL	07/01/2014	
99436	ATTENDANCE, BIRTH	07/01/2014	
LEVEL 3: Services requiring requisite experience when provided by clinics' PCPs and payable FFS when billed by clinics' primary care providers			
CPT CODE	**SERVICE_DESCRIPTION**	**DELETE DATE**	**CROSS WALK TO**
Q3014	TELEHEALTH FACILITY FEE	07/01/2014	
J1070	INJECTION, TESTOSTERONE CYPIONATE,	12/31/2016	
59400	OBSTETRICAL CARE	01/01/2016	
59430	CARE AFTER DELIVERY	12/31/2016	Z1038
LEVEL 4: Services that should be provided by a provider with specialty training			
CPT CODE	**SERVICE_DESCRIPTION**	**DELETE DATE**	**CROSS WALK TO**
Z1210	TRANS/FALL TU UNI/BIL W/M	07/01/2014	

CHCN Acupuncture Services

CHCN will continue to contract with acupuncture providers for CHCN Alameda Alliance for Health members. Please use the online provider search tool to identify providers in CHCN's network. https://portal.chcnetwork.org/FindASpecialist.

Please see below for detailed information about CHCN's acupuncture benefit.

Medical Criteria

CHCN follows the Medi-Cal medical necessity criteria for acupuncture benefits; however, CHCN does not follow the Medi-Cal limit of two visits per month. Although CHCN does not limit the number of acupuncture visits a member may receive in a month, more than 24 visits in an elapsed year requires prior authorization.

Acupuncture services are allowed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.

Procedure Codes

Acupuncture service may include one of the following:

1. One code of 97810 and up to two codes of 97811;
   or
2. One code of 97813 and up to two codes of 97814;
   or
3. One code of 99199

Procedure Code Descriptions

97810 Acupuncture, one or more needles, without electrical stimulation; initial 15 minutes of personal one-on-one contact with the patient

97811 Acupuncture, one or more needles, without electrical stimulation; each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s). Code 97811 is an add-on and must be billed on the same claim with code 97810.

97813 Acupuncture, one or more needles, with electrical stimulation; initial 15 minutes of personal one-on-one contact with the patient

97814 Acupuncture, one or more needles, with electrical stimulation; each additional15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s). Code 97814 is an add-on and must be billed on the same claim with code 97813.

99199 Unlisted special service, procedure or report used for group acupuncture visit

Provider Network

In accordance with Medi-Cal policy, acupuncture services are allowed when provided by a physician, podiatrist or certified acupuncturist

Prior Authorization

Prior authorization is not required if service is provided by contracted provider. Non-contracted providers must submit prior authorization through CHCN.

Billing

Providers may be reimbursed for acupuncture services when billed in conjunction with one of the following ICD-10-CM diagnosis codes:

- G89.0 Central pain syndrome
- G89.21 Chronic pain due to trauma
- G89.22 Chronic post-thoracotomy pain
- G89.28 Other chronic post procedural pain
- G89.29 Other chronic pain
- G89.3 Neoplasm related pain (chronic)
- G89.4 Chronic pain syndrome

CHCN Chiropractic Services

Effective 8/1/16, CHCN provides medically necessary chiropractic services to Medi-Cal managed care members. Chiropractic services are reimbursable only when provided in the federally qualified health center (FQHC). CHCN follows the Medi-Cal medical necessity criteria for chiropractor benefits; however, CHCN allows 4 visits per member per month. Visits beyond 4 in one month or 10 in an elapsed year require prior authorization.

Medical Criteria
A diagnosis must be listed that shows anatomic cause of symptoms, for instance, sprain, strain, deformity, degeneration or malalignment.

Procedure Codes
Only one chiropractic procedure code may be billed per visit. Allowable chiropractic codes are:

- 98940 Chiropractic manipulative treatment (CMT) involving one to two spinal regions
- 98941 Chiropractic manipulative treatment (CMT) involving three to four spinal regions
- 98942 Chiropractic manipulative treatment (CMT) involving five spinal regions

Provider Network
In accordance with Medi-Cal policy, chiropractic services are only a covered benefit when provided within the FQHC.

Prior Authorization

- For chiropractic services provided at a CHCN health center: Prior authorization required for 5 or more visits in a month or 11 or more visits in an elapsed year (one year from first date of chiropractic service for that member).
- Non-CHCN FQHCs must submit prior authorization through CHCN prior to any service.

Billing
Chiropractic services are reimbursable by CHCN when billed in conjunction with one of the following ICD-10-CM diagnosis codes:

- M50.11 – M50.13 Cervical disc disorder with radiculopathy
- M51.14 – M51.17 Intervertebral disc disorders with radiculopathy
- M54.17 Radiculopathy, lumbosacral region
- M54.31, M54.32 Sciatica
- M54.41, M54.42 Lumbago with sciatica
- M99.00 – M99.05 Segmental and somatic dysfunction
- S13.4 Sprain of ligaments of cervical spine
- S16.1 Strain of muscle, fascia and tendon at neck level
- S23.3 Sprain of ligaments of thoracic spine
- S29.012 Strain of muscles and tendon of back wall of thorax
- S33.5 Sprain of ligaments of lumbar spine
- S33.6 Sprain of sacroiliac joint
- S33.8 Sprain of other parts of lumbar spine and pelvis
- S39.012 Strain of muscle, fascia and tendon of lower back

COMMUNITY HEALTH CENTER NETWORK

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I: REASON FOR SUBMISSION

Reason for Submission:

☐ New EFT Authorization

☐ Revision to Current Authorization

(e.g. account or bank changes)

☐ Check here if EFT payment is being made to the Home Office of Chain

(Attach letter Authorizing EFT payment to Chain Home Office)

Since your last EFT authorization agreement submission, have you had a:

☐ Change of Ownership, and/or

☐ Change of Practice Location?

If you checked either a change of ownership or change of practice location above, you must submit a change of information (using the Medicare enrollment application) to the Medicare contractor that services your geographical area(s) prior to or accompanying this EFT authorization agreement submission.

PART II: PROVIDER OR SUPPLIER INFORMATION

Provider/Supplier: Legal Business Name

Chain Organization Name or Home Office Legal Business Name (if different from Chain Organization Name)

Account Holder's Street Address

Account Holder's City	Account Holder's State	Account Holder's Zip Code

Tax Identification Number: (designate ☐ SSN or ☐ EIN)

☐☐☐☐☐☐☐☐☐☐☐☐

Medicare Identification Number (if issued)

☐☐☐☐☐☐☐☐☐☐☐☐

National Provider Identifier (NPI)

☐☐☐☐☐☐☐☐☐☐

PART III: FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

Financial Institution City/Town	Financial Institution State
Financial Institution Telephone Number	Financial Institution Contact Person

Financial Institution Routing Transit Number (nine digits)

☐☐☐☐☐☐☐☐☐

Depositor Account Number	Type of Account (check one)
☐☐☐☐☐☐☐☐☐☐☐☐☐	☐ Checking Account ☐ Savings Account

Please include a confirmation of account information on bank letterhead or a voided check. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type. If submitting bank letterhead, the bank officer's name and signature is also required. This information will be used to verify your account number.

PART IV: CONTACT PERSON

Contact Person's Name	Contact Person's Title
Contact Person's Telephone Number	Contact Person's E-mail Address

PART V: AUTHORIZATION

I hereby authorize Community Health Center Network (CHCN) to initiate credit entries, and initiate adjustments for any duplicate or erroneous entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above to credit and/or debit the same to such account.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still considered payment to the Provider, and the Provider authorizes the forwarding of payments to the Chain Home Office.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/ Supplier, the said Provider or Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the Financial Institution and the said Provider or Supplier are in accordance with all applicable regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until CHCN has received written notification from me of its termination in such time and such manner as to afford CHCN and the Financial Institution a reasonable opportunity to act on it. CHCN will continue to send the direct deposit to the Financial Institution indicated above until notified to change the Financial Institution receiving the direct deposit. If the Financial Institution information changes, I agree to submit to CHCN an updated EFT Authorization Agreement.

SIGNATURE LINE

Authorized/Delegated Official Name (Print)	Authorized/Delegated Official Telephone Number
Authorized/Delegated Official Title	Authorized/Delegated Official E-mail Address
Authorized/Delegated Official Signature *(Note: Must be original signature in black or blue ink.)*	Date

INSTRUCTIONS FOR COMPLETING THE EFT AUTHORIZATION AGREEMENT

Please submit the form to CHCN Provider Services department via email or fax at providerservices@chcnetwork.org or 510-297-0445.

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any direct deposits are made.

PART I: REASON FOR SUBMISSION

Indicate your reason for completing this form by checking the appropriate box: New EFT authorization or change to your account information. If you are authorizing EFT payments to the home office of a chain organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the home office of the chain organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

PART II: PROVIDER OR SUPPLIER INFORMATION

Line 1: Enter the provider's/supplier's legal business name or the name of the physician or individual practitioner, as reported to the Internal Revenue Service (IRS). The account to which EFT payments made must exclusively bear the name of the physician or individual practitioner, or the legal business name of the person or entity enrolled with Medi-Cal.

Line 2: Enter the chain organization's name or the home office legal business name if different from the chain organization name.

Line 3: Enter the account holder's street address.

Line 4: Enter the account holder's city, state, and zip code.

Line 5: Enter the tax identification number as reported to the IRS. If the business is a corporation, provide the Federal employer identification number, otherwise provide your Social Security Number.

Line 6: If issued, enter the Medicare identification number assigned by a Medicare fee-for-service contractor. If you are not enrolled in Medicare, leave this field blank.

Line 7: Enter the 10 digit NPI number. The NPI is required to process this form.

PART III: FINANCIAL INSTITUTION INFORMATION

Line 8: Enter your Financial Institution's name (this is the name of the bank or qualifying depository that will receive the funds). Note: The account name to which EFT payments will be paid is to the name submitted on Part II of this form.

Line 9: Enter the city or town where your financial institution is located. Enter the state where your financial institution is located.

Line 10: Enter the bank or financial institutional telephone number and contact person's name.

Line 11: Enter the bank or financial institutional nine-digit routing number, including applicable leading zeros.

Line 12: Enter the depositor's account number, including applicable leading zeros. Select the account type.

If you do not submit this information, your EFT authorization agreement will be returned without further processing.

PART IV: CONTACT PERSON

Line 13: Enter the name and title of a contact person who can answer questions about the information submitted on this form.

Line 14: Enter the contact person's telephone number. Enter the contact person's e-mail address.

PART V: AUTHORIZATION

Line 15: By your signature on this form you are certifying that the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider or Supplier. The Provider or Supplier has sole control of the account to which EFT deposits are made in accordance with all applicable regulations and instructions. All arrangements between the Financial Institution and the said Provider or Supplier are in accordance with all applicable regulations and instructions with the effective date of the EFT authorization. You must notify CHCN regarding any changes in the account in sufficient time to allow the contractor and the Financial Institution to act on the changes.

The EFT authorization form must be signed and dated by the same Authorized Representative or a Delegated Official named on the CHCN enrollment application on file. Include a telephone number where the Authorized Representative or Delegated Official can be contacted.

Provider Claim Dispute Resolution Mechanism
(Provider Claims Appeal Process)

A contracted or non-contracted provider claim dispute is a written notice to CHCN challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination, or disputing a request for reimbursement of an overpayment of a claim.

If a provider wants to dispute a claim payment or denial (for reasons not related to provider's claim submission error or omission) the provider can submit a written dispute to the following address:

Community Health Center Network
Attn: Provider Claims Dispute Department
101 Callan Avenue, Suite 300
San Leandro, CA 94577
510-297-0210

Note: Claims that are denied due to provider's claim submission error or omission (e.g. missing/incorrect CPT, ICD-10-CM or place of service codes) or any changes in the claim form made from original submission do not qualify for the Provider Claim Dispute Resolution Mechanism. Claims resubmission with medical records for review due to bundling edits, included services, request for medical records/treatment notes, anesthesia time spent or EOB submissions should be sent directly to claims dept. not through provider disputes. These should be resubmitted within the time period for claim submission as "Corrected Claim" with a brief explanation either noted on the claim or as an attachment.

1. The provider must submit a Notice of Provider Claim Dispute (NOPD) in writing along with any relevant and supporting documentation within 365 days of CHCN's last action or, in the case of inaction, 365 days after the Time for Contesting or Denying Claims has expired.

2. The Provider Claim Dispute must include:
    a. Provider's Name
    b. Provider's ID Number
    c. Provider's Contact Information (Name, Address, Phone Number)
    d. Patient's Name
    e. Patient's DOB
    f. Claim Number (from CHCN remittance advice)
    g. Paper Claim: Copy of the original claim being disputed
    h. Clear identification of the disputed item.
    i. Clear explanation of the basis that provider believes the payment amount, denial, adjustment, or request for reimbursement is incorrect.
    j. Other pertinent documentation to support appeal

3. CHCN will acknowledge the receipt of the written claim dispute within fifteen (15) working days of receipt of the dispute.

4. If CHCN receives an incomplete provider claim dispute, CHCN will return it to the provider with a clear identification of the missing information.

5. The provider has thirty (30) working days from the receipt of the returned NOPD to resubmit an Amended Claim Dispute with the requested information.

6. CHCN will issue a written determination, including a statement of the pertinent facts and reasons, to the provider within forty-five (45) working days after receipt of the provider claim dispute or the amended provider claim dispute.

PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES ACKNOWLEDGEMENT CHCN MEDI-CAL MEMBERS ELIGIBLE ON DATE OF SERVICE CANNOT BE BILLED FOR COVERED BENEFITS AT ANY TIME.

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute.
- In order to ensure the integrity of the Provider Dispute Resolution (PDR) process, we will re-categorize issues sent to us on a PDR form which are not true provider disputes (e.g., claims check tracers or a provider's submission of medical records after payment was denied due to a lack of documentation, request for time spent, or request for treatment notes).
- For routine follow-up, use CHCN's Web Portal to view claims status: https://portal.chcnetwork.org/Login
- Mail the completed form to: CHCN PDR Department
  101 Callan Avenue, Suite 300
  San Leandro, CA 94577

***PROVIDER NAME:**	***PROVIDER TAX ID # / Medicare ID #:**
***PROVIDER ADDRESS:**	

PROVIDER TYPE ☐ MD ☐ Other _____
(Please specify type of "other")

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

*** Patient Name:**	***Date of Birth:**

*** Health Plan ID Number:**	**Patient Account Number:**	***Original Claim ID Number:** (If multiple claims, use attached spreadsheet)

Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	**Original Claim Amount Billed:**	**Original Claim Amount Paid:**

DISPUTE TYPE

☐ Claim ☐ Contract Dispute

☐ Disputing Request For Reimbursement Of Overpayment

☐ Seeking Resolution Of A Billing Determination ☐ Other:

*** DESCRIPTION OF DISPUTE:**

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

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)**

*Provider Name:	*Provider NPI#:

Page _____ of ___

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

Section 8

Compliance

Compliance Program and Fraud, Waste, and Abuse Prevention

Compliance Program Overview

Community Health Center Network (CHCN) is a not-for-profit Medi-Cal managed care organization, providing business administrative support to community health centers providing health care to Medi-Cal beneficiaries, including but not limited to administering capitated health plan contract with The Alameda Alliance for Health (Alliance) for Medi-Cal enrollees and IHSS enrollees as well as maintains a large network of specialty providers.

CHCN is committed to preventing, detecting, and investigating Fraud, Waste, and Abuse (FWA) incidents to assure public accountability and conduct proper business practices. It is also the intent of CHCN to comply with federal and state regulations, and contractual requirements concerning the detection, investigation, and resolution of suspected fraud, waste, and abuse (FWA). The Compliance program will comply with Health & Safety Code § 1348 as adopted by the Department of Managed Health Care.

The purpose of CHCN Anti-Fraud Program is to:

- Protect CHCN's ability to deliver business administrative support services to the health centers through the timely detection, investigation, and prosecution of fraud.
- Develop and implement a process to protect CHCN from internal fraud and from external fraud by providers, employees, members, and others.
- Provide various methods to report potential fraudulent activities to the appropriate authorities at CHCN.
- Outline procedures for the detection, reporting, and managing of incidents of suspected fraud;
- Coordinate the practices and procedures for the detection, investigation, prevention, reporting, correcting, and prosecution of fraud with federal, state, and local regulatory agencies and law enforcement;
- Provide FWA awareness education and training to employees, members, and providers to facilitate in the timely detection and investigation of fraud, waste, or abuse; and
- Educate CHCN employees on applicable federal and state laws including the False Claims Act and whistleblower provisions.

Anti-Fraud Activities

The Anti-Fraud Program outlines the Compliance Department's areas of focus with regards to anti-fraud activities. The Anti-Fraud Program initiatives are compiled into seven main categories: Structure, FWA Reporting, Regulatory Reporting, Non-Retaliation, FWA Detection & Prevention, Investigation & Monitoring, and Education & Training.

Structure

The CHCN's Compliance Officer (CO) is responsible for the Compliance Anti-Fraud Program and activities. The CO reports directly to the Chief Executive Officer (CEO) with a dotted line to the Board of Directors. The CO chairs the Compliance Committee (Committee) which assists the CO in overseeing the Anti-Fraud activities. The CO is responsible for the daily operations of the program, and reports incidents and fraud prevention activity to the CEO weekly and the

Committee quarterly, or more frequently if needed. The CO reports to the Board of Directors on Compliance activities at the Board meetings.

The Committee is comprised of senior leadership roles from each operational area of CHCN. The Committee is responsible for reviewing and discussing CHCN monitoring activities, new or revised state and federal regulations related to fraud detection and prevention, and operational processes needed to comply with applicable regulations. The Committee reviews internal and external fraud investigation statistics conducted by the CHCN and discusses certain cases for resolution of any issues that arise. Any significant incidents are also reported immediately by the CO to the CEO, and will be reported to the Board of Directors by the CEO and/or CO.
CHCN's Compliance Department works closely with internal departments on fraud detection process and investigations. These departments include Utilization Management, Provider Services, Customer Care, and Claims. The Compliance Department collaborates with these departments to complete certain steps of the investigation process and to develop and monitor a corrective action plan. These steps may include provider and member outreach, medical utilization data analysis, clinical review of medical records, medical coder review, and monitoring of provider claims billing patterns.

Understanding FWA

1. Definitions of FWA:
   - Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person.
   - Waste: The overutilization or inappropriate utilization of services and misuse of resources.
   - Abuse: Activities that are inconsistent with sound fiscal, business, or medical practices, and result in the following: unnecessary cost to health care programs or reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. Abuse also includes beneficiary practices that result in unnecessary costs to health care programs.

2. Examples of FWA
   The costs of fraudulent activities in public programs annually cost the state and federal taxpayers hundreds of billions of dollars. Below are examples of these types of activities:

   <u>Provider FWA</u>
   - Altering medical records to received covered services
   - Billing for services not provided or that are medically unnecessary
   - Services performed by an unlicensed provider yet billed under a licensed provider's name or information
   - Billing for non-covered services using incorrect CPT, HCPCS, and/or diagnosis code in order to have services covered
   - Payment for referrals including soliciting, offering, or receiving kickbacks or bribes
   - Unbundling of services that should be billed together and/or Upcoding
   - Balance billing Medi-Cal or Medicare beneficiaries for the difference between the allowed reimbursement rate and the customary charge for the service
   - Overutilization or underutilization

Member FWA

- Impersonation: Someone using the personal information of another person to obtain Medi-Cal or Medicare benefits for which they would otherwise not qualify or be entitled to receive
- Relocating to out-of-service area for which their benefits are assigned
- Falsely reporting of money or resources in order to obtain benefits
- Providing inaccurate or incomplete information about a medical condition to get medical treatment
- Forging, altering or selling prescriptions
- Obtaining controlled substances from multiple providers
- Using more than a single provider to obtain similar treatments and/or medications

FWA Reporting

CHCN requires employees, contracted network providers, and members to report any potential FWA incidents for investigation as soon as it is known. To assist us in our investigation efforts, please include as much of the following information as possible when reporting a potential FWA incident:

- Name, address, license number, or insurance ID of the suspect (if known)
- Description and details of the incident including who, what, where, and when with the date and time of the incident(s)
- Any documentation you have related to the incident(s)
- Your name and telephone number (if you would like to be contacted)

Individuals may report potential FWA incidents using any of the following methods:

- Contacting CHCN's Compliance Officer, Teresa Ercole directly by:
  - Phone: (510) 297-0290
  - Email: tercole@chcnetwork.org
- Or via email to our Compliance Department at compliancemailbox@chcnetwork.org
- Or calling our Toll-Free Hotline week at (833) 222-1507
  - The Compliance Hotline is a live twenty-four hours a day telephone line that can be accessed by anyone who would like to report concerns or alleged violations. Providers, members, employees, and any others can report anonymously through the hotline.

Reporting to the Appropriate Regulatory Agencies and Plans

CHCN's Compliance Department independently reports to the Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) when appropriate to coordinate FWA investigations with the regulatory agencies. It also independently reports to the Alliance when appropriate and coordinates with them to conduct FWA investigations involving their enrollees or networks. CHCN's Compliance Department also provides documentation as requested to the appropriate state and federal law enforcement agencies. Based on the preliminary investigation, if there is reason to believe a fraudulent activity occurred with respect

to a Medi-Cal enrollee, CHCN will immediately report the incident to the Alliance. CHCN will follow up on the incident and provide the Alliance with all investigation case documentation as necessary.

Non-Retaliation Policy

It is the policy of CHCN that no person shall be retaliated or discriminated against for reporting in good faith to any of the reporting methods listed above or to other proper authorities any alleged fraudulent activity committed by, on behalf of, or against CHCN.

The False Claims Act (FCA) also contains Qui Tam or "whistleblower" provisions. A "whistleblower" is an individual who reports in good faith an act of fraud, waste, and abuse to the government, or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.

FWA Detection & Prevention

CHCN strives to detect and prevent health care fraud, waste, and abuse. A variety of oversight mechanisms are used to detect fraud by employees, providers, vendors, and members. The three core drivers for detecting fraud are claims fraud data detection, fraud/suspicious reporting, and provider suspension/exclusion screening.

1. Fraud Data Detection

   Provider claims data is routinely analyzed by the Claims Department in conjunction with the Compliance Department to detect any fraudulent activity. Data analyzed is specific to providers, facilities, members, and medical services. When suspected claims are identified, the suspected claims are reviewed to determine if further investigation is valid and necessary, and if valid will proceed with additional investigation which may include medical records review, claims history review, and billed code analysis. This data analysis is critical for monitoring and identifying any repetitive fraud, waste, and abuse patterns, such as for example, over/under utilization, false claims. Unusual billing practices are also measures reviewed in the data analysis. Analysis findings are reported to the CO and, if warranted, to the Compliance Committee, CEO and Board of Directors.

2. Fraud/Suspicious Reporting

   The identification and prevention of fraud, waste, and abuse is a cooperative effort that includes all employees, providers, and members reporting any suspicious activities or claims to CHCN for investigation. The Compliance Department tracks and trends fraudulent cases reported to identify patterns with specific claims billed services, provider types, provider facilities, and medical services and durable medical equipment. From the reporting trends found, the Compliance Department will work closely with the Claims, Provider Network Management, and Quality Management Departments to monitor and investigate the trends closely to determine if there are any root causes for the specific high volume FWA cases.

3. Provider Suspensions/Exclusion Screening

   CHCN conducts monthly exclusion screening of all providers of health care services, as well as prior to contracting, to verify whether they have not been the subject of adverse government actions related to fraud, patient abuse, licensing board sanctions, license revocations, suspensions, and/or excluded from participation with the Office of Inspector General (OIG), System for Award Management (SAM), and Medi-Cal health care programs.

Investigation & Monitoring Procedures

All reported potential fraud, waste, or abuse incidents are reviewed and prioritized for investigation. The intent of the FWA investigation is to find and correct actions that lead to fraudulent or wasteful payments, overpayment recoveries related to fraudulent or wasteful activities, and work in collaboration with regulatory authorities and law enforcement. The investigator will conduct desktop reviews of the relevant documentation and data requested to conduct the investigation.

In some cases, it will be necessary to visit the site of the potential fraud (i.e. provider's office or vendor site) to guarantee the integrity of the documentation. The quality and credibility of the allegations will also be assessed along with the review of the questionable documentation to determine if fraudulent.

Corrective action plans and follow-up investigation plans are included, if applicable, to ensure any open issues and deficiencies are corrected. Corrective action plans may include the following actions: medical record review, claims audit, provider education, provider claims monitoring, overpayment recoveries, and termination. Findings are reported to the CO and to the Compliance Committee.

Education & Training

All CHCN employees are required to complete the Fraud, Waste, and Abuse Compliance training upon hire and annually thereafter. The comprehensive FWA training provides a basic understanding of how to detect fraud, waste and abuse, and why it is important to report any suspicious activity.

The training covers, among other topics, the following key concepts:

1. What is fraud, waste, and abuse;
2. How to detect and prevent FWA;
3. Warning signs for common FWA problems and examples;
4. FWA applicable statutes and laws;
5. Legal consequences and costs of FWA;
6. How to report potential FWA; and
7. Non-retaliation against reporting.

Disciplinary standards will be enforced to employees that do not meet the FWA training requirements.

Providers receive FWA education and training materials through the CHCN Provider Manual. The CHCN Provider Manual provides an overview of the importance of FWA detection, reporting, and prevention. The methods of reporting incidents and CHCN's Compliance Department contact information are included in the online FWA materials.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal law that requires the CHCN and its network providers to protect and maintain the security and confidentiality of its members' Protected Health Information (PHI) and to provide its members with certain privacy rights. PHI is any individually identifiable health information, including demographic information. PHI includes but is not limited to the member's name, address, phone number, medical information, social security number, ID card number, date of birth, and other types of personal information. This section of the Provider Manual seeks to guide network providers on the following: 1) implementation of safeguards to protect CHCN member PHI; 2) ensure appropriate uses and disclosures of PHI; 3) ensure members can timely access their own PHI; and 4) how to identify and report privacy incidents and breaches to the CHCN.

Safeguarding PHI

As covered entities under the HIPAA Privacy Rule, CHCN, and its network providers must comply with HIPAA requirements. Below are a few reminders on how to protect and secure PHI.

- Documents containing PHI should not be visible or accessible to visitors or others who are unauthorized to have access to PHI.
- When faxing documents containing PHI, verify the recipient, the recipient's fax number, and the documents being sent.
- Ensure that outgoing faxes include a fax cover sheet that contains a confidentiality statement.
- When mailing PHI, verify the recipient, the recipient's mailing address, and the documents being sent.
- Ensure that envelopes and packages are properly sealed, secured, and if using a clear window envelope, ensure that information is not visible through the window of the envelope, prior to mailing out.
- When transporting PHI, ensure that the information is protected by using binders, folders, or protective covers.
- PHI must not be left unattended in vehicles.
- PHI must not be left unattended in baggage at any time during traveling.
- PHI should be locked away during non-business hours.
- PHI must be properly disposed of by shredding. Never recycle or dispose of documents containing PHI in the trash bin.

PHI IN ELECTRONIC FORM

- When transmitting PHI via email ensure that the email is encrypted. This prevents anyone other than the intended receiver from obtaining access to the PHI.
- Do not include PHI such as an individual's name or beneficiary ID number (CIN) in the subject line of the email.
- Confirm the recipient, recipient's email address, and documents or information being sent, prior to sending the email.

- Ensure all portable data storage devices (CDs, DVDs, USB drives, portable hard drives, laptops, etc.) are encrypted.

PHI IN ORAL FORM

- Do not discuss PHI in public areas such as the patient waiting room.
- Do not discuss PHI with unauthorized people.
- Always verify the identification of an individual prior to discussing PHI with the individual.
- Ensure to speak quietly when discussing PHI.

Uses and Disclosures of Member PHI

The HIPAA Privacy Rule allows member PHI to be used and disclosed without the member's written consent for the following reasons (not a complete list):

- Treatment
- Payment
- Health care operations
- Court and administrative proceedings
- Health oversight activities
- Public health activities
- Law enforcement purposes

Network providers must obtain specific written consent through a HIPAA Compliant Authorization Form for all other uses and disclosures of PHI not for treatment, payment, or health care operations or otherwise permitted or required by the HIPAA Privacy Rule.

Member Access to PHI

The HIPAA Privacy Rule requires the CHCN and its network providers to provide members, upon request, with access to their PHI. Providers must ensure that their medical records systems allow for prompt retrieval of medical records and that these records are available for review whenever a member requests access to their PHI. Providers must also provide the member with timely access to their PHI in the form and format requested by the member.

Reporting of Privacy Incidents and Breaches to the CHCN

The HIPAA Privacy Rule requires covered entities to provide notification to enrollees following a breach of PHI. Network Providers must immediately and upon discovery report both privacy incidents and breaches involving CHCN members. A privacy incident is defined as an event or situation where an individual or organization has suspicion or reason to believe that PHI may have been compromised. Privacy incidents include but are not limited to the following:

- PHI sent to the wrong individual or organization.
- PHI sent unencrypted.
- Loss or theft of documents containing PHI in paper or electronic form.
- Loss or theft of unencrypted devices (laptop, hard drives, USB drives).
- Loss of access or other threat to network servers containing PHI.

A breach is defined as unauthorized access, use, or disclosure of PHI that violates either federal or state laws, or PHI that is reasonably believed to have been acquired by an unauthorized person. Timely reporting of incidents and breaches involving the PHI of our members is crucial in the response, investigation, and mitigation of incidents and breaches.

To report suspected or known privacy incidents and breaches you may contact the CHCN Compliance Department through any of the following means:

- Contacting CHCN's Compliance Officer, Teresa Ercole directly by:
  - Phone: (510) 297-0290
  - Email: tercole@chcnetwork.org
- Or via email to our Compliance Department at compliancemailbox@chcnetwork.org
- Or calling our Toll-Free Hotline at (833) 222-1507
  - The Compliance Hotline is a live twenty-four hours a day telephone line that can be accessed by anyone who would like to report concerns or alleged violations. Providers, members, employees, and any others can report anonymously through the hotline.