Bay Area
Care Partners

PROVIDER MANUAL 2024

SACRAMENTO COUNTY

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BUSINESS CODE OF CONDUCT

The Business Code of Conduct (BCC) establishes ethical and legal guidelines for providing care and services on behalf of Astrana Health. It demonstrates Astrana Health's commitment to compliance and applies to all Board of Directors, employees, volunteers, physicians, third-party payors, subcontractors, independent contractors, vendors, consultants, and other employees.

Compliance with all Laws and Regulations

Astrana Health will comply with all applicable laws and regulations. It is the responsibility of employees, volunteers, and business associates to be knowledgeable of and comply with such regulations in the following areas:

- Accurate Claims for Reimbursement
- Medical Necessity
- Accurate Business Records
- Cost Reports
- Refunds
- Kickback Prohibitions
- Co-Payments, Deductible & Discounts
- Honest Dealings with Payor, State, or Government Officials
- Cooperation of Audit and Investigations

SECTION 1 INTRODUCTION

IPA INTRODUCTION

Bay Area Care Partners IPA (BACP) was founded in 2024. We are committed to providing quality and patient-centered medical care through an extensive and accessible network of healthcare professionals, improving the standard of medical practices through quality improvement and to better harness resources to meet health care needs with compassion and efficiency.

BACP IPA contracts with major health plans, physicians, hospitals, and local healthcare providers to deliver optimal patient care.

Bay Area Care Partners IPA has:

- A large network in Sacramento County
- Efficient utilization review and billing process
- Multilingual customer service representatives
- Extensive urgent care facilities
- Innovative outpatient surgical centers
- Post-Acute Care Program
- Hospitalist Program
- Chronic Disease Management Program
- Palliative Care Program
- Wellness center for senior members

MSO INTRODUCTION

Astrana Health formerly Network Medical Management, is a Management Services Organization (MSO) comprised of healthcare professionals and more than 600 employee associates serving the rapid growth of Independent Physicians Associations (IPAs) and Medical Groups. Astrana Health has helped numerous IPAs and medical groups achieve their financial goals and organizational success. In 2016, Astrana Health achieved its objective of transforming from an IPA model to an Integrated Population Health Model by facilitating best practices and turning them into a comprehensive healthcare organization that is truly accessible to all. Today, we have expanded our services to ten counties in California, providing management to over 1 million members and a network of over 10,000 contracted physicians, making it one of the largest in California and the U.S. Through our broad ecosystem, we have become a leader in population healthcare management, providing quality of care and helping to alleviate costs in an extremely expensive U.S. healthcare system through integration, innovation, and cutting-edge technology.

As a management service organization, our areas of operation include utilization management, claims, eligibility, capitation, customer service, finance, contracting, credentialing, quality management, case management, IT systems, and provider services.

CONTACT SHEET

ASTRANA HEALTH

Operations Management		EMAIL
Claims	David Kwei, Sr. Director	David.Kwei@AstranaHealth.com
Claims	Octavio Campos, Sr. Director	Octavio.Campos@AstranaHealth.com
Compliance	Khurrum Shah, VP	Khurrum.Shah@AstranaHealth.com
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Credentialing	Walter Gamulo, Manager	Walter.Gamulo@AstranaHealth.com
Customer Service	Jamie Situ, Manager	Jamie.Situ@AstranaHealth.com
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Eligibility	Carol Guillermo, Director	Carol.Guillermo@AstranaHealth.com
Provider Data	Francisco Hernandez, Manager	Francisco.Hernandez@AstranaHealth.com
Provider Relations	Lisa Dao, Manager	Lisa.Dao@AstranaHealth.com
QCI - Medicare	Anna Kazaryan, Director	Anna.Kazaryan@AstranaHealth.com
Strategy and Operations	Diana Lam, Director	Diana.Lam@AstranaHealth.com
Risk Adjustment	Mauriel Chaidez-Puentes, Manager	Mauriel.Chaidez-Puentes@AstranaHealth.com
Health Services		**EMAIL**
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Health Services	Mitch Agorrilla, Sr. Director	Mitch.Agorrilla@AstranaHealth.com
Ambulatory Care Management	Linda Violas, Director Health Services	Linda.Violas@Astranahealth.com
Quality Management	Rayna Hurdle, Manager	Rayna.Hurdle@AstranaHealth.com
Inpatient CM	Jade Oculam, Sr. Manager	Jade.Oculam@AstranaHealth.com
Delegation Oversight Dept		delegation.oversight@astranahealth.com

BACP QUICK REFERENCE SHEET

AREA	CONTACT DETAILS
Main Member Service Line	• Phone: (916) 577-6230 • Hours: Mon-Fri., 8:30 AM – 5:00 PM
Claims Submission	• Via Office Ally, use Payor ID #: **NMM11** • Mail: Bay Area Care Partners c/o: Astrana Health Management, Inc. 1600 Corporate Center Dr. Monterey Park, CA 91754 ****Paper claims will not be accepted for contracted providers****
Case Management	To report an admission, • Please fax: (916) 259-7775 Ambulatory Care Management: (626)876-2191 • Ambulatorycare.dept@astranahealth.com
Eligibility	To have a new patient added, you can: • Submit through the Astrana Health Portal: https://provider-portal.astranahealth.com/login • For urgent requests, please call (877) 282-8272
Utilization Management	• Submissions: Please use the Astrana Health Portal at: https://provider-portal.astranahealth.com/login • Faxes will be accepted on a limited basis at: Routine: (916) 253-8972 Urgent: (916) 253-8982 Notes/Modifications: (916) 259-7678 • Phone: (916) 577-6242
Web Portal Assistance	• Technical Assistance/New Users: Portal.Help@AstranaHealth.com • Phone: (626) 943-6146 • Fax: (626) 943-6350
Provider Services	• Phone: (916) 577-6243 You can also email the BACP IPA Provider Relations Team at bacp.sacpr@astranahealth.com

CONTRACTED HEALTH PLANS

Bay Area Care Partners IPA currently contracts with Knox Keene licensed health plans in the areas and is contracted with the following health plans:

HEALTH PLANS	PRODUCT LINES OF BUSINESS
Anthem Blue Cross	Medicare Advantage HMO

*Please note: Services are subject to contract institution between the health plan and hospital. All scheduled hospital services must have prior authorization.

CONTRACTED HOSPITALS AND URGENT CARE

HOSPITALS

Hospital availability is dependent on the patient's health plan.
Please contact bacp.sacpr@astranahealth.com or call (916) 577-6243 to confirm.

URGENT CARE CLINICS

Availability may change from time to time. Information is current as of November 2024.
Please contact bacp.sacpr@astranahealth.com or call (916) 577-6243 to confirm locations.

CONTRACTED LABORATORY

POLICY: All laboratory procedures for Bay Area Care Partners IPA Members must be ordered through Quest Diagnostics Lab. Providers should contact Quest to set up an account, and to get access to their web portal.

PROCEDURE: When ordering routine laboratory procedures please use the Quest Diagnostics Lab. requisition form.

NON-ROUTINE: For any other complex laboratory procedure, please submit prior authorization to the UM department at https://provider-portal.astranahealth.com/login

For laboratory locations and hours of operation, please visit their website at https://www.questdiagnostics.com/locations/search

NOTE:

Your office will be held liable for all charges if you use other non-contracted Laboratory Services without prior authorization

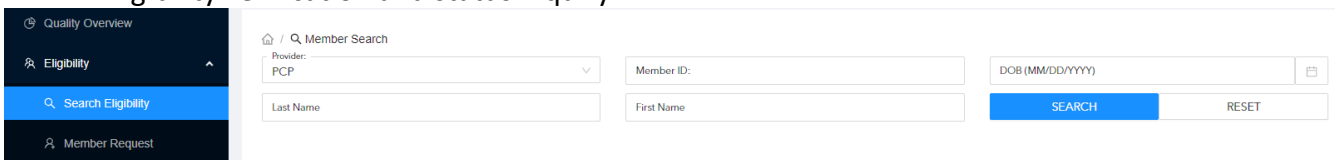
WEB PORTAL

Astrana Health's Provider Web Portal is a web-based application that enables practices to verify member eligibility, submit/view authorization requests, and submit/view claims data from any location with internet access. Providers can also take advantage of the portal to download a copy of the provider rosters (PCP and/or specialist) and can search individually for a provider (PCP and/or specialist) and/or ancillary service provider.

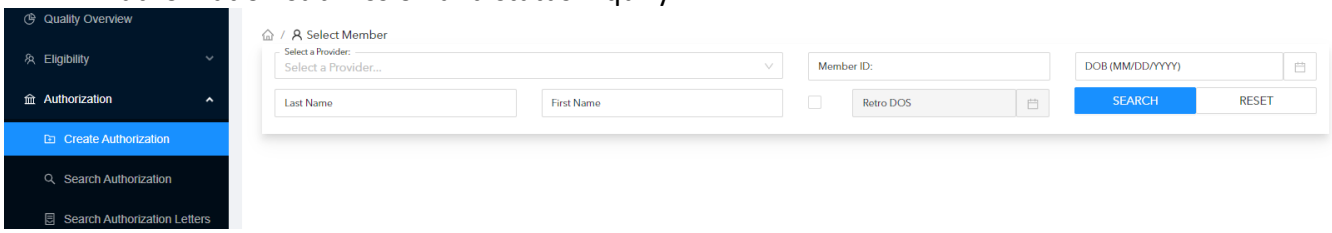
In order to set up a portal account, a practice must fill out the Web Portal New Account Registration Form available at https://provider-portal.astranahealth.com/login. The provider may also contact Astrana Health's Web Portal team by calling (626) 943-6146 or via email at Portal.Help@AstranaHealth.commailto:ProviderRelations.Dept@nmm.cc.

Portal features include:

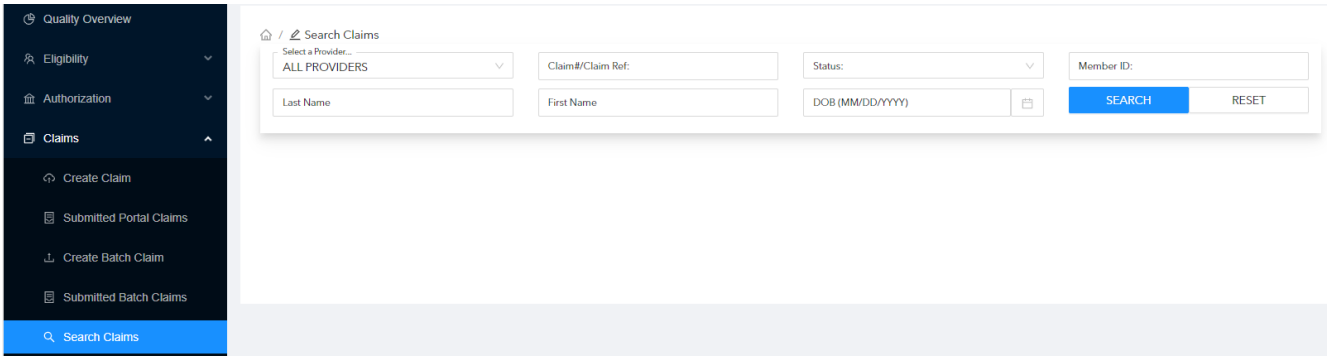
- Eligibility verification and status inquiry



- Authorization submission and status inquiry



- Claims submission and status



- New Documents (provider progress notes, hospital admit/discharge report, open authorization report, and more...)
- Member List (PCP)
- HEDIS Gap Report
- HCC RAF and Gap Reports
- Provider Resources and Member Educational Material

SECTION 2 MEMBER ENROLLMENT AND ELIGIBILITY

ELIGIBILITY VERIFICATION PROCESS

If it is a member's first time visiting a practice, the front office staff should ask the member for their health plan identification card or for a copy of the enrollment form and make a copy for their records. Each member identification card may look different, but most cards typically include the following elements:

- Member's Name
- Membership Number
- Group Number
- Type of Plan
- Effective Date
- Name of Provider (PCP)
- Name of Insurance Company – HMO/PPO/IPA
- Co-Payment Amount (varies; must be checked with member's current health plan)

Member eligibility must be verified at the time of the appointment, and a membership identification card is not necessarily valid proof of eligibility. If a practice is in doubt about a member's eligibility, front office staff may verify eligibility by calling Astrana Health's Eligibility Department at (626) 282-0288, or by contacting the health plan directly online or by phone (see table below). Given the frequency of eligibility changes, it is always best to check eligibility directly with the health plans.

HEALTH PLAN	PHONE NUMBER	WEBSITE
Anthem Blue Cross	800-845-3604	https://www.anthem.com

Adding a New Member

If a practice is unable to locate a member on the web portal but has previously confirmed eligibility, the office staff should submit a request to add the member via the following:

- Routine Requests: Astrana Health Provider Portal under Eligibility > Member Request. Please allow up to 24 hours for member to reflect on the portal.
- Urgent Requests: Via phone by calling (626) 282-0288. Member will be added within 30 minutes.

ELIGIBILITY & CAPITATION

On a monthly basis, all capitated providers will receive an eligibility and capitation report. Capitation is calculated over a six-month period (indicated on the report) to capture enrollment retro-activity and current membership. Bay Area Care Partners IPA shall provide eligibility lists and capitation reports to Primary Care Physicians within five calendar days of receipt from the health plan.

Information contained in the report includes the following:

- Member's first and last name
- Member's gender
- Member's age
- Member's health plan and identification number
- Member's PCP effective date
- Member's PCP termination date (if applicable)
- Capitation amount paid per member

- Capitation rate by member
- Capitation period by month (if any retro payments)
- Manual adjustments applied to a provider's current capitation payment
- Current month capitation payment

Vendor Portal – Electronic Capitation EOB

Astrana Health is starting a green initiative to reduce our environmental impact and has begun to post all Primary Care Physician Capitation EOB files on the Astrana Health Vendor Portal.

For authorization and security purposes, we require that the PCP office provide Astrana Health with an administrative email and/or mobile phone number to set up the credentials on the Vendor Portal.

To set up your account please visit https://vendor-portal.astranahealth.com/#/login

ZELIS E-PAYMENT CENTER

Astrana Health utilizes the Zelis Provider Network platform with our contracted providers to improve efficiency to streamline payment and data facilitation processes.

How to Enroll

To ensure timely, efficient, payments using Astrana Health's ePayment Center (Powered by Zelis). Please follow the enrollment instructions below.

What do I need to register for the ePayment Center?

- Federal tax identification number (TIN) or employer identification number (EIN)
- Your practice's corporate name and principal information
- Bank account routing transit number (RTN) or ABA routing number

How do I register for ePayment Center?

1. Visit nmm.epayment.center/register
2. Follow the instructions to obtain a registration code (a link will be sent to you)
3. Follow the link to complete your registration and set up your account
4. Log in to the portal and enter your bank account information
5. Review and accept the ACH Agreement and click "Submit"
6. Your bank account will be validated before electronic fund transfer (can take up to 6 business days)

Need Help?

Call (855) 774-4392 or email help@epayment.center with questions.

SECTION 3 PROVIDER RELATIONS

Provider Relations (PR) is committed to being accessible to all contracted physicians on a daily basis. The department serves to provide internal and external support to all IPA providers by providing guidance, training, education, direction, and support to reach the resolution of issues and/or concerns that would involve other departments. They are responsible for handling and resolving incoming provider inquiries, requests, and issues within IPA standards in a manner reflecting high-quality customer service and professionalism.

Responsibilities

Bay Area Care Partners IPA Provider Relations Department works with contracted providers to ensure that the provider has the necessary information, resources, and assistance to work with the IPA. Their list of duties/responsibilities includes the following:

- Orienting providers to processes and services around customer service, utilization management, claims, eligibility, quality management, etc.
- Provider Manual distribution
- Issue resolution involving authorizations, claims, eligibility, capitation, and contracting
- Provider education/training
- Disseminating network updates, including health plan policy changes/updates
- Health education material distribution
- Member enrollment issues
- Provider complaints
- Assistance with grievances
- HEDIS and HCC Support

Bay Area Care Partners IPA encourages providers to contact its Provider Relations Team with any questions or concerns.

Provider Relations Department
Direct: (916) 577-6242
E-mail: bacp.sacpr@astranahealth.com
Monday - Friday
8:30 AM – 5:00 PM

SECTION 4 PROVIDER REQUIREMENTS

All Contracted Providers must render services in accordance with the highest standards of competence, care, and concern for the welfare and needs of Patients/Participants/Clients and in accordance with the laws, rules, and regulations of all governmental authorities having jurisdiction.

WHAT TO DO IN CASE OF EMERGENCY

If a Bay Area Care Partners IPA patient telephones you with an emergency, the first thing to do is determine whether the patient should call 911, go to the nearest emergency room, after-hours convenient care center, or to your office. LICENSED PERSONNEL SHOULD HANDLE THE TRIAGE OF PATIENTS ONLY.

If you determine that it is a life-threatening emergency, please instruct the patient to hang up the phone and dial 911 immediately.

If you determine that the patient is stable enough to go to the nearest emergency room, after-hours convenient care center, or your office to be evaluated, please instruct the patient to be transported by another person. A patient should never be instructed to drive himself/herself in the event of a life-threatening situation. If the patient is alone and unable to arrange transportation, please contact Bay Area Care Partners IPA to arrange ambulance service. If this occurs after 5:00 PM, call (626) 282-0288 and speak to an on-call physician or case management contact.

AUTHORITY & RESPONSIBILITY

The Health Services Management has the ultimate responsibility for the performance of the organization. Management has delegated the ongoing and continuous oversight of all operations to the Executive Committee through the President and Chief Executive Officer. Bay Area Care Partners IPA does not, through its contracts, or other arrangements, delegate authority of its decision-making process and authority. The IPA retains the right and authority over all key decisions affecting the corporation and its contracted provider operations and management.

The IPA has the authority and responsibility to implement, maintain, and enforce its policies governing Contractors' duties under their agreement(s) and/or governing oversight role. The IPA has the right and responsibility to conduct audits, inspections, and/or investigations in order to oversee contractors' performance of duties described in their agreement(s) and to require Contractors to take corrective action if the IPA or the applicable federal or state regulator determines that corrective action is needed with regard to Contractors' duties under their agreement, and/or if Contractors fail to meet standards in the performance of those duties.

Contractors must cooperate with the IPA in its oversight efforts and must take corrective action as determined necessary to comply with the laws, accreditation standards, Payor Contract requirements, and/or policies governing the duties of the Contractor or the oversight of those duties.

MEDICAL DECISION & FINANCIAL STATEMENT

There is an established policy requiring practitioners and licensed utilization management staff responsible for utilization decisions to affirm that utilization decisions are based solely on the

appropriateness of care and services. The Health Services Department does not reward practitioners or other individuals conducting utilization review decisions that result in under-utilization.

OPEN COMMUNICATION WITH PATIENTS

Providers are required to participate in candid discussions with their patients regarding all decisions about their care, including but not limited to, diagnosis, treatment plan, right to refuse or accept care, care decision dilemmas, advance directive options, and estimates of the benefits associated with available treatment options, regardless of the cost or coverage. Furthermore, patients must be provided clear explanations about the risks from recommended treatments, the length of expected disability, and the qualifications of the physicians and other healthcare providers who participate in their care. Moreover, providers must inform Medi-Cal members that they have the freedom of choice in obtaining Family Planning, Abortion Services, Sexually Transmitted Disease (STD) treatment, and Sensitive Services for Minors without prior authorization.

PROVISION OF SERVICES

Contracted Providers must agree to render professional medical services to Patients/Participants/Clients referred to the Contracted Provider by Bay Area Care Partners IPA (provided that the Contracted Provider's application for participation has been approved by IPA's Credentialing Committee) Contracted Specialist Providers may not provide services to Patients/Participants/Clients, except in an emergency, without first securing authorization from Management Department. In addition, Contracted Providers must consult with the IPA and other health professionals when requested and must participate in peer review activities.

STANDARDS OF PRACTICE & COMPLIANCE LAWS

Contracted Providers must comply with all applicable laws, rules, and regulations of all governmental authorities relating to the licensure and regulation of health care providers and the provision of health care services. Providers must always conduct a professional medical practice that is consistent with the applicable State and Federal laws and with the prevailing standards of medical practice in the community. They are also expected to adhere strictly to the canons of professional ethics.

AVAILABILITY

Contracted Providers must provide available and accessible services to Patients/Participants/Clients at all times and must agree to permit Bay Area Care Partners IPA to monitor and evaluate the accessibility of care and to address problems that develop, which shall include but not be limited to, waiting time and appointments. The provider office must be open at least 16 hours per week and the Physician must be on-site at least 8 hours per week. *Please refer to SECTION 12 of this manual to review the ACCESS TO CARE STANDARDS.*

SURGERY & HOSPITAL ADMISSIONS

If a Contracted Provider is a physician or other health care professional who possesses hospital privileges, the Contracted Provider must maintain throughout the term of his/her agreement with Bay Area Care Partners IPA his/her medical staff membership at said hospital(s), and other privileges, which are deemed reasonably necessary by the IPA for the performance of the duties under the contract(s) with the IPA. Whenever a Contracted Provider recommends surgery for a

Patient/Participant/Client, the Contracted Provider must contact the IPA to obtain prior authorization for the proposed treatment. The Provider must work to perform said surgery at a contracted facility or financially responsible Health Plan contracted Hospital.

CONFIDENTIALITY OF RECORDS

Contracted providers (physicians and non-physicians) must comply with all applicable confidentiality requirements imposed by Federal and State law. This includes the development of specific policies and procedures to demonstrate compliance. All information, records, data collected and maintained for the operation of the health care service plans or other payors with which the IPA is associated, and information pertaining to Contracted Providers, IPA Patients/Participants/Clients, facilities, and associations, will be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. IPA agreements may not be construed to require confidential treatment for any information that is subject to disclosure under the California Public Records Act.

PROVIDER TERMINATION PROCEDURE

The provider must notify the Provider Relations Department in writing of his/her intent to terminate their contract at least 90 days before the intended effective date (*120 days for Anthem Blue Cross Medi-Cal*) Astrana Health will follow the termination clause in accordance with the provider contract.

The following shall be confirmed by the Provider Relations Department upon receipt of a termination request:

1. Reason for termination
2. Verify if the provider is affiliated with any other IPA managed by Astrana Health

The following notifications will be sent out once termination has been processed:

- The IPA shall send out member notices 30-60 days prior to the effective date of termination to notify of the imminent termination of a specialist provider.
- The health plan shall send out member notices to notify of the imminent termination of a PCP provider.
- The IPA shall send out a letter to the provider acknowledging the termination effective date.

CONTINUING CARE OBLIGATION

In instances where a provider contract is terminated "without cause" and any Patients/Participants/Clients are receiving care for acute or serious chronic conditions, California state law (SB1129) requires that such Patients/Participants/Clients have the right to continue to be treated by their terminated provider for up to 12 months if they so request. In accordance with CA Health and Safety Code 1373.65(f), the IPA notifies members of the termination of specialists in the preferred network. The notification to members states "If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated period. Please contact your HMO's customer service department, and if you have any questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 1-888-HMO- 2219, or at TDD number for the hearing impaired at 1- 877- 688- 9891, or online at www.hmohelp.ca.gov. "Without cause" includes terminations NOT attributable to quality of care issues, fraud, or other criminal activity.

Bay Area Care Partners IPA Patients/Participants/Clients may continue to be treated by the physician for up to 12 months, as long as the physician agrees to reasonable contract terms proposed by the IPA. This time period may be extended if the transfer of services is not considered safe. Some examples of acute medical conditions or serious conditions include, but are not limited to:

A. Second or third trimester of pregnancy (as applicable).
B. High-risk pregnancy (as applicable).
C. Recent surgery with subsequent complications requiring the patient to receive ongoing home health services.
D. Outpatient critical cases in the process of stabilization (such as intensive radiation therapy or treatment of uncontrolled diabetes); and/or
E. Terminal cases.

To assist the IPA in maintaining continuity of care for its Patients/Participants/Clients, Contracted Providers are required to share the medical records of services rendered to Patients/Participants/Clients, provided that the appropriate release of information has been obtained. Upon a member reassignment or transfer, Contracted Providers must provide one copy of these records, at no charge, to the member's new physician. Upon request, additional copies must be provided at reasonable and customary copying costs, as defined by California Health and Safety Code 1792.12.

COMPENSATION

Contracted Providers must only bill Bay Area Care Partners IPA for all approved services they provide to affiliate Patients/Participants/Clients, except for applicable copayments or deductibles. Providers may not seek any reimbursement for authorized services provided to IPA Patients/Participants/Clients from the Payors with which it contracts. Surcharges to Patients/Participants/Clients are strictly prohibited.

In the event that the IPA fails to pay Contracted Providers for authorized health care services rendered to a Patient/Participant/Client, including but not limited to insolvency, the Patient/Participant/Client will not be liable for any sums owed to Contracted Providers by the IPA. Under no circumstances may Contracted Providers or their agents, trustees, or assignees maintain any action at law against any Patient/Participant/Client to collect sums owed to Contracted Providers by the IPA. *Please also refer to Section 9 of this manual for additional information regarding Balance Billing.*

RECOVERY FROM THIRD PARTIES: LIEN RIGHTS

Where duplicate coverage exists, Contracted Providers must assist the IPA in pursuing the coordination of benefits or other permitted methods of third-party recovery. Contracted Providers must identify and notify the IPA of all instances or cases in which Contracted Providers believe that an action by a Patient/Participant/Client involving the tort or workers' compensation liability of a third party or estate recovery could result in recovery. Providers may not claim recovery of the value of covered services rendered to a Patient/Participant/Client in such cases or instances and must refer all cases or instances to Bay Area Care Partners IPA Provider Relations Department within thirty (30) days of discovery.

BOOKS & RECORDS

Contracted Providers must agree to maintain their books and records pertaining to the goods and services furnished under his/her agreement(s) with the IPA, to the cost thereof, in a form consistent with the general standards applicable to such book or record keeping. Providers must cooperate in order to enable the IPA to fulfill its contractual and statutory obligations, by allowing the IPA access to Contracted Providers' books, records, and other papers, including the following:

A. Retain such books and records for a term of at least ten (10) years from the close of the fiscal year in which the provider contract is in effect.
B. Comply with all requirements of the IPA contracts with Payors, as applicable.

In addition, these obligations are not terminated upon termination of the respective agreement(s) with the IPA whether by rescission or otherwise.

INDEPENDENT CONTRACTORS

The sole interest and responsibility of the IPA with respect to such performance is to ensure that the services are rendered in a competent, efficient, and satisfactory manner. The legal relationship between the IPA and Contracted Providers or any of the Contracted Providers' employees, associates, or subcontractors, may not be construed to cause any such employee, associate, or subcontractor to become or to be treated as an employee of the IPA.

ASSIGNMENT & DELEGATION

Contracted Providers may not assign or delegate any of the duties covered in his/her contract(s) without the prior written consent from the IPA and its Payors, as applicable.

NON-DISCRIMINATION

Providers may not discriminate against Patients/Participants/Clients in the rendition of services on the basis of race, color, national origin, ancestry, sex, marital status, sexual orientation, or age. Additionally, providers may not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (including cancer), age (over 40), marital status, and/or family care leave. All providers must ensure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. They must also comply with the provisions of the Fair Employment and Housing Act and the applicable regulations promulgated thereunder. Please visit our website at

https://www.networkmedicalmanagement.com/providers/provider-resources additional for information regarding Cultural Competency.

PROVIDERS CHARGING MEDI-CAL MEMBERS

California Welfare and Institutions Codes prohibits contracted health care providers from charging and/or collecting payment from managed Medi-Cal Members, or other persons on behalf of the Member, for filling out forms related to the delivery of medical care, missed appointments, or copies of members' medical/chart. Any Provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient, or any person other than the department or a third-party payor who provides a contractual or legal entitlement to health care services.

Under no circumstances can a Health Care Provider deny or refuse service to a member for non-payment of a missed appointment, lack of payment for co-payments, and owe balance or deductibles, as applicable.

A Health Care Provider that is not paid at billed charges may not pursue any balance billing or collection actions against any member. Such collection actions may include:

a. Sending or mailing bills to Members.
b. Calling the member with demands to pay the outstanding balance.
c. Referrals to collection agency.

If the Provider of service continues to charge a Member in violation of this policy after being notified to stop or sends the Member's account to a collections agency, the IPA reserves the right to inform the DMHC, DHCS, or other regulatory agencies of the violation. In addition, the billing of Members is in violation of health plan policies and the IPA takes all necessary actions, up to and including termination of the Provider's participation with the network to ensure that such actions stop.

MEMBER MEDICAL RECORD AVAILABILITY

Providers shall ensure that a medical record shall be established and maintained for each Member. Each Member's medical record shall be opened upon the Member's first visit. The record shall contain that information normally included in accordance with generally accepted medical and surgical practices and standards prevailing in the PCP's professional community. The PCP shall facilitate the sharing of medical information with other providers in cases of authorized referrals. Subject to applicable Federal and California laws and professional standards regarding the confidentiality of medical records. Providers shall make such records available to authorized IPA personnel in order for the IPA to conduct its Utilization Review and Quality Management Programs. Providers shall provide to the IPA and/or health Plans, at no cost, copies of the health plan member medical records for the purpose of conducting quality management, case management, and utilization management; Credentialing and peer review; claims processing; verification and payment; resolving member grievances and appeals; and other activities reasonably necessary for compliance with the standards of accreditation organizations and the requirements of State and Federal Law, including health plan's continuity of care obligations. Providers will cooperate with Quality Improvement (Q.I.) activities which include but are not limited to providing access to care.

PROVIDER LEAVE OF ABSENCE

If a PCP is, for any reason, from time to time unable to provide Covered Services when and as needed, the PCP may secure the services of a qualified covering physician who shall render such covered services otherwise required of a PCP; provided, however, that the covering physician so furnished must be a physician approved by the IPA (to include credentialed by the IPA) to provide covered services to Enrollees. The PCP shall be solely responsible for securing the services of such covering physician and paying said covering physician for those covered services provided to Enrollees. The PCP shall ensure that the covering physician:

A. Looks solely to the PCP for compensation
B. Will accept the IPA's peer review procedures
C. Will not directly bill Enrollees for Covered Services under any circumstances
D. Will, prior to all elective hospitalizations, obtain authorization in accordance with the IPA utilization review program.

A provider who is on a medical leave of absence for over 30 days is subject to termination by the IPA without cause.

The contracted PCP must notify the IPA in writing within 48 hours in advance for any leave of absence longer than 2 days. Notifications shall be sent to the Provider Relations Department via email at bacp.sacpr@astranahealth.com.

PROVIDER LEAVE OF ABSENCE FORM

Physicians are to notify Bay Area Care Partners IPA within 48 hours of any extended leave of absence longer than 2 days. It is the responsibility of the PCP to provide a means for a member to reach the PCP or on-call physician over the phone at any time. The voicemail should provide the member with the option to leave a message, information about after-hours care coverage, or refer to the ER for life-threatening situations. The PCP or on-call physician shall return calls or messages within the designated timeframe, not to exceed 12 hours.

I hereby notify Bay Area Care Partners IPA that I will be away from my practice for the following period:

Beginning Date:	
Ending Date:	
Return to Practice Date:	

My practice will be covered by the following physician(s):

Covering Physician:	
Address:	
Phone Number:	
Fax Number:	

Print Your Name _____

Signature _____ Date_____

Attention: Provider Relations Department
Email: bacp.sacpr@astranahealth.com

SECTION 5 CREDENTIALING AND RE-CREDENTIALING

Bay Area Care Partners IPA is committed to providing quality care to its members. On behalf of Bay Area Care Partners IPA, Astrana Health, Bay Area Care Partners IPA's Management Services Organization, uses a rigorous process to evaluate providers. This process thoroughly evaluates a provider's experience, licensing, sanction activity, and quality of care.

Procedure

1. The Credentialing Committee is responsible for making decisions regarding provider credentialing. The Credentialing Department reviews each initial application with all supporting verifications and documentation before submission to the Credentialing Committee.
2. Initial Application: Astrana Health uses an online credentialing portal, aka "Provider Hub", for the submission of credentialing applications. These applications will require the provider to provide information on:
    a. Reasons for inability to perform the essential functions as a provider, with or without accommodation
    b. Lack of present illegal drug use
    c. History of loss of license and felony convictions
    d. History of loss or limitations of privileges or disciplinary activities
    e. Attestation by the applicant of the correctness and completeness of the application. Attestations will cover seven (7) years for initial providers and three (3) years for re-credentialed providers
3. Completed application for Primary Care Physicians and Specialists: Each applicant will be required to complete an application. In addition, the applicant will provide:
    a. Curriculum Vitae (CV)
    b. A copy of current State Medical or Dental License(s) (pocket license)
    c. A copy of a valid DEA certificate (if applicable)
    d. Face Sheet of Professional Liability Policy or Certification for past and present coverage, in the minimum amounts of $1 million per occurrence and $3 million aggregate
    e. Board Certification Certificates (if applicable)
    f. Certificates of Degree Completion (i.e., medical, or dental school)
    g. Internships and Residency certificates of completion
    h. A copy of the Educational Commission for Foreign Medical Graduates (ECFMG), if applicable
    i. Addendum A (Provider Rights)
    j. Addendum B (as applicable)
    k. HIV Designation Form
    l. Delegation of Service Agreements (mid-levels) (as applicable)
    m. Forms of identification issued by state or federal agency
    n. Social Security Card
    o. National Provider Identifier
    p. Request for Taxpayer Identification Number (W-9)
4. Incomplete application: The Credentialing Department will send three follow-up requests for missing information (e.g., any incomplete application, is not accompanied by all supporting documentation, does not include a signed Physician Provider Agreement, or is dated more than three months before

receipt). If the requested information is not received after the third request, the application will be considered inactive.

5. Primary source verification: Upon receipt of a completed application, Astrana Health will obtain and verify the information. The Credentialing Department will obtain, through the most effective methods, additional information or clarification, as needed, to provide the Medical Director and Credentialing Committee adequate information to make an informed decision regarding the applicant's qualifications.
6. Providers' rights (Due Process). Providers shall have:
    a. The right to review the information submitted in support of their credentialing application. Exception: Applicants are not to review references, recommendations, or other information that is peer review-protected
    b. The right to respond to information obtained during the credentialing process, which varies substantially from the information provided to Astrana Health by the applicant
    c. The right to correct information provided to Astrana Health which the applicant considers to be erroneous
    d. The right to be informed upon request of the status of his/her credentialing/re-credentialing application
7. Re-applying: Providers denied by the Board of Directors will not be eligible to reapply for membership for at least two (2) years.
8. Length of appointment: Providers will be credentialed for an initial period of not to exceed three years (36 months).
9. Errors and Omissions: The providers will be immediately notified in writing of any occurrence. A copy of the official report (if applicable) will be sent to the provider along with a letter of explanation.
10. All documents received will be date-stamped and initialed.

Recredentialing:

The re-credentialing process is also completed within Astrana Health's online credentialing portal, aka "Provider Hub". Six months before the credentials expiration date, providers will receive an email from our automated credentialing system. Upon receiving the email, please follow the instructions to log in and complete the re-credentialing application. Be sure to attach/upload the following documents as may be required for the provider type:

- Midlevel practitioners (NPs/PA): Supervising/collaborating physician agreement.
- Physicians without hospital privileges: Identify the admitting physician or hospitalist group, and the name(s) of the hospitals where patients will be admitted.
- All Providers: Current copy of malpractice insurance certificate.

All questions regarding credentialing and/or re-credentialing should be directed to the Credentialing Department at (877) 282-0288.

SECTION 6 PROVIDER SATISFACTION SURVEYS

Bay Area Care Partners IPA and its network partners are constantly making strides to improve satisfaction for their providers. In an effort to evaluate its performance, Astrana Health conducts an annual member and provider satisfaction survey. The survey covers different areas of operations for an overall assessment.

Please utilize the survey link or scan the QR code below to provide us with your feedback as we strive for continuous improvement to best help our providers serve their members. Should you have any questions please contact our Provider Relations Department to speak with a PR Specialist.

Provider Satisfaction Survey Link: https://forms.office.com/r/hiEaEsn6ET?origin=lprLink

Bay Area Care Partners IPA
Provider Relations Department
Direct: (916) 577-6243
E-Mail: bacp.sacpr@astranahealth.com

SECTION 7 HEALTH SERVICES

UTILIZATION MANAGEMENT PROGRAM

Utilization management (UM) involves the evaluation of the medical necessity of services and the appropriateness of the selected level of care and procedures according to established criteria or guidelines. Resources must be effectively managed. Utilization metrics are used to determine how much care is being utilized by a network's members. Typically, utilization is measured per thousand members so that it can be compared and analyzed across providers and practices. Some common utilization metrics are:

- ER/K: Emergency room visits per thousand members
- UC/K: Urgent care visits per thousand members
- Admits/K: Admissions per thousand members
- Bed days/K: Inpatient days per thousand members

The key to successful utilization is proactive identification and medical management of those members who are at risk for inappropriate utilization of the costliest points of care. It is important to determine if these Members can be more appropriately treated in less acute settings and/or with targeted care management programs. In addition to the aforementioned list, utilization can also be measured through referral metrics on referral patterns to providers and through encounter submission data which tracks the frequency with which providers see the network's Members.

Astrana Health's Utilization Management Committee, and Quality Management Committees will regularly monitor and assess the performance of its participants (e.g., Medical Director, Utilization Management and Quality Management Committee Members, Case Managers) involved in determining medical necessity, managing care and evaluating the effectiveness of the process and outcomes involved. The assessment is based on the ability to consistently apply specified utilization management criteria (e.g., Federal and State guidelines, health plan guidelines, MCG [formerly Milliman Care Guidelines], and Health Care Management Guidelines). The Utilization Management (UM) Program is designed to monitor, evaluate, and manage the appropriateness of care resources, and promote the delivery of high-quality, medically necessary, and efficient care.

UM policies and procedures are available upon request. Please contact the UM Department at (626) 282-3749.

A. Specialty Referral Data

Specialty referral data on contracted providers is collected and tabulated every quarter by Astrana Health on behalf of Bay Area Care Partners IPA. Providers whose referral patterns differ significantly from the average will be identified and reviewed by the Utilization Management Committee. Potential outliers will be reviewed for differences in case mix, appropriateness of referrals, and evidence of knowledge or skill gaps. A statistical report will be generated for each provider indicating referral performance relative to the mean and standard deviation of the group.

B. Hospital Admission/Re-admission

Outliers for hospital admissions and/or re-admissions may be due to intensive treatment for members

or underutilization reflective of barriers to care, case mix differences, or lack of access to effective preventive health care. Outliers will be identified using MCR guidelines.

C. Emergency Room Visits

High outliers for emergency room visits may be reflective of poor access to primary care, management issues, or be due to case mix differences. A combination of high emergency room use, or low institutional use may raise concerns about barriers to primary care and secondary care. Providers with statistics higher than MCR guidelines or industry benchmarks will be flagged for possible access issues.

D. Feedback and Corrective Action

Providers reviewed by the Astrana Health Utilization Management and Quality Management Committees will receive specific feedback and/or ongoing education. Provider Corrective Action Plans (CAP) will be developed as appropriate at the recommendations of the Committees.

E. Referral to Non-contracted Provider

All Members must be referred to a contracted and credentialed provider through Bay Area Care Partners IPA. If a provider cannot be located for a particular health service, the referring provider must contact Astrana Health's Utilization Management Department for further guidance. Providers who inappropriately refer a member to a non-contracted provider without prior authorization may be held responsible for the medical charges incurred.

F. Service Coordination

Astrana Health is responsible for coordinating the following services:

- Acupuncture
- AIDS and AIDS-related conditions waiver program
- California Children Services (CCS)
- Chiropractic services
- Dental
- Direct observation therapy for the treatment of tuberculosis
- Drug and alcohol treatment
- Kidney transplants
- Lead poisoning case management
- Local education agency assessment services
- Mental health
- Prayer or spiritual healing
- Community-Based Adult Services (CBAS)
- Regional centers
- Vision
- Developmentally Disabled-Continuous Nursing Care (DD-CNC)
- Family Planning, Access, Care and Treatment Program (Family PACT)
- Transportation services
- Women Infants and Children (WIC)
- Pediatric Palliative Care Waiver (PPC)

Decision Making

Utilization Management (UM) decision-making is based only on the appropriateness of care and service and the existence of coverage. Astrana Health does not specifically reward practitioners or other individuals for issuing denials of coverage or care. No financial incentives are involved in UM decisions that result in underutilization.

PROCESS FOR SUBMITTING A REFERRAL REQUEST

An authorization referral request must be submitted with all pertinent information to Astrana Health for authorization before the provider performs any treatment and/or services. Incomplete medical information may cause a delay in the referral request. Providers can submit authorization referral requests 24 hours a day / 7 days a week. Providers can submit retro requests up to 90 days after the date of service. Authorization approval, modification, deferred, or denial determinations will be made based on medical necessity and will reflect the appropriate application of approved guidelines.

The request will be reviewed and completed accurately and timely within Industry Collaboration Effort (ICE), health plan, and/or regulatory agency compliance standards as follows:

- Urgent within 72 hours/three (3) calendar days (to be used if the 5-day turn-around time would seriously jeopardize the life, health, and or ability to regain maximum function)
- Routine within five (5) business days
- Standing Referral – may be subject to a treatment plan that may limit the number of visits to the specialist, limit the time for which the visits are authorized, or require the specialist to provide regular reports to the primary care physicians.

  Requests include:
  - Member demographics
  - Member diagnosis(s)
  - Required treatment(s)/testing
  - Requested frequency and period/duration of treatment
  - Relevant history and physical, medical records, laboratory, and radiology results.

For cases that need to be expedited (i.e., non-emergency services needed within 24 hours), providers should submit the request via the Astrana Health Web Portal and contact Astrana Health's Customer Service Department at (626) 282-0288.

Authorization Process

Providers wishing to submit an authorization referral request may fax the Astrana Health Authorization Request Form (ARF) or log into the Astrana Health Web Portal at https://provider-portal.astranahealth.com/login and follow the steps included in the Web Portal User Guide provided at the time of orientation.

After authorization is submitted, the following process will occur:

1. If the requested medical treatment, service, and/or procedure is covered by the health plan and meets the established criteria, the request will be approved for ninety (90) days. An approval letter is sent to the Member via the U.S. Postal Services (USPS) and a fax is sent to the requesting provider, or it is posted on the provider's portal.
2. If additional information is required, Astrana Health's Authorization Coordinator will contact the requesting provider and/or specialist by fax or telephone to obtain specific information as appropriate. If the case is pending additional medical information, it will be held for 14-45 days depending on the Member's health plan.
3. Once an approved decision is made, the provider will be notified within 24 hours of the decision via fax and or posted to the portal.

4. If the authorization is denied, the reason for the denial, an alternative treatment, and the Utilization Management criteria will be included in the letter. The Medical Director and/or designee shall be available by telephone to discuss the case.
5. The letters denying or modifying requested services are sent to the Member via USPS and fax or posted to the portal to the requesting provider and the Member's primary care provider within two (2) working days of the determination. Only a Medical Director or designee physician may make an adverse determination.

In some cases, a provider can re-submit an authorization with new supporting documentation. Providers should attach additional supporting documentation to the authorization via the Astrana Health Web Portal. If the provider is unable to upload the information, supporting documentation should be submitted via fax.

Treatment Authorization Request (TAR)

All Treatment Authorization Requests should be submitted through the web portal. However, a Treatment Authorization form is also available. Attach any medical information to support the request.

Fax routine and retro requests and supporting clinical information to the UM Dept. Please refer to the TAR in Section 15 for the fax number.

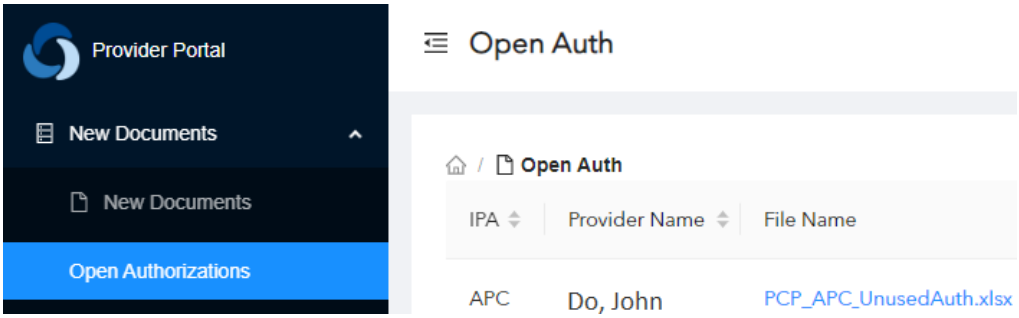
Fax urgent requests and supporting clinical information to the UM Dept. Please refer to the TAR in Section 15 for the fax number.

Standardized Prescription Drug Prior Authorization Form (Form No.61-211)

All providers must utilize the uniform Prescription Drug Prior Authorization Request form (Form No. 61-211)

Specialty Referral Tracking

The PCP and Specialist may track their Member's open referrals to ensure the Member is receiving the required care and to ensure the PCP office obtains the specialist consultation notes. On your provider portal, a list of open authorizations for your Member is provided. The list consists of authorizations that are 90 days old in which there is no claim on file. The office staff is to contact your Member to determine if this authorization should be closed, if the Member has been seen, or if the services are scheduled for a later date.



Turn Around Time Decision Standards

Routine/Non-Urgent Requests	Up to 5 business days
Urgent Requests	Up to 72 hours
Retro Requests	Up to 30 calendar days

Standing Referrals

PCP's may allow standing referrals where a member requires continuing specialty care over a prolonged period (e.g., a Member has a life-threatening, degenerative, or disabling condition that requires coordination of care by a specialist instead of PCP). PCP's and referred specialists coordinate care and treatment, along with the Member, and develop a treatment plan that addresses the number of approved visits or the period during which the visits are authorized and the plan for each visit.

Specialist Physician Referrals

When a PCP refers a member to a specialist physician, in addition to consultation, the specialist may refer the Member for additional in-network testing and services that are within the guidelines of their specialty. A treatment plan must be agreed upon by the PCP, the specialist physician, and the Member. In addition, a specialist physician may substitute as a PCP for a Member with a life-threatening condition or disease or degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period, when authorized by the medical group.

Second Opinions

Second opinions are covered even if the service is determined not to be covered. PCP's must provide referrals to another network physician when a second opinion is requested and appropriate. Patient-initiated second opinions that relate to the medical need for surgery or major nonsurgical diagnostic and therapeutic procedures are covered under Medicare. If the recommendations of the first and second physicians differ regarding the need for surgery (or other major procedures), a third opinion is also covered. Second-opinion referrals are for consultation only and do not imply referral for ongoing treatment.

Transplants

Transplant evaluation and services must be provided in a Medicare-approved transplant center; therefore, Members may only be referred to facilities that meet minimum standards established by Medicare to ensure Member safety. See https://www.cms.gov///MedicareApprovedFacilitie/index.html.

Documentation of Referrals

Referring providers are responsible for ensuring that all relevant clinical information is sent to the preferred provider. The referral, as well as denial or acceptance of the referral needs, are to be documented in the Member's medical record by both the referring provider and preferred provider. Specialists must provide the referring PCP with relevant reports on care rendered in a timely manner.

Specialist Requirements/Responsibilities

- Document all work-ups and treatments done and include them with your request for authorization
- If the Member was seen, please forward your consultation and/or progress notes to the Member's Primary Care Physician.

Primary Care Physician Requirements/Responsibilities

As a standard requirement, PCP's must document that they have received/read the specialist consultation notes and document any outreach to the Member and/or specialist provider. PCPs are responsible for coordinating care and addressing Member needs.

- If a Member missed their appointment, please follow up with the Member.
- Document all work-up and treatments done including authorization requests.

Hospice/Palliative Care

For the geriatric population and/or the terminally ill, assessment and Member wishes must be documented.

- End-of-life discussions related to advanced directives, palliative care, and/or hospice.

Referrals to Out-Of-Network Providers

All Members must be referred to a contracted and credentialed provider through Bay Area Care Partners IPA. If a provider cannot be located for a particular health service, the referring provider must contact the Utilization Management Department for further guidance. Providers who inappropriately refer a Member to a non-contracted provider without prior authorization may be held responsible for the medical charges incurred.

Prior authorization is required to refer Members to an out-of-network provider. Authorization Request Forms (ARF) must be submitted for all services from non-contracted Bay Area Care Partners IPA providers including non-contracted Bay Area Care Partners IPA behavioral health providers as these require prior authorization from the Utilization Management Department.

RECOMMENDED RECORDS & CLINICAL GUIDELINES

The following section lists recommended records and clinical guidelines for specialty referrals. For each specialty (listed alphabetically) there are documents/information that Astrana Health may require to evaluate medical necessity:

<u>Allergy</u>

- Clinical notes describing the Member's signs and symptoms and conservative management attempted; e.g., nasal steroids
- Consult notes (if obtained) by ENT

<u>Bariatric Surgery</u>

- Completion of bariatric screening tool, to include Member's height, weight, BMI, and attempts at weight reduction
- Psych and Cardiac consults

<u>Cardiac consultation is appropriate for:</u>

- Evaluation of Member who is high-risk and who remains symptomatic or uncontrolled after provider (PCP) initiation of and titration of therapy
- Evaluation of Members with unstable cardiac conditions, including unstable angina
- Sustained or complex non-sustained ventricular arrhythmia
- Sustained or severely symptomatic supra-ventricular arrhythmia
- Severe cardiomyopathy
- Angina despite maximal medication or markedly abnormal stress test
- Evaluation and surveillance of complex or cyanotic congenital disease
- Severe valvular disease
- Symptomatic
- Associated with LVD
- Atrial fibrillation (AF), if Member is a candidate for cardioversion or chronic AF with inability to control rate or patient is symptomatic with usual measures
- Chest pain with an unstable pattern of angina, exercise stress test abnormal at low-level, ischemia with LV dysfunction, angina post-M.I., suboptimal response to medications with limiting symptoms
- Palpitations, if Member is having disabling symptoms or has had syncope or near syncope
- Members with new or frequent palpitations, particularly when associated with other symptoms in the face of known CAD or significant LVD or other serious structural heart diseases
- Request for cardiac rehabilitation must be initiated/recommended by a cardiologist
- Information necessary with consultation request may include:
  - Clinical record documenting risk, condition, and treatment regimen
  - EKG
  - Previous (outside) report of cardiac cath, PTCA, CABG, stress test, Echo, Chest x-ray, etc.

<u>Endocrine</u>

- Clinical record documenting medical need for service, Member's signs and symptoms of concern, and treatment tried
- Current lab verifying deficiency/problems; e.g., thyroid panel
- Special diagnosis study reports; e.g., U.S., C.T., etc., which may have been obtained to validate/diagnose the condition

<u>Otolaryngology (ENT)</u>

- Clinical record indicating concern, physical exam findings, signs and symptoms, and conservative treatment tried; e.g., series of antibiotics (date and type), antihistamine, and/or steroid use (oral and/or nasal)
- Any current lab and/or x-ray finding specific to the concern
- Any specialty consult that may have been accomplished; e.g., allergy consultation or FNA report (of neck node)
- Any diagnostic study that indicates pathology; e.g., biopsy, MRI, CT, etc., requiring surgical intervention
- Any outside records/consultations which indicate the need for follow-up

<u>Gastroenterology</u>

- Clinical record documenting signs and symptoms; e.g., anorexia, weight loss, upper abdominal distress persistent after treatment, melena, fecal occult blood, and conservative treatment tried.
- Current lab demonstrating concern; e.g., iron deficiency, anemia.

- Current radiology report demonstrating concern; e.g., Barium Enema
- Current specialty study/exam demonstrating concern; e.g., Barium Enema or UGI series report(s)
- Past specialty study/exam/surgical report demonstrating concern; e.g., previous colorectal cancer operative report, colonoscopy, or EGD with path report (specifically, previous polyp size and type)

General Surgery

- Clinical record documenting signs and symptoms of condition and treatment tried (if appropriate)
- Current lab demonstrating concern; e.g., CBC with diff
- Current radiology report demonstrating concern; e.g., KUB, U.S.
- Current specialty exam demonstrating concern; e.g., colonoscopy/sigmoidoscopy report with path findings

Genitourinary (G.U.)

- Clinical records indicating the reason for a consult, with treatment tried
- Urinalysis and, where appropriate, C&S (which should have been treated if positive growth)
- P.S.A. report, where appropriate. If elevated, need to include previous PSA result(s) or document if this was the first PSA study
- Any special diagnostic study

Nephrology

- Clinical records indicating concern with signs and symptoms of same and treatment attempted
- Current pertinent lab reports; e.g., BUN, Creatinine
- Reports of any special diagnostic study performed

Neurology

- Clinical record documenting concern, a neurology exam appropriate to the concern, as well as signs and symptoms
- If the referral request is due to ALOC, a mini-mental status exam should be included
- Report of previous (outside) consult/report indicating the need for follow-up or further studies
- Results of any diagnostic study demonstrating concern relative to the issue to be investigated. Neurology consults should be considered before requesting EMG/NCS

Neurosurgery

- Clinical record documenting signs and symptoms of the condition, treatment tried, and neuro exam/deficit, etc.
- Current radiology/imaging reports demonstrating concern; e.g., MRI, CT.
- Consult report (if appropriate) from Neurology or Pain Specialist, suggesting further specialty care

Oncology

- Clinical record describing medical need; e.g., signs and symptoms of concern
- Current lab results
- If hospitalized, previous to consult request, copy of H&P and discharge summary
- Operative report (if the surgical procedure has been accomplished) with a pathology report
- Any staging studies (reports) accomplished

Orthopedics

- Ortho consult is appropriate for:
  - Evaluation of a condition to determine surgical remedy; e.g., osteoarthritis of hip or knee for possible replacement, possible torn ligament or meniscus, for possible orthoscopic procedure
  - Evaluation of and treatment plan advertisement of an orthopedic condition that has not been amenable to or is showing progressive disability despite usual conservative management
  - Evaluation of suspected aseptic neurosis, locked knee, unstable joint, acute or sub-acute effusions
- Provider (PCP) to submit clinical notes, including history of concern and P.E. findings, signs and symptoms expressed by Member, and treatment regimen tried
- Current x-ray reports. Member should be instructed to pick up films and take them to consult appointment, once the request has been authorized
- Current labs pertinent to concern, as appropriate
- Any specialty procedure/study report that may have been done in or outside the group/IPA specific to the concern; e.g., MRI, previous operative notes

Pain Management

- Pain Management consults are generally appropriate for:
  - Chronic long-standing back pain
  - Pain unrelieved by conservative measures
- Current clinical notes documenting Member's signs and symptoms and treatment previously tried; e.g., medication use, local injections
- Any consult (if appropriate) from neurology or neurosurgery indicating the need for further specialist consultation
- X-ray or image report defining the concern

Physical and Occupational Therapy

- Current clinical notes documenting Member's condition and treatment previously attempted (e.g., rest, medications)
- Referral should advise therapist(s) of any specific movement limitations or restrictions (i.e., do not hyper-extend joint)

Podiatry

- Clinical record documenting signs and symptoms regarding the concern and conservative management attempted
- Any comorbidities
- X-ray report of foot/feet
- Copies of any previous podiatry provider reports

Pulmonary

- Clinical record documenting signs and symptoms of concern and treatment attempted
- Radiology report; e.g., chest X-ray
- O_2 sat results
- Previous consult relative to concern or indicating need for follow-up
- Copy of any specialty diagnostic report demonstrating concern; e.g., chest CT, MRI, pulmonary function exam
- Spirometry
- Request for pulmonary rehabilitation may require Pulmonologist endorsement

Rheumatology

- Clinical record documenting signs and symptoms of concern and treatment attempted
- Lab reports documenting/demonstrating concern; e.g., Rheumatology studies, CBC with differential and platelets, chemistry panel 18, sedimentation rate, C reactive protein, rheumatoid factor, ANA
- X-ray reports documenting/demonstrating concern (if accomplished)
- Specialty reports demonstrating concern; e.g., bone density, MRI

Vascular Surgery

- Clinical record documenting signs and symptoms of concern and treatment attempted
- X-ray/Specialty study report documenting concern; e.g., U.S., previous Angiography
- Copy of previous consult (outside IPA) indicating the need for follow-up

DENIALS

Members and providers will receive written notification of any denial of medical treatment, service, and/or procedure.

1. All denials for service will be handled on time and will be entered into the system for tracking purposes.
2. Utilization review criteria are applied consistently, and the assessment information is documented by the Medical Director or designee. Approval, modification, deferred, or denial determinations will be based on medical necessity, benefit coverage, and approved criteria and guidelines.
3. All expedited appeals will be processed in compliance with the timeframe required by the Centers for Medicare and Medicaid Services (CMS) and following health plans' processes.
4. Only providers may make an adverse determination; they will use clinical reasoning and approved criteria and/or clinical guidelines to determine medical necessity.
5. The requesting provider may at any time contact the Astrana Health Medical Director or designee during normal working hours to discuss the determination of medical appropriateness.
6. Common reasons for denials:
    a. The provider is not contracted
    b. The service does not meet utilization review criteria or benefits
    c. The Member is not eligible
    d. The service is not a covered benefit (this includes "Carve-Out" plans)
    e. The Member's benefits for that service have been exhausted

TTY numbers available

Procedures and Criteria are disseminated to Members and providers upon request by calling Astrana Health's Customer Service department at (877) 282-8272 Opt.1, Monday through Friday between 8:30 AM and 5 PM. For Members with impaired hearing, Members can call our TTY telephone at (877) 735-2929, Monday through Friday between the hours of 8:30 AM to 5 PM. A requesting provider may call Astrana Health to discuss a denial, deferral, modification, or termination decision with the physician (or peer) reviewer at (877) 282-8272 ext.6195. This phone line is open 24 hours per day / 7 days per week. All calls will be returned within 24 hours.

APPEALS

Member Appeals

The policy of Astrana Health is to refer all Member appeals to the appropriate health plan. The health plan will contact Astrana Health for appropriate information needed to resolve the Member's issue. Astrana Health will contact the provider to obtain the requested information, which must be submitted within the timeframe guidelines mandated by each health plan. Providers shall comply with all final determinations made by health plans through their Member Grievance and Appeals procedures.

Provider Appeal

The Utilization Management Committee will review all denial and appeal determinations regularly. If the provider chooses to appeal the determination for a denial of a requested service, the appropriate medical information is gathered by the Utilization Management Coordinator for review by the Medical Director and/or the Utilization Management Committee. Requesting providers must resubmit new authorization with supporting documentation with the reason for appeal. If appropriate, the appeal will be reviewed at the next regularly scheduled Utilization Management Committee meeting. All expedited appeals are reviewed by the Medical Director or designee immediately, and all expedited appeal responses are made within seventy-two (72) hours. Determinations to modify, reverse, or uphold the original decision will be completed and processed within five (5) days of the appeal. Reversals of denials for requests for expedited appeals are processed immediately. The requesting provider shall receive written notification of the outcome.

PROCEDURES RECOMMENDED FOR OUTPATIENT SETTING

The following procedures are recommended to be performed in an outpatient ambulatory surgery setting. This is not an exclusive list of procedures. Exceptions require prior authorization.

A. Gastroenterology
- Liver Biopsy
- Colonoscopy (screening)
- ERCP (Endoscopic Retrograde Cholangiopancreatography)
- Sigmoidoscopy
- Esophagogastroduodenoscopy (EGD)
- Esophagoscopy

B. Gynecology
- Marsupialization of Bartholin Cyst
- Treatment of Condylomata Acuminata
- Cryotherapy (alone or with a biopsy and/or dilation & curettage)
- Dilation and Curettage
- Examination under Anesthesia
- Culdoscopy
- Hymenotomy
- Hysterosalpingogram
- Therapeutic Abortion (first trimester)
- Dilation and Evacuation (second trimester)
- Laparoscopy, diagnostic, or sterilization
- Removal of IUD
- Hysteroscopy
- Culdocentesis (office)
- Amniocentesis or Amniogram
- Perineorrhaphy (minor)
- Cervical Amputation
- Cervical Conization

C. General Surgery
- Breast Biopsy (if a two-stage procedure for a possible malignancy)
- Cervical Node Biopsy
- Lipoma Excision
- Muscle Biopsy
- Rectal Polypectomy
- Excision of Sebaceous Cyst
- Excision of Skin Lesion with Primary Closure
- Excision Bakers Cyst
- Excision Breast Masse(s)
- Excision Draining Sinus Tract
- Excision Neuroma
- Foreign Body Removal
- I & D abscesses
- Varicose Vein Ligation (without stripping)
- Minor hemorrhoidectomy

- Hernia Repair (infant)
- Paracentesis

D. Plastic Surgery
- Blepharoplasty (upper/lower or combined)
- Mammoplasty (augmentation, revision) after mastectomy for cancer, unless a major case requires postoperative hospital days.
- Small Skin Graft
- Dupuytren's Contracture
- Many Tendon Repairs
- Fingertip Injury Revisions
- Excision Lesions (minor)
- Excision Ganglion (wrist)
- Acute Nerve Repair (hand)
- Other Minor Hand Procedures
- Staged Reconstructive Procedures
- Scar Revision

E. Ophthalmology
- Argon Laser Prescription
- Chalazion
- Discussion
- Ectropion and Entropion
- Insertion of the glass tube into the lacrimal duct
- Lacrimal Duct probing
- Pterygium
- Strabismus

F. Otolaryngology
- Myringotomy (with or without tubes)
- Antral Puncture (with or without irrigation)
- Inferior Turbinate Fracture
- Nose, Closed Reduction
- Type I: Tympanoplasty with the removal of attic and oval window cholesteatoma sacs
- Nasal reconstruction
- Otoplasty unilateral, bilateral (Depending on age: young children may require hospitalization overnight)
- Cervical node biopsy
- Esophagoscopy
- Frenulectomy
- I & D abscess (simple)
- Otoscopy (with or without removal of foreign body)
- Removal of foreign body from nose or ear
- Removal of scars, moles, or basal cell CA
- Wiring simple joint fracture

G. Orthopedic Surgery
- Ganglion Excision
- Carpal tunnel decompression
- Excision of foreign body

- Tenotomy
- Manipulation of joints, individual consideration, depending upon the joint involved and indication for the procedure
- Removal of bursae (Olecranon)
- Dupuytren's Contracture
- Many Tendon Repairs

H. Urology
- Circumcision (pediatric and adult)
- Dorsal slit
- Meatotomy
- Urethra dilation
- Vasectomy
- Cystoscopy
- Fulguration of venereal warts
- Excision and biopsy of the scrotal lesion
- Cystoscopy and retrograde
- Prostatic biopsy

I. Endoscopy
- Culdoscopy
- Diagnostic cystoscopy
- Gynecological laparoscopy
- Otoscopy
- Proctosigmoidoscopy
- Fiberoptic sigmoidoscopy and fiber optic colonoscopy (diagnostic only)
- Gastroscopy

J. Thoracic or Vascular
- Esophageal dilation
- Excisional surgery: chest wall lesion
- Lymph node biopsy
- Mediastinoscopy
- Thoracentesis

K. Pulmonology
- Bronchoscopy

PROCEDURES RECOMMENDED FOR SAME-DAY SURGERY

Prior authorization is required from Astrana Health

A. Gynecology
   - Mini Lap (tubal ligation)
   - Bartholin Cystectomy
   - Vaginal Tubal Ligation

B. General Surgery
   - Pilonidal Cystectomy
   - Excision of Thyroglossal Duct Cyst
   - Varicose vein ligation with stripping
   - Hernia repair (Inguinal and Femoral)
   - Umbilical Herniorrhaphy

C. Ophthalmology
   - Correction of eye muscle impairment
   - Cataract extraction
   - Iridectomy
   - Phacoemulsification
   - Prolapsed iris, etc.
   - Reconstruction of lacrimal duct

D. Urology
   - Cystoscopy with fulguration of small bladder tumors
   - Installation of chemotherapy in the ureter and bladder locally

E. Otolaryngology
   - Ethmoidectomy (intranasal)
   - Tonsillectomies
   - Adenoidectomies
   - T & A
   - Tympanoplasty
   - Sinus surgery

F. Neurosurgery
   - Morton's neuroma
   - Neuroma

G. Cardiology
   - Pacemaker generator change
   - Pacemaker programming
   - Cardiac catheterization (if findings negative)

H. Orthopedics/Podiatry
   - Morton's neuroma
   - Hammertoes with tenotomies and resection of bone (This procedure is recommended for outpatient surgery except when performed on both feet at the same time, or when the patient is elderly and cannot ambulate on crutches or walker without physical therapy training)
   - Arthroscopy
   - Bunionectomy

I. Endoscopy
   - Observation bronchoscopy (flexible, for patients under 40 years of age)
   - Triple upper endoscopy

NO AUTHORIZATION REQUIRED/AUTO-PAYABLE SERVICES

Astrana Health is compliant with the California Senate Bill (SB) 138 which was effective January 1, 2015, and allows health plan Members 12 years and older the right to request health care and benefits information, such as Explanation of Benefits, request for additional information or medical records, to be sent to an alternate address. California SSCC law allows the Member to invoke the right when it involves a "sensitive service." The "sensitive service" outlined in SB 138 includes services and treatment for mental health, pregnancy, sexually transmitted diseases, sexual assault, drug or alcohol treatment, HIV, and counseling.

Procedure:

A. ALL services require prior authorization except the services listed below. They are exempt from prior authorization per State, Federal, or Health Plan regulations:

- Preventive Health Services including immunizations
- Preventative screenings for women, infants, children, and adolescents
- Annual well-women care
- Basic Prenatal Care, including OB/GYN in-network referrals and consults
- FDA-approved contraceptive drugs and devices without cost sharing
- Family Planning Services provided to members of childbearing age to delay or prevent pregnancy through any family planning providers.
    - Pregnancy testing and counseling
    - Vasectomies
    - Tubal ligation
    - Provision of contraceptive pills, devices, and supplies
    - Health education and counseling to make informed choices about family planning and birth control choices
    - Limited physical and history examination to support family planning and birth control choices
    - Limited physical and history examination to support family planning services
    - Laboratory and pharmacy services if medically necessary to support a choice of contraceptive methods
    - Follow-up care for any complications related to contraceptive care provided by the family planning service
    - Diagnosis, treatment, and counseling for STDs and HIV
- Communicable Disease Services
- Sexually Transmitted Disease (STD) services for both within and outside the provider network
- Sensitive Services for Minors
- Sensitive and confidential services and treatment (including, but not limited to, services relating to sexual assault, pregnancy, and pregnancy-related services, family planning, abortion/pregnancy termination, sexually transmitted diseases, drug and alcohol abuse, HIV testing and treatment, and outpatient mental health counseling and treatment)
- Pre-exposure and post-exposure HIV prophylaxis drugs (e.g. PrEP) without prior authorization or cost-sharing
- Confidential HIV testing including access to confidential HIV counseling and testing services both through the network and the out-of-network local health department and family planning

providers;
- Members may access LHD clinics and family planning clinics for diagnosis and treatment of an STD episode. For community providers other than LHD and family planning providers, out of plan services are limited to one office visit per disease episode for the purposes of:
    - Diagnosis and treatment of vaginal discharge and urethral discharge
    - STDs that are amenable to immediate diagnosis and treatment those include syphilis, gonorrhea, Chlamydia, herpes simplex, chancroid, trichomoniasis, HPV, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale and evaluation and treatment of pelvic inflammatory disease.
- Out of Network Renal Dialysis services
- Emergency services (medical screening & stabilization) including emergency behavioral health care crisis stabilization, including mental health screenings
- Urgent Care
- Urgent care for home and community service-based recipients
- Tobacco Cessation- APL 16-014
- Biomarker testing (FDA-approved therapy for advanced or metastatic stage 3 or 4 cancer only)
- Screening for certain cancers based on USPSTF recommendations
- Diabetic screenings based on USPSTF recommendations
- Non-Emergency Medical Transportation (NEMT)
- Flu Vaccines

Upon receipt of a request for prior authorization of a preventive service, Astrana Health will send the "Prior Authorization Not Required" letter, if applicable, to the member and the requesting provider to notify that the requested service is covered at no cost and does not require prior authorization.

INPATIENT CASE MANAGEMENT

A. Availability

Astrana Health's Case Management Department provides 24/7 on-call coverage for contracted providers. Providers needing to reach Case Management after hours or on weekends should call (626) 216-1441. The answering service will contact the appropriate on-call provider for any problem that may arise after hours, including emergency room authorizations or after-hour patient calls. If a Member feels they have a serious medical condition, they will be instructed to hang up and dial 911 or to go to the nearest emergency room.

B. Hospital Admissions

Non-business hours

All non-emergency hospital admissions must be authorized. Hospitals calling after hours to report a hospitalization will be put in contact with the designated Case Manager who will coordinate the Member's care accordingly. The answering service has access to contact the Case Manager after hours and on weekends. The provider should notify Astrana Health of any admissions by calling (626) 216-1441 in the event they are contacted by the hospital regarding a hospitalization.

Business Hours

Providers requesting to admit a Member into the hospital should contact Astrana Health's Case Management Department. The provider may need to submit an authorization request for hospital admission.

C. Hospitalists

To coordinate hospital admissions, Astrana Health may provide hospitalists on-call. The Case Management Department will be contacted by the admitting hospital for notification purposes. The Case Manager will contact the hospitalist assigned to coordinate the Member's care. Astrana Health encourages providers to contact its Case Management Department if they receive notification of admission or if they require assistance in directing the Member to the appropriate hospital. Case Management is available 24 hours a day / 7 days a week at (626) 216-1441. Admission face sheets and in-patient medical records can be faxed to Case Management at (408) 426-2998.

D. Discharge Planning

Case Management is available to assist providers in discharge planning and the post-acute hospital phase. During the treatment planning phase, options for post-acute services are identified early in the patient's hospitalization. If the patient discharged is from another facility, the assigned Case Manager coordinates with the hospital staff to ensure a smooth transition out of the acute care facility.

The Case Manager can assist by:

- Identifying and authorizing services that can benefit the patient after acute hospitalization.
- Working with the hospital Discharge Planner to arrange for Skilled Nursing Facility placement or home health care at home.

Inpatient CM policies and procedures are available upon request. Please contact the Inpatient CM Department at (626) 282-3749.

AMBULATORY CARE MANAGEMENT

Purpose

The Case Management (CM) Program, in collaboration with network providers, meets individual patient needs through communication and the use of available resources, intending to deliver quality cost-effective care and positive health outcomes.

Scope

Astrana Health's care management program provides individualized assistance to Members experiencing complex, acute, or catastrophic illnesses. The focus is on early identification of and engagement with high-risk Members, applying a systematic approach to coordinating care and developing treatment plans that increase satisfaction, control costs, and improve health and functional status, resulting in favorable outcomes.

The program scope includes Basic Case Management (BCM), Complex Case Management (CCM) as delegated, Pediatric Case Management, High-Risk Pregnancy Case Management, CM Triage for Coordination of Care (COC), and SNP dual eligible Case Management.

Ambulatory CM policies and procedures are available upon request. Please contact the Ambulatory CM Department at (626) 282-3749.

Case Management Program Goals, Objectives, and Functions

Astrana Health's program goals are to achieve, in collaboration with providers, the following:

Quality health outcomes – identifies, manages, measures, and evaluates the quality of health care delivered to high-risk populations. This is accomplished by using identification tools and performance benchmarks that continually evaluate clinical, functional, satisfaction, and cost indicators.

Cost-effectiveness – Astrana Health is committed to measuring the effectiveness of the care management program. Astrana Health seeks clinical and cost information feedback from internal encounter data and Health Plans to assist in enhancing the performance of medical management programs.

Resource efficiency – Astrana Health's care management team works with internal and external stakeholders (Health Plans) to improve the efficiency and effectiveness of the medical group's care management activities.

The goal of Case Management is to assist Members in navigating the health care system and obtaining necessary services in an optimal setting for any critical medical event or diagnosis they experience. The focus is on reducing future inpatient admissions and coaching self-care management. Collaborating with the Member, the PCP, and/or Providers, the Case Manager assists in identifying educational and care options that are acceptable to the Member and family. Motivational Interviewing and Coaching for behavioral changes are techniques used in the process to increase adherence to treatment plans leading to successful outcomes. CM involvement is short-term with a ninety (90) day Care Plan (CP) Goal. The processes of assessment, planning, facilitation, and advocacy for options and services are incorporated into the overall case management approach.

Access to Case Management and Complex Case Management (CCM)

Referral Criteria

Conditions, diseases, or high-risk groups most frequently managed include, but are not limited to the following:

- Over-, under-, or inappropriate utilization of services
- Multiple/frequent ER visits or acute inpatient admissions
- Multiple Referrals and/or Providers in and out of network
- Multiple/severe disabilities
- Chronic Diseases w/co-morbidities
- Permanent or temporary alteration of functional status
- Medical/psychosocial/functional complications
- Non-adherence to treatment or medication regimens, or missed appointments
    - High-cost injury or illness
- Lack of family or social support or financial resources
- Exhaustion of benefits - for example, a Member with medical necessity for a specialized hospital bed, but the Member's durable medical equipment (DME) benefit is exhausted

Source of referrals

Astrana Health utilizes the following sources to identify Members for case management:

- Health Risk Assessment

- Claims or encounter data
- Hospital discharge data
- Pharmacy data, if applicable
- Data collected through the UM management referral/authorization process, if applicable
- Data supplied by purchasers, if applicable
- Data supplied by Members or caregivers, if applicable
- Data supplied by practitioners
- Data received from health plans and internal sources are analyzed by the UM team and triaged for possible referral for CM services

The referral avenues for Members to be considered for CM or CCM referrals include the following sources:

- Astrana Health's Post Acute Care Unit
- Medical management program referral, including disease management program, UM program, or referral that comes from other organizations' programs or vendors
- Discharge planner referral
- Member or caregiver referral
- Primary Care Physician referral via Provider Portal or AmbulatoryCare.Dept@AstranaHealth.com

HEALTH SERVICES CONTACT INFORMATION

Phone Numbers

UM Customer Service: (626) 282-3749

Acute & SNF Admissions:

Office Hours – (415) 216-0088

After-Hours/Weekend – (626) 216-1441 or (626) 282-0288 x0

Fax Numbers

Routine and Retro Services: (415) 390-6754

Urgent Services: (415) 663-5197

Acute & SNF Face sheet & Clinical Notes: (415) 390-5735

E-Mail

Ambulatory Care: AmbulatoryCare.Dept@AstranaHealth.com

Delegation Oversight: Delegation.Oversight@AstranaHealth.com

Inpatient Services: CaseManagement.Dept@AstranaHealth.com

Quality Management: QualityManagementDept@AstranaHealth.com

Outpatient Services: UtilizationManagementDept@AstranaHealth.com

SECTION 8 MEDI-CAL/STATE PROGRAMS

CALIFORNIA CHILDREN'S SERVICES PROGRAM

The California Children's Services (CCS) program is a state and county-funded program that serves children under the age of 21 who have acute and chronic conditions such as cancer, congenital anomalies, and other serious medical conditions that benefit from specialty medical care and case management. State statutes and contracts require that CCS program services be carved out to the applicable health plan. As a result, upon identification of a CCS-eligible condition, providers must refer a child to the local CCS program or contact Astrana Health to assist with the referral to CCS.

The CCS program requires prior authorization through CCS for all services to be funded through CCS, per the California Code of Regulations. Services are generally authorized starting from the date of referral, with specific criteria for urgent and emergency referrals. A full description of the CCS program is available at www.dhcs.ca.gov/services/ccs/Pages/ProgramOverview.aspx

CCS provides funding for diagnosis, treatment, and medical benefits (including medication and supplies) for eligible children. Care is delivered by CCS-paneled providers, CCS-approved facilities, Special Care Centers, and other outpatient clinics. Additional services may be authorized by CCS based on a child's unique needs. This may include such necessary items as transportation to provider appointments, travel and lodging arrangements, special equipment, and shift care. The state CCS program assesses the qualifications of each provider on its panel and maintains a list of specialists and hospitals that have been reviewed and found to meet CCS program standards. CCS also provides comprehensive medical case management services to all children enrolled in the program.

Astrana Health will flag members who are receiving services from California Children's Services (CCS) and/or the Regional Center. When entering a referral, your office will receive a "pop up" telling you that your member has one of the 2 services or if your member is a Medi-Cal recipient 21 years old or younger, if the request is a possible CCS condition.

NOTE: If your member is receiving services with CCS or at the Regional Center, you are required to document this in the member's medical records at each visit.

THE VACCINES FOR CHILDREN PROGRAM (VFC)

The Vaccines for Children (VFC) Program helps provide vaccines to children whose parents or guardians may not be able to afford them. This helps ensure that all children have a better chance of getting their recommended vaccinations on schedule. Vaccines available through the VFC Program are those recommended by the Advisory Committee on Immunization Practices (ACIP). These vaccines protect babies, young children, and adolescents from 16 diseases.

Funding for the VFC program is approved by the Office of Management and Budget (OMB) and allocated through the Centers for Medicare & Medicaid Services (CMS) to the Centers for Disease Control and Prevention (CDC). CDC buys vaccines at a discount and distributes them to grantees—i.e., state health departments and certain local and territorial public health agencies—which in turn distribute them at no charge to those private physicians' offices and public health clinics registered as VFC providers.

Determining Eligibility

A child is eligible for the VFC Program if he or she is younger than 19 years of age and is one of the following:

- Medicaid-eligible
- Uninsured
- Underinsured
- American Indian or Alaska Native

Children whose health insurance covers the cost of vaccinations are not eligible for VFC vaccines, even when a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier because the plan's deductible had not been met.

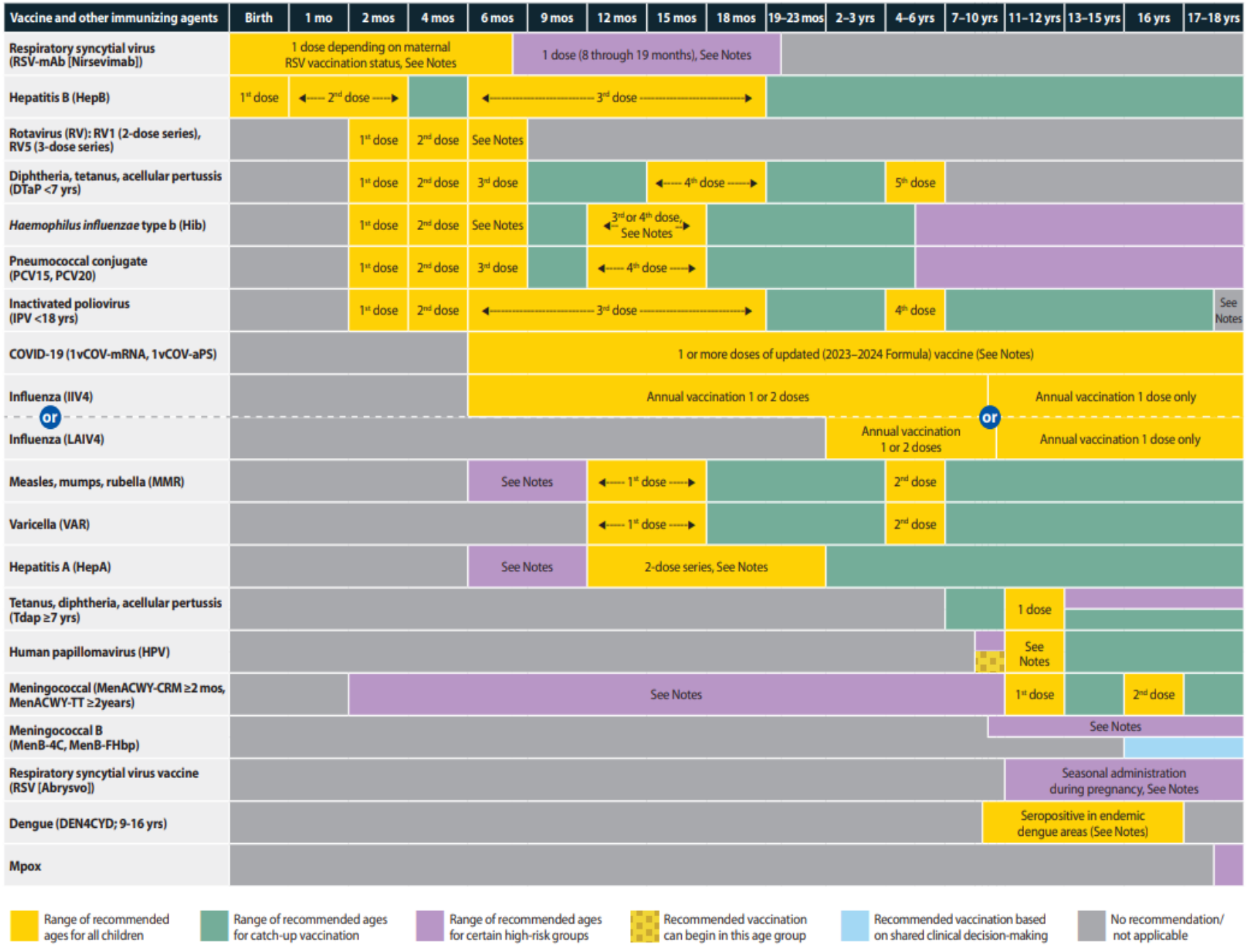
Underinsured children are eligible to receive vaccines only at Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC). An FQHC is a type of provider that meets certain criteria under Medicare and Medicaid programs. To locate an FQHC or RHC, contact the state VFC coordinator.

For additional information please visit www.cdc.gov/vaccines/programs/vfc/providers

For chart 2023 immunization chart, visit https://www.cdc.gov/vaccines/schedules/index.html

Table 1 Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2024

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars.
To determine minimum intervals between doses, see the catch-up schedule (Table 2).



CALIFORNIA IMMUNIZATION REGISTRY (CAIR)

The California Immunization Registry (CAIR) is the immunization registry for Los Angeles, San Bernardino, Riverside, and Orange County. It is a secure, confidential computer system, also called an "immunization registry" to help keep track of immunizations (shots) and make sure patients get all the shots they need at the right time. CAIR is part of the state and national effort to improve the tracking and delivery of immunizations to improve the health of all children, families, and communities.

CAIR is FREE to all healthcare providers who give immunizations as well as other organizations that have immunization requirements and/or provide assessment and referral for immunizations (e.g. schools).

The following agencies are eligible to use CAIR:

- Healthcare providers who give immunizations. This includes health department-based clinics, non-profit/community clinics, private medical practices, and hospitals.
- Schools, Daycare, and camp facilities
- Women, Infants, and Children Program (WIC)
- County and State Foster Care offices
- California Work Opportunity Program (Cal Works) program
- Health Plans
- State and County Health Departments

Some of the features of CAIR include:

- Keeps an updated immunization record in one central place that can be accessed by approved doctors and agencies
- Allows doctors/agencies to retrieve and update immunization records at the time of the patient visit
- Automatically determines the immunizations a patient needs at each visit based on the most up-to-date state and national recommendations
- Can be used to maintain immunization records for any age individual, so it can be used for childhood as well as adult and travel immunization activities
- Print reminder postcards for doctors to send to patients
- Prints an official copy of the California Immunization Record ("yellow card") for parents as well as the official California School Immunization Record ("blue card")
- Produces reports that help doctors manage their immunization services and vaccine inventory
- Helps respond to emergency events such as vaccine recalls or natural disasters

We encourage all our primary care physicians who treat pediatric patients to enroll and participate in the CAIR program, all you need is a computer, printer, and Internet access. CAIR staff will guide you through the setup process, provide training to your staff, and are available for ongoing support.

To obtain additional information, visit California Immunization Registry Portal (CAIR): https://cair.cdph.ca.gov/CAPRD/portalInfoManager.do

CHILDHOOD DISABILITY & PREVENTION PROGRAM (CHDP)

The Child Health and Disability Prevention (CHDP) is a preventive program that delivers periodic health assessments and services to low-income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

Health assessments are provided by enrolled private physicians, local health departments, community clinics, managed care plans, and some local school districts. The Child Health and Disability Prevention (CHDP) is a preventive program that delivers periodic health assessments and services to low-income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

LA Care (and Plan Partner) members under the age of 16 must be seen by a CHDP certified physician. CHDP well-child health assessments and immunizations should be rendered in accordance with the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule. CHDP well-child health assessments and immunizations should be rendered in accordance with the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule.

Please note, children should be referred for Dental Care as follows:

- Beginning at age one as required by California *Health and Safety Code* Section 124040 (6)(D)
- At any age if a problem is suspected or detected.
- Every six (6) months for maintenance of oral health
- Every three (3) months for children with documented special health care needs when medical or oral conditions can be affected, and for other children at high risk for dental caries.

Starting July 1, 2017, California state DHCS required that the CHDP *Confidential Screening and Billing Report* (PM 160) claim form would no longer be used to bill for CHDP Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) health assessments, immunizations, and ancillary services for dates of service on or after July 1, 2017. For these dates of service, qualified Medi-Cal providers enrolled in the CHDP program must bill CHDP/EPSDT services on a *CMS-1500*, *UB-04* claim form, or electronic equivalent. Providers should note the national codes cannot be submitted on the PM 160 form. Providers need to check individual Health Plan protocols for submission of CHDP claims and encounters.

For a CHDP program code conversion, providers may refer to:
https://files.medi-cal.ca.gov/pubsdoco/newsroom/25768_Cd_Conv_Table.pdf

COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)

Comprehensive Perinatal Services Program includes a wide range of culturally competent services to Medi-Cal pregnant women, from conception through 60 days postpartum.

CPSP Service Elements Include:

1. Patient (Client) Orientation: CPSP practitioners provide an initial orientation and continue to orient the client to needed services, procedures, and treatments throughout her pregnancy.
2. Initial Assessments: The initial obstetric, nutrition, health education, and psychosocial assessments are the first steps taken to determine a client's individual strengths, risks, and needs in relation to her health and well-being during pregnancy. Ideally, all four assessments are completed within four weeks of entering care.
3. Individualized Care Plan (ICP): The ICP identifies and documents the client's strengths and a prioritized list of risk conditions/problems, sets goals for interventions, and identifies appropriate referrals.
4. Interventions: Appropriate obstetric, nutrition, health education, and psychosocial interventions during pregnancy enable a woman to increase control over and improve her health and the health of her baby. Interventions can include services, classes, counseling, referrals, and instructions as appropriate to the needs and risks identified on the ICP.
5. Reassessments: Reassessments are offered at least once each trimester and postpartum and serve as an opportunity to identify other risks and check the client's progress on those issues the woman wants to change.
6. Postpartum Assessment and Care Plan: The postpartum period is the time to assess the client's health, strengths, and needs in relation to infant care skills as well as any needs of the baby. A client may receive nutrition, health education, and psychosocial support services anytime throughout the 60-day postpartum eligibility period.
7. Providers offering CPSP services should maintain a Perinatal Services protocol.

When UM referral requests are received by the IPA for OB services pertaining to Medi-Cal members, approvals will include a reminder to the provider for the provision of CPSP services. Approval notices posted to the portal will include a reminder in the portal for the provision of CPSP services. With the provision of CPSP services, providers will include all elements of CPSP services in patients' medical records.

STERILIZATION & FAMILY PLANNING SERVICES

Pursuant to state and federal requirements, sterilization services (tubal ligation or vasectomy) may be obtained by Medi-Cal members at any qualified family planning provider, in or out of the Astrana Health's HMO Medi-Cal specific network.
Providers of sterilization services for Medi-Cal members must adhere to informed consent procedures as detailed in Title 22, Section 51305,

The PM 330 consent forms, which contain federal funding language, must be used as mandated by the state of California.

When submitting a request for authorization, please include the following required documents. Failure to submit a copy of the signed PM330 and documentation of the member receiving the DHCS booklet may cause a delay in the review process.

The following are important considerations regarding Family Planning and Sterilization Services:

- Members may access family planning services both within and outside of Astrana Health on a self-referral basis without prior authorization.
- The PCP may conduct Pap Smears in their office and OB/GYNs may provide a wider scope of services.
- Family planning services are provided to members of childbearing age to enable them to determine the number and spacing of children. Services include all methods of birth control approved by the FDA.
- Members of childbearing age may access Family Planning services listed below from out of plan family planning providers to temporarily or permanently prevent or delay pregnancy.
- PCP's and OB/GYN's performing sterilization services will document referrals and family planning services information in member's charts, as well as provide information to Astrana Health.
- Member must be at least 21 years of age, mentally competent to understand the nature of the proposed procedure, and not be institutionalized. At least 30 days but no more than 180 days have passed between the date of written informed consent and the date of sterilization except in some instances advised the individual that no federal benefits may be withdrawn because of the decision not to be sterilized.
- One copy of the state of California approved booklets, in English or Spanish, must be furnished to the member, along with consent forms. Sterilization Consent forms (in English and Spanish can be downloaded from the Medi-Cal website located at www.medi-cal.ca.gov or by calling the Telephone Service Center (TSC) at 1-800-541-5555.

The following list of family planning services may be provided to Medi-Cal members by an in-network or out-of-network family planning practitioner:

- Health education and counseling are necessary to make informed choices and understand contraceptive methods.
- Verbal H & P limited to immediate problems.
- Lab tests, if medically indicated, as part of the decision-making process for choice of contraceptive methods.
- Follow-up care for complications associated with contraceptive methods issued by the family planning practitioner.

- Provision of contraceptive pills, devices, and supplies
- Provision and insertion of Norplant
- Tubal ligation
- Vasectomies
- Pregnancy testing and counseling
- Diagnosis and treatment of STDS, if medically indicated (STD diagnosis and treatment provided during a family planning encounter are considered part of family planning services).
- Screening, testing, and counseling of at-risk individuals for HIV (HIV diagnosis and treatment provided during a family planning encounter is considered part of family planning services).
- Therapeutic and elective abortions are not considered part of family planning services.
- Infertility studies, reversal of voluntary sterilization, hysterectomy for sterilization, and transportation are not covered under the Medi-Cal program and therefore are not available to Medi-Cal members under family planning or other services.
- Members may access LHD clinics and family planning clinics for diagnosis and treatment of an STD episode. For community providers other than LHD and family planning providers, out of plan services are limited to one office visit per disease episode for the purposes of:
    - Diagnosis and treatment of vaginal discharge and urethral discharge
    - STDs that are amenable to immediate diagnosis and treatment include syphilis, gonorrhea, Chlamydia, herpes simplex, chancroid, trichomoniasis, HPV, non-gonococcal urethritis, lymphogranuloma venerum and granuloma inguinale and evaluation and treatment of pelvic inflammatory disease.

Women, Infant and Children's Program (WIC) Supplemental nutritional options for children 5 and under and/or your pregnant members, including breastfeeding and formula options

- Health Plan supplemental benefits (Health Plan specific)
    - Car Seats, Coupons, etc.
- Please encourage your patient to select a contracted Pediatrician with Astrana Health IPAs.
- Our Provider Network Representative for a list of contracted Pediatricians.

EARLY START/EARLY INTERVENTION DEVELOPMENTAL DISABILITIES & REGIONAL CENTERS CARE COORDINATION

Primary Care Physicians and Providers should ensure coordination of primary and specialty care and provision of routine preventive services as needed for Medi-Cal members receiving Early Start/Early Interventions at Regional Centers.

A. Anyone can make a referral, including parents, medical care providers, neighbors, family members, foster parents, and day care providers.
B. The first step that parents may take is to discuss their concerns with their healthcare provider/doctor. Providers or parents can also call the local regional center or school district to request an evaluation for the child.
C. If the child has a visual impairment, hearing impairment, severe orthopedic impairment, or any combination of these, the provider or parents/guardians may contact the school district for evaluation and early intervention services.
D. After contacting the regional center or local education agency, a service coordinator will be assigned to help the child's parents through the process of determining eligibility.

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

a) Assign a service coordinator to assist the family through evaluation and assessment procedures.
b) Parental consent for evaluation is obtained.
c) Schedule and complete evaluations and assessments of the child's development.

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

1) Assistive technology
2) Audiology
3) Family training, counseling, and home visits
4) Health services
5) Medical services for diagnostic/evaluation purposes only
6) Nursing services
7) Nutrition services
8) Occupational therapy
9) Physical therapy
10) Psychological services
11) Service coordination (case management)
12) Social work services
13) Special instruction
14) Speech and language services
15) Transportation and related costs
16) Vision services

Member's medical records with their Primary Care Physician reflect collaboration between the Regional Center/Early Start/Early Intervention program or California Children's Services (CCS) and the PCP (i.e., MD notes [DDS or ES/EI provider]; referral from or to the Regional Center and/or Early Start program for ages 0-3). In addition, the medical record reflects the coordination of specialist services with the Health Plan network as applicable.

ALCOHOL & SUBSTANCE ABUSE; SCREENING, BRIEF INTERVENTION, & REFERRAL TO TREATMENT

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.

L.A. Care and Plan Partner primary care physicians are required to screen their patients for alcohol misuse under the expanded Medi-Cal behavioral health benefit. A highly effective method is the SBIRT approach. Healthcare practitioners can help support prevention and care through SBIRT: Provide screening and brief intervention when signs of a disorder are present and refer the patient for medically necessary treatment. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for substance use disorders.

SBIRT:

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

Evidence has shown that interventions significantly improve health in non-dependent drinkers. Similarly, benefits also occur to those with a substance use disorder. In May 2013, the US Preventive Services Task Force recommended that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with SBIRT.

For more information regarding care for Substance Use Disorders, please contact the Department of Public Health/Substance Abuse Prevention & Control (DPH/SAPC) at 1-888-746-7900 (TTY/TDD 1-800-735-2929).

The following are suggested codes that may be used by Line of Business (as of 9/15/2017):

Line of Business	Code	Description
Commercial Insurance	CPT 99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes.
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes
Medicaid	H0049	Alcohol and/or drug screening.
	H0050	Alcohol and/or drug screening, brief intervention, per 15 minutes.

MEDI-CAL RX

Starting January 1, 2022, Medi-Cal Pharmacy Benefits will be administered through the fee-for-service delivery system Medi-Cal Rx. Please visit the DHCS Medi-Cal Rx website for more information. https://medi-calrx.dhcs.ca.gov

Overview

Medi-Cal Rx will include all pharmacy services billed as a pharmacy claim, including but not limited to

- Outpatient drugs (prescription and over-the-counter), including Physician Administered Drugs or PADs
- Enteral nutrition products
- Medical Supplies
- Adult vaccinations
- The Medi-Cal Fee-For-Service Contract Drug list is posted on the Medi-Cal Rx website https://medi-calrx.dhcs.ca.gov

Medi-Cal Rx Portal Access Registration

Physicians must register for portal access to submit requests for drugs, products, and supplies covered under Medi-Cal Rx. Please use https://medi-calrx.dhcs.ca.gov/provider/ and click on the "register" link to sign up. The verification process takes time and involves mailing and receiving of actual "Personal Identification Number or PIN" in the mail in order to complete the registration process. Allow time for the mailing process before you are able to obtain drugs, products, and supplies for your patients.

All Medi-Cal Rx covered items will NOT be accepted through the Astrana Health web portal, they must go through the authorization process under the Medi-Cal Rx program.

BEHAVIORAL HEALTH TREATMENT

A mental health assessment should be conducted at each visit and documented in the patient's chart. To refer a member for behavioral health treatment, please refer to the member's health plan for coverage information.

SECTION 9 CLAIM/ENCOUNTER PROTOCOLS

ENCOUNTER DATA SUBMISSION GUIDELINES

The IPA network defines claims encounter data as the documentation of covered medical services performed by capitated providers (PCP's) and sub-specialists or vendors capitated for designated services. Providers are required to submit their encounter data within 60 days from the date of service.

Providers must certify the completeness and truthfulness of their encounter data submissions, as required by the Department of Managed Health Care (DMHC). The IPA requires that providers submit all professional claim encounter data

- Compliance with regulatory reporting requirements of the DMHC
- Compliance with NCQA-HEDIS/STAR reporting requirements
- Provide the IPA with comparative data
- Produce the Provider Profile and Quality Index
- Utilization management oversight

Capitated Primary Care Providers or other capitated vendors non-compliant with claims encounter data submission will receive a corrective action plan (issued by the IPA network). Contracted providers who fail to comply with claims encounter data submission are subject to withhold in capitation reimbursement and/or termination.

Providers should submit encounter data no later than 60 days from the date of service. Bay Area Care Partners IPA encourages providers with large volumes to submit encounter data more frequently and will continuously monitor encounter data submissions for quality and quantity.

All data elements found in the CMS 1500 form must be populated for the submission to be complete. The data elements required on the paper-based CMS 1500 form will serve as a minimum standard for electronic submissions (SECTION 10.2 of this manual includes instructions on filling out the CMS 1500 form).

Member Information:	Provider of Service Information:	Referring Physician Information:
• Member name • Member identification number • Member gender • Member date of birth • Medical Group/IPA and facility number • Patient chart number	• Name • National Provider ID (NPI) • UPIN • Federal Tax Identification (TIN) • Physician State License Number • DEA number	• Name • NPI • UPIN • TIN • Physician State License number • DEA number

All data records must include the most current industry standard diagnosis (ICD-10-CM), procedure (CPT-4, HCPCS), and place of service codes. All diagnosis codes must be reported to the highest level of specificity.

It is imperative that all capitated services be submitted on a regular basis. The health plans hold all contracted providers accountable for this statistical information regarding our patient population, especially when it comes to prevalent diseases, treatment outcomes, preventive medicine, etc.

Encounter Data submission Per Member Per Year (PMPY) threshold by line of business is as follows:

Commercial/Marketplace= 2.5 – 3.5 per member per year (overall)
Medi-Cal = 4.5 - 5.00 per member per year (overall)
Medicare = 12.00 per member per year (overall)

Encounter data can be submitted using one of the following methods:

1. Astrana Health Web Portal – https://provider-portal.astranahealth.com/login
2. Office Ally (clearing house)
3. Claimremedi (clearing house)
4. Change Healthcare (clearing house)
5. CMS 1500 form. Complete all sections indicated in the preceding example for a clean encounter submission; (Effective July 1st, 2017, Astrana Health will no longer accept paper claims for contracted providers. All claims must be submitted through electronic means.)

Encounter data must be submitted within 60 days from the date of service. Diagnosis codes must be reported to the highest level of specificity if it is available.

CLAIM SUBMISSION GUIDELINES

All claims for services provided to members of Bay Area Care Partners IPA must be submitted using one of the following methods:

- Web Portal – https://provider-portal.astranahealth.com/login (Preferred submission method)
- Office Ally (clearing house)
- Claimremedi (clearing house)
- Change Healthcare (clearing house)
- CMS 1500 Paper claims; via USPS to the following address:

  Astrana Health
  Attention: Claims Department
  1600 Corporate Center Dr.
  Monterey Park, CA 91754

Please refer back to Page 8, for payor ID and specific IPA address Suite number.

Effective July 1, 2017, we will no longer accept paper claims from contracted providers. All claims must be submitted in electronic format.

Reminders for Claims Submissions

- Providers need to submit encounter data.
- Including services provided for capitated visits.
- Claims should always be billed using the highest level of specification: 4th or 5th digit diagnosis codes, if applicable.
- Although all immunizations for members under 19 years with Medi-Cal line of business are paid by Vaccines for Children (VFC); Providers will still need to submit all encounter data to Bay Area Care Partners IPA, and the administration fee will to IPA for payment.

The following billing procedure is intended to provide a comprehensive source of instruction for billing personnel. The Health Insurance Claim Form or (CMS 1500 Form) answers the needs of many health insurers. It is a basic form prescribed by CMS for insurance claims from physicians and suppliers, except for ambulance services. Our goal is to provide quality service to all of our patients. You can help accomplish this goal by following our billing instructions. Payment is dependent on sufficient/insufficient documents submitted (i.e. Operative Report, Patient Progress Report, notes, and/or any other information on medical services or supplies). If the information is insufficient, your claim may result in non-payment.

To ensure proper payment, please refer to the following instructions when completing the elements of the CMS 1500 Form

Box #	Instruction
1a.	Type the patient's ID Number or Social Security Number.
2.	Type the patient's Last Name, First Name, and Middle Initial (as shown on the patient's ID card).
3.	Type the patient's Date of Birth and Sex.
4.	Type Primary Insured's Name.
5.	Type patient's mailing address and telephone number.
6.	Patient relationship to insured (i.e., self, spouse, child, other)
9a.	Type other insured's policy or group number.
9d.	Type complete insurance plan and product. (i.e., Medicare, commercial, Medi-Cal).
11.	Type insured's policy or group number.
11c.	Type complete insurance plan and product (i.e., Medicare, commercial, Medi-Cal)
12.	Patient or authorized representative must sign and date this item unless the signature is on file.
17.	Type or print the name of the referring or ordering physician (if applicable).
21.	Type or print the patient's diagnosis/condition. Please use the appropriate ICD-10 code number. *Please use the highest 5-digit code applicable.*
23.	Type prior authorization number for those procedures requiring professional review organization (PRO), prior approval, or attach Treatment Authorization Request (TAR).
24a.	Type the month, day, and year for each procedure service or supplies.
24b.	Type the appropriate place of service code number. Identify the location by either where the item is used, or the service is performed.
24c.	Type the procedure, service, or supply code number by using the CMS Common Procedure Coding System (HCPCS). If applicable, show HCPCS modifier with the HCPCS code. However, if you use an unlisted procedure code, include a narrative description.
24d.	Type the diagnostic code by referring to the code number shown on item 21 to relate the date of service and the procedure performed to the appropriate diagnosis. Please remember to use the highest specialty code applicable.
24g.	Type the charge for each service listed.
24f.	Type the number of days or units. This item is most commonly used for multiple visits.
25.	Type the physician's/supplier's federal tax ID number.
26.	Type the patient's account number assigned by the physician/supplier.
27.	Check the appropriate block to indicate whether the physician/supplier accepts assignment.
28.	Type the total amount of charges for the services.
29.	Type the total amount that the patient paid on the submitted charges.
30.	Type the balance due.
31.	Type the physician/supplier or his/her representative, must sign and date this item.
32.	Type the name and address of the facility if the services were performed in a hospital, clinic, laboratory, etc. If the name and address of the facility are the same as the biller's name and address shown on item 33, enter the word: "SAME".
33.	Type the name and address of the facility if the services were performed in a hospital, clinic, laboratory, etc.

CLEARING HOUSE VENDOR

Bay Area Care Partners IPA and Astrana Health have partnered with multiple clearing house vendors as methods for submitting encounters and claims. Providers are required to set up an account before they can start submitting all encounters and claims through these vendors.

Please refer back to Page 8, for payor ID and specific IPA.

- Office Ally:
  - Practices should contact Office Ally directly via phone at (866) 575-4120 or email Info@OfficeAlly.com to set up an account.
- Claimremedi:
  - Practices should contact Claimremedi directly via phone at (866) 633-4726 (Option 1) or email enrollment@claimremedi.com to set up an account.
- Change Healthcare:
  - Practices should contact Change Healthcare directly via phone at (866) 506-2830 or go to https://www.changehealthcare.com./ to set up an account.

Claims submitted via Astrana Health Web Portal, Office Ally, Claimremedi, Change Healthcare, or CMS 1500 hardcopy billing form must include the following information:

- Member's name
- Member's birth date
- Member's address
- Member's account number
- Diagnosis or nature of illness or injury (please use the appropriate code number and highest 5-digit code applicable)
- Referring or ordering provider (if applicable)
- Prior authorization number for procedures requiring professional review organization (PRO), prior approval, or attach Treatment Authorization Request (TAR)
- Month, day, and year for each procedure service or supplies
- Procedures, services, or supplies (CPT/HCPCS/HDC Code/Modifier)
- Chargesqu
- Days or units
- Rendering provider ID-UPIN, State License, and Tax ID if it uniquely identifies the provider
- Federal tax ID number
- Provider license or UPIN Number
- Total charge
- Amount member paid on a submitted charge
- Balance due
- Provider billing name, address, zip code
- Name and address of the facility if the services were performed in a hospital, clinic, laboratory, etc.

Practices should note that payment is dependent on the submission of sufficient documentation (i.e., Operative Report, Patient Progress Report, notes, and/or any other information on medical services or supplies). If the information is insufficient, the claim may result in non-payment.

ELECTRONIC REMITTANCE ADVICE (ERA)

It is the policy of Astrana Health to provide eligible providers the means of receiving electronic remittance advice (ERA/835) in lieu of paper. Astrana Health has a standard procedure that is followed to ensure provider registrations for ERA's are processed in a timely manner. To begin receiving ERAs for any payers going through Zelis Payments, you must first register and enroll with Zelis Payments.

PROCEDURE:

1. Go to nmm.epayment.center/register and click on "Get Started"
2. To create an account you will select one of two registration options:
    - *I Don't Have A Registration Code* (you've never received a payment/ERA from Zelis Payments before)
        - Complete and submit the *New Provider Registration Form.* You will receive your registration code within 28 business hours
    - *I Have A Registration Code* (you've received a payment/ERA from Zelis Payments and have a registration code)
3. Read and click "I Accept" to approve the Zelis Payments Site User Agreement and Terms
4. You will need the following information to complete your enrollment
    - *Organization Legal Name and Business Type*
    - *Contact Information for your designated EPS contacts*
    - *Banking information for payment and fees*
5. After you have logged into your account, you will need to complete the account setup (next 3 steps)
6. Payment Enrollment: Select your desired method for receiving ePayments by selecting one of these options
    - *Receive MasterCard Payments to your account*
    - *Receive Direct ACH to your bank account*
7. ERA Enrollment: Select "Clearinghouse" from the drop-down menu
    - After selecting this option, you will be automatically directed to the delivery options page where you can select "Office Ally" from the drop-down menu
    - Next, you will need to enter the provider contact information (name and telephone) then select the checkbox to confirm you are an authorized representative of your practice
    - Click "Submit"
8. Notifications: Select which notifications you would like to receive and how you would like to receive them
    - Available Notification Reports:
        - Provider Payment Alert
        - Provider Remittance Alert
        - Provider Daily EOP
        - Provider Summary
9. Click "Review Information" to examine the enrollment information you entered – Business Contact, Banking, Data Delivery, and the Select+ Service Agreement – on the page. Click "Modify" to make changes to any of the sections
10. Submit Enrollment: In the "Agreement" section at the bottom of the Enrollment Review page, check the checkbox and click "Submit" to complete your enrollment

For more information on ERA Enrollment, contact the Provider Relations Department

Direct Line: (916) 577-6243
E-mail: bacp.sacpr@astranahealth.com

PROVIDER DISPUTE RESOLUTION PROCESS

The Department of Managed Health Care promulgated regulations related to the claims settlement and dispute resolution practices of health plans and their delegated IPAs/Medical Groups ("AB1455 Regulation"). The AB1455 Regulation includes detailed information on how to submit claims and disputes to Astrana Health as well as information on Astrana Health's claim on the overpayment process. *For further information on the AB1455 Regulation, please refer to the Department of Managed Health Care's website address: https://www.dmhc.ca.gov/*

I. Claim submission instruction.

A. Claim submission address must be sent to the following:

Please refer back to Page 8, for specific IPA address Suite number.

Via Mail or Physical Delivery:

1600 Corporate Center Dr.
Monterey Park, CA 91754

B. Contact information regarding the Claim. For claim filing requirements or status inquiries call Astrana Health, Claims department Customer Service at:

Telephone Number: (877) 282-8272

C. Claim Submission Requirement. The following is a list of claim timeliness requirements, claim supplemental information, and claim documentation required based on your contract:

Contracted Providers: 90 days from date of service
Non-Contracted Providers: 180 days from date of service
Supplemental or COB claims: 90 days from date of payment, date of contest, date of denial or notice from the primary payer.

Astrana Health will send a written acknowledgment of receipt of the paper claim a day after claim posting, within the 15 working day acknowledgment requirement.

II. Dispute Resolution Process for Contracted Provider

A. Definition of Contracted Provider Dispute. A contracted provider dispute is a provider's written notice to *Astrana Health* and/or the member's applicable health plan 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 other contract dispute (or bundled group of substantially similar

multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim. Each contracted provider

dispute must contain, at a minimum the following information: provider's name; provider's identification number; provider's contact information, and:

1) If the contracted provide dispute concerns a claim or a request for reimbursement of an overpayment of a claim from *Astrana Health* to a contracted provider the following must be provided: a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;
2) If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue; and
3) If the contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the Date of Service and provider's position on the dispute, and an enrollee's written authorization for the provider to represent said enrollees.

B. Contracted Provider Dispute to Astrana Health. Contracted provider disputes submitted to *Astrana Health* must include the information listed in Section II.A., above, for each contracted provider dispute. All contracted provider disputes must be sent to the attention of *Astrana Health* at the following:

Please refer back to Page 8, for specific IPA address Suite number.

Via mail or Physical Delivery:

1600 Corporate Center Dr.
Monterey Park, CA 91754

C. Time Period for Submission of Provider Dispute.
1) Contracted provider disputes must be received by Astrana Health within 365 days from the last action date (date claim was closed or EOB was received) that led to the dispute (or the most recent action of there are multiple actions) that led to the dispute, or
2) In the case of inaction, contracted provider disputes must be received within Astrana Health 365 days for Medi-Cal or Commercial LOB. Medicare is only 60 calendar days after the provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.
3) Contracted provider disputes that do not include all required information as set forth above in Section II. A may be returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to Astrana Health within thirty (30) working days of receipt of a returned provider dispute.

D. Acknowledgement of Contracted Provider Dispute. Astrana Health will acknowledge receipt of all contracted provider disputes as follows:
1) Electronic contracted provider disputes will be acknowledged by Astrana Health within two (2) Working Days of the Date of Receipt by Astrana Health.

2) Paper contracted provider disputes will be acknowledged by Astrana Health within fifteen (15) Working Days of the Date of Receipt by Astrana Health

E. Contact *Astrana Health* Regarding Contracted Provide Dispute. All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to the attention of *Astrana Health* at the following:

Please refer back to Page 8, for specific IPA address Suite number.

Via mail or Physical Delivery:

1600 Corporate Center Dr.
Monterey Park, CA 91754

F. Time Period for Resolution and Written Determination of Contracted Provider Dispute. Astrana Health will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) Working Days or sixty (60) calendar days after the Date of Receipt of the contracted provider dispute or the amended contracted provider dispute.

G. Information retention. Copies of provider dispute and the determination, including all notes, documents, and other information the PPG used to reach its decision, must be retained for at least 7 years

III. Claim Overpayments

A. Notice of Overpayment of a Claim. If Astrana Health determines that it has overpaid a claim Astrana Health will notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the Date of Service(s), and a clear explanation of the basis upon which Astrana Health believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim. All requests for overpayments will be made within 365 days of the date of the overpayment.

B. Contested Notice. If the provider contests Astrana Health notice of overpayment of claim, the provider, within 30 Working Days of the receipt of the notice of overpayment of a claim, must send written notice to Astrana Health stating the basis upon which the provider believes that the claim was not overpaid. Astrana Health will process the contested notice in accordance with Astrana Health contracted provider resolution dispute process as described in Section II above.

C. No Contest. If the provider does not contest Astrana Health's notice of overpayment of claim, the provider must reimburse Astrana Health within thirty (30) Working Days of the provider's receipt of the notice of overpayment of claim.

D. Payment Offset. Astrana Health may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when; (i) the provider fails to reimburse Astrana Health within the timeframe set forth in Section IV.C., above, and (ii) Astrana Health contract with the provider specifically authorizes Astrana Health to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant

to this section, *Astrana Health* will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

Refer to https://www.networkmedicalmanagement.com/providers/provider-resources under claims to find the Provider Dispute Resolution Request form

BALANCE BILLING

CONTRACTED PROVIDERS CANNOT BALANCE BILL A MEDI-CAL and/or MEDICARE ELIGIBLE BENEFICIARY FOR ANY COVERED BENEFITS

Balance Billing is the practice of billing a member for the difference between what is reimbursed for a covered service and what the provider feels should have been paid. Network providers who engage in balance billing are in breach of their contract with the health plan and medical group which prohibits this practice and may be subject to sanctions by Health Plans, CMS, DHCS, and other industry regulators.

Astrana Health has been tasked with ensuring all contracted network providers have participated in education on the prohibition of balance billing. This is a requirement for all providers contracted for Medi-Cal and/or Medi-Medi plans. Providers who are contracted with Bay Area Care Partners IPA under multiple provider groups are required to take the above training only once.

Guiding Principle

CONTRACTED PROVIDERS CANNOT BALANCE BILL A MEDI-CAL and/or MEDICARE ELIGIBLE BENEFICIARY FOR ANY COVERED BENEFITS

- Purpose for this Training
  - With new managed care programs (i.e. Medi-Medi, Covered California, PASCSEIU), members and providers may not always be aware of patient costs and fees associated with these programs
  - Recent reports of balance billing warrant increased monitoring by health plans
  - Identified the need for provider and patient education on the prohibition of balance billing for covered services
- What is Balance Billing?
  - When contracted providers or hospitals change beneficiaries for Medi-Cal and/or Medicare covered services which include copays, co-insurance, deductibles, or administrative fees.
  - When non-contracted or fee-for-service providers charge members who are enrolled in managed care for any part of the covered service.
  - Provider offices charge administrative fees for appointments, completing forms, or referrals.
- When Can a Provider Bill?
  - Providers may bill patients who have a monthly Medi-Cal share of cost obligation, but only until that obligation is met for the month.
  - Medicare Part D patients, including Medi-Medi, may have a cost share for some prescription drugs
  - Cost for non-covered benefits

- Certain plans may require co-pays and co-insurance fees.

➢ Prohibition of Balance Billing

- Per Federal and State regulations, all health plans have included prohibitions on balance billing in their provider contracts
- Network providers who engage in balance billing are in breach of their contract with the health plans and medical group.
- Providers who engage in balance billing may be subject to sanctions by health plans, CMS, DHCS, and other industry regulators.

➢ Steps to Take When Balance Billing Occurs

- Tell the member – DO NOT PAY THE BILL!!
- Verify eligibility and determine if the member is a Medi-Cal and/or Medicare member
- Educate front office staff and billing departments about balance billing protections.
- Educate patients about their eligibility status and about their rights.

➢ Resources and Information

Website: http://www.calduals.org/providers/physician-toolkit/

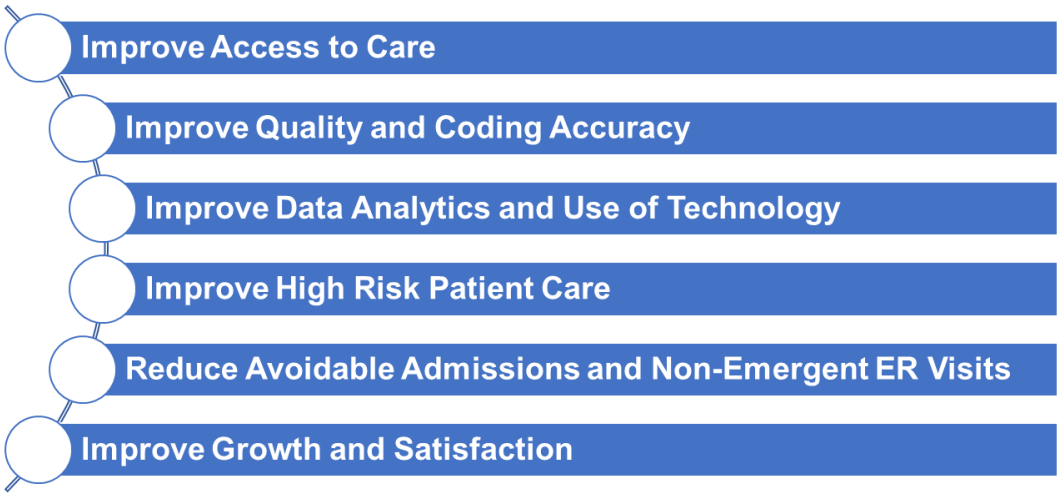
For more questions regarding Balance Billing, contact the Provider Relations Department

Provider Relations Department
Direct Line: (916) 77-6243
E-mail: bacp.sacpr@astranahealth.com

SECTION 10 POPULATION HEALTH/QUALITY

POPULATION HEALTH INTRODUCTION

As the healthcare landscape continues to shift from a fee-for-service, volume-based model, to a quality-driven, value-based care model, population health plays a critical part in providing the framework and tools to help providers drive success. Population health management is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. The goals of Astrana Health's population health program are to provide the highest quality of care most cost-effectively and to ensure high patient and provider satisfaction. With these goals in mind, our population health program will be grounded and focused on the 6 Pillars of Population Health Performance. The 6 Pillars of Population Health Performance are:



Concerning "Improve Quality and Coding Accuracy," the subsequent sections will provide more detailed information on how quality outcomes are reflected through Health Effective Data and Information Set (HEDIS) measures and how the Member's risk adjustment factor (RAF) reflects the complexity of the Member's health condition through Hierarchical Condition Categories (HCCs). Whether it's capturing HCCs or addressing/closing HEDIS measures, the work that the provider and his/her office staff do is critical to the performance of our population health program.

The subsequent sections provide more details regarding quality HEDIS measures and risk adjustment components.

HEALTH EFFECTIVE DATA & INFORMATION SET (HEDIS) OVERVIEW

Health Effective Data & Information Set (HEDIS) is a tool used by more than 1,000 health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of more than 90 measures across 6 domains of care. With data collection and technical specifications, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS results themselves to identify areas for improvement.

Each health plan implementing HEDIS is required to collect data and report HEDIS results based on the technical specifications of the HEDIS measurement sets. Health plans report their HEDIS rates separately for each product line and provide this reporting on their internal websites and marketing materials. To ensure the validity of HEDIS results, all data are rigorously audited by certified auditors using a process designed by The National Committee of Quality Assurance (NCQA).

Consumers also benefit from HEDIS data through the State of Health Care Quality report, a comprehensive look at the performance of the nation's healthcare system. HEDIS data also are the centerpiece of most health plan "report cards".

To ensure that HEDIS stays current, NCQA has established a process to evolve the measurement set each year. NCQA’s Committee on Performance Measurement, a broad-based group representing employers, consumers, health plans, and others, debates and decides collectively on the content of HEDIS. This group determines what HEDIS measures are included, and field tests determine how it gets measured.

MEASURES & CATEGORIES

HEDIS data is collected from the providers through encounters and medical record audits. The following are the key measures that will be measured through HEDIS criteria:

Category		MEASURE	MEDICARE	COMMERCIAL	MEDI-CAL
Adult Health	1	Annual Wellness Visit (AWV)	✓		
	2	Care for Older Adults (COA)	✓		
	3	Colorectal Cancer Screening (COL)	✓	✓	
	4	Eye Exam for Patients with Diabetes (EED)	✓	✓	✓
	5	HbA1C Control for Patients with Diabetes (HBD)	✓	✓	✓
	6	Kidney Health Evaluation for Patients with Diabetes (KED)	✓	✓	✓
	7	Blood Pressure Control for Patients with Diabetes (BPD)			✓
	8	Controlling High Blood Pressure (CBP)	✓	✓	✓
	9	Transition of Care (TRC)	✓		
Women's Health	10	Breast Cancer Screening (BCS)	✓	✓	✓
	11	Cervical Cancer Screening (CCS)		✓	✓
	12	Osteoporosis Management in Women Who Had a Fracture (OMW)	✓		
	13	Chlamydia Screening in Women (CHL)		✓	✓
	14	Postpartum Care (PPC)		✓	✓
	15	Prenatal Care (PPC)		✓	✓
Pediatric Health	16	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)		✓	✓
	17	Immunization for Adolescents (IMA)		✓	✓
	18	Well Child Visits in the First 30 Months of Life (W30)		✓	✓
	19	Childhood Immunization Status (CIS)		✓	✓
	20	Child and Adolescent Well-Care Visits (WCV)		✓	✓
General Health	21	Annual Physical Exam		✓	✓
	22	Initial Health Assessment (IHA)	✓	✓	✓
Medication-Related	23	Statin Therapy	✓	✓	✓
	24	Medication Adherence	✓		

For a complete summary of the most current HEDIS measures, please visit the NCQA website, http://www.ncqa.org/tabid/59/Default.aspx, or reach out to:

Quality Care Improvement Team:
Tel: (626) 282-0288 Ext. 5548
E-mail: QualityImprovement.Dept@AstranaHealth.com

HEDIS ENGAGEMENT

All contracted PCPs are required to participate with the IPA network in the HEDIS (including STAR measures) program. The IPA network will provide the PCP with gaps in care (GIC) reports, monthly eligibility, and other ad hoc reports provided by the health plans. GIC reports and other ad hoc reports will be provided electronically to the PCP ab

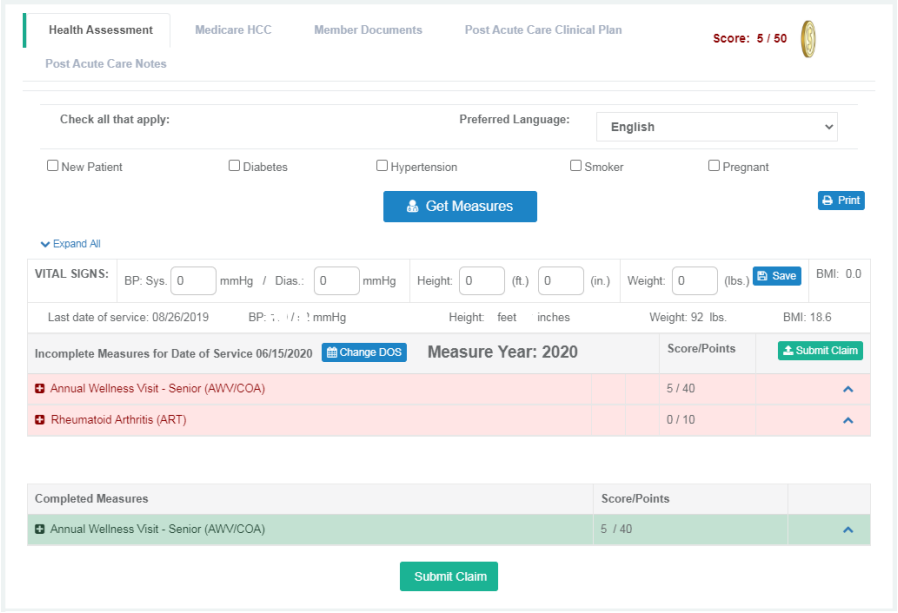
The PCP and IPA network will review the GIC reports to address the following:

1. Patients with true "gap in care"
2. Patients who have had the screening/test but may be new to the IPA and/or PCP. The IPA and PCP will work on collecting supplemental data to report findings to the applicable health plan
3. Patients who are non-compliant with disease or preventative care management

The IPA network will work with the health plans to maximize administrative and encounter data transactions. The IPA network will provide the PCP with references and resources to ensure appropriate CPT, CPT II, and ICD-10 codes are utilized by the PCP when billing. The IPA will monitor the PCP claims encounter data submissions to ensure appropriate service codes are utilized for compliance with HEDIS/STAR measures criteria.

PCP providers can use the Astrana Health Web Portal system to monitor patients with gaps in care. The Astrana Health Web Portal provides indicators (see image example below) for patients who have completed or require specific measures. It integrates data collected from Encounter data, Laboratory data, Radiology data, and Health Plan data. We encourage the PCP office to use the resources provided by the IPA to monitor patients with gaps in care to ensure the IPA is compliant with the health plan and state standards for preventative or disease management measures.

The Astrana Health Web Portal can be accessed at: https://provider-portal.astranahealth.com/login

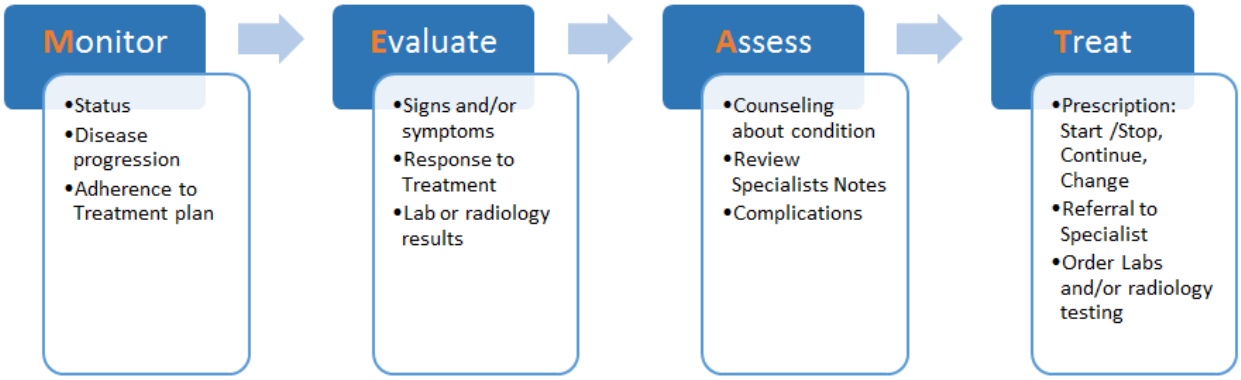


RISK ADJUSTMENT

Documentation Requirements

To ensure the accuracy and integrity of the risk adjustment data submitted to CMS:

- All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit
- Diagnosis must be accurately coded according to ICD-10 CM guidelines
- Assessing all conditions at least once annually
- The reported diagnosis must be supported by M.E.A.T.



Risk Adjustment Factor (RAF)

- Risk adjustment is calculated using an actuarial tool developed to predict the cost of healthcare for covered beneficiaries/Members
- A risk adjustment score is determined by using a combination of demographic information (Age, Sex, Status) along with disease information to predict future healthcare costs for Members
- The score is highest for the sickest patients as determined by a combination of factors
- A Risk Score of 1.000 reflects the Medicare incurred expenditures of an average beneficiary/Members

Disease Interactions

- Disease Interactions allow for additive factors based on conditions and disabled status to increase funding
- Additional risk scores are added automatically when certain diseases are coded together
    - ✓ Congestive Heart Failure and Diabetes
    - ✓ Congestive Heart Failure and Chronic Obstructive Pulmonary Disease
    - ✓ Congestive Heart Failure and Arrhythmia
    - ✓ Congestive Heart Failure and Renal
    - ✓ Cardiorespiratory Failure and Chronic Obstructive Pulmonary Disease
    - ✓ Disorders of Immunity and Cancer
    - ✓ Substance Use Disorder and Psychiatric

Hierarchical Condition Categories (HCC)

- Developed by CMS for Risk adjustment of the Medicare Advantage Program (Medicare Part C)
- Predictive Model using current year data to predict next year's risk
- HCC categories are additive
- Data Derived from:
  - ✓ Inpatient Diagnosis
  - ✓ Outpatient Diagnosis
  - ✓ Provider Office Diagnosis
  - ✓ Clinically trained non-physician provider

Comparison of RAF Score – Documentation and Coding Complexity

All Conditions Coded Complex		Some Conditions Coded Moderate		No Conditions Coded Healthy	
69-year-old female (non-dual)	0.323	69-year-old female (non-dual)	0.323	69-year-old female (non-dual)	0.323
DM w/chronic complications	0.302	DM w/chronic complications	0.302		0.000
CHF	0.331	CHF	0.331		0.000
COPD	0.335		0.000		0.000
Disease Interaction DM/CHF	0.121	Disease Interaction DM/CHF	0.121		0.000
Disease Interaction CHF/COPD	0.155		0.000		0.000
TOTAL RAF	1.567	TOTAL RAF	1.077	TOTAL RAF	0.323

*Estimated Score for illustration purposes.

Documentation Guidelines Available on Web Portal:

- ✓ Atherosclerosis of the Aorta (AAA)
- ✓ Cancer
- ✓ Chronic Obstructive Pulmonary Disease (COPD)
- ✓ Chronic Kidney Disease (CKD)
- ✓ Eligible Progress Note with Chart Mechanics
- ✓ Dementia
- ✓ Rheumatoid Arthritis
- ✓ Senile Purpura

Medical Record Review

Consistent and complete documentation in the member's medical record is an essential component of quality patient care. Primary care physicians are required to maintain a medical record for each member that must include patient records of care provided within the IPA/medical group, as well as care referred outside the IPA/medical group.

Astrana Health requires medical record reviews to assess both physician office records and institutional medical records, which are reviewed for quality, content, organization, confidentiality, and completeness of documentation.

Medical records are reviewed annually against Astrana Health medical record standards. Records are sampled from those submitted for HEDIS review. Astrana Health requires that the physician's office medical records include the following:

- Identifying information on the member (patient ID on each page)
- Problem list noting significant illnesses and medical conditions
- Allergies and adverse reactions prominently noted
- Preventive Health Services
- Proof that baseline clinical exams were conducted, documented, and pertinent to the patient's presenting complaints
- Current summary sheets of medical history including past surgeries, accidents, illnesses/past diagnoses and medications, and immunization history
- Consultation reports, hospital summaries, emergency room reports, and test reports that are easily accessible and in a uniform location
- Treatment plan consistent with the diagnosis
- Evidence of medically appropriate treatment
- Continuity and coordination of care between primary and specialty physicians
- Prescribed medications, including dosages and dates of initial prescription or refills
- Evidence that the patient has not been placed at risk by a diagnostic or therapeutic procedure
- For Medicare Advantage members, evidence on the presence or absence of Advance Directives, for adults over age 18 is prominently located in the medical record

Providers must also comply with all applicable confidentiality requirements for medical records as imposed by federal and state law. This includes the development of specific policies and procedures, when required by Astrana Health, to demonstrate compliance.

To assist Astrana Health in maintaining continuity of care for its members, physicians are required to share medical records of services and supplemental data for care rendered to Astrana Health members. Members may also be entitled to obtain copies of their medical records, including copies of Emergency Department records, X-rays, CT scans, and MRIs. Upon the reassignment or transfer of a member, the physician must provide one copy of these materials, at no charge, to the member’s new physician or IPA/medical group.

Health Risk Assessment

A Health Risk Assessment Survey is mailed to all new Astrana Health plan members. This survey is designed to identify members who may be among the frail elderly, who require reminders for preventive health services, who may require assistance with activities of daily living, and those with certain chronic diseases. Those whose results show five or more identified risks are forwarded to IPA/medical group Medical Directors quarterly for dissemination to these members' primary care physicians and/or

IPA/medical groups' case management programs. For Dual Special Needs Plan members, the Health Risk Assessment results are sent to the IPA/medical group and primary care providers with each completed Health Risk Assessment.

SECTION 11 INITIAL HEALTH APPOINTMENT

Effective January 1, 2023, “Initial Health Appointment” (IHA) replaces the previously used term, “Initial Health Assessment” based on APL 22-030 per Department of Health Care Services (DHCS). APL 22-030 supersedes APL 13-017 and Policy Letters (PL) 13-001 and 08-003. The Initial Health Appointment to include an age-appropriate Individual Health Education Behavioral Assessment (IHEBA) or a Staying Healthy Assessment (SHA) for each Member will no longer be a required component of the IHA beginning January 1, 2023.

An IHA must be completed for all Members and periodically re-administered according to requirements in the Population Health Management (PHM) Policy Guide. However, DHCS is preserving the following requirements:

- The IHA must be completed within 120 days of enrollment for new Members and must continue to include a history of the Member’s physical and behavioral health, identification of risks, an assessment of the need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases.
- For children and youth (i.e., individuals under age 21), Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings will continue to be covered per the American Academy of Pediatrics (AAP) /Bright Futures periodicity schedule, as referenced in APL 19-010.
- The provider is accountable for providing all preventive screenings for adults and children as recommended by the United States Preventive Services Taskforce (USPSTF) but will no longer require all of these elements to be completed during the initial appointment, so long as Members receive all required screenings on time consistent with USPSTF guidelines.
- DHCS will measure primary care visits as a proxy for the IHA, leveraging Managed Care Accountability Sets (MCAS) measures specific to infant and child/adolescent well-child visits and adult preventive visits. For children, DHCS will measure both primary care visits and childhood screenings, including but not limited to screenings for ACEs, developmental, depression, autism, vision, hearing, lead, and SUD.

An IHA:

- Must be performed by a Provider within the primary care medical setting.
- Is not necessary if the Member’s Primary Care Physician (PCP) determines that the Member's medical record contains complete information that was updated within the previous 12 months.
- Must be provided in a way that is culturally and linguistically appropriate for the Member.
- Must be documented in the Member’s medical record.

An IHA must include all of the following:

- A history of the Member's physical and mental health;
- Identification of risks;
- An assessment of the need for preventive screens or services;

- Health education; and
- The diagnosis and plan for treatment of any diseases

REFERENCES

1) APL 22-030 (ca.gov) https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-030.pdf
2) Population Health Management Policy Guide https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf

SECTION 12 QUALITY MANAGEMENT

PROCEDURES

Quality Management (QM) promotes the highest quality of medical care and service to Members by performing ongoing evaluations and modifications.

QM Identifies and resolves issues that directly or indirectly affect Member care.

Quality Management Committee Meetings:

- Special studies & trending
- Preventative Health Services
- Development/Implement Clinical
- Practice Guidelines
- Policy and Procedures
- Grievance Resolution
- Access Monitoring
- Culturally and Linguistically Appropriate Services (CLAS)

All Primary Care Physician offices will be audited on a routine basis by Astrana Health and periodically by all HMO companies.

It is imperative that the PCP office be kept tidy and that all logs are kept current and available for these audits.

For assistance preparing for audits, please contact our Quality Management Department at (626) 282-0288. Astrana Health will assist you in any way that we can to make sure that you are audit-ready at all times.

GRIEVANCES & APPEALS PROCESS

The policy of Astrana Health is to refer all Member grievances and appeals to the appropriate Health Plan, to ensure Members are provided appropriate medical care of the highest possible quality.

The health plan will contact Astrana Health for appropriate information needed to resolve the Member's issue. Astrana Health will contact the provider to obtain the information requested, which must be submitted within the time guidelines mandated by each health plan. Providers shall comply with all final determinations made by health plans through their Member Grievance and Appeals procedures.

ACCESS TO CARE STANDARDS

Quality and Health care access standards established by Astrana Health ensure all members have access to healthcare services. Astrana Health makes these standards known to all providers, continuously monitors its provider networks' compliance with these standards, and takes corrective action, as necessary. These standards ensure that the hours of operation of Astrana Health networks are convenient to and do not discriminate against Members, and are no less available than hours offered, and that services are available 24/7 when Medically Necessary. Astrana Health access standards are following California Managed Health Care Coalition, health plans, and NCQA standards.

Access Criterion	Bay Area Care Partners IPA Standard
Primary Care Provider (PCP) Accessibility Standards:	
Routine Primary Care Appointment (Non-Urgent)	Within 10 business days of a request
Urgent Care Appointment	Within 48 hours of request
Emergency Care	Immediate, 24 hours a day, 7 days per week
Preventive Care	Within 10 business days of a request- 30 calendar days for Medicare
First Prenatal Visit	Within 10 business days of a request
Post Stabilization Services	30 minutes (DHCS = 30 Minutes) (CMS = 1 hour)
Specialty Care Provider (SPC) Accessibility Standards:	
Routine Specialty Care Appointment (Non-Urgent)	Within 15 business days of a request
Urgent Care Appointment	Within 96 hours of request
Ancillary Care Accessibility Standards:	
Routine Ancillary Care Appointment (Non-Urgent)	Within 15 business days of a request
Behavioral Care Accessibility Standards:	
Routine Behavioral Care Appointment (Non-Urgent)	Within 15 business days of the request (Physicians) Within 10 business days of the request (non-Physicians)
Urgent Care Appointment	Within 48 hours of request
Life Threatening Emergency	Immediately
Non-Life Threatening Emergency	Within 6 hours of request
Emergency Care	Immediate, 24 hours a day, 7 days per week
After-Hours Care Standards:	
After-Hours Care	• Automated systems must provide emergency 911 instructions • An automated system or live party (office or professional exchange service) answering the phone must offer a reasonable process to connect the caller to the PCP or covering physician • Offer a call-back from the PCP, covering physician, or triage/screening clinician within 30 minutes
Physician Telephone Responsiveness:	
In-Office Waiting Room Time	Within 30 minutes
Speed of Telephone Answer	Within 30 seconds
Missed Appointments	Within 48 hours to reschedule

ASTRANA HEALTH DEFINES THE ACCESS CRITERION AS FOLLOWS:

1. Preventive care: Care or services provided to prevent disease/illness and/or its consequences. For example, an annual physical exam, immunizations, or a disease screening program.
2. Specialty care: Medical care provided by a specialist, such as a cardiologist or a neurologist.
3. Routine primary care: Services that include the diagnosis and treatment of conditions to prevent further complications and/or severity. These are non-acute, non-life, or limb-threatening.
4. Urgent care: Care given for a condition(s) that could be expected to deteriorate into an emergency or cause prolonged impairment, such as acute abdominal pain, fever, dyspnea, serious orthopedic injuries, vomiting, and persistent diarrhea.
5. Post-stabilization services: Contracted providers must provide 24/7 access to providers for prior authorization of Medically Necessary post-stabilization care and to coordinate the transfer of stabilized Members in an emergency department. Requests from the facility for prior authorization of post-stabilization care must be responded to by Astrana Health within 30 minutes (DHCS = 30 Minutes) (CMS = 1 hour) or the service is deemed approved. Upon stabilization, additional medical-necessity assessment will be performed to assess the appropriateness of care and assure that care is rendered in the appropriate venue.
6. After-hours non-urgent phone call: Examples include an Rx refill, questions regarding the current treatment plan, or problems identified.
7. After-hours emergency/urgent phone call: A call made for a life-threatening illness or accident requiring immediate medical attention for which delay could threaten life or limb.
8. Waiting time: The period from the scheduled appointment time until seen by the provider in the exam room (assuming that the Member arrives on time). The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.
9. Ancillary services: Include, but are not limited to, the provisions of pharmaceutical, laboratory, optometry, prosthetic, or orthopedic supplies or services, suppliers of durable medical equipment, home-health service providers, and providers of mental health or substance abuse services.
10. Triage or screening: The assessment of a Member's health concerns and symptoms to determine the urgency of the Member's need for care.

Providers are encouraged to accept walk-in members in case of unforeseen circumstances and should let members know of their office policy for same-day appointments.

HEALTH EDUCATION PROGRAMS

Providers are encouraged to inform Members about Health Education programs offered by Astrana Health and contracted Health Plan organizations which are available in the threshold languages and different formats. The following is a list of health education programs that are available:

- Asthma
- Childhood Obesity
- Diabetes
- Drug and Alcohol Problems
- Exercise
- Family Planning/Birth Control
- How to Quit Smoking
- Nutrition
- Parenting
- Prenatal Health (for pregnant women)
- Safety Tips
- STDs and HIV
- Tobacco Cessation
- Weight Problems

ASTRANA HEALTH
HEALTH EDUCATION REFERRAL PROCESS

1. Complete Treatment Authorization Request (TAR).
2. Retain a copy of TAR in Medical Records and document the Health Education referral in progress notes.
3. Fax to the Utilization Review Department at the number specified on the TAR corresponding to Medical Group.
4. Utilization Review Coordinators will enter the request into the system and give an authorization number.

HEALTH EDUCATION MATERIAL REQUEST FORM

If your office needs Health Education (HE) Materials, please fill out this assessment form and fax it to (626) 943-6383.

Provider Name: _____

Provider Address: _____

Provider Telephone: _____

Provider Fax Number: _____

Provider Health Plan Contracts: _____

1. Would you like more information about health education classes?
   _____Yes _____No

2. Do you have health education materials in your office?
   _____Yes _____No

3. What sources have you used to obtain health materials?
   _____

4. Please Circle Health Education Materials needed in your office and specify the languages.

Advance Directive	Hypertension	Medi-Cal Materials
Asthma	Men's Health	Healthy Family
Breastfeeding	Nutrition	Staying Healthy
Cholesterol	Pregnancy	WIC Services
Congestive Heart Failure	STD's	Parenting
Depression	Stress Management	Other: _____
Diabetes Mellitus	Smoking Cessation	_____
Family Planning	Weight Management	
GYN Disorders	Women's Health	

Language: English Spanish Chinese Other: _____
(circle one)

Completed by: _____ Date: _____

ASTRANA HEALTH USE ONLY

Date (HE) Materials sent to Provider: _____ By: _____

MEDICAL RECORD STANDARD

It is up to Bay Area Care Partners IPA to ensure that medical records are maintained in a manner that is consistent with the legal requirements, current, protected, relevant, standardized, detailed, organized, available to practitioners at each patient encounter, facilitate coordination and continuity of care, and permits effective, timely, confidential, quality review, care, and service. It is the policy of Bay Area Care Partners IPA through Astrana Health to distribute this policy to all practitioners and to ensure its practitioners comply with these standards.

1. The medical records serve as the basis for planning and maintaining the quality of patient care. Medical records that are devoid of pertinent medical information may impact other treating providers' or health professionals' ability to provide appropriate care. Failure to maintain adequate and accurate records relating to the provision of services constitutes unprofessional conduct. (Business & Professions Code 2266)
2. Reimbursement for services may be limited or denied unless documentation supports the charges that the physician is charging for the level of care.
3. Incomplete medical records documentation may interfere with a physician peer's ability to perform peer review to maintain quality health care delivery and may subject the physician to disciplinary action or severe sanction by outside review agencies.
4. Medical records are often a physician's best evidence in a professional liability lawsuit. Inadequate medical records may undermine a physician's ability to defend him or herself.
5. It is recommended that each physician office site employ a process for ensuring that pertinent medical information about medical and non-medical services rendered to Members is available at each patient visit and that periodic purging and archiving of medical records information be conducted following all applicable state and federal laws. Astrana Health has adopted a seven (7) year minimum period from the last medical visit in which to purge and archive medical records. Ten (10) years for Medicare Members. Records of minors must be maintained for at least one (1) year after a minor has reached age 18 but in no event for less than seven (7) years. Member medical information and records must be stored anonymously, and if disposed of must be destroyed in a way such that information is not identifiable. This may mean reformatting, shredding, or another form of destruction, depending on the media involved. It is Astrana Health's policy that medical records be retained for seven (7) years to retain a record of the patient care and to establish facts regarding the patient's condition and course of treatment, should those facts ever come into question. Ten *(10) years for Medicare Members), five (5) years for Medi-Cal) from the end of the current fiscal year in which the date of service occurred; the record or data was created or applied; and when the financial record was created or the Contract is terminated) (For Molina health plan, the medical records must be kept for ten (10) years for all product lines)*
6. Occasionally an entry may be made in a medical record that is incorrect due to a mistake or clerical error. If such an entry is discovered, it should be corrected. The erroneous entry itself should not be obliterated or erased. Rather, a line should be marked through it to indicate the error, with the current date and initials of the person correcting the entry. Obliteration of the entry with correction fluid so that it may not be read, may raise a question later as to what the entry contained or why it was erroneous and may jeopardize the defense of a medical malpractice case should one be filed. Modifying or altering a medical record for fraudulent

purposes is prohibited by law and may result in both disciplinary action by the California Medical Board and criminal action punishable as a misdemeanor. (B&P Code 2262 & Penal Code 471.5)

The clinical record should be maintained and organized in the following manner:

1. An individual medical record is maintained for each patient. Each patient's medical record will be individualized, format standardized, organized, and secure and permit effective confidential Member care, and quality review.
2. Each patient medical record will be filed and stored in a central place (restricted from public access), utilizing a standardized and centralized medical group network tracking system assuring ease and accuracy of filing, retrieval, availability, and accessibility as well as confidentiality. *Personnel must be periodically trained and have evidence of confidentiality on HIPPA guidelines.*
3. Member identification is on each page, including first and last name, and/or unique patient number established for use on clinical sites. Electronically maintained records and printed records from electronic systems contain patient identification.
4. Biographical/personal data will include name, date of birth, address, employer name/phone, sex, home phone, work phone, principally spoken/written language, marital status, and insurance information which will be kept in the Member's medical record.
5. Member's emergency contact information must be documented in the medical record. This shall include the name and phone number of a relative or friend or a home, work, cellular, or message phone number. If the patient is a minor, the emergency contact must be a parent or guardian. If the patient refused to provide information, "refused" is noted in the medical record.
6. Entries must contain author authentication including title and date.
7. Entries must be legible to someone other than the writer.
8. Medical records are consistently organized, content and formats of printed and or/electronic records within the practice site are uniformly organized.
9. Medical records content is securely fastened.
10. There must be evidence that the Advanced Health Directive information has been offered and discussed with adult patients 18 years of age and over.
11. Documentation is to occur within 24 hours of the patient visit.
12. Identifiable chronic problems/significant conditions (inclusive of behavioral health) are listed and must be maintained and dated in the medical record such as on a problem list. A chronic problem is defined as one which is of long duration, shows little change, or is a slow progression. *The absence of chronic problems will be noted on the problem list.*
13. An identifiable current continuous medication is listed with name, strength, route, dosage, duration, dates of initial or refill prescriptions, and quantity of all prescribed medications must be noted and maintained in the medical record. Discontinued medication must be noted in the progress notes and the stop date will be noted in the medication list.
14. All services provided directly by the PCP, reasons for and results of ancillary services, diagnostic and therapeutic services. *This includes all diagnostic and therapeutic services for which a Member was referred by a practitioner such as home health nursing reports, specialty physician reports, hospital discharge reports, and physical therapy reports.*
15. Allergies and adverse reactions shall be prominently displayed on the front of the medical record or inside cover, including in the problem list and on each visit progress note. If the Member has no allergies or adverse reaction, "No Known Allergies" (NKA), or "No known Drug Allergies" (NKDA), this also needs to be noted in the medical record.

16. The history of the present illness must be documented. Physical exam must be documented related to presenting complaint including subjective and objective information.
17. Diagnosis or medical impression, clinical findings, and evaluation must be documented regarding each visit.
18. The plan of treatment must be documented and consistent with findings and care that is medically appropriate.
19. Follow-up plan and date of a return visit, if indicated is noted specifically in weeks, months, or as needed.
20. Unresolved and/or continuing problems are addressed in subsequent visit(s).
21. Evidence of continuity of care between PCP and providers if applicable via progress note notation indicating review of consultant's reports and actions taken by PCP if necessary or that patient was contacted. Evidence of appropriate use of consultants, if applicable. All requested referral information is to be placed in the Member's medical records. *The medical record shall include identification for all practitioners participating in the Member's care and information on services they render.*
22. Evidence of appropriate utilization of labs and other diagnostic studies with reasons for and results of studies. All labs and diagnostic reports should reflect PCP review via initials and date. This includes pertinent inpatient records that must be maintained in the office medical record. These records may include but are not limited to the following: history and physical, surgical procedure reports, ER reports, and/or discharge summaries.
23. Missed/failed appointments, cancellations, and follow-up contacts/outreach efforts are noted in the medical record to ensure appropriate medical care and Member non-compliance monitoring. "No-show", "Rescheduled" or "Canceled" is noted in the medical records as applicable. In addition, the Practitioner must document intervention in the medical records.
24. Evidence of compliance with established practice guidelines and related policies and procedures. (e.g., Confidentiality, Missed Appointments, Notification of Test Results, After Hours Calls, Treatment Consent)
25. Documentation shall substantiate medical care rendered.
26. Initial Health Assessment (IHA) must be completed on all Members within 120 days of the effective date of enrollment into the plan or documented within 12 months of prior Member's enrollment. This assessment must include a comprehensive history and physical, assessment to determine health practices, values, behaviors, beliefs, literacy levels, and health educational needs.
27. Individual Health Education Behavioral Assessment (IBEHA) for new Members must be conducted within 120 days of effective enrollment date as part of the initial health assessment. For existing Members, age-appropriate IBEHA is conducted at the Member's next non-acute care visit, but no later than the next scheduled health screening exam. The tool is re-administered at appropriate age intervals.
28. The Member's primary language must be noted in the medical record.
29. Linguistics needs for non or limited English proficient Members will be prominently noted in the medical record. Request for language and/or interpretation services will be documented. The Member's refusal of these services will also be documented. Evidence of documentation on request for and refusal of Language interpretive services.
30. Tracking of record location when out of the filing system will be accomplished by way of a tickler system indicating medical record whereabouts.
31. Medical record data obtained between visits will be forwarded to the PCP's office for review and incorporated into the patient's medical record.

32. Adult patients (18 years and older) who inspect their medical records are allowed to provide a written addendum to their records if the patients believe that the records are incomplete or inaccurate. This addendum is included when disclosed to other parties.
33. Medical records shall be transferred among practitioners when a Member changes to a new PCP (before the Member's first visit with the new PCP). The privacy of the medical record must be safeguarded in transit. The requested information must be delivered on time (before the Member's first visit with the new PCP) to ensure continuity of care. A practitioner furnishing a referral service must report appropriate information to the referring practitioner/provider on time. Also, the record contains referral notes from medical practitioners to behavioral health practitioners (as applicable) and documented evidence of clinical feedback (i.e. consultations report inclusive of diagnosis, treatment plan, and psychopharmacological medication, as applicable) Practitioners shall request information from other treating practitioners as necessary to provide care on time. *For Senior Members there is no charge for medical records and information transfer. Release of medical records to the Member must include reasons but not be limited to the Member's request and quality improvement activities.*

Disclosure of Medical Information/HIPPA- The expanded definition of "individually identifiable" (includes name, address, phone number, Social Security number, email address, etc.)

- Prohibition of requiring a patient as a condition to receiving Healthcare services to sign an authorization, release, consent, or waiver permitting disclosure of medical information subject to confidentiality protection under the law.
- Medical information is released after Member authorization and following applicable Federal or State law.
- A Member has the right to authorize/deny the release of PHI beyond uses for treatment, payment, or health care operations
- Disclosures and security measures for PHI meet the requirements under HIPPA
- In the event of improper use or disclosure of PHI, steps must be taken to notify the health plan by self-reporting.

Health Maintenance documentation must include the following:

A. Appropriate adult past medical history documentation to include:
    1. Smoking habits
    2. Alcohol use
    3. Substance abuse history
    4. Family planning, reproductive health history
    5. Surgical procedures
    6. Illnesses & serious accidents
    7. Discharge summaries from hospitalized Members
    8. Inpatient hospital admissions
    9. For Members seen multiple times are easily identified and include serious accidents, operations, and illnesses.

B. Appropriate Children/Adolescents' past medical history documentation must include:
    1. Smoking history

2. Alcohol usage/history of substance abuse for patients over 12 years of age
3. Surgical procedures
4. Childhood illnesses
5. Personal/psychosocial/family history
6. Completed and current record
7. Documentation of education and age-appropriate preventive/risk screening services and risk factors following Astrana Health practice guidelines (including behavioral health practice guidelines, if applicable)
8. For Members seen </= 18 years, past medical history relates to prenatal care, birth, operations, and childhood illnesses.

Pediatric Preventive Services Documentation should include the following:

A. Referral to Health Assessment Procedure to notify beneficiary to receive a health assessment:
   1. For Members under the age of 18 months, the PCP is responsible for performing an initial health assessment (IHA) within 60 days of enrollment or within periodic timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.
   2. For Members 18 months of age and older upon enrollment, including all adults, the PCP is responsible for ensuring an initial health assessment (IHA) is performed within 120 days of enrollment.

B. Initial Health Assessment documentation for Medi-Cal (CHDP PM 160 INF) (Staying Healthy Assessment form) Members must include:
   1. Health Developmental history
   2. Unclothed physical examination
   3. Assessment of Nutritional Status
   4. Inspection of ears nose, mouth, throat, teeth, and gums (any referrals if applicable, including but not limited to dental care, and eye care)
   5. Vision Screening
   6. Hearing Screening
   7. Tuberculosis Testing, Laboratory Testing for anemia, diabetes, and urinary tract infections
   8. Testing for sickle cell trait and Lead Poisoning
   9. Immunizations appropriate to age following recommendations of the Advisory Committee on Immunization Practices of the American Academy of Pediatrics
   10. Health education and anticipatory guidance

C. Periodic Assessments should include:
   1. Persons Eligible for periodic assessments shall receive one assessment during each designated age period. Providers must follow the schedule recommended by the American Academy of Pediatrics.

D. Appropriate Health Education Documentation must include:
   1. Date of health education intervention Type and topic of health education Intervention (i.e. one-on-one class, sub-group).
   2. Patient feedback or comments regarding health Intervention.
   3. Referrals to other classes if applicable.

4. Follow-up from previous health interventions with explicit notations in the medical record particularly for consultation, abnormal lab, and imaging study results

E. Community Resource- Documentation in the patient's medical records if receiving services from/through
   1. California Children's Services (CCS)
   2. Regional Center
   3. Women, Infants, and Children (WIC)

ADVANCE DIRECTIVE

Advance directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under state law and signed by a patient, that explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.

Astrana Health providers shall provide to each adult (18 years and older) subscriber (incapacitated included) an Advance Directive Brochure on the first visit or when reasonably feasible. Also, the PMG/IPA will assist Members in their understanding of advance directives. This information may be given to the Member's family or surrogate. The provider (staff) is instructed to follow up to ensure that the information is given directly to the individual at the appropriate time.

Following title 22 of the California Code of Regulations, medical records for adults 18 years and older must include documentation; documentation of discussion; whether the Member has been informed of (advance directive brochure), or has or has not executed an advance directive, such as a durable power of attorney for health care (DPAHC), by the primary care physician. Forms are available at Advance Health Care Directive Registry | California Secretary of State www.sos.ca.gov

Additionally, you may refer to the Astrana Health Web Portal under the section "Provider Recourses" for a copy of an Advanced Directive form.

PATIENT'S RIGHTS AND RESPONSIBILITIES

As a member of Bay Area Care Partners IPA, you have certain rights and responsibilities. This chapter explains these rights and responsibilities and includes legal notices that you have a right to as a member.

Your Rights:

- To be treated with respect and dignity, 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 health plan and its services, including covered services, practitioners, and member rights and responsibilities
- To get fully translated written member information in your preferred language, including all grievance and appeals notices
- To make recommendations about Bay Area Care Partners IPA's member rights and responsibilities policy
- To be able to choose a primary care provider within Bay Area Care Partners IPA's network
- To have timely access to network providers
- To participate in decision-making with providers 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 you got
- To know the medical reason for Bay Area Care Partners IPA's decision to deny, delay, terminate, or change a request for medical care
- To get care coordination
- To ask for an appeal of decisions to deny, defer, or limit services or benefits
- To get no-cost interpreting and translation services for your language
- To get free legal help at your local legal aid office or other groups
- To formulate advance directives
- To ask for a State Hearing if a service or benefit is denied and you have already filed an appeal with Bay Area Care Partners IPA and are still not happy with the decision, or if you did not get a decision on your appeal after 30 days, including information on the circumstances under which an expedited hearing is possible
- To disenroll (drop) from Bay Area Care Partners IPA and change to another health plan in the county upon request
- To access minor consent services
- To get no-cost written member information in other formats (such as braille, large-size print, audio, and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare and Institutions (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 truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage
- To have access to and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations (CFR) sections 164.524 and 164.526
- Freedom to exercise these rights without adversely affecting how you are treated by Bay Area Care Partners IPA, your providers, or the state
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health

Centers, Indian Health Clinics, midwifery services, Rural Health Centers, sexually transmitted infection services, and emergency services outside Bay Area Care Partners IPA's network pursuant to the federal law

Your Responsibilities:

- Contact your PCP right away to schedule an Initial Health Assessment (within 120 days of enrollment) for you or your child.
- Give us, your doctors, and other healthcare providers the information needed to help you receive the best possible care and all the benefits you are entitled to.
- Understand your health problems as well as you can and work with your doctors or other healthcare providers to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Follow your doctor's advice about taking good care of yourself.
- Use the right sources of care.
- Bring your insurance ID card with you when you visit your doctor.
- Treat your doctors and other caregivers with respect.
- Understand this health plan.
- Know and follow the rules of this health plan.
- Know that laws govern this health plan and the types of service you receive.
- Know that we cannot discriminate against you because of your age, sex, race, national origin, culture, language needs, sexual orientation, or health.

Notice of Non-Discrimination:

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

Notice of Privacy Practices:

A statement describing policies and procedures for preserving the confidentiality of medical records is available and will be given to you upon request.

If you are of the age and capacity to consent to sensitive services, you are not required to get any other member's authorization to get sensitive services or to submit a claim for sensitive services. You can read more about sensitive services in the "Sensitive Care" section of this handbook.

You can ask Bay Area Care Partners IPA to send communications about sensitive services to another mailing address, email address, or telephone number that you choose. This is called a "request for confidential communications." If you request confidential communications, Bay Area Care Partners IPA will not give information on your sensitive care services to anyone else without your written permission. If you do not give a mailing address, email address, or telephone number, Bay Area Care Partners IPA will send communications in your name to the address or telephone number on file.

Bay Area Care Partners IPA will honor your requests to get confidential communications in the form and format you asked for. Or we will make sure your communications are easy to put in the form and format you asked for. We will send them to the place you choose. Your request for confidential communications

lasts until you cancel it or submit a new request for confidential communications.

Confidential Communications of Medical Information:

Any member, including an adult or a minor who can consent to a health care service without the consent of a parent or legal guardian, pursuant to State or Federal law, may request confidential communication, either in writing or electronically.

The confidential communication request will apply to all communications that disclose medical information or a Provider's name and address related to the medical services received by the individual requesting the confidential communication. A confidential communication request will be valid until either a revocation of the request is received from the member who initially requested the confidential communication or a new confidential communication request is received. Bay Area Care Partners IPA will implement the confidential communication request within seven (7) calendar days of receiving an electronic request or a request by phone, or within fourteen (14) calendar days from the date we receive a written request by first-class mail. We will also acknowledge that we received the request and will provide the status if the member contacts us.

Notice about Laws:

Many laws apply to this Member Handbook. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are state and federal laws about the Medi-Cal program. Other federal and state laws may apply too.

Notice about Medi-Cal as a payer of last resort, other health coverage, and tort recovery. The Medi-Cal program follows state and federal laws and regulations relating to the legal liability of third parties for health care services to members. Bay Area Care Partners IPA will take all reasonable measures to ensure that the Medi-Cal program is the payer of last resort. Medi-Cal members may have other health coverage (OHC), also referred to as private health insurance. As a condition of Medi-Cal eligibility, you must apply for or retain any available OHC when there is no cost to you. Federal and state laws require Medi-Cal members to report OHC and any changes to an existing OHC. You may have to repay DHCS for any benefits paid by mistake if you don't report OHC quickly. Submit your OHC online at http://dhcs.ca.gov/OHC. If you do not have access to the internet, you can report OHC to Bay Area Care Partners IPA. Or call 1-800-541-5555 (TTY 1-800-430-7077 or 711) inside California, or 1-916-636-1980 (outside California). The California Department of Health Care Services (DHCS) has the right and responsibility to collect for covered Medi-Cal services for which Medi-Cal is not the first payer. For example, if you are injured in a car accident or at work, auto or workers' compensation insurance may have to pay first or reimburse Medi-Cal. If you are injured, and another party is liable for your injury, you or your legal representative must notify DHCS within 30 days of filing a legal action or a claim.
Submit your notification online:

- Personal Injury Program at https://dhcs.ca.gov/PI
- Workers' Compensation Recovery Program at https://dhcs.ca.gov/WC
- To learn more, visit https://dhcs.ca.gov/tplrd or call 1-916-445-9891

Notice About Estate Recovery:

The Medi-Cal program must seek repayment from probated estates of certain deceased members for Medi-Cal benefits received on or after their 55th birthday. Repayment includes Fee-for-Service (FFS) and managed care premiums or capitation payments for nursing facility services, home and community-based

services, and related hospital and prescription drug services received when the member was an inpatient in a facility or was receiving home and community-based services. Repayment cannot exceed the value of a member's probated estate.

To learn more, go to the DHCS estate recovery website at https://dhcs.ca.gov/er or call 1-916-650-0590.

Notice of Action:

Bay Area Care Partners IPA will send you a Notice of Action (NOA) letter any time Bay Area Care Partners IPA denies, delays, terminates or modifies a request for health care services. If you disagree with Bay Area Care Partners IPA's decision, you can always file an appeal with Bay Area Care Partners IPA. Refer to Section 7 of this manual for information on filing your appeal. When Bay Area Care Partners IPA sends you a NOA it will tell you all the rights you have if you disagree with a decision we made.

Contents in notices

If Bay Area Care Partners IPA bases denials, delays, terminations, or changes in whole or in part on medical necessity, your NOA must contain the following:

- A statement of the action Bay Area Care Partners IPA intends to take
- A clear and concise explanation of the reasons for Bay Area Care Partners IPA decision
- How Bay Area Care Partners IPA decided, including the rules used
- The medical reasons for the decision. Bay Area Care Partners IPA must clearly state how the member's condition does not meet the rules or guidelines.

SECTION 13 CULTURAL AND LINGUISTIC SERVICES

OVERVIEW

Culturally and linguistically appropriate services (C&L) areas include:

A. Identification of Limited English Proficient (LEP) and hearing-impaired Members and recording language preferences/American Sign Language in medical records.

B. Posting signs at all Member key points of contact to inform LEP and hearing-impaired Members of the availability of free interpreter services.

C. Ability to access interpreter services through Astrana Health and/or health plans for medical and non-medical points of contact.

D. Ensuring access to free interpreter services to LEP and hearing-impaired Members on a 24-hour basis which includes an after-hours protocol on how to access interpreter services. This also includes face-to-face and over-the-telephone interpreter services.

E. Offering interpreter services and recording requests/refusal of interpreter services in LEP or hearing-impaired Member's medical records. Minors are prohibited from being used as interpreters except in emergency/life-threatening situations.

F. Attend and/or promote cultural competency training/resources for providers and staff. Ensure the qualifications of bilingual staff are kept on file.

G. Making available Member information and health education materials to LEP Members in the threshold languages and alternative formats such as Braille, large print, etc.

H. Having the right of the Members/providers to file a grievance when a C&L is not met and having the availability of the form in the threshold languages and how to obtain it. If Providers need Health Education materials, they must contact the Quality Management department at (626) 282-0288 and fill out the Material Needs Form (page 89).

Practices should contact Astrana Health's Customer Service Department at (877) 282-8272 or the Member's health plan Customer Service to obtain more information on how to access cultural and linguistic services for Members of Astrana Health which is located on the back of the member's insurance card.

C&L SERVICES – PROVIDER RESPONSIBILITY

The California Department of Health Services (DHS) and Astrana Health and its affiliates expect providers/practitioners to adhere to the following:

24-Hour Access to Interpreters

When the Provider/Practitioner does not speak the Members' language, he/she must ensure 24-hour access to interpreters for Members whose primary language is not English. To access interpreters for Astrana Health Members at no cost to you or the patient call Language Line Services at 1-800-367-9559, the access code for Astrana Health is 2554 or ID 295164 or utilize free interpretation services provided by the contracted health plan. It is never permissible to ask a family member to interpret.

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

Documentation

If a patient insists on using a family member as an interpreter or refuses the use of interpreter services after being notified of his or her right to have a qualified interpreter at no cost, document this in the Member's medical record.

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

Should the Member refuse to utilize the Interpretative Services, the Request/Refusal for Interpretive Services Form must be completed and placed in the Member's medical record.

Facility Signage

DHS requires that Provider offices post important signs in the threshold languages such as the "free interpretation services" poster. Check the health plan's website for downloadable signs in a variety of languages. If you need particular signage and cannot locate it, contact the Quality Management Department for assistance at (626) 282-0288 ext.6207.

ASTRANA HEALTH LANGUAGE LINE SERVICES INFORMATION

Language Line Automated Access offers a fast and efficient way to connect to a professional Interpreter, anytime, anywhere. Language Line Automated is an over-the-phone interpretation service that has more than 140 languages, 24 hours a day. The following is a *Quick Reference Guide* on how to use this free service provided for your office by Astrana Health. Please ensure that all users in your office know how to use the conference feature on their phones for this service to be used efficiently.

Login Information	*Help Information*
Toll Free Line: 1-800-367-9559	Customer Service Line: 1-800-752-6096 - Option 1
Client ID# 295164	E-mail: www.LanguageLine.com
Access Code: 2554	

1. Place the non-English speaker on Conference Hold.
   A. If you are placing an outbound call, access the Interpreter first and then place the call to the non-English speaker.
2. Dial Language Line Services at 1-800-367-9559
3. Follow Prompts
   A. Press 1 for Spanish.
      - Say “help” if you encounter a problem. Your call will be transferred to a representative.

   B. Press 2 for all other languages.
      - Speak the name of the desired language clearly; (e.g., “Chinese”, “Japanese”). *Say only the language name* – do not add any other words. The system will repeat your request and ask that you:
        - Press 1 to confirm the language.
      - Say “help” if you encounter a problem. Your call will be transferred to a representative.
4. Enter your 6-digit Client ID# (provided above) on the telephone keypad.
5. Enter your numeric Access Code (provided above) followed by the pound sign (#) on the telephone keypad.
6. Your Interpreter is connected to the call. Brief the Interpreter about the nature of the conversation and provide specific information to be relayed to the non-English speaker.
7. Add a non-English speaker to the line after you have briefed the Interpreter.

INTERPRETIVE SERVICES REQUEST/REFUSAL FORM

Patient Name: _____

Primary Language: _____

- ❑ Yes, I am requesting interpretive services.
  Language: _____
- ❑ I prefer to use my family or friends as an interpreter. (Interpreters must be over 18 years of age)
- ❑ No, I do not require interpretive services.
- ❑ N/A

  Please explain: _____

  _____

  _____

_____ _____

Patient Signature Date

Other languages are available upon request. (Spanish, Chinese, Vietnamese, Armenian, Russian, Khmer)

*Please place in the patient's medical record.

SECTION 14 COMPLIANCE

COMPLIANCE TRAINING

Astrana Health has developed this Training Program to ensure commitment to all applicable Federal, State, and Health Plan standards. This Training Program is to be a comprehensive statement of the responsibilities and obligations of all provider staff (including temporary staff) who interact with and/or provide covered services to Astrana Health beneficiaries. All contracted providers and their clinical staff shall review and attest to the completion of the following material within 90 days of becoming contracted with the IPA and Annually thereafter.

- CMS Fraud, Waste & Abuse (FWA) & General Compliance (*False Claims Act, OIG & SAM Listing)*
- Cultural Competency Training
- HIPAA Privacy Training
- Standard of Conduct
- Model of Care Training (MOC) *(Each contracted health plan has a unique MOC training that must be completed)*

For full training material on all topics listed above, refer to:
https://www.networkmedicalmanagement.com/providers/provider-resources

REPORTING FRAUD WASTE & ABUSE TO ASTRANA HEALTH

Detecting and preventing FWA is the responsibility of everyone, including providers, provider staff, subcontractors, and members. Astrana Health has written policies and procedures to address the prevention, detection, and investigation of suspicious activity. Astrana Health also conducts compliance training and regularly publishes articles related to FWA on the Company's Intranet site. The Company has also established an Ethics Hot Line (1-626-943-6286) for employees, plan members, agents, and vendors to report suspected FWA anonymously.

If you have any questions or concerns, please contact our Compliance Department via phone, fax, email, or mail.

Compliance Hotline: (844) 975-2651
Email: Compliance@AstranaHealth.com
Mailing Address: 1668 South Garfield Ave. 2nd Floor, Alhambra, CA 91801 (please address Astrana Health Compliance Department).

You can also email the questions or findings to Compliance@AstranaHealth.com Compliance Program is approved by the Governing Board.

ADDITIONAL PROVIDER TRAINING

In addition, this Provider Manual will be made available on Astrana Health's Web Portal for providers to review and will be updated on an annual basis. As a regulatory requirement, provider offices must attest to completing an annual review of UM policies, updates, clinical criteria, and other programs outlined below. Trainings below are subject to audit and may change periodically.

Information on these topics can be found at:
https://www.networkmedicalmanagement.com/providers/provider-resources

- Access to Care Standards
- Advance Directives
- Balance Billing Guidelines
- Behavioral Health Treatment (BHT)
- Bright Future American Academy of Pediatrics
- California Children's Service Program (CCS)
- California Immunization Registry Program (CAIR)
- Childhood Disability and Prevention Program (CHDP)
- Childhood Lead Poisoning Screening Care Guideline
- Cognitive Health Assessment (CHA) - Dementia Care
- Comprehensive Perinatal Services Program (CPSP)
- Contracted provider (PCP/SPC) responsibilities
- Contracted specialist requirements
- Cultural and Linguistics Training
- Early Start/Early Intervention Developmental Disabilities and Regional Centers
- EI/ES/DDS Regional Center
- End of Life Option Act
- Family Planning Services *(Women, Infant, and Children's (WIC) Program & Health Plan Supplemental Benefits)*
- General UM Provider Updates *sent via fax and/or available within your provider web portal account*
- Health Home Process
- Hospice/Palliative Care
- Initial Health Appointment Guidelines
- Language Assistance Program (LAP) *see PDF Insert*
- Medi-Cal Preventative Services Prior Auth Not Required
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) *Alcohol and Substance Abuse*
- Specialty Referral Tracking
- Standing Referral Requirements
- Sterilization
- Vaccine for Children Program (VFC)

Upon reviewing all training material, an attestation form must be signed and returned. The signature will indicate that the provider and all clinical staff members have reviewed the training material for all listed topics for the given year.

The attestation form is to be returned to Provider Relations Dept at:
BACP.ProviderRelations@astranahealth.com

SECTION 15 FORMS/ADDITIONAL RESOURCES