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1.0 L.A. CARE HEALTH PLAN

Dear Provider:

L.A. Care has information about many different topics that might be helpful to you on our website. It is a useful way to get information about L.A Care and its processes. Please visit our provider website at www.lacare.org for information about L.A. Care’s:

- Quality Improvement Program
- Policy encouraging practitioners to freely communicate with patients about their treatment, regardless of benefit coverage limitations
- Requirement that practitioners and facilities cooperate with QI activities; provide access to their medical records, to the extent permitted by state and federal law; and maintain confidentiality of member information and records.
- Policy on notification of specialist termination
- Access standards
- Case Management services and how to refer patients
- Disease Management Program information and how to refer patients
- Coordination of Medicare and Medicaid benefits
- Care services to members with special needs.
- Clinical Practice Guidelines, including ADHD and Depression
- Medical record documentation standards; policies regarding confidentiality of medical records; policies for an organized medical record keeping system; standards for the availability of medical records at the practice site; and performance goals
- UM Medical Necessity Criteria including how to obtain or view a copy
- Policy prohibiting financial incentives for utilization management decision-makers
- Instructions on how to contact staff if you have questions about UM processes and the toll free number to call
- Instructions for triaging inbound calls specific to UM cases/issues
- Availability of, and the process for, contacting a peer reviewer to discuss UM decisions
- Policy on denial notices
- Policy regarding the appeals notification process
- Pharmaceutical procedures
- Policy regarding your rights during the credentialing/recredentialing process including to review information and correct erroneous information submitted to support your credentialing application, as well as obtain information about the status of your application; and how to exercise these rights
- Member’s Rights and Responsibilities
- Web-based Provider and Hospital Directory
If you would like paper copies of any of the information available on the website, please contact us at 1-866-LACARE6 (1-866-522-2736)

L.A. Care Health Plan

1.1 GENERAL INTRODUCTION

1.1.0 About the L.A. Care Provider Manual

The purpose of the L.A. Care Provider Manual is to furnish providers with information on critical processes for all L.A. Care direct lines of businesses. Effective January 1, 2008, L.A. Care Health Plan’s Medicare Advantage HMO Special Needs Plan (MA-SNP) began serving enrolled dual eligible members. This version of the L.A. Care Health Plan Provider Manual has been created specifically for the care of L.A. Care’s MA-SNP members. The manual is broken down by functional area and provides information and applicable requirements for both Medicare and Medi-Cal processes.

1.1.1 Responsibility of Participating Providers

L.A. Care Health Plan (L.A. Care) requires that its contracted medical groups, hospitals, ancillary providers and other Participating Physician Groups (PPGs) fulfill specified responsibilities. There is a segment entitled “Responsibility of Participating Providers” at the beginning of most sections of this manual that clarifies what functions, if any, are the responsibility of L.A. Care’s contracted providers. Please read each of these sections carefully in order to determine what functions are the responsibilities of L.A. Care, and which are the responsibility of PPGs, hospitals, ancillary providers, or other participating providers.

1.1.2 L.A. Care’s Commitment to Provide Excellent Services

L.A. Care’s overall goal is to develop policies, procedures, and guidelines for effective implementation of provider services in its direct product lines. To accomplish this goal, L.A. Care will work cooperatively with medical groups to ensure that providers have timely access to information and the appropriate resources to meet service requirements.
1.1.3 Traditional and Safety Net Providers
L.A. Care considers the following provider types as Traditional or Safety Net Providers: CHDP providers, Federally Qualified Health Centers, licensed community clinics and Disproportionate Share Hospitals. L.A. Care encourages PPGs to contract with these providers to the fullest extent possible.
### L.A. CARE DEPARTMENTAL CONTACT LIST

L.A. Care Health Plan Medicare Advantage (HMO SNP)
1055 W. 7th Street
Los Angeles, CA 90017
(213) 694-1250

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>NAME</th>
<th>EXTENSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitation</td>
<td>Director</td>
<td>4236</td>
</tr>
<tr>
<td>Case Management</td>
<td>Case Management Nurse</td>
<td>5406</td>
</tr>
<tr>
<td>Claims</td>
<td>Director</td>
<td>4314</td>
</tr>
<tr>
<td></td>
<td>For all claims for which L.A. Care is responsible, please mail to:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>L.A. Care Health Plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attn: Claims Dept.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P.O. Box 712129</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Los Angeles, CA 90071</td>
<td></td>
</tr>
<tr>
<td>Regulatory Auditing &amp; Compliance</td>
<td>Compliance Officer</td>
<td>4292</td>
</tr>
<tr>
<td>Cultural &amp; Linguistic Services</td>
<td>Director</td>
<td>4559</td>
</tr>
<tr>
<td>Eligibility Verification</td>
<td>Member Eligibility Verification</td>
<td>888-839-9909</td>
</tr>
<tr>
<td>Encounter Data</td>
<td>Provider Information Line</td>
<td>866-LA-CARE6 or 1-866-522-2736</td>
</tr>
<tr>
<td>Health Promotion &amp; Education</td>
<td>Director</td>
<td>4559</td>
</tr>
<tr>
<td>Marketing</td>
<td>Marketing Manager</td>
<td>4464</td>
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**L.A. CARE DEPARTMENTAL CONTACT LIST (CONTINUED)**

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<tr>
<th>DEPARTMENT</th>
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<th>EXTENSION</th>
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<tr>
<td>Member Services</td>
<td>General Information Line Director</td>
<td>888-839-9909 4250</td>
</tr>
<tr>
<td>Network Operations</td>
<td>Director</td>
<td>4036 4504</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Director</td>
<td>4251</td>
</tr>
<tr>
<td>Prior Authorizations/Hospital Admissions</td>
<td>L.A. Care UM Department must be notified within 24 hours or the next business day following the admission. To obtain an Authorization:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CALL TOLL-FREE: 877-HF1-CARE (431-2273)</td>
<td></td>
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<tr>
<td></td>
<td>FAX: 213-623-8669</td>
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<tr>
<td></td>
<td>WRITTEN REQUESTS:</td>
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<td></td>
<td>L.A. Care Health Plan</td>
<td></td>
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<tr>
<td></td>
<td>1055 West Seventh Street</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Los Angeles, CA 90017</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attn.: Authorization</td>
<td></td>
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<tr>
<td>Provider Credentialing, Performance and Certification</td>
<td>Manager</td>
<td>4026</td>
</tr>
<tr>
<td>Provider Information/Data Issues</td>
<td>Provider Inquiry Line</td>
<td>866-LA-CARE6 or 866-522-2736</td>
</tr>
<tr>
<td>Provider Network Operations</td>
<td>Director</td>
<td>4036</td>
</tr>
<tr>
<td>Quality Management</td>
<td>Director</td>
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<td>Utilization Management</td>
<td>Director</td>
<td>4427</td>
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<tr>
<td>Utilization Management</td>
<td>Manager</td>
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<tr>
<td>Outreach/Sales</td>
<td>Director</td>
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### Glossary of Terms

<table>
<thead>
<tr>
<th>Acronym or Word(s)</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ancillary Service</td>
<td>The following services are considered ancillary: ambulance transportation; durable medical equipment (DME) including but not limited to apnea monitor, artificial limbs, and hearing aids; home health care; prosthetic and orthodontic devices; and skilled nursing facilities.</td>
</tr>
<tr>
<td>BOG</td>
<td>Board of Governors</td>
</tr>
<tr>
<td>CAP</td>
<td>Corrective Action Plans</td>
</tr>
<tr>
<td>CCS</td>
<td>California Children’s Services – This program provides health care services to children with certain physical limitations and diseases whose families cannot afford all or part of the care.</td>
</tr>
<tr>
<td>CHDP</td>
<td>Child Health &amp; Disability Prevention</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>DDS</td>
<td>Developmental Disability Services</td>
</tr>
<tr>
<td>SDHS</td>
<td>State Department of Health Services</td>
</tr>
<tr>
<td>DMHC</td>
<td>Department of Managed Health Care</td>
</tr>
<tr>
<td>DOFR</td>
<td>Division of Financial Responsibility</td>
</tr>
<tr>
<td>FSR</td>
<td>Facility Site Review</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Health Plan Employer Data and Information Set</td>
</tr>
<tr>
<td>IBNR</td>
<td>Incurred But Not Reported</td>
</tr>
</tbody>
</table>
## GLOSSARY OF TERMS (CONTINUED)

<table>
<thead>
<tr>
<th>ACRONYM OR WORD(s)</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPA</td>
<td>Independent Practice Association – In the L.A. Care Healthy Families Program Provider Manual, IPA will be referred to Participating Physician Groups (PPGs).</td>
</tr>
<tr>
<td>L.A. Care</td>
<td>L.A. Care Health Plan (Local Initiative Health Authority for Los Angeles County)</td>
</tr>
<tr>
<td>MIPPA</td>
<td>Medicare Improvements for Patients and Providers Act of 2008</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>MA-PD</td>
<td>Medicare Advantage Prescription Drug</td>
</tr>
<tr>
<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Provider</td>
</tr>
<tr>
<td>PNRA</td>
<td>Provider Network Research &amp; Analysis Unit</td>
</tr>
<tr>
<td>QIP</td>
<td>Quality Improvement Program</td>
</tr>
<tr>
<td>SED</td>
<td>Severely Emotionally Disturbed</td>
</tr>
<tr>
<td>SNP</td>
<td>Special Needs Plan</td>
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</table>
2.0 MEMBERSHIP AND MEMBERSHIP SERVICES
This section covers membership and member services for L.A. Care Health Plan members. Topics include eligibility, enrollment and disenrollment, primary care provider assignment, complaint resolution, and member rights and responsibilities.

2.1 RESPONSIBILITY OF PARTICIPATING PROVIDERS
Participating Physician Groups (PPGs) in L.A. Care are responsible for adhering to the member services provisions and guidelines specified in this section.

2.2 PROGRAM ELIGIBILITY
To enroll in L.A. Care’s MA-SNP plan, beneficiaries must reside in Los Angeles County, be entitled to Medicare Part A, and enrolled in Medicare Part B. Beneficiaries cannot have End-Stage Renal Disease (ESRD), with limited exceptions, such as if they are already a member of L.A. Care. In addition, beneficiaries must also be eligible for Medi-Cal. More specifically, beneficiaries cannot: 1) have a Medi-Cal share of cost, or 2) be in a long-term care aid code category. Failure to meet this requirement may result in termination of enrollment from L.A. Care after 180 days.

2.2.1 Conditions of Enrollment
All new enrollments will be confirmed with CMS. L.A. Care will enroll all MA-SNP members though the Medicare sales and enrollment process, and will comply with all of CMS’ marketing, sales and enrollment process requirements. L.A. Care staff will provide each new enrollee with a Summary of Benefits, a Provider Directory, a Pharmacy Directory, a copy of the Pharmacy formulary and an effective date at the time of enrollment.

2.3 MEMBER ENROLLMENT, ASSIGNMENT AND DISENROLLMENT

2.3.1 Member Enrollment
2.3.1.1 L.A. Care will enroll all prospective enrollees into its MA-SNP plan. Prospective enrollees will complete a CMS-approved L.A. Care enrollment form and the L.A. Care Enrollment Center will process all new enrollments with CMS.

2.3.1.2 All dual eligibles have a Medicare Special Election Period, which allows them to enroll in and disenroll from a Medicare-Advantage plan on a monthly basis. Dual
eligibles may join a Medicare-Advantage plan outside of their Initial Election Period and Medicare’s Annual Election Period.

2.3.2 Selection, Assignment, and Change of Primary Care Physician

2.3.2.1 Selection

2.3.2.1.1 At the time of enrollment, MA-SNP enrollees will select both a primary care physician and a PPG. Both of these selections are required elements on the enrollment form.

2.3.2.1.2 The enrollee’s choice of primary care physician and PPG will be listed on the member’s identification card. The identification card will be sent to the member within 10 days of enrollment confirmation from CMS.

2.3.2.2 Change of Participating Physician Group (PPG) and/or Primary Care Physician (PCP)

2.3.2.2.1 Member-Initiated Change

2.3.2.2.1.1 Members may change their PCP or PPG on a monthly basis. Members requesting to change to another PPG or PCP can do so by calling L.A. Care Health Plan at 1-888-522-1298 (TTY/TDD) 1-866-522-2731.

2.3.2.2.2 The change will occur on the 1st of the following month, provided the request is received by Member Services by the 20th of the month.

2.3.3 Notification of Enrollment

L.A. Care will mail the member a letter acknowledging receipt of the completed enrollment form within 10 days of receiving the completed enrollment election. L.A. Care will send a letter confirming the enrollment within 10 days of receiving confirmation from CMS on the transaction reply listing. L.A. Care will also send a Welcome Packet to the member’s home address. The Welcome Packet includes a welcome letter, member identification card, Provider Directory, and the Evidence of Coverage/Member Handbook.
2.3.4 Disenrollment

2.3.4.1 Disenrollment refers to the termination of a member’s enrollment with L.A. Care Health Plan. Disenrollment does not refer to a member transferring from one PCP or PPG to another.

2.3.4.2 Members may voluntarily disenroll from L.A. Care Health Plan’s MA-SNP plan at their discretion. To voluntarily disenroll from L.A. Care’s MA-SNP plan, members may:

- Contact L.A. Care’s Member Services Department to request disenrollment;
- Enroll in another Medicare-Advantage Plan; or
- Contact CMS directly at (1-800-MEDICARE) to disenroll from L.A. Care.

2.3.4.3 Members may be involuntarily disenrolled from L.A. Care’s MA-SNP Plan. A Member may be disenrolled from L.A. Care for the following reasons:

- Loss of Medicare Parts A and B
- Loss of Medi-Cal eligibility. L.A. Care provides up to 6 months to regain Medi-Cal eligibility before disenrolling.
- Moved out of Los Angeles County for more than 6 months.
- Knowingly falsifies or withholds information about other parties’ reimbursement for their prescription drug coverage.
- Intentionally provides incorrect information on their enrollment application, affecting their eligibility to enroll in L.A. Care.
- Behave in a way that is disruptive, to the extent that continued enrollment seriously impairs our ability to arrange or provide medical care for them or for others who are members of L.A. Care. This type of disenrollment requires CMS approval.
- Allow someone else to use L.A. Care’s membership card to receive medical care. CMS may refer the case to the Inspector General for further investigation if disenrolled for this reason.
2.4 MEMBER IDENTIFICATION CARD
The L.A. Care member identification card provides a member’s program name, member ID number, language, pharmacy claims information, and PCP name, phone number and address.

Members who are enrolled in L.A. Care’s MA-SNP plan for their Medicare benefits and in L.A. Care Direct for their Medi-Cal benefits will be issued an ID card that has a Medicare SNP ID number (“MA-SNP ID”) and a Medi-Cal ID number (“Member ID”). See the example below:

![Medicare Advantage (HMO SNP) ID Card Example](image)

Members who are enrolled in L.A. Care’s MA-SNP plan for their Medicare benefits and are still enrolled in Medi-Cal fee-for-service for their Medi-Cal benefits will be issued an ID card that only has a Medicare SNP ID number.

2.5 ELIGIBILITY VERIFICATION
A member’s possession of an L.A. Care membership identification card does not guarantee current membership with L.A. Care or with the PPG identified by the card. Verification of an individual’s membership and eligibility status is necessary to assure that payment is made to the PPG for the healthcare services being rendered by the provider to the member.

To verify member eligibility, providers should call L.A. Care’s Provider Information line at 1-866-LACARE6 (1-866-522-2736) or check L.A. Care Connect on http://www.lacare.org.

2.6 EVIDENCE OF COVERAGE
An L.A. Care Evidence of Coverage (EOC)/Member Handbook is sent to members upon enrollment and annually thereafter. The EOC provides members with a description of the scope of covered services and how to
access such services. You can obtain a copy of the EOC by logging onto www.lacare.org, or by calling L.A. Care Health Plan’s Member Services Department at 1-888- 522-1298.

2.7 MEMBER’S RIGHTS AND RESPONSIBILITIES

L.A. Care members have specific rights and responsibilities that are fundamental to the provision and receipt of quality healthcare services. Member rights and responsibilities are described in L.A. Care’s Evidence of Coverage (EOC) Member Handbook and are listed below.

Member Rights

- **Your right to be treated with dignity, respect and fairness.** You have the right to be treated with dignity, respect, and fairness at all times. L.A. Care and its providers must obey laws that protect you from discrimination or unfair treatment. We don’t discriminate based on a person’s race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If you need help with communication, such as help from a language interpreter, please call Member Services. Member Services can also help if you need to file a complaint about access (such as wheelchair access). You may also call the Office for Civil Rights at 1-800-368-1019 or (TTY) 1-800-537-7697, or your local Office for Civil Rights.

- **Your right to the privacy of your medical records and personal health information.** There are Federal and State laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in L.A. Care is protected. We will make sure that unauthorized people don’t see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who isn’t providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care. L.A. Care will release your information, including your prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations. The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with notice that tells about these rights and explains how we protect the privacy of your health information. You have the right to look at medical records held by L.A. Care or its providers, and to get a copy of your records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your
request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Member Services.

- **Your right to see network providers, get covered services, and get your prescriptions filled within a reasonable period of time.** You will get most or all of your care from network providers, that is, from doctors and other health providers who are part of L.A. Care. You have the right to choose a network provider (we will tell you which doctors are accepting new patients). You have the right to go to a women’s health specialist in L.A. Care’s network (such as a gynecologist) without a referral. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. “Timely access” means that you can get appointments and services within a reasonable amount of time.

You have the right to timely access to your prescriptions at any network pharmacy.

- **Your right to know your treatment options and participate in decisions about your health care.** You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our Plan. This includes the right to know about the different Medication Therapy Management Programs we offer and in which you may participate. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a provider has denied care that you believe you were entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision called an organization determination or a coverage determination.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of your refusing treatment.
Your right to use advance directives (such as a living will or a power of attorney). You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called “advance directives.” There are different types of advance directives and different names for them. Documents called “living will” and “power of attorney for health care” are examples of advance directives.

If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare such as HICAP (Health Insurance Counseling and Advocacy Program). HICAP can be reached at 1-800-434-0222. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe that a doctor or hospital hasn’t followed the instructions in it, you may file a complaint with:

Medical Board of California
Central Complaint Unit
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
• Your right to get information about L.A. Care Health Plan. You have the right to get information from us about L.A. Care. This includes information about our financial condition, and how L.A. Care compares to other health plans. To get any of this information, call Member Services.

• Your right to get information in other formats. You have the right to get your questions answered. L.A. Care must have individuals and translation services available to answer questions from non-English speaking beneficiaries, and must provide information about our benefits that is accessible and appropriate for persons eligible for Medicare because of disability. If you have difficulty obtaining information from L.A. Care based on language or a disability, call 1-800-MEDICARE (1-800-633-4227). (TTY) users should call 1-877-486-2048.

• Your right to get information about our network pharmacies and/or providers. You have the right to get information from us about our network pharmacies, providers and their qualifications and how we pay our doctors. To get this information, call Member Services.

• Your right to get information about your prescription drugs, Part C medical care or services, and costs. You have the right to an explanation from us about any prescription drugs or Part C medical care or service not covered by L.A. Care. We must tell you in writing why we will not pay for or approve a prescription drug or Part C medical care or service, and how you can file an appeal to ask us to change this decision. You also have the right to this explanation even if you obtain the prescription drug, or Part C medical care or service from a pharmacy and/or provider not affiliated with our organization. You also have the right to receive an explanation from us about any utilization-management requirements, such as step therapy or prior authorization, which may apply to L.A. Care. Please review our formulary website or call Member Services for more information.

• Your right to make complaints. You have the right to make a complaint if you have concerns or problems related to your coverage or care. If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against L.A. Care in the past. To get this information, call Member Services.

Member Responsibilities

Your responsibilities as a member of L.A. Care include:
- Getting familiar with your coverage and the rules you must follow to get care as a member. Call Member Services if you have questions.

- Using all of your insurance coverage. If you have additional health insurance coverage or prescription drug coverage besides L.A. Care, it is important that you use your other coverage in combination with your coverage as a member of L.A. Care to pay your health care or prescription drug expenses. This is called “coordination of benefits” because it involves coordinating all of the health or drug benefits that are available to you.

- You are required to tell L.A. Care if you have additional health insurance or drug coverage. Call Member Services.

- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in L.A. Care and you must present your Plan membership card to the provider.

- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.

- Acting in a way that supports the care given to other patients and helps the smooth running of your doctor’s office, hospitals, and other offices.

- Paying your co-payment for your covered services. You must pay for services that aren’t covered.

- Notifying us if you move. If you move within our service area, we need to keep your membership record up-to-date. If you move outside of Los Angeles County you cannot remain a member of L.A. Care, but we can let you know if we have a Plan in that area.

- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please contact Member Services.

How members can get more information about their rights
If members have questions or concerns about their rights and protections, they may,

- Call L.A. Care’s Member Services Department at 1-888- 522-1298 (TTY/TDD) 1-(866)-522-2731.
• Get free help and information from their State Health Insurance Assistance Program (SHIP).
• Visit www.medicare.gov to view or download the publication “Your Medicare Rights & Protections.”
• Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

2.8 NOTICE TO MEMBERS REGARDING CHANGE IN COVERED SERVICES

Members must be informed about any change in provision of services. L.A. Care must send written notification of any change to the member no less than sixty (60) days, or as soon as possible prior to the date of actual change. In case of an emergency, the notification period will be within fourteen (14) days prior to changes, or as soon as possible.

In some circumstances, when the event includes termination of a provider’s contract, L.A. Care makes arrangements for members affected by the termination to continue care with their terminating provider until their treatment is completed. In order for L.A. Care to make these arrangements, the medical conditions must meet specific criteria; the provider must be willing to continue seeing the member and must be willing to accept L.A. Care’s rate of reimbursement.

2.9 Member Grievance Procedure

A Grievance is defined as any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which L.A. Care or delegated entities provide health care services, regardless of whether any remedial action can be taken. This can include concerns about the operations of L.A. Care or its providers such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, and the respect paid to members. An expedited grievance may also include a complaint that the health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.
L.A. Care accepts any information or evidence concerning a grievance pertaining to its Plan either orally or in writing, for up to 60 days after the precipitating event.

L.A. Care acknowledges, investigates and resolves standard grievances within thirty (30) calendar days of the oral or written request. However, if information is missing or if it is in the best interest of the member, L.A. Care may extend the timeframe by an additional 14 days. L.A. Care responds to expedited grievances within 24 hours of the oral or written request. Expedited grievances include those cases where a member objects to: 1) L.A. Care’s decision to extend the timeframe to make an organization determination or reconsideration; or 2) L.A. Care’s refusal to grant a request for an expedited organization determination or reconsideration.

If a complaint is not resolved to the member’s satisfaction, the member has the right to seek the opinion of the Quality Improvement Organization (QIO).

L.A. Care maintains a comprehensive complaint resolution system. L.A. Care and its PPGs work together to resolve member complaints. However, it is L.A. Care’s responsibility to handle member complaints. PPGs are encouraged to attempt to address member questions or concerns before referring members to L.A. Care. All member complaints must be reported to L.A. Care’s Member Services department. PPGs are required to respond to requests for information related to grievances within five (5) business days. If a PPG fails to provide the requested information, L.A. Care or the designated agent will be provided access to copy the appropriate medical records or other necessary information at the expense of the PPG.

L.A. Care tracks complaints by category and PPG. Grievance reports are reviewed and analyzed for appropriate corrective action plans.

**Member Appeal Procedure**

**Organization Determination**

An initial determination informing members of L.A. Care’s decision to provide medical care, or pay for services already received.

**Appeal Level 1: Appeal to L.A. Care**

**Standard Reconsideration of Organization Determination**
Members may file reconsiderations of organization determinations with L.A. Care’s Grievance and Appeals Unit. All reconsiderations must be filed within 60 days of notification of the organization determination decision. L.A. Care will resolve all reconsiderations regarding payment for services already received within 60 days. L.A. Care will resolve all standard reconsiderations regarding medical care within 30 days. However, if information is missing or if it is in the best interest of the member, L.A. Care may extend the timeframe by an additional 14 days. If L.A. Care decides in favor of the member with respect to payment reconsideration, L.A. Care must pay within 60 days of receiving the appeal. If L.A. Care decides in favor of the member with respect to a standard reconsideration of medical care, L.A Care must authorize or provide services within 30 days of receiving the appeal. If L.A. Care upholds an adverse determination, L.A. Care will automatically forward the case to the Independent Review Entity (IRE) within 30 days for cases involving medical care and within 60 days for cases involving payment decisions.

**Expedited Reconsideration of an Organization Determination**

L.A. Care will resolve all expedited reconsiderations within 72 hours, or sooner required based upon the health condition of the member. L.A. Care may extend the timeframe for an additional 14 days if information is missing or if it is in the best interest of the member. If L.A. Care decides in favor of the member, L.A. Care must authorize or provide care within 72 hours of receiving the expedited appeal. If L.A. Care upholds an adverse determination, L.A. Care will automatically forward the case to the Independent Review Entity (IRE) within 24 hours for review.

**Appeal Level 2: Independent Review Entity (IRE)**

At the second level, the appeal is reviewed by an outside, Independent Review Entity (IRE) that is contracted with CMS. If the IRE decides in favor of the member with respect to payment of medical services already received, L.A. Care must pay within 30 days of receiving the decision. If the IRE decides in favor of the member with respect to a standard decision about medical care not yet received, L.A Care must authorize services within 72 hours or provide services within 14 days of receiving the decision. If the IRE upholds the Plan’s determination, the member may request a Level 3 appeal, review by an Administrative Law Judge (ALJ).

**Appeal Level 3: Administrative Law Judge (ALJ)**

If the amount remaining in controversy meets the appropriate threshold requirement, any party to the reconsideration who is dissatisfied with the reconsideration determination has a right to a hearing before an ALJ. During the ALJ review, members may present evidence, review the record and be represented by counsel. The request must be filed within 60 calendar days of
notification of the decision made by the IRE. The ALJ will make a decision as soon as possible. If the ALJ decides in favor of the member, L.A. Care must pay for, authorize, or provide the medical care or services within 60 days of receiving the decision. If the ALJ upholds the IRE’s determination, the member may request a Level 4 appeal, review by the Medicare Appeals Council (MAC).

**Level 4: Medicare Appeals Council (MAC)**

Members must file with the MAC within 60 calendar days of the decision made by the ALJ. If the MAC reviews your case, (it does not review every case it receives) it will make a decision as soon as possible. If the MAC decides in favor of the member, L.A. Care must pay for, authorize, or provide the medical care or services within 60 days of receiving the decision. If the MAC upholds the ALJ’s determination, or decides not to review the case, the member may request a Level 5, Federal Court.

**Appeal Level 5: Federal Court**

In order to request judicial review, the member must file a civil action in a United States district court within 60 calendar days after the date notified of the decision made by the MAC. However, the amount in controversy must meet the appropriate threshold. For 2012, the amount in controversy threshold is $1,350.00. If the threshold is met and a Federal Court Judge agrees to review the case, a decision will be made according to the rules established by the Federal judiciary.

**When Members Disagree with Hospital Discharge**

A Member remaining in the Hospital who wishes to appeal L.A. Care’ discharge decision that Inpatient Services are no longer necessary may request an immediate review with the Quality Improvement Organization (QIO). The Member will not incur any additional financial liability if:

- The Member remains in the Hospital as an Inpatient;
- The Member submits the request for immediate review to the QIO that has an agreement with the Hospital;
- The request is made either in writing, by telephone or fax; and
- The request is received by noon of the first working day after the Member receives written notice of the Plan’s determination that the Hospital stay is no longer necessary.

**Special Considerations Regarding Termination of Skilled Nursing Facility (SNF), Home Health Agency (HHA) and Comprehensive Outpatient Rehabilitation Facility (CORF) Services**
Regarding Medicare Members, a termination of service means the discharge of a Member from Covered Services, or discontinuation of Covered Services. When the Member has been authorized by L.A. Care to receive an ongoing course of treatment from that Provider.

- The Member must contact the QIO, verbally or in writing, no later than noon of the day before the Covered Services are to end. At the same time the Physician Group will notify the Plan of the Notice of Medicare Non Coverage (NOMNC) issued to the Member. The Plan will track issuance and follow-up on all NOMNCs from delegated Physician Groups.
- If the Member disagrees with the NOMNC and requests an Appeal, the Plan will prepare the Detailed Explanation of Non-Coverage (DENC) for the Provider to issue to the Member. If the Member requests an Appeal with the QIO, the Plan must obtain the Member’s medical records from the Provider and send:
  - A copy of the DENC, along with the Member’s medical records, to the QIO by close of business on the day of the QIO submitted to Plan appeal notification. The Plan may request that the records be sent directly to the QIO. The QIO must make a decision and notify the Member and the Plan by close of business the following day.
- On the next business day, the Plan will notify the Physician Group of the fast-track Appeal request and the QIO’s determination. If the QIO overturns the decision, the Physician Group shall continue authorization to the Group Provider, provide the Plan with proof of continued authorization and prepare and issue a new NOMNC notice when new discharge orders are written.
- If the Member fails to file a timely Appeal with the QIO, the Member may request an expedited Appeal from the Plan [42 CFR 422.624; 42 CFR 422.626]

3.0 ACCESS TO CARE

This section summarizes the access to care requirements for L.A. Care Participating Physician Groups (PPGs) for all of L.A. Care Health Plan’s direct product lines.

3.1 RESPONSIBILITY OF PARTICIPATING PROVIDERS

All PPGs are responsible for fulfilling the access standards below. L.A. Care monitors the ability of its members to access these services according to the specified “L.A. Care Access Standard.”

L.A. Care will disseminate age and gender specific preventive care guidelines on an annual basis.
### L.A. CARE/PARTICIPATING PHYSICIAN GROUP ACCESS REQUIREMENTS

<table>
<thead>
<tr>
<th>Service</th>
<th>L.A. Care Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of ancillary services</td>
<td>Available within a reasonable distance from the primary care physician</td>
</tr>
<tr>
<td>Availability of hospitals</td>
<td>Travel time and distance standards of 15 miles travel distance or 30 minutes travel time from their residence or workplace</td>
</tr>
<tr>
<td>Availability of primary care physician – distance requirements</td>
<td>Travel time and distance standards of 10 miles travel distance or 30 minutes travel time from their residence or workplace</td>
</tr>
<tr>
<td>(PCP Geo Access reports)</td>
<td></td>
</tr>
<tr>
<td>Availability of specialty care</td>
<td>Travel time and distance standards of 15 miles travel distance</td>
</tr>
<tr>
<td>Member requested primary care physician changes</td>
<td>Members can request a PCP change monthly. L.A. Care will process the member requested PCP change</td>
</tr>
<tr>
<td>Maximum member ratio</td>
<td>PCP to member ratio (1:2000)</td>
</tr>
<tr>
<td></td>
<td>Provider to Extender Ratio</td>
</tr>
<tr>
<td></td>
<td>• Nurse Practitioner – 1:4</td>
</tr>
<tr>
<td></td>
<td>• Physician Assistant – 1:2</td>
</tr>
<tr>
<td></td>
<td>L.A. Care allows a provider an additional 1000 members per extender up to a maximum of 5000 members per PCCP</td>
</tr>
<tr>
<td>Routine specialty referral authorization</td>
<td>Within 10 working days</td>
</tr>
</tbody>
</table>


### 3.3 PRIMARY CARE AND SPECIALIST PHYSICIAN ACCESS REQUIREMENTS

<table>
<thead>
<tr>
<th>Service</th>
<th>L.A. Care Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment making systems</td>
<td>An efficient and effective written or computerized appointment making system, which includes following up on broken appointments</td>
</tr>
<tr>
<td>Appointments for routine primary care</td>
<td>30 calendar days maximum</td>
</tr>
<tr>
<td>Services for a member who is symptomatic but does not require immediate diagnosis and/or treatment</td>
<td></td>
</tr>
</tbody>
</table>
| Appointments for routine prenatal care      | - Within two weeks from request during the 1\(^{st}\) and 2\(^{nd}\) trimester  
- Within three working days from request during 3\(^{rd}\) trimester                                                                                                                                                    |
| Appointments for routine preventive care    | Physical exam/preventive services – four (4) weeks maximum for appointment                                                                                                                                                   |
| Appointments for urgent care                | Within 24 hours                                                                                                                                                                                                              |
| Routine specialty referral appointment      | Within 10 working days                                                                                                                                                                                                     |
| Availability of interpreter service         | L.A. Care provides 24 hours/7 days a week interpretive services                                                                                                                                                              |
| Availability of primary care physician – time requirements | 24 hours/7 days a week                                                                                                                                                                                                     |
| Preventive Exams                            | Children under the age of 18 months – within 60 calendar days of enrollment or within the AAP periodicity timelines for ages two and younger, whichever is less  
18 months of age and older – within 120 calendar days of enrollment  
EPSDT/CHDP or preventive health examination within four weeks from request |
<p>| A periodic health evaluation for a member with no acute medical problem, including: |                                                                                                                                                                                                                       |
| Initial Health Assessments and Behavioral Risk Assessments |                                                                                                                                                                                                                       |
| AAP periodic screenings                     | As prescribed by AAP Periodicity guidelines                                                                                                                                                                                |</p>
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency appointment: Services for a potentially life threatening condition requiring immediate medical intervention to avoid disability or serious detriment to health</td>
<td>Immediate, 24 hours a day/7 days a week</td>
</tr>
<tr>
<td>Non-emergent telephone appointment responsiveness</td>
<td>45 minutes</td>
</tr>
<tr>
<td><strong>Office waiting time:</strong> The time a member with a scheduled medical appointment is waiting to see a doctor once in the office</td>
<td>5 - 45 minutes</td>
</tr>
<tr>
<td><strong>Telephone waiting time:</strong> The maximum length of time for office staff to answer the phone</td>
<td>30 seconds</td>
</tr>
<tr>
<td><strong>Call Return Time (After Hours):</strong> The maximum length for PCP or on-call provider to return a call</td>
<td>30 minutes</td>
</tr>
</tbody>
</table>
| Services for members with disabilities | Compliance with all provisions of the Americans with Disabilities Act:  
- At least one designated handicapped parking space  
- A handicapped bathroom or alternative access which is equipped with handrails in the bathroom  
- A wheelchair access ramp  
- A handicapped water fountain or alternative provisions  
- An elevator |
### 3.4 PHARMACY SERVICE ACCESS REQUIREMENTS

<table>
<thead>
<tr>
<th>Service</th>
<th>L.A. Care Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denied or modified prescription</td>
<td>Medical Director or Pharmacist makes a determination on denied or modified prescriptions within 24 hours for expedited request and 72 hours for standard request</td>
</tr>
<tr>
<td>Drug prior authorization request</td>
<td>24 hours for expedited request and 72 hours for standard request</td>
</tr>
<tr>
<td>Availability of counseling in the members language</td>
<td>Availability of verbal counseling in appropriate threshold language</td>
</tr>
<tr>
<td>Emergency pharmacy services</td>
<td>30 day supply for continuity of care until determination of request can be done</td>
</tr>
</tbody>
</table>

### 3.5 MONITORING

The PCP is responsible for responding to any access deficiencies identified by review methods, examples of which include:

- Facility Site Review (FSR)
- Exception reports generated from member grievances
- Medical records review
- Random surveys sent to members
- Feedback from PCP regarding other network services (i.e., pharmacies, vision care, hospitals, laboratories, etc.)
- Access to care studies
- Provider office surveys or visits
4.0 SCOPE OF BENEFITS
This section summarizes the scope of benefits for direct product lines under L.A. Care.

4.1 RESPONSIBILITY OF PARTICIPATING PROVIDERS
L.A. Care is contracted with various provider organizations for the provision of health benefits. Under the terms of provider agreements with L.A. Care, certain Participating Physician Groups (PPGs) and hospitals have agreed to assume the financial responsibility of providing specified health benefits. To determine which health benefits a PPG and hospital may be delegated and therefore financially responsible for providing services, please refer to the Division of Financial Responsibility (DOFR) of the entity’s agreement with L.A. Care. Each agreement summarizes which health benefits a PPG or hospital is financially responsible for providing.

4.2 HEALTH BENEFITS – MEDI-CAL
Covered services, including services for the detection of symptomatic diseases, as defined by Title 22, Section 51301 through Section 51365 of the California Code of Regulations, should be provided with no copayment. A listing of these benefits and services may be found in the Medi-Cal Managed Care Evidence of Coverage or L.A. Care UM Policies. The benefits and service requirements are also available online at www.ccr.oal.ca.gov.org.
4.3 HEALTH BENEFITS – MEDICARE ADVANTAGE HMO

With the exception of certain Part D covered drugs, there will be no cost-sharing for any of Medicare Advantage HMO plan benefits. A list of current benefits can be found on the L.A. Care Medicare web site pages in the Summary of Benefits or Evidence of coverage.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Covered</th>
<th>Member Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor Visits</td>
<td>Yes</td>
<td>$0</td>
</tr>
<tr>
<td>Inpatient Hospital Services (90 days per benefit period)</td>
<td>Yes</td>
<td>$0</td>
</tr>
<tr>
<td>Inpatient Mental Health (up to 190 lifetime days)</td>
<td>Yes</td>
<td>$0</td>
</tr>
<tr>
<td>Skilled Nursing facility (100 days per benefit period)</td>
<td>Yes</td>
<td>$0</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Yes</td>
<td>$0</td>
</tr>
<tr>
<td>Hospice (care must be provided by Medicare certified hospice; FFS Medicare pays)</td>
<td>Yes</td>
<td>$0</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>Yes</td>
<td>$0</td>
</tr>
<tr>
<td>Outpatient Mental Health</td>
<td>Yes</td>
<td>$0</td>
</tr>
<tr>
<td>Outpatient Substance Abuse</td>
<td>Yes</td>
<td>$0</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>Yes</td>
<td>$0</td>
</tr>
<tr>
<td>DME and Prosthetic Devices</td>
<td>Yes</td>
<td>$0</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>Yes</td>
<td>$0</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Yes</td>
<td>$0</td>
</tr>
<tr>
<td>Hearing Services (diagnostic hearing exam)</td>
<td>Yes</td>
<td>$0</td>
</tr>
<tr>
<td>Out of Area (see World-wide emergency care)</td>
<td>Yes</td>
<td>$0</td>
</tr>
</tbody>
</table>

**Supplemental Benefits**

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Covered</th>
<th>Member Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>World-wide Emergency Care (covered outside the U.S. with a $10,000 annual limit)</td>
<td>Yes</td>
<td>$0</td>
</tr>
<tr>
<td>Non Emergency Transportation (up to 28 one-way trips annually)</td>
<td>Yes</td>
<td>$0</td>
</tr>
<tr>
<td>Vision Services (annual exam and glasses - $100 annual limit on eyewear)</td>
<td>Yes</td>
<td>$0</td>
</tr>
<tr>
<td>Preventive Dental Services (limitations apply – see dental benefit booklet)</td>
<td>Yes</td>
<td>$0</td>
</tr>
<tr>
<td>In-house Assessment (annual)</td>
<td>Yes</td>
<td>$0</td>
</tr>
</tbody>
</table>

**Benefits**

**How to Access Mental Health Services:**
Both beneficiaries and providers can call Pacific Behavioral Health at (866) 908-0677 to coordinate access to care or they can call L.A. Care’s Member Services or the Provider Inquiry Line.

**Supplemental Benefits**

**How to access Dental Services:**
Dental services can be accessed directly through an in-network provider. There is no prior authorization required for preventive services. Comprehensive dental services are also available and copayments will vary for these services. Both beneficiaries and providers can call Liberty Dental Plan at 1-888-700-5243 to refer members for dental care.

Supplemental Benefits

How to access Non Emergency Transportation:
Transportation services can be accessed by contacting L.A. Care’s Member Services or the Provider Inquiry Line to have GMD Transportation pick up a member.

How to access Vision Care:
Contact VSP Member Services at (800) 877-7195 or (800) 428-4833 for the hearing impaired, or visit their website at www.vsp.com to locate a participating provider.

Annual In-house Assessment:
L.A. Care’s Member Services will initiate the outreach to members to conduct assessment. If member has not been contacted or has had an In-house assessment within six (6) months of their enrollment with L.A. Care, please provide the (888) 4LA-CARE or (888) 452-2273 to the members for them to call at their convenience to set up an appointment.

Medicare Part D 2010 Coverage

L.A. Care Health Plan Medicare Advantage-HMO members pay nothing for generic drugs up to the initial coverage limit of $2,830. Before a member’s total yearly drug costs reach the $2,830 Initial Coverage Limit, members pay $0 for generic drugs and $3.30 for brand name drugs. Members typically pay $1.10 co-pay per prescription for generic drugs and $3.30 for brand name drugs during the coverage gap (between $2,830 and $4,550). Once a member reaches $4,550 in yearly out-of-pocket drug costs, they pay $0 for covered drugs. Copayments may vary depending on the member’s low-income subsidy level.

What drugs are covered by this Plan?
L.A. Care Health Plan has a formulary that lists all drugs covered. Drugs on the formulary will generally be covered as long as the drug is medically necessary, are covered by Part D, the prescription is filled at a network pharmacy or through our network mail order pharmacy service. Certain prescription drugs have additional requirements for coverage or limits on our coverage. The formulary is updated monthly and the current formulary list can be found on the L.A. Care Medicare website pages.

How do members get their prescription filled?
Beneficiaries must obtain their prescriptions from a network pharmacy or through the network mail order pharmacy service. A Pharmacy Directory will be provided in the new enrollment packet.
What is the mail order pharmacy service?
Beneficiaries can obtain their prescriptions for medications taken on a regular basis, for a chronic or long-term medical condition through the network mail order pharmacy service. Orders must be for at least a 90-day supply, and no more than a 90-day supply of the drug. Mail orders will take approximately three (3) days to process.

It is not required to use the mail order service to get an extended supply. Network pharmacies can also provide extended supplies. All drugs listed on our formulary are available through the mail order pharmacy service.

For further details regarding Part D Coverage please call our Pharmacy Department at (888) 4LA-CARE.

4.4 MECHANISMS TO CONTROL UTILIZATION OF SERVICES
L.A. Care may create mechanisms to help contain costs for providing health care benefits to members. Such mechanisms may include, but are not limited to:
- Requiring prior authorizations for benefits
- Providing benefits in alternative settings
- Providing benefits by using alternative methods

4.5 PHARMACY BENEFITS – MEDI-CAL

Prescription Drugs
Medically necessary drugs not covered under Medicare Part D, when prescribed by a participating licensed practitioner acting within the scope of his or her licensure, and drugs are listed on L.A. Care’s Drug Formulary, and filled at a participating pharmacy. There are five (5) categories of drugs that will be covered under Medi-Cal:

- Cough/cold medications
- Over-the-counter medications (except for insulin & syringes which are covered by Medicare Part D)
- Barbiturates
- Benzodiazepines
- Prescription vitamins and minerals

4.6 EXCLUDED PHARMACY BENEFITS – MEDI-CAL

- Experimental or investigational drugs, unless accepted for use by the standards of the medical community.
- Drugs or medications for cosmetic purposes.
- Medicines not requiring a written prescription order (except insulin and diabetes monitoring supplies, spacer devices, and peak flow meters).
- Dietary supplements, appetite suppressants or any other diet drugs or medications (except when medically necessary for treatment of morbid obesity).
Any benefits in excess of limits specified previously.
- Services, supplies, items, procedures or equipment, which are not medically necessary as determined by L.A. Care, unless otherwise specified.

4.7 NON-FORMULARY DRUGS PRIOR-AUTHORIZATION REQUIRED – MEDI-CAL

Drugs not included in L.A. Care’s Drug Formulary and deemed medically necessary may be provided subject to Prior Authorization. Provider questions concerning non-formulary drug coverage and Prior Authorization requirements may be directed to the MedImpact, L.A. Care’s pharmacy benefit manager, at 1-800-788-2949. L.A. Care’s Director of Pharmacy will review all requests not meeting prior approval criteria. Denials may be appealed through the L.A. Care Grievance and Appeals process.

4.8 PHARMACY BENEFITS – MEDICARE ADVANTAGE

Please see Chapter 16 of this manual for a description of Part D prescription drug coverage for L.A. Care Health Plan’s Medicare Advantage-HMO.
5.0 UTILIZATION MANAGEMENT

This section summarizes L.A. Care Health Plan’s (L.A. Care) Utilization Management (UM) Processes for direct contract Participating Physician Groups (PPGs). UM functions/activities vary depending on specific contractual agreements with each contracted PPG, provider, and hospital. Please check your contract Division of Financial Responsibility (DOFR), or contact L.A. Care’s Provider Information Line at 1-866-LACARE6 or Utilization Management at 1-877-431-2273.

L.A. Care performs UM activities which are consistent with State and Federal regulations, State contracts and other L.A. Care Health Plan policies, procedures and performance standards as set forth in L.A. Care’s UM Program Document.

L.A. Care is staffed with professional registered nurses and paraprofessionals who are available to assist the PPG and their providers with UM activities. These activities include but are not limited to:

- Benefit interpretation
- Referral management, outpatient and in-patient
- Coordination of care and services for linked programs (CCS, DDS, Mental Health, etc.)
- Coordination of End Stage Renal/Chronic Kidney Disease benefit
- Coordination of services that require disenrollment (e.g., transplants, Long Term Care, Waiver Programs)
- Complex care management and care coordination
- Education of PPG/providers on policies, procedures and legislative updates

5.1 GOAL AND OBJECTIVES

Goal
The goal of L.A. Care Health Plan’s Utilization Management Program (UM) is to ensure and facilitate the provision of appropriate medical and behavioral health care and services to L.A. Care Health Plan members. The program is designed to monitor, evaluate and support activities that continually improve access to and quality of medical care provided to L.A. Care Health Plan members.

Objectives
The Utilization Management Program’s objectives are designed to provide mechanisms that assure the delivery of quality health care services and to optimize opportunities for process improvement through:
• management, evaluation, and monitoring of the provision of healthcare services rendered to L.A. Care Health Plan members for the enhancement of, and access to, appropriate services.
• facilitating communication and develop partnerships between Participating Provider Groups/Providers (PPGs/Providers), members, and L.A. Care Health Plan.
• developing and implementing programs to encourage preventive health behaviors, which can ultimately improve quality outcomes.
• monitoring PPGs/Providers provision of health assessments and basic medical case management to all members.
• assisting PPGs/Providers in providing ongoing medical care for members with chronic or catastrophic illness.
• developing and maintaining effective relationships with linked and carved-out service providers available to L.A. Care Health Plan members through County, State, Federal, and other community based programs to ensure optimal care coordination and service delivery.
• facilitating and ensure continuity of care for L.A. Care Health Plan members within and outside of L.A. Care Health Plan’s network.
• integrating quality and utilization management activities.
• ensuring a process for UM that is effective and coordinated through Committees, work groups and task forces with the involvement and cooperation of experts in all fields of medicine, management, patient advocacy and other relevant fields.
• providing leadership to PPGs/Providers through the development of and/or recommendations for program and process changes/improvements that result from data collection and analysis of utilization activities.
• ensuring that UM decisions are made independent of financial incentives or obligations.

5.2 SCOPE OF SERVICE

• The scope of L.A. Care Health Plan’s Utilization Management Program includes all aspects of health care services delivered at all levels of care to L.A. Care Health Plan members. L.A. Care Health Plan offers a comprehensive health care delivery system along the continuum of care, including urgent and emergency services, ambulatory care, preventive services, hospital care, ancillary services, behavioral health (mental health and addiction medicine), home health care, hospice, rehabilitation services, skilled nursing services, and care delivered through selected waiver programs, and through linked and carved out services.
• L.A. Care Health Plan administers the delivery of health care services to its members through different contractual agreements.
L.A. Care Health Plan’s Programs are administered through different contractual arrangements with medical groups and Independent Provider Associations (IPAs) or collectively called Participating Provider Groups (PPGs), which may include delegation of some or all UM functions.

L.A. Care and L.A. Care’s PPGs shall provide or arrange for all medically necessary covered services for members.

If medically necessary services are not available within the L.A. Care, PPG contracted network contracts are initiated on an individual basis to ensure availability of medically necessary care and services in accordance with benefit agreements.

At a minimum the UM program includes the following:

- Assures that services which are medically necessary are delivered at the appropriate level of care, including inpatient, outpatient, and the emergency room.
- Assures that authorized services are consistent with the benefits provided by the Plan.
- Provides a comprehensive analysis of care by identifying under- and over-utilization patterns by physician and within the Plan.
- Reviews care and identifies trends that positively and negatively impact the quality of care provided to the members.
- Defines, monitors, and trends medical practice patterns impacting members’ care.
- Ensures that appropriate medical review guidelines are available and used by UM personnel.
- Identifies, develops, revises, and implements appropriate policies, procedures, processes, and mechanisms for UM that can be used to evaluate medical necessity for requested services on a timely and regular basis.
- Instructs all institutions, physicians, and other health care clinicians regarding the criteria used, the information sources employed, and the methods utilized in the approval and review processes.
- Provides the health plan network with information related to effective mandated information system and communications for the monitoring, management, and planning of medical services.
- Ensures that network institutions, physicians, and other health care clinicians provide services unless otherwise mandated by regulatory standards.
- Determines if illness or injury are covered under other programs including third-party payers, California Children’s Services (CCS), Genetically Handicapped Persons Program (GHPP) or Mental Health Services.
Ensures that guidelines, standards, and criteria set by governmental and other regulatory agencies are adhered to as appropriate.

Facilitates consistent practice patterns among institutions, physicians, and other health care clinicians with L.A. Care Health Plan by offering feedback to the PPGs/Providers to assist in optimizing appropriate medical practice patterns.

Provides case management services to ensure cost effective ongoing care at the appropriate level.

Utilizes information in member and physician satisfaction surveys to develop quality improvement activities as appropriate.

Conducts inter-rater reliability of physician and non-physician reviewers to assess determinations made as part of the UM process.

Provides required reports.

Ensures coordination and continuity of care for members receiving linked and carved out services.

### 5.3 AUTHORIZATION REVIEW PROCESS

**Treatment Authorization Review (TAR) Processes**

Request for services are reviewed in accordance with approved guidelines and criteria as adopted by L.A. Care Utilization Management Program, Utilization and Quality Management Committees. Decisions are made according to medical necessity criteria and the member’s benefit structure. There are eight (8) components of the Utilization Management Referral (Treatment Authorization Request – TAR) review process.

- Prior Authorization/Pre-Service Review
- Concurrent Review
- Retrospective/Post-service Review
- Emergent/Urgent Review
- Expedited Review
- Second Opinion Review
- External Independent Review/Independent Medical Review
- Reconsideration Review

**Authorization considerations for Services covered under Medi-Cal**

Because L.A. Care SNP members have full Medi-Cal coverage, the request for services authorizations also consider services that are not covered under Medicare. Following services not covered under Medicare would be covered under Medi-Cal:
- **Monthly plan premium** is $0 since members are covered by Medi-Cal.
- **The Part B premium** is $96.40, however SNP members will pay $0, since the premium is paid by Medi-Cal on the member’s behalf.
- **Inpatient Hospitalization**: $0 for unlimited number of days for inpatient coverage in the hospital as long as the member’s stay is medically necessary and authorized.
- **Long Term care (Skilled Nursing Facility)**: Medi-Cal covers additional days beyond the Medicare limit if extra days are authorized and medically necessary.
- **Vision Care**: Member pays $0 for glasses or contact lenses every two years if medically necessary. In addition, member pays $0 for an office visit every other year, unless there is a medical need for additional visits.
- **Hearing Aids**: Members pay $0 for hearing aids that are provided by an in-network specialist.
- **Acupuncture**: Members pay $0 for acupuncture services from the Medi-Cal fee-for-service program.
- **Podiatry**: Member pays $0 for up to 12 additional routine/maintenance visits per year (24 total per year, including nail trimmings, cutting and removal of calluses, etc).
- **Incontinence Supplies**: Member pays $0 for medically necessary incontinence supplies.
- **Dental Services**: Member pays $0 for dental services from Dentical.
- **Excluded Medicare Part D Drugs**: member pays $0 for certain excluded drugs covered by Medi-Cal, including prescribed over-the-counter drugs. Please refer to the Pharmacy section in this manual for details.

### 5.4 STANDARD UTILIZATION MANAGEMENT CRITERIA

Established criteria are required for approving, modifying, deferring, or denying requested services. L.A. Care utilizes evaluation criteria and standards to approve, modify, defer, or deny services. UM Criteria are:
- developed with involvement from actively practicing health care providers
- consistent with sound clinical principles and processes
- evaluated and updated if necessary, at least annually

L.A. Care utilizes the UM Committee to involve providers in the development and or adoption of specific criteria used by L.A. Care and its delegated providers.

Clinical criteria are used to determine medical necessity in the referral management (Treatment Authorization Request – TAR) review process to
ensure consistency of authorization and review decisions by UM staff. Consistency of application of criteria is checked at all levels of delegation via the annual audit.

Criteria to determine appropriateness of medical services utilized by PPGs/Providers and their networks shall be consistent with those utilized by L.A. Care Health Plan. PPGs/Providers may develop additional clinical criteria for use within their system, but they must be reviewed and approved by L.A. Care Health Plan prior to their implementation. All approved criteria must be transmitted and utilized throughout PPGs/Providers and provider networks, and shall be made available by the PPGs/Providers to providers, members and the public upon request. The potential criteria sources include but are not limited to:

- Center for Medicare and Medicaid Services National Coverage Determinations
- InterQual
- Milliman Healthcare Management Guidelines
- Apollo Criteria
- Other L.A. Care Health Plan approved criteria

L.A. Care Health Plan draws from and follows the recommendations of a number of nationally recognized sources in the development of medical policy and criteria related to preventive care, admissions, outpatient surgeries and diagnostic and therapeutic services. Examples of these organizations include:

- Centers for Disease Control
- American College of Obstetrics and Gynecology
- Diagnostic and Treatment Technology Assessment (DATTA)
- Food and Drug Administration (FDA)

For provider or member appeals resulting from a denial of services using consensus based criteria, L.A. Care will review the request for services based on available evidence based criteria or guidelines.

When appropriate, L.A. Care Health Plan’s CMO may assemble a panel of independent experts to assist in medical necessity determinations. At the L.A. Care Health Plan level, adverse decisions may be appealed to the L.A. Care Health Plan CMO or designee. Additional appeals may be pursued in accordance with CMS requirements and L.A. Care Health Plan policy, if disagreements with L.A. Care Health Plan Peer Review/Grievance Committee decisions occur.

Members, providers and the public may obtain UM criteria or UM Policies and Procedures used by L.A. Care in referral management
determinations by calling the UM Department at (877) 421-2273. UM staff shall relay the request to the UM Director (or designee) for response. All requests for UM criteria are logged in the UM Criteria tracking log and are processed upon request in accordance with state requirements.

5.5 ACCESS TO CARE CRITERIA

L.A. Care and PPGs utilization management policies and review criteria are available for disclosure to L.A. Care Health Plan, Providers, members, and the public upon request in accordance with established regulatory and contractual requirements and L.A. Care Health Plan requirements.

5.6 EMERGENCY HEALTH CARE SERVICES

L.A. Care and its PPGs ensure that emergency health care services are available and accessible within the service area 24 hours a day, seven days a week, and shall provide 24 hours access for members and providers to obtain timely authorization for medically necessary care.

For circumstances where the member has received emergency services and care is stabilized, but the treating provider believes that the member may not be discharged safely; a licensed physician and surgeon shall be available for consultation and for resolving disputed requests for post-stabilization care.

5.7 REFERRAL MANAGEMENT PROCESS

L.A. Care Health Plan may delegate referral management to the PPGs. While PPGs have some degree of latitude in establishing review processes, they must contain the following provisions according to their delegation agreement, which are established in L.A. Care Health Plan’s policies and procedures:

- Appropriately licensed health professionals conduct the supervision of all review decisions and processes.
- No other individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for reason of medical necessity or benefit limitations.
- Review decisions are supervised by qualified medical professionals and all denials/modifications will be reviewed by a qualified Physician.
- Physician consultants from the appropriate specialty areas of medicine and surgery who are certified by the applicable American Board of Medical Specialties shall be utilized as necessary. A list of these physician consultants (reviewers) shall be available to the PPGs and L.A. Care Health Plan.
• There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, updated regularly, and consistently applied.
• Reasons for decisions are clearly documented.
• There is a well-publicized appeals procedure for both providers and members.
• Decisions are made in a timely manner.
• UM decisions are made independent of financial incentives or obligations.
• Records, including any CMS Member Notices and Medi-Cal Notice of Actions, shall meet the mandated retention requirements. The retention requirements for Medicare records is 10 years.

5.8 SEPARATION OF MEDICAL DECISIONS AND FINANCIAL CONCERNS
Under Federal Code of Regulations and California Health and Safety Code 1367(g), medical decisions regarding the nature and level of care to be provided to an enrollee, including the decision of who will render the service, must be made by qualified medical providers, unhindered by fiscal or administrative concerns. Utilization Management decisions are therefore made by medical personnel and are based solely on medical necessity. Practitioners may openly discuss treatment alternatives (regardless of coverage limitations) with members without being penalized for discussing medically necessary care with the member. L.A. Care requires that each PPG and hospitals UM program include provisions to ensure that financial and administrative concerns do not affect UM decisions.

5.8.1 Over/Under Utilization Monitoring/ Detection/ Correction
L.A. Care’s and delegated providers’ descriptions of over/under utilization monitoring/detection systems must include monitoring inappropriate emergency room usage for routine primary and specialty care and the review of services for appropriateness and effectiveness of cost effective patient care for detecting/correcting over- and under-utilization.

L.A. Care's UM Committee performs the following over/under utilization monitoring/detection mechanisms at a minimum:

- Medicare HEDIS measures

Use of Services
- Frequency of Selected Procedures
- Inpatient Utilization - General Hospital/Acute Care
- Ambulatory Care
- Inpatient Utilization - Non-Acute Care
- Mental Health Utilization - Inpatient Discharges and Average Length of Stay
- Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
- Chemical Dependency Utilization - Inpatient Discharges and Average Length of Stay
- Identification of Alcohol and Other Drug Services
- Outpatient Drug Utilization (for those with a drug benefit)

- **Ambulatory and Hospitalization Services**

  L.A. Care monitors potential over-under utilization of services by reviewing ambulatory and hospital data. This data includes PPG encounter data and L.A. Care claims data. The reports include:

  - Outpatient Services
    - Primary Care
    - Specialty Care
    - Ancillary Services
  - Emergency Room utilization
  - Hospital Services
    - Bed Days
    - Average Length of Stay
    - Hospital Readmissions

- **Emergency Room Reports** - This data will be compiled into a monthly and rolling report for analysis by the UM Committee. Trends in Emergency Room Department utilization may indicate access, education or under-utilization issues at any of these levels while indicating over-utilization at the Emergency Room level.

- Hospitalization Admit and Re-admit data will be studied by utilizing encounter data and analyzing reports at L.A. Care level that indicate a trend of admission and re-admission for same/similar diagnosis. If a pattern is found at any level, the possibility of under-utilization of inpatient services or outpatient support services may exist and warrant further investigation.

  Encounter data will be run periodically against a “patterns of care” program to analyze encounter patterns by diagnosis or procedure.
against the standards in the patterns systems. Under-utilization, over-utilization or non-submission of encounter data may be reason for widely aberrant patterns.

Review of disenrollment (voluntary and involuntary), out of plan service or grievance trends which may indicate access or quality issues will be conducted quarterly. The results will be reviewed by the UM and QA/QI directors reported with recommendations to the appropriate Quality Committees.

Recommendations from the various Quality Committees will be conveyed to the PPGs via the Provider Network Operations assigned staff or Joint Operation Meetings.

5.9 DELEGATION OF UTILIZATION MANAGEMENT

L.A. Care Health Plan has a formal process by which Utilization Management functions (which includes Case Management activities) are delegated to the PPGs. Policies and Procedures and the delegation agreement describe (in detail) delegation standards, initial delegation requirements, and ongoing monitoring and reporting requirements.

If a federal or state law does not allow the organization to fulfill NCQA requirements, NCQA holds the organization harmless for all affected scoring elements. In other words, NCQA may score an element NA or give the organization credit, if appropriate, when there is a direct conflict between an NCQA requirement and a federal or state law. The organization must present NCQA with documentation identifying the regulation and the conflict and alert the ASC prior to the survey start date (submission date).

L.A. Care Health Plan requires that delegated PPGs have a Utilization Management Program in place to monitor and evaluate the care and services provided to its members. PPGs UM program will be consistent with L.A. Care Health Plan’s UM program and meet State and Federal requirements and regulations. L.A. Care Health Plan will monitor the infrastructure and activities of the PPGs and the oversight of their respective networks to assure compliance with contractual and regulatory requirements. PPGs are required to submit to L.A. Care Health Plan:

- An annual Utilization Management Program document and program evaluation,
- Monthly encounter data,
- Oversight reports as defined in the delegation agreement
- Referral management activity and supplemental reports as defined in the delegation agreements.
PPGs/Providers must have systems in place which address the mandatory requirements to coordinate care between managed care plans and identified linked and carved-out programs as defined by the contract.

De-Delegation of UM Activities

L.A. Care Health Plan may require or impose corrective action, including revocation of delegated status, if the PPG does not comply with the delegated Utilization Management requirements. If L.A. Care Health Plan withholds or withdraws delegated status for Utilization Management from a PPG, L.A. Care Health Plan’s Utilization Management department shall assume the level of UM activity appropriate to the non-delegated PPG. L.A. Care Health Plan reserves the right to continue to delegate Utilization Management to the PPGs if they meet L.A. Care Health Plan’s standards for delegation. L.A. Care Health Plan’s Utilization Management department will provide consultation to the PPG and may actively participate with the PPG to assist the PPG to come into compliance with a UM delegated function prior to L.A. Care Health Plan’s revocation of a UM delegated status.

5.10 STANDARDS FOR DELEGATION OF UM FUNCTIONS

L.A. Care Health Plan shall retain the ultimate responsibility for ensuring that PPGs utilize and maintain an effective Utilization Management Program.

The following required guidelines provide high level descriptions of required Utilization Management processes and functions to be delegated to the PPGs through L.A. Care Health Plan’s policies and procedures:

The delegated PPGs must have a written utilization management program/plan in place. The program must have documented goals and objectives and describe the organizational structure and staffing for performing the program functions.

The delegated PPG must have UM operations that meet all contractual, regulatory, and L.A. Care Health Plan regulatory requirements, including but not limited to meeting all timeliness and corresponding standards.

The UM program must identify and correct areas of over-utilization and under-utilization of services.

The delegated PPGs must have an established utilization management committee which meets at least quarterly to review utilization issues and determine improvement plans where indicated. L.A. Care Health Plan
representatives may attend the committee meeting, upon advance request.

The minutes of the utilization management committee must be made available upon request to L.A. Care Health Plan.

L.A. Care Health Plan Utilization Management staff must be permitted reasonable access to the PPGs utilization management files, minutes and records of the UM Committee meetings, for the purpose of auditing utilization management activities.

PPGs and providers within their networks will have processes in place to take appropriate action in areas where problems are identified and provide feedback to L.A. Care Health Plan regarding the conclusions, recommendations, actions and follow-up. Serious quality issues, limitation of providers’ practice, suspension or sanction activity will be reported to L.A. Care Health Plan immediately.

PPGs will have policies and procedures to ensure separation of clinical decision making from financial incentives.

UM data must be sent to L.A. Care Health Plan in a timely manner and in an appropriate format as requested by L.A. Care Health Plan’s UM and Information Services departments for trending and reporting in compliance with State and Federal regulatory requirements.

### 5.11 DELEGATION MONITORING AND OVERSIGHT

L.A. Care is responsible for evaluating PPGs’ ability to perform the delegated activities including an initial review to assure that the PPG has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities. Delegation monitoring shall be performed to ensure PPGs meet standards set forth by the L.A. Care and regulatory body requirements. This includes the continuous monitoring, evaluation and approval of the delegated functions.

L.A. Care Health Plan will monitor and oversee the delegated UM activities of the PPGs and their networks to ensure ongoing compliance with State, Federal, and L.A. Care Health Plan requirements. UM data submitted to L.A. Care Health Plan by PPGs will be analyzed and areas for improvement identified and managed through the Corrective Action Plan (CAP) process with the PPG/Provider or through the Quality Improvement Process, as appropriate, in accordance with L.A. Care Health Plan’s organizational sanction policies. L.A. Care Health Plan will perform different types of audits and oversight activities of PPGs as
appropriate. The UM data and oversight activities will include, but not be limited to the following:

**UM Reports**

PPGs are required to submit to L.A. Care Health Plan on a monthly basis via mail, electronic mail or fax:

- Oversight reports include referral management activity and supplement reports as defined in the delegation agreement including but not limited to:
  - Quarterly PPG Reporting of Medicare Organizational Determinations (Fully Favorable, Partially Favorable, and Adverse) on the ICE Medicare Part C Report Template PPG Reporting of Medicare Organization Determinations or L.A. Care approved template
  - ICE Provider Group reporting template or L.A. Care
  - Care Transitions Reports
  - Continuity of Care
  - Case Management
  - Medi-Cal Linked and Care Out Services (Dual Eligibles)

- L.A. Care contracted/delegated medical groups (PPGs) are provided with required templates for quarterly reporting for Medicare Organization Determinations:
  - For Medicare Part C Reporting – L.A. Care utilizes the ICE format with instructions/templates. (Attachment A)
  - For Medicare logs of organization determinations – L.A. Care utilizes the CMS required format with instructions/templates. (Attachment B)

- PPGs are required to submit the reports to L.A. Care Medical Management Department on a quarterly basis:
  - Reports are required to be submitted by the 45th day following the close of the quarter.
  - Fax or email to L.A. Care’s UM Delegation Oversight Coordinator by Right Fax 213-438-5710
  - Organization Determination reports data based on the required reporting periods of
    - 1/1 through 3/31 (1st Q) – Due May 15th
• 4/1 through 6/30 2nd Q – Due Aug 15th
• 7/1 through 9/30 3rd Q – Due Nov 15th
• 10/1 through 12/31 4th Q – Due Feb 15th

• General Directions for reporting CMS Part C Initial Determinations to L.A. Care:
  ▪ Reports may be submitted using the ICE quarterly report format (Attachment A).
  • NOTE: PPG’s must submit a log of the actual data elements used to identify the Initial Determinations.
  • This log must contain the following elements:
    o PPG name,
    o Member ID (usually the HIC #),
    o unique case # (usually the Referral number),
    o resolved date (by MM/DD/YYYY),
    o Type of IO (Initial Organization - IO,
    o Decision ID (1=Fully Favorable, 2=Partially Favorable, 3=Adverse).

  A sample log may be found at the end of this section - (Attachment B)
  • Exclude dismissals, withdrawals or Quality Improvement Organization reviews of request for continued Medicare-covered services (e.g. SNF).
  • Includes only organizational determinations that are filed directly the delegated entities (e.g., excludes all organization determinations that are only forwarded to the organization from the CMS Complaint Tracking Module (CTM) and not filed directly with the organization or delegated entity).
  • Includes all methods by which organization determination requests are received (e.g., auth request form, by telephone, letter, fax, in-person).
  • Includes all organization determinations regardless of who filed the request.

Quarterly report Log of all Medicare Organization Determinations.

In addition to L.A. Care’s requirement for the standard Quarterly submission of the Medicare Advantage Part C Reporting for CMS, L.A. Care will now also require an additional Quarterly report Log of all Medicare Organization Determinations. Therefore, starting 4th Quarter 2011, we expect to receive two reports regarding Medicare.
Please note that because this new log is an Excel file, it must be submitted as an Excel file through Secure E-mail or to the L.A. Care FTP site so that it can be sorted by L.A. Care and / or CMS (Do not submit by FAX or Right Fax). Please send report to EMetivier@LACare.org only by secure e-mail or to the L.A. Care FTP site with an email to EMetivier@LACare.org advising of placement on the L.A. Care FTP Site.

*For Partially Favorable or Adverse (Modification or Denial) determinations, the Notice of Action letters (CMS/DHCS/L.A. Care) and medical records utilized in the determination must be sent to the L.A. Care UM Department on the date of the denial.

The submitted reports, combined with information obtained via site visits and audits, will be used to accomplish the UM oversight functions required by regulation and/or contract requirement.

Medicare Part C Reports from PPGs will be included in the total report that L.A. Care sends to CMS on a quarterly basis. The PPG logs of Initial Determinations on L.A. Care’s excel format will be sent to CMS when requested.

L.A. Care Health Plan will analyze the reports and present the results to the PPGs at the Utilization Management Committee meeting. The goal of performing plan and group specific analysis is to monitor utilization activities, member access to care, and to validate and compare to community norms/ benchmarks. Any variance(s) will be reviewed and discussed at the Utilization Management Committee meetings, and periodically at the Quality of Care Committee. All the information obtained in these reports will be shared with the PPGs/ Providers for UM and QI purposes.

Oversight Audits
Oversight for L.A. Care Health Plan’s directly contracted PPGs are performed as prescribed in the UM Oversight Plan as approved by the UM Committee. Wherever possible these audits may be done in conjunction with other L.A. Care Health Plan departments to improve efficiencies and decrease duplication. The primary objective of the oversight audit is to ensure compliance with L.A. Care Health Plan’s Utilization Management Department policies and procedures, standards of care, Local, State, and National regulatory requirements, and provisions of the purchaser contracts (e.g. SDHS, MRMIB). The oversight audit consists of document review and staff interviews to verify that policies/procedures/processes have been implemented and are being applied and complied with. This may include, but not be limited to, audits of case files and medical records.
The oversight audits are conducted to ensure compliance with the following requirements:

- Annual approved Utilization Management Program, Work Plan, and Evaluation
- UM Policies/Procedures/Processes
- UM Care Coordination for in and out of network referrals/hospitals
- UM Care Coordination for Linked and Carved Out Services
- Initial Health Assessments
- Medicare standards

Supplemental Audits
Previously termed focused audits and supplemental audit topics may be identified by the Utilization Management Committee, CMO, Medical Director, and/or as a mid-year assessment of new legislative implementation requirements or indicated as a consequence of findings from internal (e.g., performed by L.A. Care) or external (e.g. State or Federal) oversight/audit activity. The purpose of a supplemental audit is to capture more specific/detailed information that may not be captured through Encounter Data, Supplemental Reports or the annual oversight audit. The goal of the supplemental audit is to ensure compliance with L.A. Care Health Plan’s Utilization Management department policies and procedures, standards of care, regulatory requirements, and provisions of purchaser’s contracts with a specific issue. The supplemental audit may consist of document review, file review and/or medical record review and staff interviews. Supplemental audits may be used to capture more specific or detailed information and/or to follow-up on identified deficiencies or areas of concern.

A sampling methodology, used to select member records, ensures a representative sample from the delegated entity for the supplemental audit. Supplemental audit tools are scored according to the methodology approved by the UM Committee.

The supplemental audit may address any Utilization Management and coordination of care category as identified by L.A. Care Health Plan in our purchasers’ contract.

Continuous Monitoring Activities
Continuous Monitoring Activities are used to further supplement the basic oversight activities of annual/focused audits and supplemental report submission review in order to provide more comprehensive and timely oversight in selected areas where episodic audits/review have not been adequate in ensuring compliance with regulations. A sampling methodology appropriate to each continuous monitoring activity is defined to ensure
representative sampling, and approved by the UM Committee. Examples of continuous monitoring may include, but are not limited to:

- Referral Management Review, including denials and denial notifications
- Care Coordination for Linked and Carved Out Services

Decisions by the Plan or delegated PPG are tracked for any trends and appropriate actions taken as necessary.

The L.A. Care UM Department reviews denials issued and submitted by the delegated Physician Groups. Delegated PPGs are required to submit all denial letters with any supporting documentation current to the denial or on a weekly basis to the Plan.

Plan and PPG denial letters are evaluated for compliance in the following areas:

1. Timeliness of the decision-making and notification process
2. Physician involvement in the decision making
3. Clear and concise denial reason
4. Appropriate information available for decision-making
5. Documentation of criteria for medical necessity denials or benefit reference
6. Appeal rights and process (*NOTE: Appeals process differs for members enrolled in the Medicare Advantage SNP and for members enrolled in MCLA for Medi-Cal only,*)
7. Appropriate template

If deficiencies are found in the initial review, the Plan or delegated PPGs are notified of the areas of deficiencies for immediate correction. Continued non-compliance issues are reported to the Delegation Oversight Committee for recommendations.

Delegated Physician Group letters are also audited during the annual oversight audits.

Corrective action plans are required for those PPGs with less than 90% compliance.

- PPGs with deficiencies or corrective action plans will be monitored according to L.A. Care policy.
- If a PPG remains non-compliant, the findings will be reported to the Delegation Oversight Committee for a decision regarding continued delegation.
The Plan will provide delegated PPGs with the approved CMS/SDHS or L.A. Care letter templates that need to be used, at least once every year or more often as the need arises. This is to ensure that the PPG are using standard regulatory approved language.

5.12 RESPONSIBILITY OF PARTICIPATING PROVIDER GROUPS

5.12.1 PPGs are responsible for primary (basic) medical case management, coordinating health care services, and referral management of services for which the PPG has financial responsibility, for members enrolled with their primary care physicians.

5.12.2 The PPG also has responsibility for notification to and obtaining prior-authorization from L.A. Care’s UM department for services which L.A. Care has sole financial responsibility.

PPGs that do not obtain prior authorization for services that are the responsibility of L.A Care and not defined as eligible under the Risk Pool arrangement are subject to assume the financial risk for said service. Please refer to the contract DOFR and or the mutually agreed upon Delegation Agreement.

5.12.3 The PPG agrees and is required to:

5.12.3.1 make available to L.A. Care any requested data, documents and reports
5.12.3.2 allow site visits, periodic attendance at UM meetings, evaluation and audits by L.A. Care or other agencies authorized by L.A. Care to conduct evaluations.
5.12.3.3 have representation and involvement in activities scheduled to enhance and/or improve the quality of health care services provided to our members.

5.13 SERVICES REQUIRING PRIOR AUTHORIZATION

The delegation of certain UM activities affords flexibility for PPGs to establish internal prior authorization requirements. These requirements must be reviewed and approved by L.A. Care through the delegation process.

There are services for which the PPG must submit a request/referral to L.A. Care for prior authorization, or notification concurrently with or retrospective of the services for authorization by L.A. Care. All authorization requests submitted to L.A. Care will be responded to within the defined timeframes as identified in the most recent product specific version of the applicable “Decision Making Timeliness Matrix” (Attachment included)
Unless defined in the most recent L.A. Care PPG Auto Approval Listing, the services listed below, and any future updates dependent on delegation and DOFR, must first be authorized by L.A. Care’s UM department:

- Durable Medical Equipment (DME)
- Home Health Services
- Hospital admission (non-emergent/urgent)
- Skilled Nursing Facility admissions, skilled and long term care
- Medical Supplies not provided in physicians’ offices
- Most elective surgical and invasive diagnostic procedures (inpatient or outpatient facility component)
- Orthotics & Prosthetics
- Physical/Occupational & Speech therapies (see DOFR)
- Rehabilitation services
- Transplant evaluation
- Self-injectibles

Referrals may be submitted on paper, by phone, or electronically. All requests must be submitted on a L.A. Care Referral Form and include the following information:

- Requesting provider
- Patient’s name, date of birth, address, phone number, and social security number
- Confirmation of current L.A. Care eligibility
- Patient’s diagnosis and medical history supportive to the service requested
- Supportive medical records needed to make a determination
- Appropriate coding (using current CPT4, ICD9, and/or HCPCS codes), identification of services requested
- Identification of requested provider of service, including name, type of provider, location and provider’s phone number

5.14 ORGANIZATIONAL DETERMINATIONS - DEFERRAL, MODIFICATION, AND/OR DENIAL DETERMINATIONS AND NOTIFICATION REQUIREMENTS – Medicare Advantage SNP Only

Referral Status and Timelines –

L.A. Care’s (LAC) Utilization Management Department reviews referral/authorization requests and makes organization determinations based on medical necessity through the application of approved clinical criteria and assessment of the individual needs of the member.
**Organization Determinations** means any determination (whether adverse, fully favorable or partially favorable) made by L.A. Care for any of the following:

- Requests for service
- Discontinuation of service that the enrollee believes should be continued because they believe the service to be medically necessary.
- Refusal to pay for services in whole or part, including the type or level of services that enrollee believes should be furnished by the Medicare Advantage organization.
- Payment for any health services furnished by a provider other than the Medicare Advantage organization that the enrollee believes are covered under Medicare or if not covered by Medicare, should have been furnished or arranged for by the Medicare Advantage organization.
- Payment for temporarily out of area renal dialysis services, emergency services, post stabilization care, or urgently needed services.
- Failure of Medicare Advantage organization to approve, furnish, arrange, or provide the enrollee of timely notice of an adverse determination, such that a delay may adversely affect the health of the enrollee.

**Routine** (non expedited or standard) Organization Determinations are made using appropriate clinical and CMS coverage guidelines and the member is notified within 14 calendar days of receipt of the request, per Medicare timeliness standards.

**Expedited Determination** for urgent requests: To request an expedited determination, an enrollee or a physician must submit an oral or written request directly to L.A. Care or the delegated PPG... Urgent requests for services are referred to the PPG or L.A. Care depending upon the entity responsible for reviewing the referral request... Urgent referral requests are submitted when services are required to prevent serious deterioration of health following the onset of an unforeseen condition or injury. Urgent referral requests made to L.A. Care will be reviewed by an L.A. Care UM Specialist to assess whether the care requested meets the definition for urgent processing. If request is approved for urgent processing, L.A. Care or the delegated PPG makes its determination and notifies the enrollee and the physician involved of its decision (whether adverse or fully favorable, partially favorable or adverse) as expeditiously as the enrollee’s health condition requires, but no later than 72 hours after receiving the request.
Based on CMS standards, referrals that do not meet the criteria for urgent processing will be reviewed by L.A. Care’s Medical Director. If the service requested does not meet the criteria for an urgent request, the referral request will be converted to a routine request for processing within the routine timeframe which is 14 calendar days from the date and time of the request. Members may file an expedited grievance if they do not agree with L.A. Care’s decision.

If the referral request does not meet criteria for medical necessity or covered benefit, these requests are subject to a modification or denial by L.A. Care’s Medical Director. PPGs will be notified by L.A. Care’s UM staff member prior to the change in referral status. Appropriate communications are sent to the member and provider. If the services are denied, the denial notice must be the appropriate CMS approved denial letter (Notice for Denial of Medical Coverage, NDMC) and must include the reason for the denial, the criteria used, and include Medicare appeal rights.

A physician will make all determinations of deferment, modification or denial of requests for services.

**Extensions:** L.A. Care or delegated PPGs may extend the routine request or 72 hour deadline (expedited or urgent request) by up to 14 calendar days if the enrollee requests the extension or if L.A. Care or the PPG justifies a need for additional information and how the delay is in the interest of the enrollee (for example, receipt of additional information from non-contracted providers may change L.A. Care’s decision to deny). When the organization extends the deadline, it notifies the member in writing of the reasons for the delay and informs the member of the right to file a grievance if he or she disagrees with the organization’s decision to grant an extension. The member is given prompt oral notice of the extension (as expeditiously as the member’s health condition requires but no later than upon expiration of the extension) and a written notification follows within 3 calendar days. The letter confirms the oral notification. *(See: Attachment A - ICE Medicare Timeliness Standards)*

**Only a qualified physician can make a determination to deny or modify a request.** Denials and modifications of requested services may be issued with an alternative care option when appropriate.

A request for authorization that results in a modification, reduction, or denial of Covered Services based on medical necessity or Benefit coverage shall be reviewed by the L.A. Care or PPG Medical Director or designated Physician reviewer. The Plan or PPG should clearly document
and communicate the reasons for each denial. The intent is for Providers and Members to receive sufficient information to render an informed decision whether or not to appeal the modification or denial of coverage. This policy covers both non-behavioral and behavioral healthcare.

L.A. Care and delegated PPGs shall comply with the standards for timeliness in decision making and notification of UM denial or modification decisions per specifications of the UM Timeliness Guidelines required by CMS or DHCS. Notifications may be given orally, electronically, or written as specified in regulatory guidelines. L.A. Care will notify Physician Groups of any changes in these standards as required.

If a request is denied or modified, the Plan or the delegated PPG shall utilize either the:

- CMS mandated Notice of Denial of Medical Coverage (NDMC) and the supplemental CMS Region IX approved template letters for Medicare Members.
- DHCS Notice of Action (Only for those services not covered by CMS but covered by DHCS),

Denials include modifications or delays in the Covered Service requested.

A denial letter is issued based on standard criteria (medical or Benefits) and must include the following:

a) A description of the Covered Service being denied, modified or deferred
b) Clear and concise explanation of the reason(s) for the decision. This should be presented in a clear, understandable language.
c) A description of the criteria, guidelines, protocol, or benefit provision used to make the decision.
d) Notification that a Member can obtain a copy of the criteria, guideline, protocol, or actual Benefit provision on which the denial decision was based, upon request.
e) An alternate treatment plan will be identified when medically indicated.
f) A description of Appeal and or reconsideration rights, including the right to submit written comments, documents, or other information relevant to the Appeal.
g) An explanation of the Appeal process, including the right to Member representation (for Medicare Members only) and time frames for deciding Appeals.
h) A description of the Expedited Appeal process if a denial is an urgent pre-service or urgent concurrent denial.
i) Name and phone number of the Physician reviewer involved in the initial determination.
j) A Member’s right to select an authorized third party, such as legal counsel, relative, friend or any other person as a representative (applies to Medicare Members only).

**UM REFERRAL PEER REVIEW DISCUSSION** – PPG or L.A. Care are required to provide access to the Medical Director or physician reviewers responsible for the UM determination.

**PEER REVIEW DISCUSSIONS**
A provider requesting a second review of a referral request for authorization may write or call the Medical Director/ designated peer reviewer and provide additional information for further discussion. This process, or reconsideration, usually occurs prior to the issuance of the denial notification to the member under the following terms:

- Reconsideration must occur within one (1) business day from the receipt of the provider telephone call or written request.
- If the Medical Director or designated peer reviewer reverses the original determination based on additional information given by the provider, the case will be closed.
- If reconsideration does not resolve a difference of opinion, the provider may then submit a request for review through the expedited or standard appeal process to L.A. Care.
- If the group’s reconsideration process results in a denial, deferral, and/or modification with which the provider is still dissatisfied, the provider may request a formal appeal to L.A. Care for a higher level review.

**NOTIFICATIONS**
The PPG or L.A. Care will send written notification of prior-authorization request denial, deferral, and/or modification to the member or member’s representative, member’s PCP, and/or attending physicians and L.A. Care, according to the provisions below:

- All denials and modifications of service requests, including denials for non-covered benefits, must be communicated to the provider and member in writing within the required timeframes and utilize the
appropriate CMS template notices. The communication must contain the following:

- Specific reason(s) for the decision
- Medical or other criteria used in making the decision
- All appeal options and processes including necessary instructions and applications (e.g. Independent Medical Review, routine and expedited appeal processes, etc.)
- Name and contact information of the physician reviewer making the determination
- Written notification will also include information describing the grievance processes for CMS or Department of Health Services

Timelines for decision making –

SEE ATTACHED PRODUCT SPECIFIC DECISION-MAKING MATRICES – Attachment C

Self-Referral Services - Medicare Advantage –SNP Only
For Medicare Advantage-SNP members, certain services are available without referral or authorization. These include:

- **Routine women’s health care**, which include breast exams, mammograms (x-rays of the breast), Pap tests, and pelvic exams. This care is covered without a referral from a plan provider.
- **Flu shots** and **pneumonia vaccines**, as long as they are furnished by a plan provider.
- **Emergency services**, whether provided in or out-of-network
- Urgently needed care received from non-plan providers when the member is temporarily outside the Plan’s service area. Also, urgently needed care that the member gets from non-plan providers when they are in the service area but, because of unusual or extraordinary circumstances, the Plan providers are temporarily unavailable or inaccessible.
- **Dialysis** (kidney) services received when the member is temporarily outside the Plan’s service area.

5.15 **AFTER HOURS UM ACCESS**
L.A. Care and its delegated entities shall provide 24 hours/7 days/week telephone access to utilization management professionals and ensure that multilingual capability is available at the 24-hour number:
Multi-lingual capability is provided by L.A. Care through a telephonic interpretation services contracted vendor.

A physician or contracting physician shall be available 24 hours a day to:
authorize medically necessary post-stabilization care and coordinate the transfer of stabilized members in an emergency department, if necessary:

- response to request is required within 30 minutes or the service is deemed approved in accordance with Title 22, CCR, Section 53855 (a), or any future amendments
- authorize non-urgent care following an exam in the emergency room
- response to request is required within 30 minutes or the service is deemed approved in accordance with Department of Health Services (DHCS) contractual requirements
- respond to expedited requests for:
  - appeals of denial of services
  - quality of care grievances

L.A. Care’s UM physician and staff are available after hours (24 hours, 7 days/week) for provider and access to care determinations. If you have a question regarding UM referrals for urgent services provided after normal business hours, please contact:

L.A. Care Health Plan  
Attn: UM Department  
1055 West Seventh Street, 10th Floor  
Los Angeles, CA  90017  
(877) 431-2273 – Request the “Nurse on Call”  
Fax: (213) 438-5777

5.16  EXCEPTIONS TO AUTHORIZATIONS

5.16.1 In developing prior-authorization requirements, certain parameters and any future updates must be followed by the PPG. These parameters include exceptions to prior-authorization or services for which prior authorization is disallowed. The services include the following:

- Emergency services (medical screening and stabilization).
- Preventative health services for all ages including immunizations
  - Medicare – SNP - flu and pneumococcal vaccinations and screening mammograms.
- Services identified in the most current version of the L.A. Care “Direct Referrals List”
5.17 Hospital Inpatient Care

Unless noted in the PPGs delegation agreement, the Plan is responsible for hospital inpatient concurrent review. The Plan UM staff or case manager will collaborate with the attending Physician (Hospitalist), Hospital case manager and Physician Group Case Manager for continuing Inpatient Services and discharge planning.

The attending PPG is responsible for the professional component of inpatient care and shall perform rounds on all Members who are Inpatients, as will, when appropriate, the Member’s PCP, if the attending Physician is a Specialist Physician. The PPG shall monitor continuing care, collaborate with the Plan when continued Inpatient Services are required and initiate discharge planning and follow-up services, when indicated.

Hospital inpatient care may be pre-planned, pre-authorized, urgent or emergency admissions. The PCP is responsible for obtaining required pre-authorizations for inpatient care from the PPG. The PCP must notify the PPG of an emergency admission. Unless delegated for concurrent review, the PPG must notify L.A. Care of all inpatient admissions. L.A. Care maintains a list of contracted hospitals and ancillary services. If you do not have a PPG copy, please contact your L.A. Care Provider Network Operations representative.

Emergent inpatient admissions – for PPGs that are managing an inpatient admission and do not coordinate within one (1) business day of the admission, the hospital facility charges may be subject to capitation adjustment as defined in the terms of the PPG contract at the discretion of L.A. Care.

Elective inpatient admissions – for PPGs that do not obtain prior authorization for the admission by LA. Care, the hospital facility charges are subject to capitation adjustment as defined by the terms of the PPG contract at the discretion of L.A. Care.

While a member is hospitalized, the PPG/PCP must:

- Coordinate, with the assistance of UM staff, care for members admitted to out of network facilities for emergency care or other reasons. After determination of the appropriateness of an emergency admission and a transfer assessment is made, the member will either be transferred to a network facility or care will be continuously monitored at the initial facility of admission until discharge or a transfer is appropriate.
• Respond to the concurrent review process, including level of care, length of stay, and medical necessary elements when he/she acts as the attending physician or works in conjunction with the attending physician for a hospital stay.

• Assist with the discharge planning by ordering and requesting authorization for appropriate elements of discharge.

**Emergency Notification of Admission**
All elective and emergency inpatient admissions must be brought to the attention of L.A. Care’s UM department **within 24 hours of the admission**. These notifications may occur by calling in or faxing the patient’s admission face sheet to the following:

L.A. Care Utilization Management Department
1-877-431-2273
Fax: 213-438-5777

**Emergent inpatient admissions** – for PPGs that are managing an inpatient admission and do not coordinate within 1 business day of the admission, the hospital facility charges may be subject to capitation adjustment as defined in the terms of the PPG contract.

**Transfers from Non-Participating Providers**
In cases where a Member requires Emergency Services at a Hospital or facility other than a Plan contracted Hospital, Physician Group and Group Providers shall make best efforts to transfer such Members to a Plan-designated Hospital as soon as medically appropriate (i.e., following stabilization of the Member). Group Providers shall coordinate and accept transfer of care from Non-Participating Providers when and as medically appropriate, whether the Member’s Emergency or post-Emergency Services has been rendered Out-of-Area or In-Area. Physician Group shall consult with the Plan regarding arrangements for Member transfers. If a Member is Out-of-Area and, in the opinion of Physician Group’s designated Physician and/or Plan’s Medical Director, said Member requires continued Physician Services upon transfer, and Physician Group’s designated Physician and other Group Physicians do not accept transfer of the Member for such Covered Services, Physician Group shall bear the costs of Physician Services rendered from the date Member is deemed transferable. In the event disputes arise between Physician Group and Plan relating to the Plan Medical Director’s decision regarding a Member’s transferability, Physician Group may appeal such decision to Plan’s UMC.

**Inpatient Concurrent Review**
Inpatient concurrent review is usually a coordinated effort between L.A. Care and the PPG. Once notified, L.A. Care’s UM staff will perform telephone reviews with the hospital staff:

- Inpatient concurrent review will begin within one (1) day of notification of the admission and include an assessment of the appropriateness of the level of acute care by using accepted criteria.
- Concurrent review will be conducted on or before the dates assigned at the end of the initial review and each subsequent review. Concurrent review includes an evaluation of the following:
  - Appropriateness of acute admission
  - Plan of treatment
  - Level of care
  - Intensity of services/treatment
  - Severity of illness
  - Quality of care
  - Discharge planning

- These reviews will be conducted utilizing accepted guidelines for acute levels of care, such as intensity of service and severity of illness criteria, Milliman Care Guidelines, or other guidelines and criteria developed and/or approved by L.A. Care.

- Concurrent quality issues noted during utilization review will be documented and reported to the PPG, L.A. Care’s UM Medical Director and Quality Improvement department. When appropriate, quality issues will be discussed with the attending physician by the UM medical staff for appropriate intervention. Depending on the urgency or gravity of the situation, discussion of the issues may also be necessary with Senior Executive Administration.

- Utilization review concurrent focus will be proactive, and UM/Case Management levels of focus will be employed as appropriate.

**Discharge Planning**

- L.A. Care’s UM staff will begin discharge planning within 24 hours of notification of admission and facilitate the involvement of a multidisciplinary team of physicians, nursing, social work, and others, as appropriate.
• Patient and family intervention will occur, as appropriate, throughout the stay to assure discharge plans are in place and appropriate for each member. Discharge plans will consider the disease process, treatment requirements, the family situation, and available benefits and community resources.

• Average length-of-stay guidelines will be used for discharge planning purposes. Discharge screens, lower level of care guidelines, or clinical decision made by the physician are to be used for the final discharge date plan.

• Questionable continued stay plans are to be discussed with the attending physician and then reviewed by L.A. Care’s physician reviewer for further discussion with the attending physician.

Notification of Hospital Discharge Rights to Members

L.A. Care’s Medicare Advantage members receive the “Important Message (IM) from Medicare” from affiliated hospitals upon admission. The message explains the member’s rights including the right to appeal to the Quality Improvement Organization (QIO) if they believe they should not be discharged. Medicare enrollees who are hospital inpatients have a statutory right to appeal to the Quality Improvement Organization – which is the Health Services Advisory Group, Inc. (HSAG) in California for an immediate review when a hospital and a Medicare health plan, with physician concurrence, determine that inpatient care is no longer necessary.

• **Hospitals must issue** the IM within 2 calendar days of admission and must obtain the signature of the enrollee or his or her representative and provide a copy at that time.

• The message is a statutorily required notice that explains the enrollee’s rights as a hospital patient, including discharge appeal rights.

• Hospitals will also deliver a copy of the signed notice as far in advance of discharge as possible, but **not less than 2 calendar days** before discharge.

• Enrollees who are being transferred from one inpatient hospital setting to another inpatient hospital setting do not need to be provided with the follow up copy of the notice prior to leaving the original hospital, since this
is considered to be the same level of care. Enrollees always have the right
to refuse care and may contact Health services Advisory Group [HSAG]
(The Quality Improvement Organization {QIO} appointed by CMS for
California) if they have a quality of care issue. The receiving hospital must
deliver the Important Message from Medicare again according to the
procedures in this rule.

A “follow up” copy of the signed IM must be delivered to the enrollee prior to
discharge using the following guidelines:

- **Delivery Timeframe:** Hospitals must deliver the follow up copy as far
  in advance of discharge as possible, but **not less** than 2 calendar days
  before the planned date of discharge. Thus, when discharge seems
  likely within 1- 2 calendar days, hospitals should make arrangements
to deliver the follow up copy of the notice, so that the enrollee has a
meaningful opportunity to act on it. However, when discharge cannot
be predicted in advance, the follow up copy may be delivered as late
as the day of discharge, if necessary. If the follow-up copy of the notice
must be delivered on the day of discharge, hospitals must give
enrollees who need it at least 4 hours to consider their right to request
a QIO review.

- L.A. Care’s Medicare Advantage members have a right to request an
  immediate review by the QIO when L.A. Care and the hospital (acting
directly or through its utilization review committee), with physician
concurrence, determine that inpatient care is no longer necessary.

- **Members Submitting a Request:** An L.A. Care Medicare Advantage
  member who chooses to exercise the right to an immediate review
must submit a request to QIO (HSAG in California) as indicated on the
IM notice. In order to be considered timely, **the request must be
made no later than midnight of the day of discharge**, may be in
writing or by telephone, and must be requested before the enrollee
leaves the hospital. The member, upon request by HSAG, should be
available to discuss the case. The member may, but is not required to,
submit written evidence to be considered by HSAG.

- **Timely Requests:** When the member makes a timely request for a
QIO review – that is, requests a review no later than midnight of the
day of discharge – the member is not financially responsible for
inpatient hospital services (except applicable coinsurance and
deductibles) furnished before noon of the calendar day after the date
the member receives notification of the determination from HSAG.
Liability for further inpatient hospital services depends on HSAG decision as follows:

**Unfavorable determination:** If QIO notifies the member that they did not agree with the member, liability for continued services begins at noon of the day after QIO notifies the enrollee that HSAG agreed with the hospital’s discharge determination, or as otherwise determined by HSAG.

**Fully and/or Partially Favorable determination:** If QIO notifies the enrollee that they agreed with the member, the member is not financially responsible for continued care (other than applicable coinsurance and deductibles) until L.A. Care and hospital once again determine that the member no longer requires inpatient care, secure the concurrence of the physician responsible for the enrollee’s care, and the hospital notifies the member with a follow up copy of the IM.

**L.A. Care or its Delegates to Provide the Detailed Notice of Discharge:** When QIO notifies L.A. Care that a member has requested an immediate review, the plan must, directly or by delegation, deliver a [Detailed Notice of Discharge](#) to the member with a copy to HSAG at the same time but not later than noon of the day after HSAG’s notification. L.A. Care is responsible for ensuring proper execution and delivery of the Detailed Notice, regardless of whether it has delegated that responsibility to its providers. If a member requests more detailed information prior to requesting a review, plans may, directly or by delegation, deliver the detailed notice in advance of the member requesting a review.

**Use of Standardized Notice:** L.A. Care uses the standardized form {CMS-10066). This notice is also available on the [Link for Hospital Discharge Appeal Notices](#). Plans may not deviate from the content of the form except where indicated. The OMB control number must be displayed on the notice. The Detailed Notice must be the standardized notice provided by CMS and contain the following:

- A detailed explanation of why services are either no longer reasonable and necessary or are otherwise no longer covered.
- A description of any applicable Medicare coverage rule, instruction, or other Medicare policy, including information about how the enrollee may obtain a copy of the Medicare policy.
- Any applicable Medicare health plan policy, contract provision, or rationale on which the discharge determination was based.
- Facts specific to the enrollee and relevant to the coverage determination sufficient to advise the enrollee of the applicability of the coverage rule or policy to the enrollee’s case.
● Any other information required by CMS.

Providing Information to QIO: Upon notification by QIO of the member’s request for an immediate review, L.A. Care and hospital must supply all information that QIO needs to make its determination, including copies of both the IM and the Detailed Notices, as soon as possible, but no later than noon of the day after QIO notifies the L.A. Care and/or hospital of the request. In response to a request from L.A. Care, the hospital must supply all information that QIO needs to make its determination, including copies of both the IM and the Detailed Notices (if applicable) as soon as possible, but no later than close of business of the day the plan notifies the hospital of the request for information. At the discretion of QIO, L.A. Care and the hospital may make the information available by telephone or in writing. A written record of any information not transmitted in writing should be sent as soon as possible.

Coverage during QIO’s expedited review: L.A. Care is financially responsible for coverage of services during QIO’s review as provided for in these rules, regardless of whether it has delegated responsibility for authorizing coverage or discharge determinations to its providers.

Reconsiderations
An enrollee who is dissatisfied with QIO’s determination can request a reconsideration from QIO in accordance with CMS regulation 42 § 422.626(f).

● Submitting a Request: If QIO upholds L.A. Care’s discharge decision in whole or in part, the enrollee may request, no later than 60 days after notification, that QIO has upheld the decision that QIO reconsider its original decision.

● Note: If the enrollee is no longer an inpatient in the hospital and is dissatisfied with QIO’s determination, the enrollee may appeal directly to an Administrative Law Judge (ALJ), the Medicare Advisory Council (MAC), or a federal court.

5.18 Medicare Advantage Special Needs Plan – Standard Reconsideration of Organization Determination (Appeals)
Any party who is dissatisfied with an L.A. Care or PPG organizational determination (adverse, fully favorable or partially favorable) or with one that has been reopened and revised may request reconsideration of the determination in accordance with the procedures as outlined in CMS regulations 42CFR422.582, concerning a request for reconsideration, or
42CFR422.584, concerning certain expedited reconsiderations. Members have the right to appeal decisions regarding their health care if they do not agree with:

- Payment for emergency services, post-stabilization care, or urgently needed services
- Renal dialysis services out-of-area
- Payment for any other health services furnished by a Non-Contracting Physician Group or facility the enrollee believes are covered under Medicare, or should have been arranged for, furnished, or reimbursed by L.A. Care
- Services not received, but which the enrollee feels L.A. Care is responsible to pay for or arrange
- Discontinuation of services that the enrollee believes are still medically necessary covered services

Medicare Advantage members will file reconsiderations of organization determinations with L.A. Care’s Grievance and Appeals Unit. All reconsiderations must be filed within 60 calendar days of notification of the organization determination decision. If the request for reconsideration is filed beyond the sixty calendar (60) days from the date of the notice of the organization determination, a party to the organization re-determination request may file a request for good cause extension with L.A. Care.

L.A. Care Health Plan designates someone other than the person involved in making the initial organization determination when reviewing a reconsideration. If the original denial was based on a lack of medical necessity, then the reconsideration is performed by a physician with expertise in the field of medicine that is appropriate for the services at issue. In cases involving emergency services, L.A. Care Health Plan applies the prudent layperson standard when making the reconsideration determination.

**Request for Payment reconsiderations:** L.A. Care will resolve all reconsiderations regarding payment for services already received within 60 calendar days from the date of the request for reconsideration.

**Request for Service Reconsiderations:** L.A. Care will resolve all standard reconsiderations regarding medical care within 30 calendar days. However, if information is missing or it is in the best interest of the member, L.A. Care may extend the timeframe by an additional 14 calendar days.
Favorable and/or Partially Favorable decision for member, payment request: If L.A. Care decides in favor of the member with respect to a payment reconsideration, LA. Care must pay within 60 calendar days of receiving the appeal.

Unfavorable decision for member, payment request: If L.A. Care upholds an adverse payment determination, it will automatically forward the case to the independent review entity (Maximus) within 60 calendar days for cases involving payment decisions.

Favorable and/or Partially Favorable decision for member, service request: If L.A. Care decides in favor of the member with respect to a standard reconsideration of medical care or service, LA. Care must authorize or provide services within 30 calendar days of receiving the appeal.

Unfavorable decision for member service request: If L.A. Care upholds an adverse determination, L.A. Care will automatically forward the case to the independent review entity (Maximus) within 30 calendar days for cases involving medical care.

Reversal of L.A. Care’s Decision by IRE (Maximus): If, on reconsideration of a request for service, L.A. Care’s determination is reversed in whole or in part by the independent review entity contracted by CMS, L.A. Care will authorize the service under dispute within 72 hours from the date it receives notice reversing the determination, or provide the service under dispute as expeditiously as the enrollee’s health condition requires, but no later than fourteen (14) calendar days from that date. L.A. Care’s Medical Management Department will inform the independent review entity contracted by CMS that the organization has effectuated the decision.

- If decision is upheld by the IRE, then the enrollee may appeal directly to an Administrative Law Judge (ALJ), the Medicare Advisory Council (MAC), or a federal court.

Medicare Advantage SNP – Expedited Reconsideration of an Organization Determination:

L.A. Care will resolve all expedited reconsiderations within 72 hours, or sooner based upon the health condition of the member. LA. Care may extend the timeframe for an additional 14 days if information is missing or if it is in the best interest of the member. If L.A. Care decides in favor of the member, L.A. Care must authorize or provide care within 72 hours of receiving the expedited appeal. If L.A. Care upholds an adverse
determination, L.A. Care will automatically forward the case to the independent review entity within 24 hours for review.

**Expedited Grievance:**

A member may file an expedited grievance under the following circumstances:

- L.A. Care health plan or the delegated PPG extends the time frame to make an organization determination or reconsideration; or
- A Medicare health plan refuses to grant a request for an expedited organization determination or reconsideration;

L.A. Care or the delegated PPG must respond within 24 hours to an enrollee’s expedited grievance. L.A. Care or the delegated PPG communicates with the member about the right to file an expedited grievance using a CMS model notice.

### 5.19 Special Considerations Regarding Termination of Skilled Nursing Facility (SNF), Home Health Agency (HHA) and Comprehensive Outpatient Rehabilitation Facility (CORF) Services

Regarding Medicare Members, a termination of service is the discharge of a Member from Covered Services, or discontinuation of Covered Services, when the Member has been authorized by L.A. Care to receive an ongoing course of treatment from that Provider. For purposes of this Section, “Member” shall also encompass “or Member’s representative,” as applicable.

a) The “Notice of Medicare Non-Coverage” (NOMNC) will be issued by L.A. Care or it Delegates when:

1) A Member is being discharged from a Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) services;

2) The Plan has made a determination that Covered Services are no longer covered or necessary. With respect to the exhaustion of Medicare Benefits (100 days for SNF), per CMS directive, the Notice of Denial of Medical Coverage (NDMC) should be used to convey this information, rather than the NOMNC. The QIO does not normally conduct Appeal reviews related to the exhaustion of Benefits, therefore, these Appeals will be handled by the Plan; or
3) A determination that such Covered Services are no longer Medically Necessary.

b) **Delivery of Notice:** In accordance with Medicare Valid Delivery requirements, the Plan, in collaboration with the Provider, issues the NOMNC that notifies the Member of the termination of Covered Services or discharge, no later than **two calendar days or at the next to last visit**, if the span of time between service visits exceeds two days, before the proposed end of Covered Services. If the Member disagrees with the termination of services/discharge,

1) the Member must contact the QIO, verbally or in writing, no later than noon of the day before the Covered Services are to end. At the same time the Provider entity or delegated PPG will notify L.A. Care of the NOMNC issued to the Member. L.A. Care will track issuance and follow-up all NOMNC’s from delegated PPGs or Provider entities.

2) If the Member disagrees with the NOMNC and requests an Appeal, L.A. Care will prepare the Detailed Explanation of Non-Coverage (DENC) for the Provider to issue to the Member. If the Member requests an Appeal with the QIO, L.A. Care will process as follows:

   a. Plan must obtain the Member’s medical records from the Provider and send a copy of the DENC, along with the Member’s medical records, to the QIO by close of business on the day of the QIO submitted to Plan appeal notification. The Plan may request that the records be sent directly to the QIO.

   b. The QIO must make a decision and notify the Member and the Plan by close of business the following day. On the next business day, the Plan will notify the delegated PPG of the fast-track Appeal request and the QIO’s determination. If the QIO overturns the decision then the PPG or L.A. Care shall continue authorization to the Group Provider. The delegated PPG must provide the Plan with proof of continued authorization and prepare and issue a new NOMNC notice when new discharge orders are written. If the Member fails to file a timely Appeal with the QIO, the Member may request an expedited Appeal from the Plan based on CMS regulation [42 CFR 422.624; 42 CFR 422.626]

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**5.20 Second Opinion Process**
The second opinion program provides members and providers with the ability to validate the need for specific procedures. The use of screening criteria will be employed in addition to securing a second physician consult, when necessary. Second opinions will be rendered by an appropriately qualified health care professional identified as a primary care physician or a specialist who is acting within his or her scope of practice, and who possesses clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Second opinion request will be processed in accordance with the state regulatory requirements at no cost to the member.

5.21 STANDING REFERRALS

A standing referral is a referral made by the PCP for more than one (1) visit to a specialist or specialty care center as indicated in an approved treatment plan for a particular diagnosis. A member may request a standing referral to a specialist through his/her PCP or through a participating specialist.

L.A. Care Health Plan maintains a referral management process and also delegates the referral management process to delegated entities.

Delegated entities shall maintain policies and procedures for the referral management that include review of standing referrals for members who require specialty care or treatment for a medical condition or disease that is life threatening, degenerative, or disabling.

Authorization and Referral Processes

- Authorization determinations for specialty referral/services shall be processed in accordance with L.A. Care's and/or its delegated entities policies and procedures for referral management and within required time frames for standing referrals as described in this procedure.
- Services shall be authorized as medically necessary for proposed treatment identified as part of the member's care treatment plan utilizing established criteria and consistent with benefit coverage.
- Once a determination is made, the referral shall be made to the Specialist within four (4) business days of the date the proposed treatment plan, if any, is submitted to the physician reviewer.
- The duration of a standing referral authorization shall not exceed one year at a time, but may be renewed for periods up to one year if medically appropriate.
Credentialing Requirements

The specialist provider/special care center shall be recredentialed by and contracted with L.A. Care or its delegated entities' network to provide the needed services or:
- If standing referrals are made to providers who are not contracted with L.A. Care or its delegated entities' network, L.A. Care and/or its delegated entities shall make arrangements with that provider for credentialing prior to service, appropriate care coordination, and timely and appropriate reimbursement.
- In approving a standing referral in-network or out-of-network, L.A. Care and PPGs delegated for UM will take into account the ability of the member to travel to the provider.
- Delegated entities can request assistance from L.A. Care for locating a specialist (See Specialty Care Liaison Program Procedure).

HIV/AIDS Referrals

When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, L.A. Care and/or its delegated entities shall refer the member to an HIV/AIDS specialist.
- When authorizing a standing referral to a specialist for purposes of having that specialist coordinate the member’s health care who is infected with HIV, L.A. Care and/or its delegated entities shall refer the member to an HIV/AIDS specialist. The HIV/AIDS specialist may utilize the services of a nurse practitioner or physician if:
  - the nurse practitioner or physician assistant is under the supervision of an HIV/AIDS specialist; and
  - the nurse practitioner or physician meets the qualifications specified in the state regulations; and
  - the nurse practitioner or physician assistant and that provider’s supervising HIV/AIDS specialist have the capacity to see an additional patient

Care Coordination:

The PCP shall retain responsibility for basic case management/coordination of care unless a specific arrangement is made to transfer care to the specialist for a specified period of time, in accordance with the delegated entities contract with L.A. Care.

Requests for standing referrals will be processed in accordance with the state regulatory requirements.
5.22 INITIAL and PERIODIC HEALTH ASSESSMENTS (IHA)

Delegated providers shall have processes in place to ensure the provision of an IHA (complete history and physical examination) to each new Medicare – Medicare Advantage (for members new to Medicare) within the first six months of the effective date of enrollment with Medicare. This is a one-time preventive physician exam. The one-time exam includes a thorough review of:

- Health issues
- Health education
- Preventive services

L.A. Care Health Plan shall provide lists of new member Enrollees to the delegated PPGs/PCPs on a monthly basis. L.A. Care and its Delegated providers shall make reasonable attempts to contact a member and schedule an IHA. All attempts shall be documented.

- Documented attempts that demonstrate unsuccessful efforts to contact a member and schedule an IHA shall be considered evidence in meeting this requirement.
- For follow-up on missed and broken appointment documentation requirements see Section: Coordination of Medically Necessary Services

L.A. Care and its delegated PPGs are responsible for maintaining and disseminating to its Provider Network, protocols and High Risk Categories by age groupings based on the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) and Center for Medicare and Medicaid Services (CMS) for use in determining the provision of clinical preventive services.

Delegated providers shall ensure that the performance of the initial complete history and physician exam for adults includes, but is not limited to:

- blood pressure,
- height and weight,
- total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
- clinical breast examination for women over 40;
- screening mammogram for women age 40 and over, baseline mammograms for women between ages 35-39
- Pap smear (or arrangements made for performance) on all women determined to be sexually active or be at high risk for vaginal or cervical cancer,
- Chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for Chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
- A series of 3 Human Papillomavirus (HPV) shots for all adolescent girls, preferably at age 11-12 years, to prevent cervical cancer and genital warts. The vaccine is also recommended for girls and women 13-26 years of age who did not receive it when they were younger.
- Screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,
- Colon cancer screening for members over 50 years of age (fecal occult blood test, flexible sigmoidoscopy, screening colonoscopy or barium enema); there is no minimal age for a screening colonoscopy
- Prostate Cancer Screening for men over 50 years
- Bone Mass Measurements for members at risk for osteoporosis
- Diabetes screening
- Glaucoma screening for members at high risk for glaucoma

Medicare Advantage-SNP members are eligible to receive via direct access (self-referral) flu and pneumococcal vaccinations at no cost to the member. Female Medicare Advantage-SNP members also have the option of obtaining direct access to a women’s health specialist for women’s routine and preventive health services.

The IHA must include documentation that members are informed of specific health care needs that require follow-up and receive, as appropriate, training in self care and other measures that they may take to promote their own health

High risk individuals are defined as individuals whose family history and/or life-style indicates a high tendency towards disease, or who belong to a group (socioeconomic, cultural, or otherwise) which exhibits a higher tendency toward a disease.

Each provider, supplier and practitioner furnishing services to members shall maintain an enrollee health record in accordance with standards established by Medicare and L.A Care policy taking into account professional standards. These standards should ensure the appropriate and confidential exchange of information among provider network components.
**Adult Preventive Services**
Delegated Providers shall cover and ensure the delivery of all preventive services and medically necessary diagnostic and treatment services for adult members.

Delegated Providers shall ensure that the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, health adult Members {age twenty-one (21) and older}.

As a result of the IHA or other examination, discovery of the presence of risk factors or disease conditions will determine the need for further follow-up, diagnostic, and/or treatment services.

In the absence of the need for immediate follow-up, the core preventive services identified in the requirements for the IHA for adults described above shall be provided in the frequency required by the USPSTF Guide to Clinical Preventive Services.

Delegated Providers shall cover and ensure the provision of all medically necessary diagnostic, treatment, and follow-up services which are necessary given the finding or risk factors identified in the IHA or during visits for routine, urgent, or emergent health care situations. Delegated Providers shall ensure that these services are initiated as soon as possible but no later than 60 days following discovery of a problem requiring follow up.

**Immunizations for Adults**
Delegated Providers are responsible for ensuring all adults are fully immunized and shall cover and ensure the timely provision of vaccines in accordance with the most current California Adult Immunization recommendations.

In addition, Delegated providers shall cover and ensure the provision of age and risk appropriate immunizations in accordance with the finding of the IHA, other preventive screenings and/or the presence of risk factors identified in the health education behavioral assessment.

**5.23 COMPREHENSIVE HEALTH RISK ASSESSMENT**
Medicare Advantage-SNP: Comprehensive Health Risk Assessments
Within ninety days (90) of enrollment, L.A. Care will make a good faith effort to conduct perform a telephonic comprehensive health risk assessment for newly enrolled members. The assessment provides an early identification of health care services needs to provide coordination of plan services that integrate services through arrangements with community and social services programs generally available through contracting or non-contracted providers, including nursing home and community-based services.

This information will be shared with the assigned PPG and PCP for the purpose of providing continuity of care and services.

L.A. Care conducts a comprehensive initial health risk assessment (HRA) by telephone or by a written survey with new members as soon as possible (and no later than 90 days) after confirmation of enrollment to welcome the member. **NOTE: This is not inclusive of the initial health assessments (IHA) performed by the PCP.** L.A. Care does not delegate the performance of comprehensive health risk assessment to the contracted PPGs.

The purpose is to identify any potential medical needs, and assist with transition and coordination of care. Typical medical needs identified may include but are not limited to the following:

- Risk of future hospitalization
- Chronic, complex, or serious conditions that may require Case Management intervention,
- Durable medical equipment in the home (or needed in the home),
- Confined to a skilled nursing facility (SNF), or
- Any condition or education needs that may require intervention of the multidisciplinary team.

In addition the self-reported assessment includes:

- Living situation
- Social needs
- Special health care needs/chronic conditions
- Previous health services utilization
- Medication profile

Based on findings from the assessment, a health risk assessment profile report is developed. This includes the following categories:
HIGH RISK: These members have been determined to have greater than a 50% chance of being hospitalized within the next 12 months.

MODERATE RISK: These members are deemed to be “Moderate Risk” patients due to a high frailty score, inpatient stay, diabetes, treatment for health problems, taking medication for a heart problem, or having no one to care for them for a few days within the past 12 months.

LOW RISK: These members have low risk factor(s) based on answers to the assessment questionnaire.

A Care Manager will review the HRA database on a daily basis. Members may be contacted by a care manager to review the responses to identify any specific health care needs that require follow-up and receive, as appropriate, training in self-care; identify other measures they may need to promote their health status and identify systems to address barriers to compliance with prescribed treatments or regimes. A member specific HRA summary is sent to the: Primary Care Provider (PCP), Participating Physician Group (PPG) and the contracted complex care management vendor.

Primary Care Physicians (PCPs) are expected to contact the assigned member to schedule an appointment as follows:

- High Risk within 7 days
- Medium Risk within 30 days
- Low Risk within 45 days; for new members no later than 120 calendar days from enrollment

PPGs are expected to coordinate requested services from the PCP or specialist.

Based upon the HRA score, members are assigned to L.A. Care’s appropriate care management program.

5.24 COORDINATION OF MEDICALLY NECESSARY SERVICES

The PCP is responsible for providing members with routine medical care and serve as the medical case manager within each managed care system. Referrals are made when services are medically necessary, outside the PCP’s scope of practice, or when members are unresponsive to treatments, develop complications, or specialty services are needed.
The PCP is responsible for making referrals and coordinating all medically necessary services required by the member. Pertinent summaries of the member’s record should be transferred to the specialist by the PCP. Authorization flow charts are provided at the end of this section.

**Outpatient Referral**

If the PCP determines that a member requires specialty services or examinations outside of the standard primary care, the provider must request for these services to be performed by appropriate contracted providers. The provider must ensure the following steps in coordinating such referrals:

1. Submit a referral request to the PPG or the designated hospital physician to obtain authorization for those services.

2. The PPG will process the request, or contact the L.A. Care UM department to obtain authorization for the facility component of services needed, as appropriate.

3. After obtaining the authorization(s), PCP will refer the member to the appropriate specialist or facility. The PCP, office staff, or member may arrange the referral appointment.

   - Note the referral in the member’s medical record and attach any authorization paperwork.

   - Discuss the case with the member and the referral provider.

   - Receive reports and feedback from the referral provider regarding the consultation and treatment. (A written report must be sent to the PCP by the referral provider, or facility the member was referred to.)

   - Discuss the results of the referral and any plan for further treatment, if needed, and care coordination with the member.

Specialty referrals that require prior authorization must be tracked by the PCP’s office and authorizing PPG for follow-up through a tickler file, log or computerized tracking system. The log or tracking mechanism should note, at a minimum, the following for each referral:

   - Member name and identification number
   - Diagnosis
   - Date of authorization request
   - Date of authorization
   - Date of appointment
Missed or Broken Appointments

Appointments may be missed due to member cancellation or no show. Providers are required to attempt to contact the member a minimum of three times when an appointment is missed or broken. Attempts to contact must include:

- **First Attempt** – phone call to member (or written letter if no telephone). If member does not respond, then;
- **Second Attempt** – phone call to member (or written letter if no telephone). If member does not respond then;
- **Third Attempt** – written letter

Pregnant member with two or more missed/broken appointments must be referred to the L.A. Care UM Care Manager for follow-up after the broken appointment procedure is completed without response from the members.

Documentation must be noted in the member’s medical record regarding any missed or broken appointments, reschedule dates, and attempts to contact.

Missed and Broken Procedure or Laboratory Test

Appointments for procedures or tests may be missed or broken. The provider must contact the member by phone or letter to reschedule. Documentation must be noted in the medical record regarding any missed or broken procedure or tests, reschedule dates, and any attempts to contact the member.

Receipt of Specialist’s Report

The PCP must ensure timely receipt of the specialist’s report (e.g., use of tickler file). Specialists are required to submit a written report to the referring physician. This written report must include the specialist’s findings, recommended treatment, results of any studies, test and procedures and recommendations for continued care.

Reports for specialty consultations or procedures should be in the member’s chart within a given timeframe, usually two (2) weeks. For urgent and emergent cases, the specialist should initiate a telephone report to the PCP as soon as possible, and a written report should be received within two (2) weeks.
If the PCP has not received the specialist’s report within the determined timeframe, the PCP should contact the specialist to obtain the report.

Unusual Specialty Services
L.A. Care and its delegated PPGs/PCP must arrange for the provision of seldom used or unusual specialty services from specialists outside the network if unavailable within network, when determined Medically Necessary.

Services Received in an Alternative Care Setting
The PCP should receive a report with findings, recommended treatment and results of the treatment for services performed outside of the PCPs office. The provider must also receive emergency department reports and hospital discharge summaries and other information documenting services provided.

Home health care agencies submit treatment plans to the PCP after an authorized evaluation visit and every 30 days afterward for review of continued home care and authorization.

The PCP should also receive reports regarding diagnostic or imaging services with abnormal findings or evaluations and subsequent action.

5.25 CARE TRANSITIONS

L.A.’s Care Medical Management Department and its delegate is responsible for management of the process for care transitions and makes a special effort to coordinate care when members move from one care setting to another, such as when they are discharged from a hospital.

Transitions are the movement of a member from one care setting to another as the member’s health status changes; for example, moving from home to a hospital as the result of exacerbation of a chronic condition or moving from a hospital to a rehab facility after surgery.

Managing Transitions: L.A. Care’s Care Managers facilitate safe transitions by either conducting or assigning providers the following tasks and monitoring system performance:

- For planned transitions from members’ usual setting of care to the hospital and transitions from the hospital to the next setting, identifying that a planned transition is going to happen
For planned and unplanned transitions from members’ usual setting of care to the hospital and transitions from the hospital to the next setting, sharing the sending setting’s care plan with the receiving setting within one business day of notification of the transition.

For planned and unplanned transitions from any setting to any other setting, communicating with the member or responsible party about the care transition process.

For planned and unplanned transitions from any setting to any other setting, communicating with the member or responsible party about changes to the member’s health status and plan of care.

For planned and unplanned transitions from any setting to any other setting, providing each member who experiences a transition with a consistent person or unit within L.A. Care’s Medical Management department who is responsible for supporting the member through transitions between any points in the system.

For planned and unplanned transitions from any setting to any other setting, notifying the patient’s usual practitioner of the transition.

For all transitions, L.A. Care Medical Management Department shall conduct an analysis of L.A. Care’s aggregate performance on the above aspects of managing transitions at least annually.

Coordinating Services for members at high risk for transition:

L.A. Care handles coordination of care through either the Case Management or UM staff. L.A. Care works with members (or their responsible parties) and with their primary care physician or providers to stabilize the member’s conditions and to manage care in the least restrictive setting. Examples of coordinating care include:

- Contacting at risk member or responsible party, determining whether home health care would prevent a hospital admission and ordering the service as necessary.
- Contacting the member’s treating physician to alert him/her about the potential for adverse drug events based on pharmacy claims review.
- Intervening to help member receive the necessary monitoring for blood-thinning medications as an example.

Educating members or responsible parties about transitions and how to prevent unplanned transitions:
As part of the identifying and coordinating care to prevent potential problems, L.A. Care’s UM/Case Management staff educates at risk members or responsible parties about how to maintain health and remain in the least restrictive setting. L.A. Care contacts all SNP members at least annually regardless of whether or not they are at risk, with information about potential problems and how to avoid them.

5.26 CERVICAL CANCER SCREENING

L.A. Care and/or its delegated providers shall have procedures to provide for Cervical Cancer Screening, a covered preventive health benefit for L.A. Care Health Plan members.

The coverage for an annual Cervical Cancer Screening test shall include the conventional Pap test, a human papillomavirus (HPV) screening test that is approved by the Federal Food and Drug Administration, and the option of any Cervical Cancer Screening test approved by the federal Food and Drug Administration, upon the referral of the member’s health care provider (PCP or treating physician, a nurse, practitioner, or certified nurse midwife, providing care to the member and operating within the scope of practice otherwise permitted for the licensee).

L.A. Care and/or its delegated entities shall ensure that routine referral processes are followed when the member, in addition to the conventional Pap test, requests a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration, and the option of any Cervical Cancer Screening test approved by the federal Food and Drug Administration.

5.27 CARE MANAGEMENT

*L.A. Care does not delegate complex case management to the PPGs.*

Case Management means a collaborative process of managing the provision of health care to enrollees with selected conditions, (e.g., chronic, catastrophic, high cost cases, etc.). The goal is to coordinate the care to promote both quality and continuity of care.

Case management is divided into three components:

- Basic medical case management,
- Complex Care Management
- Targeted Case Management

In day-to-day operations, these three components work closely together to provide members with continuous, coordinated, quality healthcare. L.A.
Care Health Plan recognizes the importance of continuous and coordinated health care as a key element to achieving high quality, cost effective care.

**Basic Medical Case Management Services** means services provided by a Primary Care Provider to ensure the coordination of Medically Necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules and the continuity of care for L.A. Care enrollees. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.

The Primary Care Physician (PCP) has the principal role as the basic Medical Case Manager for his/her assigned members. The PCP conducts the Initial Health Assessment, provides all basic medical care/case management to assigned members, and coordinates referrals to specialists, ancillary services and linked services as needed.

L.A. Care Health Plan also recognizes that some members have complex needs that require more than usual coordination of services and therefore provides the targeted or complex nursing case management in assistance to the PCP’s basic care/case management. Members with more complex needs are actively enrolled into the care management program.

L.A. Care’s Care Management Program includes four levels:
- Basic Care Management
- Complex Care Management
- Targeted Care Management
- Care Coordination

**Basic Care Management**
The Primary Care Physician (PCP) is responsible for Basic Care Management for his/her assigned members. The PCP is responsible for ensuring that members receive an initial screening and health assessment, which initiates Basic Medical Care Management.

The PCP conducts the initial health assessment upon enrollment, and through periodic assessments provides age-appropriate periodic preventive health care according to established preventive care guidelines. The PCP also makes referrals to specialists, ancillary services, and linked and carved out services, as needed, based on the member’s individual treatment plan.

For members with more complex Care Management needs, L.A. Care provides complex care management services to assist the PCP. When the PCP has
assistance from a Care Manager for Complex and/or Targeted Care Management, the PCP continues to play the central role in the management of the member’s care.

Complex Care Management

Complex Care Management is provided for members with extensive utilization of medical services or those having chronic or immediate medical needs requiring more management than is normally provided through the Basic Care Management. Complex Care Management is a collaborative process between the Primary Care Provider and a RN Care Manager who provides assistance in planning, coordinating, and monitoring options and services to meet the Member’s health care needs.

The program incorporates the dynamic processes of individualized screening, assessment, problem identification, care planning, intervention, monitoring and evaluation. The Care Management Program uses an interdisciplinary collaborative team approach comprised of patient care management and education through experienced licensed professionals in collaboration with the Primary Care Physician and community and state specific resources. The team consists of Medical Directors, Registered Nurse Care Managers, Nurse Practitioners, Clinical Pharmacists, social workers and non-clinical support staff Coordinators.

The team works closely with contracted practitioners and agencies in the identification, assessment and implementation of appropriate health care management interventions for eligible children and adults with special health care needs, including the provision of care coordination for specialty and state waiver programs.

L.A. Care’s Care Management team is responsible for working collaboratively with all members of the health care team including the PCP, hospital discharge planners, specialty practitioners, ancillary practitioners, community and state resource staff. The Care Managers, in concert with the health care team, focus on coordinating care and services for members whose needs include preventive services, ongoing medical care, rehabilitation services, home health and hospice care, and/or require extensive coordination of services related to linked and carved out services or the coordination and/or transfer of care when “carved-out” services are denied.

Care Managers assist in assessing, coordinating, monitoring, and evaluating the options and services available to meet the individual needs of these members across the continuum. The essential functions of the Care Manager include:

- Assessment
- Care Planning
- Interventions
- Coordination and Implementation
• Monitoring/Evaluation
• Facilitation
• Advocacy

Through interaction with members, significant others and health care providers, the care manager collects and analyzes data about the actual and potential care needs for the purpose of developing individualized care plans.

Targeted Care Management
Targeted Care Management (TCM) assists Members within specific target groups to gain access to needed medical, social, educational and other services. In prescribed circumstances, Targeted Care Management is available as a carve-out Medi-Cal benefit through the State of California, Los Angeles County Public Health Department and their contractors as specified in Title 22, Section 51351. The Care Managers are responsible for identifying members that may be eligible for TCM services and must refer members, as appropriate, for the provision of TCM services. TCM services are integrated into the overall care plan, as a barometer for measuring disease progression and cost of care. State and county TCM services may include, but is not limited to, Pediatric and adult partial hospitalization programs (i.e. adult day health care centers, pediatric day care centers, MSSP, AIDS Waiver Programs, community based in-home operation services)

L.A. Care is responsible for co-management of the member’s health care needs with the TCM providers, providing preventive health services and for determining the medical necessity of diagnostic and treatment services. The TCM services will serve to supplement care where needed to keep the member safe within their community based setting.

Care Coordination

L.A. Care’s Care Management Program is a member advocacy program designed and administered to assure that the member’s healthcare services are coordinated with a focus on continuity, quality and efficiency in order to produce optimal outcomes.

*Care coordination by Care Managers or designated staff (i.e. UM Specialist, Care Coordinators) is provided for members needing assistance in coordinating their health care services. This service includes members who may have opted out of complex care management but have continuing coordination of health care needs.*
These include, but are not limited to, members assigned to or receiving:

- Out of Area/Network services
- Hospital discharge follow up calls
- Non-emergency medical transportation

Identifying Members for Care Management

Although all members are actively enrolled in the care management program, the program also uses multiple data sources to identify members that are eligible for the program but no yet referred.

These include, but are not limited to, the following:

- Claims and Encounter Data
- Pharmacy Data
- Laboratory Data, when available
- Behavioral Health Joint Operations Report
- PPG Supplemental Reports
  - Catastrophic Medical Condition (e.g. Genetic conditions, Neoplasms, organ/tissue transplants, multiple trauma)
  - Chronic Illness (e.g. Asthma, Diabetes, Chronic Kidney Disease, HIV/AIDS)
- Hospital Utilization
  - Hospital discharge data
  - Hospital Length of Stay (LOS) exceeding 10 days
  - Readmission Reports
  - Skilled Nursing facility (SNF), rehabilitation admissions
  - Acute Rehabilitation admissions
- Ambulatory Care Utilization Reports
  - Emergency Room utilization
  - Nurse Advice Line Reports/ER Referrals
- Referral Management Reports
  - Precertification Data
  - Prior Authorization Data
  - High-technology home care requiring greater than two weeks duration of home care
  - Long Term Care referrals and monitoring logs
  - Non-adherence with treatment plan
Access to Care Management

On a monthly basis, Medicare Operations distributes a list of all newly enrolled members to the SNP program to the Utilization Management Department. Members are assigned to a care management team to initiate the program activities.

In addition to the monthly enrollment list, members may be referred to care management in several ways:

- Physicians and Other Practitioners
- PPG Medical Directors
- L.A. Care Health Plan Medical Directors
- Internal L.A. Care Staff (including UM Staff)
- External Service Partners
- Disease Management/Health Education Staff
- Nurse Advice/Health Information Line
- Hospital Discharge Planners/Case Managers
- Member self referral
- Family/Caregiver referral

Care Management System

L.A. Care utilizes a care management system that is developed using an algorithmic logic script. The script was developed using evidence based guidelines and is supported by prompts to guide care managers through the assessment on ongoing management of members. The care management system has automated features that provide accurate documentation for each entry; recording actions or interactions with members, practitioner or providers; and automatically date, time and user stamp entries. The system also has automatic prompts for follow up care.

Program Activities

Members are contacted telephonically to review the program elements and assess the member’s level of interest in program participation. The program elements include:

- Welcome Packet and gift, includes toll free contact information for the care manager
- Periodic telephone contacts by a member of the care management team
- Screening and assessments
- Educational material, as the need is identified
Supportive care coordination

The care management program is based on active participation. The member may opt out of care management services at any time during the process. Care managers are responsible for fully explaining the program and the benefits of the program to assure that the member is making an informed decision. If the member opts out of care management, he/she is offered the opportunity to be enrolled again at any time.

The initial comprehensive health risk assessments are conducted within the first 90 days of enrollments and annual reassessments within 12 months of the last risk assessment. As special needs members may have labile health status and need more frequent assessments; consequently, annual reassessment will be adjusted to coincide with health status changes.

The health risk assessment is a standardized screening tool administered by a non-clinical staff member. Members are screened to prioritize a further assessment by the Care Manager. The tool includes a review of care. The tool is automatically scored and a risk assessment profile is generated based on the responses. Members are stratified for intervention using the risk assessment score as defined below in Health Risk Assessment Scores – Health Risk Assessment

### Health Risk Assessment Profile Scores

<table>
<thead>
<tr>
<th>Risk Score</th>
<th>Risk Profile</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>= or &gt;80</td>
<td>Referral to care manager within 3 business days</td>
</tr>
<tr>
<td>Moderate</td>
<td>41 - 79</td>
<td>Referral to care manager with 7 business days</td>
</tr>
<tr>
<td>Low</td>
<td>= or &lt;40</td>
<td>Referral to care manager with 10 business days</td>
</tr>
</tbody>
</table>

**Patient Health Questionnaire (PHQ-9) Depression Screener Scoring/Care Management Interventions**

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Provisional Diagnosis</th>
<th>Treatment Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-9</td>
<td>Minimal</td>
<td>Support and</td>
</tr>
</tbody>
</table>
• 15 - 19
  symptoms/Minor Depression
  Moderately severe
depression

• 20 - 27
  Severe depression

•
  member education; follow up call in one month
  Support, member education; referral to Primary Care Physician; assess for possible referral to the behavioral health provider
  Support, member education; immediate referral to Primary Care Physician
ACUITY LEVELS

<table>
<thead>
<tr>
<th>ACUITY LEVELS</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTENSITY 1</td>
<td>Contacts &gt; 1X per day</td>
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<tr>
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<td>Contacts &gt;/=3X per week but not to exceed daily (i.e. 3-5 X/week)</td>
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<tr>
<td>INTENSITY 4</td>
<td>Contacts &gt;/= 2 X/month but not to exceed weekly (i.e., 2-4 X/month)</td>
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<tr>
<td>INTENSITY 5</td>
<td>Intensity level 4 X 2 months. (i.e. transplants awaiting organs, follow-up on established compliance to Care Plan)</td>
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</tbody>
</table>

Hospice Care Services

- Hospice for Medicare-SNP Hospice Care Services are available through the Medicare program. Members and providers may directly contact a federally qualified hospice provider for assistance.

  If you require assistance in locating a hospice provider, you may contact the UM Department at (877) 431-2273.

- Hospice for Medi-Cal Members

  Members and their families shall be fully informed of the availability of hospice care as a covered service and the methods by which they may elect to receive these services. For individuals who have elected hospice care, continuity of medical care shall be arranged, including maintaining established patient-provider relationships, to the greatest extent possible.

  L.A. Care and the delegated PPGs shall cover the cost of all hospice care provided as defined by the DOFR. PPGs are also responsible for all medical care not related to the terminal conditions.

  Admission to a nursing facility of a member who has elected hospice services as described in Title 22, CCR, Section 51349, does not affect the member’s eligibility for enrollment.
Hospice services are covered services and are not long term care services regardless of the member's expected or actual length of stay in a nursing facility.

Members with a terminal condition covered by CCS must be clearly informed that election of hospice will terminate the child's eligibility for CCS services.

PCP responsibilities:
Member is assessed by his/her physician (generally his/her PCP/Hospice Physician) as having terminal medical condition resulting in a life expectancy of six (6) months or less.
- Hospice services are fully explained to the member by his PCP.
- Arrange for continuity of medical care, including maintaining established patient-provider relationships, to the greatest extent possible.

PPG Responsibilities:
- Ensure contracted PPGs are educated on end-of-life care and referral procedures to a qualified hospice program.

Member requests or is offered hospice election for palliative and comfort level treatment in lieu of normal Medi-Cal coverage for services related to the terminal illness.

Hospice Levels of Care:
- **Routine Home Care** - Routine home care shall be covered for each day the recipient is at home and is not receiving continuous care.
- **Continuous Home Care** - Continuous home care shall be covered only during periods of crisis when skilled nursing care is necessary on a continuous basis to achieve palliation or management of the patient's pain or symptoms in order to maintain the recipient in his/her residence. Continuous care may include homemaker and/or home health aide services but must be predominantly nursing in nature.
- **Respite Care** - shall be covered only when provided in an inpatient facility, on an occasional, intermittent and non-routine basis and only when necessary to relieve family members or other persons caring for the terminally ill individual.
- **General inpatient care** shall be covered only when the patient requires and receives general inpatient care in an inpatient facility for pain control or chronic symptom management which cannot be managed in the patient's residence.
Of the four levels of care described in subsection (a) above, only general inpatient care is subject to prior authorization. Authorization for general inpatient care shall be granted only when all applicable requirements, as set forth in the Criteria for Authorization of Hospice Care section of the Department's Manual of Criteria for Medi-Cal Authorization, are met. Refer to UM Procedure 5003.9 UM Referral Management Timeframes for the DHS required In-Patient Hospice Referral timeframe.

Voluntary Statement of Election of Hospice Services: The patient or his lawfully designated representative voluntarily files a statement of election with a Medicare and Medicaid-certified hospice provider acknowledging the request for palliative services only as it relates to the terminal illness and a waiver of regular medical coverage.

The election statement must contain the following:
- Identification of the hospice provider
- The individual's or representative's acknowledgement that:
  - He or she has full understanding that the hospice care given as it relates to the individual's terminal illness will be palliative rather than curative in nature.
  - Certain Medi-Cal benefits as specified in subsection (f) are waived by the election.
  - The effective date of the election.
- Signature of the individual or representative.

Elections may be made for up to two periods of 90 days each, one subsequent period of 30 days, and one 180-day extension of the 30-day period. Hospice services shall not be covered beyond 390 days.

An election period shall be considered to continue through the initial election period and through subsequent election periods as long as the hospice provider agrees to renew the election and as long as the individual:
- Remains in the care of the hospice; and
- Does not revoke the election

Revocation or Modification of a Voluntary Statement of Election of Hospice: An individual's voluntary election may be revoked or modified at any time. To revoke the election of hospice care, the individual or representative must file a statement with the hospice that includes the following information:
- A signed statement that the individual or representative revokes the individual election for Medi-Cal coverage for the remainder of the election period.
- The effective date, which may not be earlier than the date the revocation is made.
Revocation shall constitute a waiver of the right to hospice care during the remainder of the current 90 or 30-day election period plus any extension.

An individual may, at any time after revocation, execute a new election for any remaining entitled election period.

An individual may, once in each election period, elect to receive services through a hospice program different from the hospice with which the election was made. Such change shall not be considered a revocation pursuant to subparagraph (A). Such change shall be made in accordance with the procedure specified in 42 Code of Federal Regulations, Part 418, Subpart B.

An individual who voluntarily elects hospice care under subsection (c) shall waive the right to payment on his or her behalf for all Medi-Cal services related to the terminal condition for which hospice care was elected, except for:

- A signed statement that the individual or representative revokes the individual election for Medi-Cal coverage for the remainder of the election period.
- The effective date, which may not be earlier than the date the revocation is made.
- Revocation shall constitute a waiver of the right to hospice care during the remainder of the current 90 or 30-day election period plus any extension.
- An individual may at any time after revocation execute a new election for any remaining entitled election period.
- An individual may once in each election period elect to receive services through a hospice program different from the hospice with which the election was made. Such change shall not be considered a revocation pursuant to subparagraph (A). Such change shall be made in accordance with the procedure specified in 42 Code of Federal Regulations, Part 418, Subpart B.

An individual who voluntarily elects hospice care under subsection (c) shall waive the right to payment on his or her behalf for all Medi-Cal services related to the terminal condition for which hospice care was elected, except for:

- Services provided by the designated hospice
- Services provided by another hospice through arrangement made by the designated hospice.
- Services provided by the individual's attending physician if that physician is not employed by the designated hospice or receiving compensation from the hospice for those services
- A plan of care shall be established by the hospice for each individual before services are provided. Services must be consistent with the plan of care. The plan of
The following services, when reasonable and necessary for the palliation or management of a terminal illness and related conditions are covered when provided by qualified personnel:

- Physician services when provided by any Medi-Cal enrolled physician except that the services of the hospice medical director or the physician member of the interdisciplinary group, as required under 42 Code of Federal Regulations, Part 418, Subpart C shall be performed by a doctor of medicine or osteopathy.
- Medical social services when provided by a social worker with at least a Bachelor's degree in social work, from a school approved or accredited by the council on Social Work Education, under the direction of a physician.
- Counseling services when provided to the terminally ill individual and the family member or other persons caring for the individual at home. Counseling shall, as appropriate, be provided for the purpose of training the individual's family or other caregiver to provide care and to help the individual and those caring for him or her to adjust to the individual's approaching death and to cope with feelings of grief and loss.
- Short-term inpatient care when provided in a hospice inpatient unit or in a hospital or a skilled nursing facility/Level B, that meets the standards specified in 42 Code of Federal Regulations, Part 418, Subpart E regarding staffing and patient areas.
- Drugs and Biologicals when used primarily for the relief of pain and symptom control related to the individual's terminal illness.
- Medical supplies and appliances
- Home health aide services and homemaker services when provided under the general supervision of a registered nurse. Services may include personal care services and such household services as may be necessary to maintain a safe and sanitary environment in the areas of the home used by the patient.
- Physical therapy, occupational therapy and speech-language pathology when provided for the purpose of symptom control, or to enable the patient to maintain activities of daily living and basic functional skills.
MEDI-CAL

Admissions while in a nursing facility
Admission to a nursing facility of a member who has elected hospice services as described in Title 22, CCR, Section 51349, does not affect the member's eligibility for enrollment under this Contract. Hospice services are Medi-Cal covered services and are not long term care services regardless of the member's expected or actual length of stay in a nursing facility.

Members with a terminal condition covered by CCS
Members with a terminal condition covered by CCS must be clearly informed that election of hospice will terminate the child's eligibility for CCS services.

Hospice for Medicare Advantage-SNP Members
Hospice is a Medicare covered benefit, although it is carved out of the set of benefits that can be covered by Medicare managed care plans and paid for by Medicare fee-for-service. As a result, L.A. Care’s Medicare Advantage-SNP plan does not cover hospice services. Claims for hospice services provided to L.A. Care’s Medicare Advantage SNP members should be submitted to the appropriate Medicare fee-for-service fiscal intermediary.

TRANSPLANTS

Transplants are a covered benefit under the Medicare Advantage plan. The PCP and delegated PPGs are responsible for facilitating transplant evaluations arrangements with the Medicare Centers of Excellence or Medicare approved transplant centers. Members referred for potential transplants are eligible for care coordination assistance through the L.A. Care’s Care Management Program (See Section: Care Management)

Referrals for the facility component must be coordinated with the L.A. Care UM Department. For a copy of the L.A. Care policy for Major Organ Transplants or a listing of the Medicare transplant centers, please contact the L.A. Care UM Department at (877) 431-2273
Medi-Cal

Transplants are a covered benefit through the MediCal Fee-For-Service program. For additional information on assisting members coordinate the transplant benefits, see Section: Care Coordination - Excluded Services Requiring Member Disenrollment/Transplants or you may contact the L.A. Care UM Department.

5.28 DISEASE MANAGEMENT/CHRONIC CARE IMPROVEMENT

L.A. Care does not delegate disease management to the PPGs/PCPs.

The Centers for Medicare and Medicaid Services defines disease management as a "system of coordinated health care interventions and communication for populations with conditions in which patient self-care is substantial". Disease Management supports the provider-patient relationship and treatment plan while emphasizing prevention and self-management.

L.A. Care offers a variety of disease management programs which focus on the development, implementation and evaluation of a system of coordinated health care interventions and communication for members with chronic conditions and individuals that care for them. Using a multi-disciplinary approach, members are identified, stratified, assessed and care plans are developed to assist members and their families with navigating the managed care system and managing their chronic conditions. Programs may include:

- Self-management support
- Education and materials
- Community referrals
- Care coordination

Providers or members may contact L.A. Care Quality Management Department to inquire about the available programs.

5.29 MENTAL HEALTH AND SPECIALTY MENTAL HEALTH SERVICES

Medicare Advantage

Mental health benefits are as defined in the CMS benefit section.
L.A. Care Health Plan will ensure contracted PPG network PPGs and Primary Care Physicians (PCP) provide basic outpatient mental health services, within the scope of the PCP’s practice and training, and shall ensure appropriate referral of members to and coordination of care with LAC for assessment and treatment of mental health conditions, outside the scope of their practice and training.

- All inpatient and outpatient mental health services are the responsibility of L.A. Care and managed by L.A. Care’s current contracted behavioral health vendor.

- Members and providers may directly refer to the contracted behavioral health provider by calling L.A. Care’s Member Service Department at 1-888-522-1298 (TTY/TDD 1-866-522-2731).

**MEDI-CAL:**

- All inpatient mental health and outpatient specialty mental health services are carved out of and excluded from L.A. Care Health Plan’s responsibilities under the Medi-Cal contract with DHS, and will be provided by the L.A. County Department of Mental Health (LAC/DMH) in accordance with the current Memorandum of Understanding (MOU) between L.A. Care Health Plan and LAC/DMH.

- L.A. Care Health Plan will ensure contracted PPGs network and Primary Care Physicians (PCPs) provide basic outpatient mental health services, within the scope of the PCP’s practice and training, and shall ensure appropriate referral of members to and coordination of care with LAC/DMH for assessment and treatment of mental health conditions, outside the scope of their practice and training.

- L.A. Care Health Plan’s UM Liaison will act as a resource to the PPGs/PCP’s to ensure understanding of the referral process and to define services that are part of the PPGs’ and PCPs’ responsibility.

- The resolution of disputes is a shared responsibility between L.A. Care and LAC/DMH and will be processed as defined in the fully executed Memorandum of Understanding, L.A. Care policies and the established state laws and regulations.

**5.30 ALCOHOL & DRUG TREATMENT PROGRAMS**
MEDICARE ADVANTAGE:

- Substance abuse benefits are as defined in the CMS benefit section.

- Members and providers may directly refer to the contracted behavioral health provider by calling L.A. Care’s Behavioral Health Provider at (877) 344-2858.

MEDI-CAL

5.30.1 Inpatient Detoxification
5.30.1.1 L.A. Care will ensure appropriate medical inpatient detoxification is provided under the following circumstances:

5.30.1.2 Life threatening withdrawal from sedatives, barbiturates, hypnotics or medically complicated alcohol and other drug withdrawal.

5.30.1.3 Inpatient detoxification is covered in the rare cases where it is medically necessary to monitor the member for life threatening complications; two or more of the following must be present, tachycardia, hypertension, diaphoresis, significant increase or decrease in psychomotor activity, tremor, significant disturbed sleep pattern, nausea and vomiting, threatened delirium tremens.

5.30.1.4 When the member is medically stabilized, the PCP/L.A. Care shall provide a referral and follow-up to a Substance Abuse Treatment Program.

5.30.2 Outpatient
5.30.3.1 L.A. Care will maintain processes to ensure that Alcohol and Drug Abuse Treatment Services be available to members and are provided as a linked and carved out benefit through the Office of Alcohol and Drug Programs of L.A. County.

5.30.3.2 The following services are provided by the Alcohol and Drug Programs of L.A. County:
- Outpatient Methadone Maintenance
- Outpatient Drug Free Treatment Services
- Perinatal Residential Services
- Day Care Habilitative Services
5.30.3.3 L.A. Care and its contracted PPGs will ensure Primary Care Physician (PCP) screening of L.A. Care Health Plan members for substance abuse during the Initial Health Assessment and in all subsequent visits as appropriate. When substance use is recognized as a potential condition, PCPs will refer to a treatment facility serving the geographic area. Referral is done by using the substance abuse referral form or by referral to the Community Assessment Services Center toll free number (800) 564-6600.

5.30.3.4 Members can access substance abuse treatment services by self-referral, by a family referral or referral from the PCP or other appropriate provider.

5.30.3.5 During treatment for substance abuse, all medical services will continue to be provided by the PCP or other appropriate medical provider. The PCP will make relevant medical records available to the Substance Abuse Treatment Program with appropriate consent and release of medical record information following Federal and State guidelines.

5.31 DENTAL SERVICES

MEDICARE ADVANTAGE – SNP

- Preventive dental care is a covered service through L.A. Care’s Medicare Advantage Program. Medicare Advantage-SNP members have professional dental services covered through Medi-Cal’s Denti-Cal program (please see description below). However, L.A. Care’s Medicare Advantage plan covers anesthesia services and related medical services provided to a member in a dental office, inpatient or outpatient facility, or an ambulatory surgical center. Such services must support a dental surgery or dental procedure, provided that such anesthesia services and related medical services meet plan coverage and medical necessity requirements.
MEDI-CAL

Dental Care Treatment Services are a carved out benefit to Medi-Cal members through the Medi-Cal Denti-Cal Program. L.A. Care and its delegated PPGs are responsible for Dental Screening and Referral of Members to the Carved out Medi-Cal Denti-Cal Program for Dental Treatment when treatment needs are identified.

Primary Care Providers should perform dental screenings as part of the IHA, periodic, and other preventive health care visits and provide referrals to Medi-Cal Denti-Cal Program for treatment in accordance with the most current:

- CHDP/American Academy of Pediatrics (AAP) guidelines for Member age 21 and younger.
- Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) for adult members {age twenty-one (21) and older}.

Dental Screening Requirements:
L.A. Care recommends dental screening for all members is included as part of the initial and periodic health assessments:

For members under twenty-one (21) years of age, a dental screening/oral health assessment shall be performed as part of every periodic assessment, with annual dental referrals made commencing at age three (3) years or earlier if conditions warrant.

Covered Medical Services not provided by Dentist or Dental Anesthetists:
L.A. Care and its delegated PPGs shall cover and ensure the provision of covered medical services that are not provided by dentists or dental anesthetists. Covered medical services include:

- Contractually covered prescription drugs
- Laboratory service
- Pre-admission physical examinations required for admission to an out-patient surgical service center or an in-patient hospitalization required for a dental procedure (including facility fee and anesthesia services for both inpatient and outpatient services).

Financial Responsibility for General Anesthesia and Associated Facility Charges:
L.A. Care and its delegated PPGs are responsible to cover general anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center setting, when the clinical status or underlying medical condition of the patient requires dental procedures that
ordinarily would not require general anesthesia to be rendered in a hospital or surgery center setting (as defined by the Division of Financial Responsibility - DOFR). A prior authorization of general anesthesia and associated charges required for dental care procedures is required in the same manner that prior authorization is required for other covered diseases or conditions.

General anesthesia and associated facility charges are covered for only the following member, and only if the members meet the criteria as follows:

- Members who are under seven years of age.
- Members who are developmentally disabled, regardless of age.
- Members whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

The professional fee of the dentist and any charges of the dental procedures itself is not covered. Coverage for anesthesia and associated facility charges may be covered and are subject to the terms and conditions of the plan benefits as described in the Division of Financial Responsibility.

Referral to Medi-Cal Dental Providers through Carved Out Medi-Cal Dental Program:

L.A. Care and its delegated PPGs must refer members to the appropriate Medi-Cal dental providers for treatment of dental care needs.

Updated lists of Medi-Cal dental providers are made available to network providers.

CCS Referrals
Dental services for a child with complex congenital heart disease, cystic fibrosis, cerebral palsy, juvenile rheumatoid arthritis, nephrosis, or when the nature or severity of the disease makes care of the teeth complicated may be covered by CCS. Contact the L.A. Care UM Department or CCS for assistance.

When a child has a handicapping malocclusion, Orthodontia care may be covered by CCS. Contact the L.A. Care UM Department or CCS for assistance.

Routine dental care and orthodontics is not covered by CCS.
5.32 VISION SERVICES
MEDICARE ADVANTAGE – SNP

- Vision care is a covered benefit and the responsibility of L.A. Care. To access this service, members and providers should contact VSP at 800-877-7195.

MEDI-CAL

L.A. Care and its delegated PPGs shall cover and ensure the provision of eye examinations and prescriptions for corrective lenses as appropriate for all Members according to the current Medi-Cal benefits for eye examinations and lenses.

Members are eligible for the eye examination with refractive services and dispensing of the prescription lenses every two years. Additional services and lenses are provided based on medical necessity for examinations and new prescriptions.

L.A. Care and its delegated PPGs shall arrange for the fabrication of optical lenses for Members through Prison Industry Authority (PIA) optical laboratories.

Department of Health Services (DHS) is responsible for reimbursing PIA for the fabrication of the optical lenses in accordance with the contract between DHS and PIA.

5.32.1 Long Term Care (LTC) (After exhaustion of Medicare Benefits)

5.32.1.1 L.A. Care and its delegated PPGs are responsible for ensuring that members, other than members requesting hospice services, in need of nursing Facility services are placed in a health care facility that provides the level of care most appropriate to the member's medical needs. These health care facilities include Skilled Nursing Facilities, sub-acute facilities, pediatric sub-acute facilities, and Intermediate Care Facilities.

5.32.1.2 Admission to a nursing Facility of a member who has elected hospice services as described, does not affect the member's eligibility for Enrollment. Hospice services are covered services and are not long term care services regardless of the member's expected or actual length of stay in a nursing facility.
5.32.5.3 L.A. Care and its delegated providers shall:
   5.32.5.3.1 assure that decisions to transition a member to LTC are based on the appropriate level of care based on Medi-Cal criteria

   5.32.5.3.1.1 Needs assessment and potential length of stay should be discussed with the treating provider and facility.

5.32.5.4 If the member requires LTC, in the Facility for longer than the month of admission plus one month, Delegated providers will submit a Disenrollment request for the member to L.A. Care to submit to DHS for approval.

   5.32.5.4.1 L.A. Care UM Staff are responsible for:
   5.32.5.4.1.1 coordinating the services required with the treating provider and facility
   5.32.5.4.1.2 completing appropriate documentation and forwarding to L.A. Care Member Services to complete disenrollment forms.

   5.32.5.4.2 L.A. Care Member Services is responsible for:
   5.32.5.4.2.1 initiating the disenrollment process to Health Care Options
   5.32.5.4.2.2 coordinating the decision response with UM staff

5.32.5.5 When Health Care Options notifies L.A. Care that the disenrollment request is approved, an approved Disenrollment request will become effective the first day of the second month following the month of the member’s admission to the facility, provided that L.A. Care submitted the disenrollment request at least 30 calendar days prior to that date.

5.32.5.6 If L.A. Care submits the disenrollment request less than thirty (30) calendar days prior to that date, disenrollment will be effective the first day of the month that begins at least thirty (30) calendar days after submission of the disenrollment request.
5.32.6 Coordination of Care

5.32.6.1 L.A. Care and its delegated providers shall provide all Medically Necessary Covered Services to the member until the disenrollment is effective:

5.32.6.1.1 assuring that continuity of care is not interrupted;
5.32.6.1.2 completing all administrative work necessary to assure smooth transfer of responsibility for the health care of the Medi-Cal beneficiary.
5.32.6.1.3 assuring that medical necessity of continued care is reviewed regularly until patient is transitioned to Long Term Care.

5.32.6.2 Upon the disenrollment effective date, the member’s orderly transfer to the Medi-Cal Fee-For-Service provider;

5.32.6.2.1 The PCP, with assistance from the Case Manager, has responsibility to ensure that the member’s medical record and all appropriate information is transferred to the member’s Fee For Service provider.

5.32.6.2.2 This includes notifying the member and his or her family or guardian of the disenrollment; assuring the appropriate transfer of medical records from the Plan to the Medi-Cal Fee-For-Service provider; assuring that continuity of care is not interrupted; and, completion of all administrative work necessary to assure a smooth transfer of responsibility for the health care of the Medi-Cal beneficiary.

5.32.6.2.3 If the member’s PCP continues to act as the patient’s physician under Fee For Service, the long term care facility will be notified. If it is necessary for the member to have another physician, L.A. Care or if applicable, the delegated PPG works with the long term care facility to achieve an orderly transfer of care and records.

5.32.6.3 When Health Care Options notifies L.A. Care that the disenrollment request is not approved:
5.32.6.3.1 L.A. Care Member Services notifies the Care Manager to assist the PCP with management of patient’s needs. Until Placement is available, a patient who is eligible for a waiver program will be monitored closely.

5.33 L.A. CARE APPEALS PROCESS

L.A. Care does not delegate the appeal (reconsideration) process. The PPG must ensure timely submission of appeals to L.A. Care. If the PPG receives an appeal from a member, it should be faxed to L.A. Care Member Services Department same day of receipt. A member has the right to appeal directly to L.A. Care for all decisions to modify or deny a request for services. A physician, acting as the member’s representative, may also appeal a decision on behalf of the member.

Members and providers may also appeal L.A. Care’s decision to modify or deny a service request (this does not apply to the retrospective claims review/provider dispute resolution process). The appeal request is reviewed by a physician or physician consultant not involved in the prior determination.

Member requested appeals may be initiated orally or in writing. Request may be made by contacting L.A. Care at:

L.A. Care Health Plan
Members Services Grievances/Appeals
1055 W. Seventh Street, 10th Floor
Los Angeles, CA 90017
(888) 452-2273
Fax # - (213) 623-8097

L.A. Care follows the federal, state and NCQA requirements for the timely resolution of member complaints. If you would like additional information on the L.A. Care appeal resolution process, please contact the L.A. Care UM Department at (877) 431-2273.

Medicare Advantage-SNP

Please see Section 5.18 for more details about reconsiderations of organization determinations (appeals), inpatient discharge appeals, and review of discharge from CORF, SNF and home health facilities.
5.34 SATISFACTION WITH THE UTILIZATION MANAGEMENT PROCESS

L.A. Care will evaluate both Member and Provider satisfaction with the UM process. Performance is assessed at least annually. The outcomes of the survey will be reported to the appropriate L.A. Care Quality Management committees. The committee will identify areas of dissatisfaction, set priorities for improvement, and evaluate the effectiveness of interventions. Where opportunities for improvement are identified, PPGs may be requested to initiate action to change processes to meet defined goals and to meet Members’ and Providers’ expectations.
ATTACHMENT A.

Standardized ICE Reporting Document
Medicare Advantage Part C Reporting

UM Determinations

Health Plan Name:
Medical Group/IPA
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Management Company / TPA
Enter name of Management Company/ (if applicable)

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Report Preparer Certification**

** The data submitted is for Federal reporting and is accurate & complete

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ICE Approved: 5/27/09
**Attachment B**

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Attachment C

Medicare Advantage Authorization Information for CMS Part C
Reporting

SUMMARY:
The Centers for Medicare and Medicaid Services (CMS) has implemented reporting requirements for 2009 that require submission of data on a quarterly basis regarding organizational determinations (favorable, partial and unfavorable) for all Medicare Advantage organizations and their delegated provide groups. Collection of this data commenced beginning 1/1/09 and will continue indefinitely. Regulatory support for these measures is found in 42CFR Subpart M 422.566 – 422.576 and 42 CFR Subpart M 422.578. seq. 42 CFR Subpart K 422.516 (a) (6).

In order to simplify reporting by delegated provider groups across various health plans, the attached reporting template was developed. Each Medicare Advantage health plan is required to collect clinical authorizations and denials, similar to the ongoing ICE reporting for paid and denied claims. Reporting is a Medicare requirement from all MA plans and entities delegated for pre service organization determinations. The party responsible for reporting must be authorized on behalf of the delegated entity to attest to the accuracy of the submission. While data must be reported for each month, the data collection will be on a quarterly basis consistent with the CMS reporting requirements.

The current ICE UM reports are submitted semi-annually and some groups do not differentiate data by Health Plan, requiring separate reporting to be compiled and submitted to CMS. (ICE reporting on Claims continues separately through the ICE approved claims reporting process)

How a delegated Provider Group Can Submit Report to a MA Health Plan: Submit data in the “ICE MA Part C Clinical Decision Reporting template” Excel Workbook located on the ICE website via the following link: http://www.iceforhealth.org/library.asp?sf=&scid=1906#scid1906. Please email the MA plan-specific report to your UM contact at the MA plan. Include data only for the individual health plan members you are reporting on. Include data only for the individual health plan members you are reporting on. Include all fully favorable, partially favorable, and denied organizational determinations not related to post service claim determinations. This includes determinations based on medical necessity and benefit determinations, as well as eligibility denials. All reporting for each month is based on the date of the decision. You may send in monthly reports or aggregated quarterly reports. Each MA health plan must receive reports no later than the 15th day of the month following the close of each quarter, so that data can be aggregated for UM decisions for all delegated provider groups and then reported to CMS.
Submit Clinical data in the ICE MA Part C UM Reporting Excel workbook as detailed below:

For example, THE DEADLINE FOR SUBMISSION for Q3 2011 to the MA Plans is 10/15/10
The deadlines for submission of subsequent quarters are 1/15/11, 4/15/11, 7/15/11, 10/15/11 etc.

Included below is updated information from the CMS July 22 memo and attached July 21, 2009 Guidance www.cms.hhs.gov/HealthPlansGenInfo/16_ReportingRequirements.asp

The reporting for each collection period for organization determinations includes only those cases where final decisions were made during the reporting period, regardless of when the case was initially received. UM determinations for Pre-Service should be included under UM; Post Service determinations are not part of the UM reporting and are included under the separate claims reporting. Concurrent review is irrelevant for Part C data reporting requirement purposes.

Plans and delegated entities must report those decisions that meet the definition of “organization determination” under 42 C.F.R. §422.566(b). Thus, CMS expects plans to include all pre-service network and non-network denial data.

A Quality Improvement Organization (QIO) review of an individual’s request to continue Medicare-covered services (e.g., a SNF stay) should not be counted as an organization determination for Part C Reporting purposes. A plan’s review of an individual’s request to continue Medicare-covered services (e.g., if a beneficiary misses the QIO review deadline) should be counted as a reconsideration for this effort.

Clinical Data:

- Include data for each health Plan’s Members Separately
- Each month’s data reporting is for decisions made during the month
- Use the attached Excel workbook titled “ICE Request for Part C Reporting” as a template for your report.
- Please provide monthly totals (for example: Month 1 of a quarter’s reporting period (January), Month 2 (February), and Month 3 (March) for the number of decisions made regarding requests for services.
  - Report in each of the following categories:
    - Fully Favorable UM Organization determinations,
    - Partially Favorable UM Organization determination
    - Adverse Organization determinations adverse (Denials)
 ATTACHMENT D  
Utilization Management Timeliness Standards  
Centers for Medicare and Medicaid Services (CMS)  

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision</th>
<th>Notification Timeframes</th>
</tr>
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<tbody>
<tr>
<td><strong>Standard Initial Organization Determination (Pre-Service)</strong></td>
<td>As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.</td>
<td>Within 14 calendar days after receipt of request.</td>
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<tr>
<td>- If No Extension Requested or Needed</td>
<td></td>
<td>▪ Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.</td>
</tr>
<tr>
<td><strong>Standard Initial Organization Determination (Pre-Service)</strong></td>
<td>May extend up to 14 calendar days.</td>
<td>▪ <strong>Use the MA-Extension: Standard &amp; Expedited to notify member and provider of an extension.</strong></td>
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<tr>
<td>- If Extension Requested or Needed</td>
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<td>Extension Notice:</td>
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<td>▪ Give notice in writing within 14 calendar days of receipt of request. The extension notice must include:</td>
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<td>1) The reasons for the delay</td>
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<td>2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension.</td>
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<td>Note: The Health Plan must respond to an expedited grievance within 24 hours of receipt.</td>
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<td><strong>Decision Notification After an Extension:</strong></td>
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<td>▪ Must occur no later than expiration of extension. Use NDMC template for written notification of denial decision.</td>
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<tr>
<td>Type of Request</td>
<td>Decision</td>
<td>Notification Timeframes</td>
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<tr>
<td><strong>Expedited Initial Organization Determination</strong></td>
<td>Promptly decide whether to expedite – determine if:</td>
<td>If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member’s rights followed by written notice within 3 calendar days of the oral notice.</td>
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<tr>
<td>- If Expedited Criteria are not met</td>
<td>1) Applying the standard timeframe could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function, or</td>
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<td>2) If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member’s request for an expedited decision.</td>
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<td>If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies:</td>
<td>▪ Use the MA Expedited Criteria Not Met template to provide written notice. The written notice must include:</td>
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<td>• Automatically transfer the request to the standard timeframe.</td>
<td>1) Explain that the Health Plan will automatically transfer and process the request using the 14-day timeframe for standard determinations;</td>
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<td>• The 14 day period begins with the day the request was received for an expedited determination.</td>
<td>2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization’s decision not to expedite the determination;</td>
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<td>If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies:</td>
<td>3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician’s support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member’s ability to regain maximum function, the request will be expedited automatically; and</td>
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<td>4) Provide instructions about the expedited grievance process and its timeframes.</td>
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<td><strong>Expedited Initial Organization Determination</strong></td>
<td>As soon as medically necessary, within 72 hours after receipt of request (includes weekends &amp; holidays).</td>
<td>Within 72 hours after receipt of request.</td>
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<tr>
<td>- If No Extension Requested or Needed</td>
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<td>▪ <strong>Approvals</strong></td>
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<td>(See footnote)</td>
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<td>- Oral or written notice must be given to member and provider within 72 hours of receipt of request.</td>
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<td>- Document date and time oral notice is given.</td>
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<td>- If written notice <strong>only</strong> is given, it must be received by member and provider within 72 hours of receipt of request.</td>
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<td>▪ <strong>Denials</strong></td>
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<td>- When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice.</td>
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1 Note: Health Plans may have referral requirements that may impact timelines. When processing expedited requests, groups must factor in the time it may take to refer the request to the health plan in the total 72 hours to ensure that expedited requests are handled timely.
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<tr>
<th>Type of Request</th>
<th>Decision</th>
<th>Notification Timeframes</th>
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<td></td>
<td><strong>May extend up to 14 calendar days.</strong></td>
<td>- Document date and time of oral notice.</td>
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<td><strong>Note:</strong> Extension allowed <em>only</em> if member requests or the provider /</td>
<td>- If only written notice is given, it must be <em>received</em> by member and provider within 72 hours of receipt of request.</td>
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<td>organization justifies a need for additional information and is able</td>
<td>- Use NDMC template for written notification of a denial decision.</td>
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<td>to demonstrate how the delay is in the interest of the member (for</td>
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<td>example, the receipt of additional medical evidence from non-contracted</td>
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<td>providers may change a decision to deny). Extensions <em>must not</em> be used</td>
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<td>to pend organization determinations while waiting for medical records</td>
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<td>from contracted providers.</td>
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<td><strong>Extension Notice:</strong></td>
<td><strong>Use the MA-Extension: Standard &amp; Expedited template to notify member and provider of an extension.</strong></td>
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<td>- Give notice <em>in writing</em>, within 72 hours of receipt of request. The</td>
<td><strong>Extension Notice:</strong></td>
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<td>extension notice must include:</td>
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<td>1) The reasons for the delay</td>
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<td>2) The right to file an expedited grievance (oral or written) if they</td>
<td><strong>Decision Notification After an Extension:</strong></td>
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<td>disagree with the decision to grant an extension.</td>
<td><strong>Decision Notification After an Extension:</strong></td>
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<td><strong>Approvals</strong></td>
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<td>- Oral or written notice must be given to member and provider no later than upon expiration of extension.</td>
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<td>- Document date and time oral notice is given.</td>
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<td>- If written notice <em>only</em> is given, it must be <em>received</em> by member and provider no later than upon expiration of the extension.</td>
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<td><strong>Denials</strong></td>
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<td>- When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice.</td>
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<td>- Document date and time of oral notice.</td>
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<td>- If only written notice is given, it must be <em>received</em> by member and provider no later than upon expiration of extension.</td>
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<td>– Use NDMC template for written notification of a denial decision.</td>
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<tr>
<td>Type of Request</td>
<td>Decision</td>
<td>Important Message from Medicare (IM)</td>
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| Hospital Discharge Appeal Notices (Concurrent) | Attending physician must concur with discharge decision from inpatient hospital to any other level of care or care setting. Continue coverage of inpatient care until physician concurrence obtained. Hospitals are responsible for valid delivery of the revised Important Message from Medicare (IM): 1) within 2 calendar days of admission to a hospital inpatient setting. 2) not more than 2 calendar days prior to discharge from a hospital inpatient setting. Health Plans or delegates are responsible for delivery of the Detailed Notice of Discharge (DND) when a member appeals a discharge decision. DND must be delivered as soon as possible but no later than noon of the day after notification by the QIO (Quality Improvement Organization). | Hospitals must issue the IM within 2 calendar days of admission, obtain the signature of the member or representative and provide a copy of the IM at that time. Hospitals must issue a follow up IM not more than 2 calendar days prior to discharge from an inpatient hospital.  
- NOTE: Follow up copy of IM is not required:  
  - If initial delivery and signing of the IM took place within 2 calendar days of discharge.  
  - When member is being transferred from inpatient to inpatient hospital setting.  
  - For exhaustion of Part A days, when applicable.  
If IM is given on day of discharge due to unexpected physician order for discharge, member must be given adequate time (at least several hours) to consider their right to request a QIO review. | - Upon notification by the QIO that a member or representative has requested an appeal, the Health Plan or delegate must issue the DND to both the member and QIO as soon as possible but no later than noon of the day after notification by the QIO.  
- The DND must include:  
  - A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered.  
  - A description of any applicable Medicare coverage rules, instructions, or other Medicare policy, including information about how the member may obtain a copy of the Medicare policy from the MA organization.  
- Any applicable Medicare health plan policy, contract provision, or rationale upon which the discharge determination was based.  
- Facts specific to the member and relevant to the coverage determination |
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<th>Type of Request</th>
<th>Decision</th>
<th>Important Message from Medicare (IM)</th>
<th>Detailed Notice of Discharge (DND)</th>
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<td><strong>Termination of Provider Services:</strong></td>
<td>The Health Plan or delegate is responsible for making the decision to end services no later than two (2) calendar days or 2 visits before coverage ends:</td>
<td>The SNF, HHA or CORF is responsible for delivery of the NOMNC to the member or authorized representative:</td>
<td>sufficient to advise the member of the applicability of the coverage rule or policy to the member’s case. Any other information required by CMS.</td>
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<td>▪ Skilled Nursing Facility (SNF)</td>
<td>▪ Discharge from SNF, HHA or CORF services OR ▪ A determination that such services are no longer medically necessary</td>
<td>▪ The NOMNC must be delivered no later than 2 calendar days or 2 visits prior to the proposed termination of services and must include: member name, delivery date, date that coverage of services ends, and QIO contact information. ▪ The NOMNC may be delivered earlier if the date that coverage will end is known. ▪ If expected length of stay or service is 2 days or less, give notice on admission.</td>
<td>▪ Detailed Explanation of Non-Coverage (DENC) Notification</td>
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<td>▪ Home Health Agency (HHA)</td>
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<td>▪ Comprehensive Outpatient Rehabilitation Facility (CORF)</td>
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**Note:** This process does not apply to SNF Exhaustion of Benefits (100 day limit).

**Note:** Check with Health Plan or delegate for delegated responsibility, as a Health Plan or delegate may choose to deliver the NOMNC instead of the provider.
ATTACHMENT E

PPG Medicare Utilization Management Reporting to L.A. Care Health Plan

1. L.A. Care contracted/delegated medical groups (PPGs) are provided with required templates for quarterly reporting for Medicare Organization Determinations:
   a. For Medicare Part C Reporting – L.A. Care utilizes the ICE format with instructions/templates. (Attachment A)
   b. For Medicare logs of organization determinations – L.A. Care utilizes the CMS required format with instructions/templates. (Attachment B)

2. PPGs are required to submit the templates to L.A. Care Medical Management Department on a quarterly basis
   a. Organization Determination reports data based on the required reporting periods of
      - 1/1 through 3/31 (1<sup>st</sup> Q)
      - 4/1 through 6/30 (2<sup>nd</sup> Q)
      - 7/1 through 9/30 (3<sup>rd</sup> Q)
      - 10/1 through 12/31 (4<sup>th</sup> Q)
   b. Reports are required to be submitted on the 15<sup>th</sup> of the month following the quarter by to L.A. Care’s UM Delegation Oversight Coordinator by Right Fax 213-438-5710

General Directions to PPGs for reporting the number of Initial Determinations to L.A. Care on the ICE quarterly report format (Attachment A) and also PPG’s Log of Initial Determinations on L.A. Care’s required Initial Determinations excel log format (Attachment B)

- Exclude dismissals, withdrawals or Quality Improvement Organization reviews of request to continued Medicare-covered services (e.g. SNF).
- Includes only organizational determinations that are filed directly the delegated entities (e.g., excludes all organization determinations that are only forwarded to the organization from the CMS Complaint Tracking Module (CTM) and not filed directly with the organization or delegated entity).
- Includes all methods by which organization determination requests are received (e.g., auth request form, by telephone, letter, fax, in-person).
- Includes all organization determinations regardless of who filed the request.
6.0 QUALITY IMPROVEMENT PROGRAM (QIP)

L.A. Care annually prepares a comprehensive Quality Improvement Program that clearly defines L.A. Care’s QI structures and processes designed to improve the quality and safety of clinical care and services for its membership. A complete written copy of L.A. Care’s Quality Improvement Program is available upon request by calling (213) 694-1250 x4027.

The L.A. Care Quality Improvement Program will:

- Define, oversee, continuously evaluate and improve the quality and efficiency of health care delivered through organizational commitment to the goals and principles of our organization.
- Ensure medically necessary covered services are available and accessible to members taking into consideration the member’s cultural and linguistic needs.
- Ensure our contracted network of providers cooperate with L.A. Care quality initiatives.
- Ensure that timely, safe, medically necessary, and appropriate care is available.
- Consistently meet quality standards as required by contract, regulatory agencies, recognized care guidelines, industry and community standards.
- Promote health education and disease prevention designed to promote lifelong wellness by encouraging and empowering the member to adopt and maintain optimal health behaviors.
- Maintain a well-credentialed network of providers based on recognized and mandated credentialing standards.
- Safeguard members’ protected health information (PHI).

Annual QI Program Evaluation

Annually, L.A. Care reviews data reports and other performance measures regarding program activities to assess the effectiveness of its QI Program. This evaluation includes a review of completed and continuing program activities and audit results; trending of performance data; analysis of the results of QI initiatives including barriers, successes, and challenges; an assessment of the effectiveness of monitoring activities and identifying and acting upon quality of care and service issues; an evaluation of the overall effectiveness of the QI program including progress toward influencing network-wide safe clinical practices; and the goals and plans for the next year.

Annual QI Work Plan

The annual QI Work Plan is developed in collaboration with staff and is based, in part upon the results of the prior year’s QI Program evaluation. Each of the elements identified on the Work Plan has activities defined, responsibility
assigned and the date by which completion is expected. Quarterly updates to the Work Plan are documented and reported to the Quality Oversight Committee and the Compliance and Quality Committee of the Board.

**COMMITTEE STRUCTURE**
L.A. Care’s quality committees oversee various functions of the QI program. The committees serve as the major mechanism for intradepartmental collaboration for the Quality Program. There is physician network participation on many of L.A. Care’s QI Committees.

**Clinical Care Measures**
L.A. Care measures clinical performance through Healthcare Effectiveness Data and Information Set (HEDIS). L.A. Care expects that the network assist the health plan in continuously improving its HEDIS rates. The network is also expected by contract to cooperate with the annual HEDIS data collection efforts and keep encounter data current and accurate.

**Service Measures**
L.A. Care monitors services and member satisfaction by collecting, analyzing and acting on numerous sources of data such as Member Satisfaction (CAHPS), Complaints and Appeals, Access to and Availability of Practitioners and Provider Satisfaction.

**Medicare Advantage-SNP Measures**
As required by CMS, the following measures will be collected annually
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Health Outcomes Survey (HOS).

**Continuity and Coordination of Medical Care**
How well does your office coordinate care? If referring to a specialist, contact the specialist before the patient’s appointment. Have staff set up a quick phone appointment and fax over the patient’s medical history. Request that the specialist also contact you once the evaluation and/or treatment is finished. Keep track of specialty referrals that require prior authorization. Talk to the PPG or IPA about getting timely hospital discharge reports that will help you follow up and coordinate care after a hospitalization or emergency room visit.

**Continuity and Coordination of Medical and Behavioral Health Care**
L.A. Care contracts with a vendor to provide inpatient and outpatient mental health services including drug and alcohol abuse services. Mental health care is covered when services are ordered and performed by a plan mental health professional. For a directory of the vendor’s behavioral health providers, please refer to the electronic provider and hospital directory on L.A. Care’s website. A search for a behavioral health provider will link you directly to the network.

Preventive Health Care Guidelines-  
Clinical Practice Guidelines for Acute and Chronic Medical Care- See L.A. CARE website for current and updated guidelines including Asthma and Diabetes

Clinical Practice Guidelines for Behavioral Health Care - See L.A. CARE website for current guidelines including Depression.

Chronic Care Improvement Programs
The objective of each of L.A. Care’s Chronic Care Improvement Programs is to improve the health status of its eligible members with chronic conditions. The programs achieve this objective by educating the member and by enhancing the member’s ability to self-manage his or her condition or illness. Chronic Care Improvement Programs are developed from evidenced-based clinical practice guidelines and support the practitioner–patient relationship and plan of care. The current programs address Asthma (L.A. Cares About Asthma) and Diabetes (L.A. Cares About Diabetes). To enroll a member, contact L.A. Care at 1-866-LA-CARE6 (1-866-522-2736).

Patient Safety
L.A. Care is committed to improving patient safety and promoting a supportive environment for network practitioners and other providers to improve patient safety in their practices. Many of the ongoing QI Program measurement activities, including measures for accessibility, availability, adherence to clinical practice guidelines and medical record documentation include safety components.

Disease Reporting Statement
L.A. Care complies with disease reporting standards as cited by the California Code of Regulations, Title 17 (Section 2500), which states that public health professionals, medical providers and others are mandated to report approximately 85 diseases or conditions to their local health department. The primary objective of disease reporting and surveillance is to protect the health of the public, determine the extent of morbidity within the community, evaluate risk of transmission, and intervene rapidly when appropriate. Forms to report
7.0 CREDENTIALING

7.1 OVERVIEW

7.1.1 L.A. Care’s direct contracted practitioners are required to be credentialled in accordance with L.A. Care’s credentialing criteria and the standards of the Department of Health Services (DHCS), DMHC, NCQA, and CMS requirements.

7.1.2 L.A. Care requires that all practitioners who are performing services for L.A. Care members have a current license at all times to provide patient care to members and abide by State and Federal laws and regulations. All practitioners must be qualified to participate in the Medi-Cal and CMS product lines in order to participate in all lines of business. Failure to meet Medi-Cal, CMS requirements may be cause for removal from L.A. Care’s network.

These requirements include verification of the following circumstances:

Excluded Providers

Confirmation that practitioners or other health care providers/entities are not “excluded providers” on the Office of the Inspector General (OIG) sanction list that identifies those individuals found guilty of fraudulent billing, misrepresentation of credentials, etc. Organizations employing or contracting with health providers have a responsibility to check the sanction list with each new issuance of the list, as they are prohibited from hiring, continuing to employ, or contracting with individuals named on that list. All contracted PPGs and vendors are required to review this publication on a monthly basis and are required to ensure they are reviewing the most current iteration. Lists of the excluded providers are available at: http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp and https://www.epls.gov/.

Medi-Cal Suspended and Ineligible Providers

Medi-Cal law (Welfare and Institutions Code, Section 14123) mandates that the Department of Health Care Services (DHCS) suspends a Medi-Cal provider when he/she has been (a) convicted of a crime involving fraud or abuse of the Medi-
Cal program, or (b) suspended from the federal Medicare program for any reason.

Suspension is automatic when either of the above events occurs, and suspended Medi-Cal providers will not be entitled to a hearing under the California Administrative Procedures Act.

All contracted PPGs and vendors, i.e., carved out contacts, are required to review this publication on a monthly basis and are required to ensure they are reviewing the most current iteration.

**Opt-Out Providers**

If a practitioner opts out of Medicare, that practitioner may not accept Federal reimbursement for a period of 2 years. The only exception to that rule is for emergency and urgently needed services. Payment must be made for emergency or urgently needed services furnished by an “opt-out” practitioner to a member, but payment should not otherwise be made to opt-out providers. Information on providers who opt-out of Medicare may be obtained from the local Medicare Part B carrier. This list must be checked on a regular basis.

All contracted Participating Practitioner Groups (PPGs) and vendors are required to review this publication on a monthly basis and are required to ensure they are reviewing the most current iteration.

**National Provider Identifier (NPI) Number**

All practitioners of Covered Services, including physicians and specialists, must have a valid National Provider Identifier (NPI) Number.

All contracted Participating Practitioner Groups (PPGs) and vendors are required to verify that all their contracted practitioners have a valid NPI number.

**CLIA Certification**

The Centers for Medicare & Medicaid Services (CMS) regulates all laboratory testing (except research) performed on humans in the U.S through the Clinical Laboratory Improvement Amendments (CLIA). CLIA requires all facilities that perform even one test, including waived tests, on materials derived from human body for
the purpose of providing information for diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of health of, human beings to meet certain Federal requirements. If a facility performs tests for these purposes, it is considered a laboratory under CLIA and must apply and obtain a certificate from the CLIA program that corresponds to the complexity of the tests performed.

All contracted Participating Practitioner Groups (PPGs) and vendors shall ensure that all contracted laboratory testing sites have either a current and valid CLIA certificate or waiver of a certificate of registration along with a CLIA identification number. This must be monitored on an ongoing basis.

7.1.3 PPGs will establish standards, requirements and processes for the evaluation of practitioners, non-practitioner health care professionals and health delivery organizations that comply with L.A. Care, NCQA, DHCS, and CMS requirements who are performing services for L.A. Care members to ensure that these practitioners and health delivery organizations are qualified to perform the services, and are licensed and/or certified consistent with State laws and regulations. These standards, requirements and processes are applicable whether or not credentialing and re-credentialing activities (herein after referred to as “credentialing”) are delegated.

7.1.4 The acceptance of a practitioner into the L.A. Care network is contingent upon successfully completing the credentialing review process. The re-credentialing process is implemented every three (3) years in accordance with L.A. Care, NCQA, DHCS, and CMS requirements. Continuation of participation with L.A. Care is dependent upon successfully completing the re-credentialing process.

7.1.5 L.A. Care’s Board of Governors has delegated the responsibility to the Credentialing/Peer Review Committee, to review and make recommendations on practitioner initial credentialing, re-credentialing applications, and oversight functions for delegated activities for participation in the L.A. Care network.

7.2 DELEGATION OF CREDENTIALING

7.2.1 L.A. Care is responsible for monitoring all contracted PPGs, credentialing, and re-credentialing activities. A PPG must pass the L.A. Care Credentialing department’s pre-delegation credentialing audit in order to be delegated the credentialing responsibility.
Otherwise, L.A. Care’s Credentialing department is responsible for a PPG’s credentialing activities. Regardless of a PPG’s credentialing delegation status, L.A. Care retains the right to approve new practitioners and sites, and to terminate or suspend individual practitioners, based on credentialing issues at all times.

7.2.2 Definition of Delegation: Delegation is a formal process by which an organization gives another entity the authority to perform certain functions on its behalf. Although the organization can delegate the authority to perform such a function, it cannot delegate the responsibility for assuring that those functions are performed appropriately.

7.2.3 If the PPG delegates any credentialing and re-credentialing activities, there is evidence of oversight of the delegated activity. The PPG is accountable for credentialing and re-credentialing its practitioners, even if it delegates all or part of these activities. There must be annual evidence of a mutually agreed upon delegation agreement by both the PPG and the delegate, i.e., NCQA certified CVOs, non-certified CVOs, etc. The delegation agreement must meet all elements of NCQA’s standard CR12. As a note, CMS does not recognize NCQA certified CVOs. As such, all files are subject to full file review.

7.2.4 When delegates have access to the PPG’s protected health information (PHI) on members or practitioners, or create such information in the course of their work, the mutually agreed-upon document must ensure that the information will remain protected. This is not applicable if there is no delegation arrangement, or if the delegation arrangement does not involve the use, creation or disclosure of protected health information.

7.2.5 If the delegation arrangement does not include the use of PHI in any form, an affirmative statement to that fact in the delegation agreement is sufficient, but is not required; the PPG may document the lack of PHI in a delegation arrangement in other manners.

7.2.6 Prior to delegation, L.A. Care’s Credentialing Department audits the PPG (the potential delegated entity) to determine if the PPG meets L.A. Care’s criteria for delegation. The Credentialing Department evaluates the potential delegated entity’s ability to perform the delegated activities, which will include all activities related to credentialing and re-credentialing in accordance with the standards of L.A. Care, NCQA, DHCS and CMS. Using a modified version of the Standardized Audit Tool in accordance with L.A. Care, NCQA,
DHCS and CMS standards, the Credentialing Department will evaluate delegated entity’s performance.

7.2.7 Types of Delegation Status

7.2.7.1 After completion of the pre-delegation audit, the audit tool is scored and recommendations regarding delegation are presented to the Credentialing/Peer Review Committee and the Quality Oversight Committee (QOC) as follows:

7.2.7.1.1 **Delegation** – PPG group scores between 80% to 100% on the pre-delegation audit. A corrective action plan must be successfully completed if score is below 100%.

7.2.7.1.2 **Full delegation** – PPG scores 100%. No CAP required.

7.2.7.1.3 **Full delegation** – PPG scores between 80-99%. CAP required. A corrective action must be successfully completed.

7.2.7.1.4 **Provisional Delegation** – PPG scores between 70%-79% on the pre-delegation credentialing audit. A corrective action plan must be successfully completed and a re-audit performed after ninety (90) days.

7.2.7.1.5 **Denial of Delegation** – PPG chooses not to pursue delegation of credentialing, or it receives less than a 70% on the pre-delegation credentialing audit. PPG has a Non-Delegated credentialing status for a minimum of one year. The credentialing of PPG’s practitioners is performed by L.A. Care’s Credentialing department.

7.2.7.2 Following recommendations by the Credentialing/Peer Review Committee, delegation letters will be sent to the PPG’s scoring 80% or above, and Delegation Agreements for credentialing will be executed.

7.2.8 Levels of Delegation

7.2.8.1 **Partial** – Some credentialing activities have been delegated to the PPG, and some activities have been retained by L.A. Care. The Delegation Agreement will identify in detail exactly what functions have been delegated to the PPG.

7.2.8.2 **Full** – All credentialing activities have been delegated to either the PPG or a combination of a hospital and medical
7.2.9 Delegation Oversight

7.2.9.1 The PPG agrees, upon delegation, to make available to L.A. Care the credentialing and re-credentialing status on the PPG’s participating practitioners, including credentialing data elements as well as documents and quarterly reports, as appropriate, using the standardized ICE form or another approved L.A. Care format.

7.2.9.2 Credentialing and recredentialing files will be reviewed according to the following file pull methodology: A roster of practitioners credentialed and recredentialed within the audit period will be requested. NCQA’s 8/30 methodology will be used in evaluating files. The minimum files reviewed will be eight (8) initial files and eight (8) recredential files. If any element should fall out of the 8/30 Rule, then the deficient element(s) will be reviewed for the remaining files, up to a maximum of 30 initial credentialing and 30 recredentialing files.

7.2.9.3 L.A. Care’s oversight audit will include a review of the PPG’s credentialing policies and procedures, Committee meeting minutes, application(s), file review, and other related documentation of PPG’s credentialing and recredentialing process in accordance with L.A. Care, NCQA, DHCS, and CMS guidelines.

7.2.9.4 Results of L.A. Care’s oversight audit will be reported to the PPG, including corrective action plan if deficiencies are noted. The PPG will implement such corrective action plan within the time period stated and will permit a re-audit by L.A. Care or its agent, if requested. If PPG fails to adequately correct the deficiencies within the required time period, L.A. Care retains the right to perform a focused audit as deemed necessary. L.A. Care may de-delegate credentialing and assume responsibility for all or part of credentialing functions.

7.2.9.5 The Credentialing Department works collaboratively with the delegate when deficiencies have been identified through the oversight process. The delegate is given a Corrective Action Plan (CAP) and asked to respond within 30 days. If no response is received within 30 days, the
Regulatory Affairs and Compliance (RAC) Department sends a second letter requesting a response within 14 days and advising that failure to respond may be cause for revocation of the delegation agreement.

7.2.9.6 PPG that receives a rating of “excellent”, “commendable”, “accredited”, or “certified”, from NCQA, will be deemed to meet L.A. Care’s requirements for credentialing. These PPGs may be exempt from the L.A. Care audit of credentialing in elements for which they are accredited or certified. As a note, CMS does not recognize NCQA certified CVOs. In such cases, all files may be subject to full file review. L.A. Care retains overall responsibility for ensuring that credentialing requirements are met and will require documentation from PPG to establish proof of NCQA accreditation status. Elements not listed in the NCQA accreditation documentation will require further validation through annual or pre-delegation audits. L.A. Care retains the right to perform oversight audits as necessary.

7.2.10 Delegation Revocation

7.2.10.1 At L.A. Care’s discretion, or in the event that L.A. Care determines that significant deficiencies are occurring related to performance by the delegate and are without remedy, additional focused audits may be initiated and/or CAPs may be implemented as stipulated in the written delegation agreement.

7.2.10.2 L.A. Care retains the right to approve new participating practitioners and sites (delegated or sub-delegated), and to terminate, suspend, and/or limit participation of PPG’s practitioners who do not meet L.A. Care’s credentialing requirements.

7.3 PPG RESPONSIBILITIES

7.3.1 PPG must have policies and procedures to address credentialing of practitioners, non-practitioner health care professionals, licensed independent practitioners and health delivery organizations that fall within its scope of credentialing. PPG must state in policy that they do not make credentialing and re-credentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g., abortions)
or patients (e.g., Medicaid) in which the practitioner specializes. A statement that the PPG does not discriminate does not meet the intent of the requirement. The policy must explicitly describe that the organization takes steps to monitor for and prevent discriminatory practices during the credentialing and recredentialing processes.

7.3.2 PPG will establish standards, requirements and process for the health delivery organizations that are performing services for L.A. Care members to ensure that these practitioners and health delivery organizations are qualified to perform the services, and are licensed and/or certified consistent with L.A. Care, NCQA, DHCS, and CMS requirements. These standards, requirements and processes are applicable whether or not credentialing and recredentialing activities are delegated.

7.3.3 PPG’s policies must explicitly define the process used to ensure that the information submitted to L.A. Care is consistent with the information obtained during the credentialing process which is included in member materials and practitioner directories. Specifically, any practitioner information regarding qualifications given to members should match the information regarding practitioner’s education, training, certification and designated specialty gathered during the credentialing process. "Specialty" refers to an area of practice, including primary care disciplines.

7.3.4 PPG will establish a peer review process by designating a Credentialing Committee that includes representation from a range of participating practitioners. The credentialing process can encompass separate review bodies for each specialty (e.g., practitioner, dentist, and psychologist) or a multidisciplinary committee with representation from various types of practitioners and specialties.

7.3.5 PPG must notify the practitioner, in writing, of any adverse actions to the practitioner and notify L.A. Care of PPG’s action taken.

7.3.6 PPG must notify L.A. Care in writing, if any contracted practitioner has any adverse action or criminal action taken against them promptly and no later than fourteen (14) calendar days from the occurrence of any adverse event, criminal action, changes in privileges, accusation, probation, or other disciplinary action of practitioners. Failure to do so may result in the removal of the practitioner from L.A. Care’s network.
7.3.7 L.A. Care reserves the right, pursuant to the Participating Practitioner Group Services Agreement, to coordinate, consolidate, and participate in any PPG participating practitioner disciplinary hearing, conducted in accordance with L.A. Care Policy and Procedures, and California Business and Professions Code Section 805.

7.3.8 PPGs that are delegated for credentialing and recredentialing are required to review, investigate and take appropriate action for any adverse events or criminal actions taken against a contracted provider including, but not limited to fair hearing and reporting to appropriate authorities as delegated. L.A. Care retains the right to approve, close panel to new membership and/or terminate contracted practitioners at all times.

7.3.9 PPG will advise L.A. Care of any changes to its credentialing and re-credentialing policies and procedures, processes, delegation or sub-delegation, and criteria within thirty (30) days of the change. If L.A. Care deems the changed items not in compliance with L.A. Care, NCQA, DHCS, and CMS requirements, L.A. Care shall notify PPG immediately. PPG will have 30 days to be in compliance, and, if not in compliance, L.A. Care may de-delegate credentialing and assume responsibility for all or part of the credentialing functions.

7.3.10 PPG will provide quarterly reports to L.A. Care following the end of each report month (May 15th, August 15th, November 15th, February 15th) with accurate and complete PPG practitioner data. PPG must provide Board certification status and Board expiration date when adding a practitioner to L.A. Care’s network and any updates.

7.3.11 Using the standardized ICE format and Excel grid will include the following:
- 7.3.11.1 Number of adds/deletes of PCPS (i.e. MDs, Dos, etc.)
- 7.3.11.2 Number of adds/deletes of SCPS (i.e. MDs, and Dos, etc.)
- 7.3.11.3 Numbers of adds/deletes of independent practitioners (i.e. DCs, DPMs, etc.)
- 7.3.11.4 Any new or revised policies and procedures, additions of a computer system, CVO
- 7.3.11.5 Practitioners termed for quality issues

7.3.12 PPG will submit a profile of the PCP or SCP credentialing information to L.A. Care. Along with the profile, first and last page of the contract, W-9, all addenda to the California Participating Physician Application (CPPA), and appropriate hospital coverage letter, if applicable, must be attached. In addition, all PCPs
requesting to treat members 0-16 years of age must be CHDP certified. To expedite the addition of the PCP who has requested to treat members 0-16 years of age, PPG must supply a copy of the certification letter. PPG will be responsible to manage the CHDP certification process within their network.

CHDP exceptions will be reviewed on a case by case basis by L.A. Care’s Chief Medical Officer or designee and presented to the Credentialing Committee for action. All requests for an exception will include, but will not be limited to the consideration of the practitioner’s board certification status, member grievances, facility site review compliance, regulatory compliance, performance, hospital privileges, and geographic need. Supporting documentation is required. The decision of L.A. Care’s Credentialing Committee or designee will be final. Notice of the decision will be forwarded to the Plan Partner or PPG following the Committee’s decision by the Credentialing Department. L.A. Care’s Credentialing Committee is currently accepting exceptions requests.

7.3.13 PPG profiles must meet L.A. Care’s requirements as follows: Practitioners who do not have hospital privileges with a L.A. Care contracted hospital, may use the PPGs admitting panel or have a direct agreement with a practitioner who has admitting privileges within the same specialty at a L.A. Care contracted hospital. This agreement must capture responsibility for the provisions and coordination of care, when patients are discharged from the hospital, referral of patients back to PCP with a hospital discharge summary, and coordinate a seven day week, 24-hour call coverage utilizing the practitioners that are contracted with the PPG.

7.3.14 PPG will notify L.A. Care within thirty (30) days of any changes in the status of any of the PPG’s participating practitioners, including, but not limited to, termination, resignation.

7.3.15 PPGs will ensure that practitioners and all of their contracted sites are reviewed in accordance with the requirements of L.A. Care, NCQA, DHCS and CMS requirements. All Practitioners must have a current (i.e., within 3 years of the date of initial credentialing/re-credentialing) full scope site review at the time of initial credentialing/re-credentialing. Practitioners who are only contracted for the Medicare program are only required to undergo a medical record review.

7.3.16 PPG’s Board of Governors (Board), or the group or committee to whom the Board has formally delegated the credentialing function,
reviews and approves the credentialing policies and procedures on an annual basis.

7.3.17 Provisional Credentialing
The PPG may conduct provisional credentialing (in compliance with L.A. Care, NCQA, DHCS, and CMS requirements) of practitioners who completed residency or fellowship requirements for their particular specialty area within the 12 months before the credentialing decision.

7.4 CREDENTIALS COMMITTEE
7.4.1 The Credentials Committee will consist of not less than three (3) participating practitioners in good standings with state and federal agencies in order to ensure accurate representation of medical specialties.

7.4.2 Administrative support staff may attend at the request of the Chair but are not entitled to vote.

7.4.3 A quorum should consist of three (3) practitioner committee members. Any action taken upon the vote of a majority of members present at a duly held meeting at which a quorum is present shall be an act of the committee.

7.4.4 Meetings and Reporting
7.4.4.1 The Credentials Committee shall meet at least quarterly but as frequently necessary to demonstrate follow-up on all findings and required action; and maintain a permanent record of its proceedings and actions. The activities, findings, recommendations, and actions of the committee must be reported to the governing body or designee in writing on a scheduled basis.

7.4.4.2 Additional meetings of the credentials committee may be called by the Committee Chairperson on an as-needed.

7.4.5 Committee Decisions
7.4.5.1 L.A. Care considers the decision made by the Credentials Committee to be final.

7.4.5.2 The PPG’s credentialing policies and procedures must include a time frame for notifying applicants of credentialing decisions, not to exceed sixty (60) calendar days from the committee’s decision.
7.4.6 Participation of Medical Director or other Designated Practitioner
7.4.6.1 PPG must have a practitioner (medical director or equally qualified designated practitioner) who has overall responsibility for the credentialing process. Credentialing policies and procedures must clearly indicate the Medical Director is directly responsible for the credentialing program and must include a description of his/her participation.

7.4.7 Committee Functions
7.4.7.1 Review and evaluate the qualifications of each practitioner applying for initial credentialing, and recredentialing.

7.4.7.2 Investigate, review and report on matters referred by the Medical Director or his/her designee or the Board regarding the qualifications, conduct, professional character or competence of any applicant or practitioner, and;

7.4.7.3 Submit periodic reports to the appropriate Committee and/or Board on its activities, i.e., ongoing monitoring reports, credentialing activity reports, etc.

7.4.7.4 Review annually policies and procedures relevant to the credentialing process, and make revision as necessary to comply with L.A. Care, NCQA, DHCS, and CMS requirements, regulations and practices.

7.4.7.5 PPG’s Credentials Committee must review practitioner credentials and give thoughtful consideration to the credentialing elements before making recommendations about a practitioner’s ability to deliver care. At a minimum, the Credentials Committee must receive and review the credentials of practitioners who do not meet the PPG’s established criteria.

7.4.7.6 PPG’s Credentialing Committee must clearly document detailed discussion that reflects thoughtful consideration of credentials reviewed during its meeting in the minutes. Discussion that demonstrates approval/denial does not meet the intent of detailed discussion.

7.4.7.7 When the credentialing function is not delegated to the PPG, L.A. Care’s Credentialing department will be responsible for credentialing and recredentialing activities in-house.

7.4.7.8 L.A. Care’s Credentialing/Peer Review Committee may
terminate, suspend or modify participation of those practitioners who fail to meet eligibility criteria. The decisions to terminate, suspend, or modify participation of a contracted practitioner as a result of a reportable quality of care issue shall be subject to an appeals process by the practitioner.

7.4.8 Credentials Committee File Review

7.4.8.1 PPG's policies and procedures must describe the process used to determine and approve clean files. They must identify the Medical Director as the individual with the authority to determine that a file is "clean" and to sign off on it as complete, clean and approved. With regard to clean files, the practitioner may not provide care to members until the final decision of the Credentialing Committee or the Medical Director or his or her equally qualified designee.

7.4.8.2 PPG's credentialing and re-credentialing policies must explicitly define the process used to reach a credentialing decision.

7.5 Recredentialing

7.5.1 Participating practitioners must satisfy re-credentialing standards required for continued participation in the network. Recredentialing is completed three years from the month of initial credentialing and every three (3) years thereafter.

7.5.2 A facility site review does not need to be repeated as part of the re-credentialing process if the site has a current passing score (this applies to PCPs). A passing site review survey will be considered "current" if it is dated within the last three (3) years (with use of new tool) of the re-credentialing date, and does not need to be repeated until the due date of the next scheduled site review survey or when determined necessary through monitoring activities by the Plan.

7.5.3 If a provider is contracted for the Medi-Cal and Medicare programs, they are subject to both a site review and medical record review. However, if the provider is only contracted for the Medicare program, a medical record review is all that is required. However, Facility Site Review or other L. A. Care staff may visit a provider’s office at any time without prior notification.

7.6 Confidentiality and Practitioner Rights

7.6.1 PPG's credentialing policies and procedures must clearly state the confidential nature of information obtained in the credentialing process. The PPG must also describe the mechanisms in effect to
ensure confidentiality of information collected in this process. The PPG must ensure that information obtained in the credentialing process is kept confidential and, ensure that practitioners can access their own credentialing information, as outlined in Right to review information, below.

7.6.2 During the credentialing process, all information that is obtained is considered confidential. All Committee meeting minutes and practitioner files are to be securely stored and can only be seen by an appropriate Medical Director or his/her equally qualified designee, and the Credentials Committee members. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes consistent with Section 1157 of the State of California Evidence Code and Section 1370 of the Health and Safety Code of the State of California.

7.6.3 PPG’s policies and procedures must state that practitioners are notified of their right to review information obtained by the PPG to evaluate their credentialing application. The evaluation includes information obtained from any outside source (malpractice insurance carriers, state licensing boards, etc.).

7.6.4 PPG must have written policies and procedures for notifying a practitioner in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner. The policies and procedures must clearly identify timeframes, methods, documentation and responsibility for notification.

7.6.5 PPG is not required to reveal the source of information if the information is not obtained to meet PPG credentialing verification requirements or if disclosure is prohibited by law.

7.6.6 Policies and procedures must also state the practitioner’s right to correct erroneous information submitted by another source. The policy must clearly state:

- Timeframe for changes
- Format for submitting corrections
- The person to whom corrections must be submitted
- Receipt of documented corrections
- How practitioners are notified of their right to correct erroneous information as outlined in this manual.

7.6.7 PPG’s credentialing policies and procedures must state that practitioners have a right to be informed of the status of their
applications upon request, and must describe the process for responding to such requests, including information that the PPG may share with practitioners. This element does not require the PPG to allow a practitioner to review references, recommendations or other peer-review protected information.

7.7 APPEAL AND FAIR HEARING

7.7.1 Delegated PPG, or if not delegated, L.A. Care must have a mechanism for fair hearing and appeal process for addressing adverse decisions that could result in limitation of a practitioner’s participation based on issues of quality of care and/or service, in accordance with all applicable statutes. The process should include notification to practitioner within an established time frame and established time frame for practitioner to request a hearing, scheduling of hearing requests, followed by the procedures hearings, the composition of the hearing committee and the agenda for the hearing.

7.7.2 PPG must have an appeal process for instances in which it chooses to alter the conditions of a practitioner’s participation based upon issues of quality of care and/or service. Except as otherwise specified in this manual, any one or more of the following actions or recommended actions taken for a medical disciplinary cause or reason shall be deemed actual or potential adverse action and constitute grounds for a hearing:

7.7.2.1 The following actions entitle the practitioner the opportunity to appear before a Peer Review Committee to present rebuttal evidence before a final determination is made. The practitioner shall have the right to be represented by an attorney during this process. The following actions also entitle the practitioner the opportunity for a hearing before a hearing panel in the event that the final determination of a Peer Review Committee is adverse to the practitioner, unless the right to a hearing has been forfeited as described below. The actions to which this section applies are:

- Denial of initial panel appointment
- Denial of reappointment to panel
- Suspension of panel appointment (except as described below)
- Revocation of panel appointment
- Other adverse restrictions on panel appointment (except as described below)
7.7.3 A Peer Review Committee has the right to recommend suspension of a practitioner’s panel appointment for up to fourteen (14) calendar days while an investigation is being conducted to determine the need for peer review action, without the practitioner having a right to the rebuttal and/or fair hearing process set forth below.

7.7.4 A Peer Review Committee has the right to recommend immediate suspension or restriction of a practitioner’s membership if the committee reasonably believes that the health of any individual would be jeopardized by the continued participation of the practitioner. In the case of such an immediate suspension or limitation on privileges (summary action), the practitioner has the right to notice, opportunity to present rebuttal information and fair hearing, in accordance with the procedure described in L.A. Care’s Policy LS-005, but those rights apply subsequent to the summary action, rather than prior to it.

7.7.5 Required Reporting

7.7.5.1 PPG must file a Section 805 report with the Medical Board of California and a report with the National Practitioner Data Bank/Healthcare Integrity Protection Data Bank within thirty (30) calendar days after the effective date of the action, if any of the following events occur:

7.7.5.1.1 The practitioner’s application for participation status (credentialing) is denied or rejected for a medical disciplinary cause or reason.

7.7.5.1.2 The practitioner’s participation status is terminated or revoked for a medical disciplinary cause or reason.

7.7.5.1.3 Restrictions are imposed or voluntarily accepted for a cumulative total of thirty (30) days or more for any 12-month period, for a medical disciplinary cause or reason.

7.7.5.1.4 The practitioner resigns or takes a leave of absence from participation status following notice of any impending investigation based on information indicating medical disciplinary cause or reason.
7.7.5.2 The practitioner must be notified of any adverse actions in writing, and if credentialing is delegated to a PPG, a copy of the notification letter must be submitted to L.A. Care. If any contracted practitioner has any adverse action or criminal action taken against them, the PPG must notify L.A. Care promptly and no later than fourteen (14) calendar days of any adverse event or criminal action, changes in privileges, accusation, probation, or other disciplinary action against a practitioner.

7.7.6 Ongoing Monitoring of Sanctions, Complaints, and Quality Issues

7.7.6.1 PPG must implement a process for monitoring practitioner sanctions, complaints and the occurrence of adverse events between re-credentialing cycles. The PPG must conduct ongoing monitoring of all practitioners who fall within the scope of credentialing. The PPG must be fully compliant with L.A. Care, NCQA, DHCS, and CMS and use the approved current sources of sanction information.

7.7.6.2 PPG develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between re-credentialing cycles, and takes appropriate action against practitioners when it identifies occurrences of poor quality. PPG identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.

7.7.6.3 PPG must show how they monitor all adverse events and demonstrate this process has been reviewed by the Credentials committee at least every six months.

7.7.6.4 PPG must provide proof of any practitioner identified on the OIG, Medi-Cal Suspended & Ineligible List, Medicare Opt-Out, etc. The PPG must demonstrate that they have taken action to terminate the contracted practitioner. If a practitioner has been identified on any of the lists above, they are to be terminated for all lines of business for L.A. Care.

7.7.6.5 PPG must notify L.A. Care promptly and no later than fourteen (14) calendar days of any adverse event or criminal action, changes in privileges, accusation, probation, or other disciplinary action against a practitioner.
Failure to do so may result in the removal of the practitioner from L.A. Care’s network.

7.7.6.6 L.A. Care retains the right, based on quality, facility site review, adverse events, criminal actions, or changes in privileges, accusations, and/or probation to close practitioners to new member assignment until such time the L.A. Care’s Credentialing Committee determines otherwise.

7.7.7 EXPIRED LICENSE

7.7.7.1 Failure to Renew

Practitioners contracted with L.A. Care shall be licensed or certified by their respective board or agency, where licensure or certification is required by law. The license to practice medicine in California must be renewed upon expiration (every two (2) years).

7.7.7.2 If any practitioner fails to renew their license by the expiration date, the following steps will be initiated by L.A. Care.

7.7.7.2.1 If the identified practitioner(s) has member enrollment:
  o Close provider’s panel to new members upon license expiration.
  o Notify PPG of expiration and possible reassignment of members
  o Remove assigned members from unlicensed practitioner/practitioner 5 business days following license expiration, if not renewed
  o Reassign members to a qualified licensed credentialed practitioner
  o Remove unlicensed practitioner from network

7.7.7.2.2 If the identified practitioner(s) has no member enrollment:
  o Close practitioner’s panel to new members
  o If practitioner/practitioner has not renewed by the 5th business day following the expiration date, the unlicensed
8.0 PROVIDER NETWORK OPERATIONS (PNO)

8.1 SPECIFIC AREAS

8.1.1 Provider Contracting
The Provider Network Contracting team is responsible for developing and negotiating financially sound contracts with physicians, Participating Physician Groups (PPGs), hospitals, ancillary providers and other health professionals in order to maintain a comprehensive network of health care providers for the provision of health care services to covered members.

8.1.2 Provider Relations
8.1.2.1 Provider Relations Manager and Provider Network Representatives are responsible for the following:

8.1.2.1.2 Serving as key contacts for PPGs, hospitals, and other providers to resolve all operational and ongoing service issues.

8.1.2.1.3 Coordinating closely with Provider Contracting, Provider Information Management, Member Services, Claims, Utilization Management, and PPGs when necessary to resolve issues.

8.1.2.1.4 Training PPG personnel to ensure L.A. Care procedures and requirements are understood and followed.

8.1.2.1.5 Conducting Joint Operations Meetings to ensure that administrators and staff are kept informed of policy and procedure changes.

8.1.2.1.6 Provider grievance resolution.

8.1.3 Provider Network Research & Analysis Unit
The Provider Network Research & Analysis Unit (PNRA) has program responsibility over multifaceted, highly technical functions that bring together the services of information technology, provider network information, and statistical studies and reporting. In this capacity, PNRA has oversight responsibility for the management,
accessibility, and usability of provider information. PNRA is also responsible for conducting comprehensive provider related studies as mandated by the Centers for Medicare & Medicaid Services (CMS) and other governing agencies/bodies. Other key functions of the PNRA unit are the production of L.A. Care’s provider directories and the entry/updating of contractual terms/rates into L.A. Care’s transaction system for our directly contracted PPGs, hospitals, ancillary providers, and individual providers for claim payment purposes.

8.2 PROVIDER TRAINING AND EDUCATION
8.2.1 Provider education is implemented by L.A. Care and its PPGs. Goals, objectives, curricula, and implementation guidelines are established by L.A. Care. The PPGs are responsible for conducting provider training and orientation. L.A. Care provides additional resources and opportunities for provider education.

8.2.2 L.A. Care provides special training and workshops for traditional and safety net providers. These workshops encompass focused clinical competence training, product line workshops, and other related clinical practice management issues along with the Health Promotion Services department.

8.2.3 Ultimately, the goal of provider training and education is to improve the delivery of services to members by providing appropriate forums for providers to:

8.2.3.1 Be better informed about products offered by L.A. Care and its systems and processes.

8.2.3.2 Understand the needs of L.A. Care members.

8.2.3.3 Improve clinical, patient interaction, and administrative/management skills.

8.2.4 A training and education curriculum will be developed and implemented by the PPGs with collaborative oversight, guidance, and approval of L.A. Care or it will be provided directly by L.A. Care. L.A. Care’s Health Promotion Services department and PNO share responsibility for L.A. Care’s involvement in this process.

8.3 TRAINING AND EDUCATION MATERIALS AND METHODS
All provider training and education materials produced and distributed by PPGs must be approved by L.A. Care prior to distribution. The following provider training and education materials must be used by the PPGs:
8.3.1 **Provider Manuals**
Each PPG must distribute a provider manual to its contracted network within Los Angeles County that includes information about L.A. Care’s contracted programs.

8.3.2 **Orientation Sessions and On-site Visits**
Provider orientation sessions and on-site visits will be conducted by PPGs to provide an in-service on their provider manual and to conduct additional training, as needed, for newly contracted providers and programs within ten (10) calendar days of effective contract.

8.3.3 **Provider Bulletins and Newsletters**
PPGs should publish and distribute provider newsletters and/or bulletins at least semi-annually. The newsletters should provide relevant and timely information concerning applicable standards, services available to members, quality improvement activities, updates, and other pertinent issues related to the delivery of health services to L.A. Care members. Semi-annual general meetings that provide updates on health care delivery issues, hosted by PPGs and its providers, will meet the requirement of publishing semi-annual newsletters/bulletins.

8.3.4 **Focused Seminars, Workshops and Symposia**
L.A. Care and PPGs will work together to conduct focused seminars, workshops, and symposia on special topics.

8.4 **PROVIDER DIRECTORIES**
L.A. Care produces a provider directory for each product line on a regular basis. The directory includes a listing of all the PPGs, PCPs, hospitals and pharmacies. Data for the directory will be compiled by L.A. Care from PPG provider uploads. Upon request, L.A. Care will send a directory to the requesting party.

8.5 **MID-LEVEL MEDICAL PRACTITIONERS**

8.5.1 The use of non-physician practitioners is designed to increase members' access to appropriate primary care and specialty medical services, maximize the patient’s health and well-being, and promote cost-effective care. The delegation of specified medical procedures to non-physician practitioners does not relieve the supervising physician of ultimate responsibility for the welfare of the patient or the actions of the non-physician practitioner.
8.5.2 Physicians may supervise up to four mid-level medical practitioners according to the following ratios of a full-time equivalent physician supervisor to mid-level medical practitioners:

8.5.2.1 One physician to four nurse practitioners
8.5.2.2 One physician to three certified nurse midwives
8.5.2.3 One physician to two physician assistants
8.5.2.4 Four non-physician practitioners in any combination that does not include more than three certified nurse midwives or two physician assistants and maintain the full-time equivalence limits.

8.5.3 A single non-physician practitioner can potentially increase the supervising physician’s capacity by 1,000 members. However, when all practitioners are added, the physician cannot be responsible for more than 5,000 patients in total. The non-physician practitioner may only provide those medical services that he/she is competent to perform and that are consistent with the practitioner’s education, training and experience, the terms of which must be delineated in writing by the supervising physician. The stipulated scope of practice must be in full compliance with standards set forth by the Physician Assistant Examining Committee of the Medical Board of California, California Board of Nursing, the Nursing Practice Act, DMHC the California Code of Regulations, the California Administrative Code, the California Business and Professions Code, and the requirements of any other applicable professional licensing body, law and regulations.

8.5.4 A scope of practice agreement which is signed by the non-physician practitioner and the supervising physician, as well as standardized procedures, must be filed and maintained at the medical practice site. The scope of practice agreement must address the following elements:

8.5.4.1 Delegated responsibilities
8.5.4.2 Disciplinary policies
8.5.4.3 Method and frequency of physician supervision
8.5.4.4 Monitoring and evaluation of the non-physician practitioner
8.5.4.5 Chart review requirements
8.5.4.6 Term of the agreement/contract

8.5.5 The following requirements must be included within the standardized procedures for mid-level medical practitioners, and reflected in written agreements as indicated above:

8.5.5.1 The supervision or back-up physician must be available in person or through electronic means at all times when the non-physician practitioner is caring for patients.
8.5.5.2 The supervising physician must review on a continual basis tasks delegated to the non-physician practitioners for competency.

8.5.5.3 Medical record documentation by the non-physician practitioner must be reviewed and counter-signed by the supervising physician within thirty (30) calendar days of the date care was provided.

8.5.6 Each PPG must set and implement credentialing elements for mid-level medical practitioners and ensure that they are consistent with the criteria and scope of practice requirements set forth in this manual and any other policies, procedures, and directives issued by L.A. Care. As part of the credentialing process, the appropriate credentialing committee, prior to the provision of care by mid-level medical practitioners, must verify that a signed scope of practice agreement, a signed set of procedures by the supervising provider, and appropriate license(s) are present. L.A. Care will audit the PPG’s credentialing verification process.

8.6 ELIGIBILITY LISTS

8.6.1 Monthly Eligibility lists (E-lists) for the Medicare Advantage Program are provided to PPGs by or on the tenth (10th) business day of each month. The E-list contains the current month’s eligibility information for members assigned to PCPs within each PPG. Daily eligibility can be verified by L.A. Care’s IVR system or by using L.A. Care Connect.

8.6.2 Please call L.A. Care’s Provider Information Line at 1-866-LACARE6 or your assigned Provider Network Representative if you have any questions about your eligibility lists.

8.7 PROCEDURE FOR HANDLING PROVIDER QUESTIONS & CONCERNS

8.7.1 Communication

Providers can communicate their questions and concerns to their PPG or to L.A. Care directly. Providers may communicate with L.A. Care by telephone, in person, in writing, or by e-mail.

8.7.2 Resolution

8.7.2.1 Provider Network Representatives from the PPG or L.A. Care will answer most provider questions and resolve provider concerns immediately. Any question or concern, which suggests a quality of care issue, will be handled as a
clinical grievance. Any question regarding Part “D” benefits will be forwarded to the L.A. Care Health Plan Part “D” hotline. (1-800-633-4273

8.7.2.2 The provider network representative will answer the provider’s question and inform the provider of his/her right to file an informal complaint or formal grievance if desired. If the provider asks a question over the telephone or in person, the answer will be provided orally. If the provider writes a letter, the answer will be provided in writing within seven (7) business days.

8.8 PROVIDER GRIEVANCES
Provider administrative grievances will be handled as specified below.

8.8.1 Communication of Formal Grievances
8.8.1.1 Providers must communicate their formal grievances directly to their PPG. This communication must be in writing.

8.8.1.2 If the provider wishes to file a formal grievance, the Grievance and Appeals representative will give the provider detailed instructions for filing a grievance. The Grievance and Appeals unit will assist providers in filing grievances, including assistance with completing a grievance form, if applicable.

8.8.1.3 The Grievance and Appeals representative will record the grievance on the provider grievance log. Regardless of the method of filing of the provider’s grievance, the Grievance and Appeals unit will send an acknowledgment letter to the provider within five (5) working days.

8.8.1.4 If a provider contacts L.A. Care directly with a grievance, the Grievance and Appeals representative will record the information on the provider grievance log, contact the provider’s PPG, and send an acknowledgement letter within five (5) business days. The PPG will be responsible for resolving the grievance within thirty (30) calendar days and informing L.A. Care of the resolution/disposition. L.A. Care will be responsible for informing the provider of the resolution/disposition in this case.

8.9.2 Resolution
8.9.2.1 All grievances will be resolved within thirty (30) calendar days.
8.9.2.2 Extensions to grievances will be requested of the Grievance and Appeals Manager. A fifteen (15) or thirty (30) calendar day extension may be granted. If an extension is granted, a letter to the grieving provider will be sent with appropriate reasons for the extension.

8.9.2.3 The PPG and/or L.A. Care will provide written notice of grievance resolution/disposition and deliver each letter by way of certified mail.

8.9.3 Dispute Resolution

8.9.3.1 A provider has the right to file an appeal. The provider must submit a detailed written grievance, including the desired resolution and all supporting documentation and correspondence to the PNO Director at L.A. Care. L.A. Care will respond with an acknowledgement letter within five (5) business days.

8.9.3.2 A Provider Relations Subcommittee will convene within thirty (30) calendar days of receipt of the dispute to decide whether the committee has authority to address the issue. The grieving party will have the opportunity to address the issue in front of the committee if L.A. Care’s committee has deemed it applicable. A resolution will be made by the committee with notification to the provider within seven (7) business days of the decision.

8.9.3.3 All providers have the right to file a grievance with the Department of Managed Health Care (DMHC). The toll-free telephone number is (800) 400-0815. If you have a grievance against L.A. Care Health Plan, contact L.A. Care and use our grievance process.
9.0 HEALTH EDUCATION

Health education is the process of providing health information, skill training, and support to individuals to enable and empower them to modify their behaviors and improve their health status. L.A. Care Health Plan is responsible for the planning, implementation, and evaluation of member health education, health promotion, and patient education for our direct lines of business members. Primary care providers (PCPs) are responsible for delivering individual education during member doctor visits, continually reinforcing positive health behavior change in patients, documenting the delivery of health education services in the patient’s medical record, and administering the Individual Health Education Behavioral Assessment Tool (IHEBA). PPGs are responsible for assisting L.A. Care in educating providers about health education requirements, services and available resources.

The mission of L.A. Care Health Plan’s Health Education, Cultural and Linguistic Services Department (HECLS) is to improve direct line of business member health status through the delivery of wellness and disease prevention programs and to ensure access to culturally and linguistically appropriate resources and health care. This is achieved through assisting direct line of business members to:

- Effectively use the managed health care system, including primary and preventive health care services, obstetrical care, health education services and appropriate use of complementary and alternative care
- Modify personal health behaviors, achieve and maintain healthier lifestyles, and promote positive health outcomes
- Learn and follow self-care regimes and treatment therapies for existing medical conditions, chronic diseases or health conditions.

Health Education Services

*Health In Motion™ L.A. Care Members Only*, L.A. Care Health Plan’s mobile health education program brings health education directly to L.A. Care members in their communities. *Health In Motion™ L.A. Care Members Only* is for L.A. Care Health Plan’s direct line of business members (MCLA, L.A. Care Healthy Families, L.A. Care Healthy Kids, and L.A. Care Medicare Advantage HMO SNP). Services are offered as individual counseling over the phone and/or group appointments. All classes are available at no cost to the member and are conducted in English and Spanish. Interpretation services (including American Sign Language) are also available. Programs include:
Chronic Disease

- **Asthma 101**: (1 session) Educates participants on risk factors, asthma attack prevention, medication adherence, and the use of peak flow meters and spacers.

- **Diabetes 101 – Sugar in the Blood**: (1 session) Teaches basic diabetes in easy-to-understand terms, risk factors for diabetes, symptoms of diabetes, the importance of knowing blood sugar numbers, and ways to prevent or control diabetes.

- **Healthier Living**: (6 session series) Teaches skills to help manage patient’s chronic disease. Instruction includes nutrition, goal setting, and how to better communicate with providers and family members.

- **Love Your Heart, Lower Your Blood Pressure**: (1 session) Teaches skills to prevent and manage high blood pressure. Instruction includes nutrition and exercise information.

- **Take Action Against Cholesterol**: (1 session) Teaches skills to prevent and manage high cholesterol. Instruction includes nutrition and exercise education.

- **Living With Diabetes**: (5 session series) Teaches skills to help manage diabetes. Instruction includes awareness of disease complications, nutrition, and exercise education.

Wellness

- **Burn Rubber**: (1 session) An exercise program where participants will “burn” calories with the use of a “rubber” resistance band. Popular resistance band exercises have been modified to perform in a chair to meet the needs of the senior population. Eight different exercises are covered for a total body workout.

- **Cold or Flu? Antibiotics Won’t Work for You!**: (1 session) Teaches participants the difference between a virus and bacteria, what antibiotics are used for and how to take them, awareness of the risk of antibiotic resistance, and ways to help relieve cold and flu symptoms without the use of antibiotics.

- **Know Your Medicine**: (1 session) Teaches adults the different types of drugs and what makes them different, the difference between generic and brand-name drugs, ways to take medications safely and how to get the most of your personal pharmacist.

- **Living Well With A Disability**: (8 session series) A peer support workshop for anyone with a health challenge or
disability to build skills, and maintain a life of healthy independent living.

- **Stress Management**: (1 session) Teaches what stress is, its effect on health, signs/symptoms of stress, and ways to manage stress

**Nutrition**

- **Bust a Myth**: (1 session) Takes a closer look at common health myths. Each myth is “busted” as popular health beliefs regarding nutrition and exercise are examined. Topics include healthier selections with drinks and fast food options, dieting, and exercise.

- **Snack Right!**: (1 session) Basic nutrition education for the entire family.

Primary care physicians may refer L.A. Care direct line of business members to health education by utilizing the on-line Health Education Referral Form located in L.A. Care Connect, L.A. Care’s provider portal at [http://www.LACare.org/providers/lacareconnect](http://www.LACare.org/providers/lacareconnect). Providers may alternately complete and fax a hard copy referral form to the Health Education Department. Health education staff will contact the patient and schedule the requested health education service(s). The outcome of the health education referral will be sent back to the member’s PCP. The PCP must document health education referrals and outcome data in the patient’s medical record.

**L.A. Care Health Plan Family Resource Centers**

L.A. Care Health Plan operates two community health education resource centers in the South Los Angeles communities of Lynwood and Inglewood. L.A. Care Health Plan partners with community organizations to offer no or low-cost health education classes on asthma, diabetes, HIV, exercise, nutrition, parenting, smoking cessation, weight management, senior wellness, and activities and services for people with disabilities. New member orientations, health screenings, and application and enrollment assistance are also provided. For more information go to: [http://www.lacare.org/providers/familyresourcecenters](http://www.lacare.org/providers/familyresourcecenters)

**Nurse Advice Line**

L.A. Care Health Plan offers a nurse advice line 24-hours a day, seven days a week to all direct line of business members.

**Health Education Programs**

L.A. Care Health Plan conducts health education programs targeting specific vulnerable populations.
Tobacco Cessation Health Education Program. Adult L.A. Care Health Plan Members (MCLA and Medicare Advantage HMO SNP) who have filled prescriptions for smoking cessation medication (nicotine gum, patch, lozenge, Buproprion, Varenicline) are mailed health education materials promoting available smoking cessation resources including “You Can Quit Smoking—Support and Advice from L.A. Care Health Plan” and a listing of free local smoking cessation resources. Outbound calls are made to members two weeks after the mailing to ensure receipt of the packet and to administer a phone survey to assess the resources used and their smoking status.

Health Education Materials and Resources

Health Education Materials
L.A. Care makes health education materials available in multiple topics and languages to meet the needs of direct line of business members. Health education topics include: asthma, breastfeeding, dental, diabetes, exercise, family planning, HIV/STD prevention, hypertension, immunizations, injury prevention, nutrition, parenting, perinatal/pregnancy, substance abuse, tobacco prevention/cessation, and weight management and more.

Providers may order L.A. Care health education materials through the health education material order form on-line application located at: http://www.lacare.org/providers/resources/healtheducation. Written Health Education Materials provided by L.A. Care comply with the guidelines set forth by DHCS. Health education materials distributed to L.A. Care members by L.A. Care Health Plan and its provider network undergo review using the Readability and Suitability Checklist (RSC). The RSC refers to the form provided by Medi-Cal Managed Care Division (MMCD) to ensure health education materials developed, adapted, or used for members are systematically evaluated to assess their suitability for Medicaid populations.

Alternative Formats – L.A. Care Health Plan makes health education materials available in alternative formats (Braille and large print) upon request.

Community Resource Directory
L.A. Care Health Plan provides an on-line community resource directory focusing on health education/social services within Los Angeles County. The resource directory includes program topics, languages, location, and contact information. The resource directory is available on-line at http://www.lacare.org/providers/resources/crd.
Individual Health Education Behavioral Assessment Tool – “Staying Healthy”

PCPs are responsible for ensuring the use of the Individual Health Education Behavioral Assessment (also called “IHEBA” or “Staying Healthy.”) The goals of the IHEBA are to:

- Identify high-risk behaviors of plan members
- Prioritize individual health education needs related to lifestyle, environment, and cultural and linguistic background
- Assist physicians in initiating and documenting focused health education interventions and follow-up.

The IHEBA is a DHCS requirement per MMCD Policy Letter 99-07. The IHEBA is designed to help open a dialogue between patients and providers about behavioral risk factors and health education needs. “Staying Healthy” is currently available in five age categories (0-3; 4-8; 9-11; 12-17; 18+) and seven languages (English, Spanish, Chinese, Hmong, Laotian, Russian and Vietnamese). Hmong and Laotian are not required for Los Angeles County.

PCPs must ensure the “Staying Healthy” Behavioral Assessment Tool is administered to all new L.A. Care members as part of the Initial Health Assessment within 120 days of enrollment and within 60 days of enrollment for children under the age of 18 months. It must also be administered to all existing members who present for a scheduled visit. These assessments must be reviewed at least annually and re-administered by the doctor at the appropriate age intervals.

L.A. Care Health Plan makes the “Staying Healthy” Assessment Tool and supporting resources available to network providers. “Staying Healthy” forms and “Staying Healthy” California tip sheets can be downloaded from the L.A. Care Health Plan website http://www.lacare.org/providers/resources/stayinghealthyforms or ordered using the Health Education and Cultural & Linguistics Material Order application.

Provider Education

The provider network must be regularly educated on health education requirements, services and available resources. L.A. Care health plan shares this responsibility with PPGs. Provider education methods include, but are not limited to, provider orientations and in-services, meetings, provider newsletters, faxes, mailings and special trainings.

Content of provider education includes, but is not limited to:

- Communication of regulatory agencies’ and L.A. Care Health Plan health education requirements
• Availability of health education services and resources

• Availability of health education materials and the process for obtaining materials

• Health education material requirements including qualified health educator oversight, reading level, field testing (if applicable), medical accuracy, availability of materials in alternative formats, and cultural/linguistic appropriateness

• Individual Health Education Behavioral Assessment Tool (IHEBA) requirement

• Benefits and barriers of breastfeeding. Stipulation that formula samples, coupons and materials from infant formula companies should not be routinely distributed to pregnant and postpartum women as per MMCD Policy Letter 98-10

L.A. Care Health Plan PPGs are responsible for educating providers on health education requirements and available L.A. Care services as listed above. Methods may include, but are not limited to: provider mailings and newsletters; meetings, seminars or other trainings; on-site visits; blast-faxes; provider manual and policies and procedures; and website postings.

10.0 CULTURAL & LINGUISTIC SERVICES

Cultural and linguistic competence is an on-going learning process that profoundly impacts the diverse communities within Los Angeles County. The direct relationship between culture, language and health is complex and inextricably linked to the health status of individuals and subsequently communities. For this reason, it is essential that L.A. Care and Participating Provider Groups (PPGs) strive to ensure culturally and linguistically competent healthcare services to members.

PPGs’ Cultural & Linguistic Services Program must be consistent with L.A. Care Health Plan’s Cultural & Linguistics Program and meet State and Federal requirements and regulations.

10.1 STAFFING

PPGs must designate at least one staff person who is responsible for the coordination and tracking of cultural and linguistic services. To encourage collaboration and coordination of services, the designated individual shall participate in L.A. Care cultural and linguistic liaison meetings with L.A. Care Cultural & Linguistic Services Department staff. PPGs must ensure that the roles and responsibilities of the designated cultural and linguistic staff member are included in organizational documents, including, but not limited to, job description and policies and procedures.
10.2 INTERPRETING SERVICES
PPGs are required to make available interpreting services, including American Sign Language, to L.A. Care members at all key (medical and non-medical) points of contact. PPGs may access these services via L.A. Care’s contracted agency, or may contract with agencies that provide interpreting services. Interpreting services must be provided by a qualified interpreter who is either on-site at provider facilities or available by telephone. Interpreting services to L.A. Care members must be provided at no cost to the members. PPGs and their network providers cannot require members to provide their own interpreters. However, friends and family members may be used as interpreters, if requested by the member after being informed of their right to free professional interpreting services. Member refusal of the use of an interpreter must be documented in the member’s medical records. Minors are not permitted to interpret except under the most extraordinary circumstances, such as a medical emergency.

Providers are also required to document member language preference, including American Sign Language in the medical record. To ensure clarity regarding interpreting services, PPGs are required to develop, implement and monitor policies and procedures for both their own organization and their subcontracted provider network. PPGs are also required to educate their staff and provider network about interpreting services available through L.A. Care.

10.3 ACCESSING INTERPRETING AND AMERICAN SIGN LANGUAGE (ASL) SERVICES
It is required that provider facilities post interpreting services signage translated in L.A. Care threshold languages. The signage must be visible to members and clearly state the members’ right to request free interpreting services.

If PPGs do not have a contract with an interpreting services agency, they may access L.A. Care’s interpreting services for telephonic and face-to-face interpreting as well as ASL. To access telephonic interpreting services, PPGs may call Pacific Interpreters at 1-800-259-4521. Please have the following information ready in order to receive services:

- L.A. Care Interpreter Access Code: 841908
- Language needed
- Caller’s name
- Patient insurance program
- L.A. Care member ID number
- Provider site number
Face-to-face interpreting services including American Sign Language can be obtained through L.A. Care. Please call L.A. Care’s Member Services Department at 1-888-4LA-Care (1-888-452-2273) at least 7-10 business days prior to the patient’s appointment. Have the following patient information ready:

- Provider name
- Language being requested (including American Sign Language)
- L.A. Care member’s name and ID number
- Date of birth
- Requestor name and contact number
- Date, time, and duration of appointment
- Location of appointment (i.e. address, suite #, major cross streets)
- Type of appointment (i.e. consultation, specialist, OB/GYN, etc.)
- Purpose of appointment
- Contact person at appointment site
- Other special instructions (i.e. patient has other disabilities, driving directions, parking, etc.)

### 10.4 ACCESSING CALIFORNIA RELAY SERVICE (CRS) FOR MEMBERS WITH HEARING OR SPEECH LOSS

PPGs and network providers can call the CRS directly for members with hearing or speech loss. The statewide access for voice or Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) is 1-888-877-5379 voice (SPRINT) or 1-800-735-2922 voice (MCI).

California Relay Service (CRS) is an exchange service that can be used to contact a member. A member can also use the service to contact his/her provider. CRS enables a person using a TTY to communicate with a person who does not use a TTY by phone. The service also works in reverse by allowing a non-TTY user to call a TTY user. Trained relay operators are on-line to relay the conversation as it takes place.

*Note: Many older deaf people or grassroots community members may not recognize the term TDD, it is recommended to use TTY or TTY/TDD.*

### 10.5 LANGUAGE PROFICIENCY

Clinical and non-clinical bilingual staff members who interface with limited English proficient members are required to be assessed using the Employee Language Skills Self-Assessment Tool developed by the Industry Collaboration Effort (ICE). A print ready copy of the tool is available from L.A. Care’s Cultural & Linguistic Services Department or from the L.A. Care website at [www.lacare.org](http://www.lacare.org)
PPGs are required to further document any training completed, as well as the number of years served/worked as an interpreter, by bilingual staff. Physicians are required to complete the Employee Language Skills Self-Assessment Tool once every three years; other staff members are required to complete the tool annually. Completed assessments and supporting documents are required to be on file and available during L.A. Care site visits.

10.6 MATERIALS TRANSLATION
Threshold languages for L.A. Care’s SNP product line are English and Spanish. L.A. Care routinely translates member informing materials for SNP members into Spanish and additional languages upon request. PPGs are required to translate PPG-generated member informing materials into Spanish. Any materials that are translated by PPG or provider staff are required to adhere to L.A. Care’s Cultural & Linguistic Services Department translation process. The process includes translation and second review by two separate individuals. PPGs are strongly encouraged to contract with a qualified translation services vendor. If PPG or provider staff are used for translations, the staff member(s) responsible for translations must have qualifications on file (such as an ATA membership or formal language assessment). Translations done by in-house staff must also undergo a second review by a qualified translator. PPGs must track all materials translated (either by contracted vendors or by in-house staff), and must keep a copy of the source document, the translated document, and a signed attestation available for review during annual audits.

10.7 COMPLAINTS & GRIEVANCES
In accordance with state and federal laws, members have the right to file a complaint or grievance if they have been denied interpretation services or if member information was not available in their primary language. All complaints and grievances are filed with L.A. Care’s Member Services Department and are routed to the appropriate areas within the organization. Grievance forms in threshold languages can be accessed via L.A. Care’s website.

10.8 REFERRALS TO CULTURALLY APPROPRIATE SOCIAL SERVICES
PPGs and providers are required to refer members to culturally and linguistically appropriate services. Documentation of referrals must be forwarded to L.A. Care on a quarterly basis. To facilitate provider referral to community resources, L.A. Care developed and distributed the Community Resources Directory – Health & Social Service Agencies 2010. Providers are required to document all member referrals to health education and social service agencies in the member’s medical record. Member medical records will be monitored for referral documentation during facility site review.
10.9 PROVIDER EDUCATION/TRAINING
PPGs are responsible for educating network providers on cultural and linguistic requirements, programs, and services. PPGs are also required to attend and promote cultural competency trainings made available by L.A. Care.

Supporting documentation of provider education must be available for review and must include:
• Copies of program handouts or correspondence
• Sign-in sheets
• Agenda/ Training Outline
• Meeting minutes

10.10 MONITORING/COMPLIANCE
PPGs are required to develop and distribute policies and procedures that outline all cultural and linguistic requirements listed in this provider manual. PPGs are also responsible for provider education and oversight to ensure full compliance with state and federal laws.
11.0 FINANCE

Under contractual agreement, each month L.A. Care and Participating Physician Groups (PPGs) accept capitated payments for the provision of health services to L.A. Care members, regardless of how frequently members access services. This section covers guidelines for financial reports and requirements, capitation, and other related issues.

11.1 CAPITATION PAYMENTS

11.1.1 One-hundred percent (100%) of capitation payments will be remitted to a PPG no later than the tenth (10) calendar days (except as defined in “Financial Security Requirements,” and “Assumption of Financial Risk”). The payments will constitute payment in full for health care and administration services rendered under the PPG’s L.A. Care Services Agreement.

11.1.2 FOR FURTHER INFORMATION REGARDING PPG COMPENSATION, PLEASE REFER TO THE CAPITATION SCHEDULE OF THE L.A. CARE PHYSICIAN CAPITATED SERVICES AGREEMENT.

11.2 CAPITATION STATEMENT REPORT

11.2.1 A Capitation Statement Report will be placed in a protected PPG web site on or before the tenth (10) business day of every month. The Capitation Statement Report will provide a summary of the capitation payment for each enrolled member assigned to each PPG, and will include the following information:

- Number of current active enrollees (initial eligibles).
- Number of retroactive disenrollments (decaps). This number represents the number of retroactive disenrollment months processed.
- Capitation amount.
- Capitation total.

11.2.2 The Capitation Statement Report is also used to create the Group Capitation Payment Summary Report.

11.3 INSURANCE

Each PPG is responsible for total costs, except as provided herein, for care rendered to members enrolled with that PPG under the terms of its Services Agreement with L.A. Care. The PPG must maintain adequate insurance set forth in the following:

11.3.1 Professional Liability Insurance. The PPG has, and shall maintain at its expense throughout the term of this Agreement, Professional Liability Insurance for each Affiliated Provider with
limits of not less than one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) in the aggregate for the year of coverage or such other amount acceptable and permitted by Health Plan in writing. PPG shall provide reasonable prior written notice to Health Plan of a change of insurance carrier for Health Plan’s prior written approval, which approval shall not be unreasonably withheld. PPG shall provide copies of such insurance policies within five (5) business days of a written request by Health Plan.

11.3.2 FTCA Alternative. In lieu of providing Professional Liability Insurance as set forth in Section 1.13(a), PPG may provide Health Plan with evidence of liability protection under the Federal Tort Claims Act by the Bureau of Primary Health Care in accordance with Section 224(h) of the Public Health Service Act, 42 U.S.C. 233(h), as amended (“FTCA Coverage”). However, PPG shall ensure that only those providers covered pursuant to section 1.13(a) or under FTCA Coverage may provide provider services to members.

11.3.3 Reinsurance/Stop-Loss Insurance. The PPG must maintain adequate stop-loss insurance to cover PPG’s catastrophic cases in an amount reasonably acceptable to L.A. Care, but in no event less than thirty thousand dollars ($30,000.00) plus fifty percent (50%) of any medically necessary billed charges. The cost of the PPG’s reinsurance/stop-loss coverage is the PPG’s sole financial responsibility.

11.3.4 General Liability Insurance. The PPG shall maintain general liability insurance in at least the minimum amounts acceptable to L.A. Care to cover any property loss that is not covered under any lease agreement with the landlord, or contract agreement with the management company. The limits of liability shall not be less than $100,000.00 for each claim and $300,000.00 in aggregate under each policy period.

11.3.5 Errors and Omissions. The PPG shall maintain Errors and Omissions (E&O) Insurance that covers the claims made against managed care activities. The insurance policy shall be written on a claim made basis. The limits of liability shall not be less than $100,000 for each claim and $100,000 in aggregate for each policy period.

11.3.6 Directors and Officers. The PPG shall maintain Directors and Officers (D&O) that covers claims made against directors and officers of the company. The insurance policy shall be written on a claim made basis. The limits of liability shall not be less than
$100,000 for each claim and $100,000 in aggregate for each policy period.

11.3.7 Independent Certified Public Accounting Firm Liability Insurance. PPG shall ensure that all independent certified public accounting firm conducting audits on PPG’s financial statements maintain at its expense throughout the term of this agreement, liability insurance with limits of not less than two hundred and fifty thousand dollars ($250,000.00) in aggregate for the year of coverage or such other amount acceptable and permitted by health plan in writing. PPG shall provide copies of such insurance policies within five (5) business days of a written request by health plan.

11.4 MINIMUM FINANCIAL SOLVENCY STANDARDS

11.4.1 Each PPG must maintain adequate financial resources to meet its obligations as they become due. PPGs contracted with L.A. Care shall be solvent at all times, and shall maintain the following minimum financial solvency standards:

- **11.4.1.1** Prepare quarterly financial statements in accordance with Generally Accepted Accounting Principles (GAAP). These financial statements must include but are not limited to a Balance Sheet, a Statement of Income, and a Statement of Cash Flow and be submitted to the Financial Compliance department of L.A. Care no later than 45 calendar days after the close of each quarter of the fiscal year.

- **11.4.1.2** Reimburse, contest or deny at least ninety-five percent (95%) of all claims consistent with applicable law, regulation and contractual timeliness requirements.

- **11.4.1.3** Estimate and document, on a monthly basis, the organization’s liability for incurred but not reported (IBNR) claims using a lag study, an actuarial estimate, or other reasonable method as stipulated by Title 28, California Code of Regulations, Section 1300.77.2.

- **11.4.1.4** Maintain, at all times, a positive Working Capital (current assets net of related party receivables less current liabilities).

- **11.4.1.5** Maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as defined in Title 42, C.F.R., Sections 422.2, 422.504(a)(14), 423.4, and 423.505(b)(23).
11.4.1.6 Maintain a “Cash to claims ratio” (cash, readily available marketable securities and receivables, excluding all risk pool, risk-sharing, incentive payment program and pay-for-performance receivables, reasonably anticipated to be collected within 60 days divided by the organization’s unpaid claims (claims payable and incurred but not reported (IBNR) claims) liability as listed per SB 260 Title 28, California Code of Regulations, Section 1300.75.4.2. Maintain at all times a "cash to claims ratio" of .60 as of January 1, 2006, .65 as of July 1, 2006 and .75 as of January 1, 2007.

11.4.1.7 On an annual basis, submit to the Financial Compliance department of L.A. Care, financial statements, including but not limited to a Balance Sheet, a Statement of Income, and a Statement of Cash Flow audited by an independent Certified Public Accounting Firm within 150 calendar days after the close of the fiscal year.

11.4.2 Each PPG must actively monitor its providers to measure their financial stability. Copies of all reports, including findings, recommendations, corrective action plans, and other information regarding these reviews must be provided to L.A. Care upon request.

11.4.3 On a discretionary basis, the Financial Compliance department of L.A. Care will have the right to periodically schedule audits to ensure compliance with the above requirements, CMS requirements and all regulations per SB 260 Title 28, California Code of Regulation requirements. Since the financial solvency standards apply to the entity as a whole, the audits will be conducted for all books of business, not only for the line(s) of business contracted with L.A. Care. Representatives of the PPGs shall facilitate access to records necessary to complete the audit.

11.5 REIMBURSEMENT SERVICES AND REPORTS

11.5.1 In accordance with the provisions of PPG’s Subcontracts, the PPG will provide all normal reimbursement services, including those relating to the payment of capitation, processing and payment of any claims on a fee-for-service basis, administration of any stop-loss and risk-sharing programs, and any other payment mechanisms. Claims processing may be delegated to PPGs in cases where utilization management is delegated.

11.5.1.1 PPGs that are delegated for the claims processing function must submit a monthly claims timeliness report (in an ICE approved
Medicare template) and a respective supporting claims data file to L.A. Care by the 15th calendar day of each month following the month being reported.

11.5.2 Upon request, the PPG will provide to L.A. Care a copy of payment records, summaries and reconciliations with respect to L.A. Care members, along with any other payment compensation reports which the PPG customarily provides to its providers.

11.6 RECORDS, REPORTS, AND INSPECTION

11.6.1 Records Each PPG will maintain all books, records, and other pertinent information that may be necessary to ensure the PPG’s compliance with its L.A. Care Services Agreement, and the requirements of CMS for a period of 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. These books, records, and other information must be maintained in accordance with generally accepted accounting principles, applicable state law and regulations, and CMS and DMHC requirements.

11.6.2 These books and records will include, without limitation, all physical records originated or prepared pursuant to the performance under this contract including but not limited to:

- Working papers
- All reports submitted to DMHC
- Financial records
- All books of account
- Encounter data
- All medical records
- Hospital discharge summaries
- Medical charts and prescription files
- Any other documentation pertaining to medical and non-medical services rendered to members
- Records of Emergency Services and other information as reasonably requested by L.A. Care and DMHC to disclose the quality, appropriateness, and/or timeliness of health care services provided to members under the PPG’s Physician Capitated Services Agreement
- PPG subcontracts
- Reports from other contracted and non-contracted providers
- Any reports deemed necessary by L.A. Care, CMS and DMHC to ensure compliance by L.A. Care with the regulatory requirements.

11.6.3 Each PPG will maintain all books and records necessary to disclose how the PPG is fulfilling and discharging its obligations under their L.A. Care Services Agreement, and their responsibilities...
as defined by CMS and DMHC. These books and records will be maintained to disclose the following:

- Quantity of covered services provided.
- Quality of those services.
- Method and amount of payment made for those services.
- Persons eligible to receive covered services.
- Method in which the PPG administered its daily business.
- Cost of administering its daily business.

11.6.4 Inspection of Records
PPGs will allow L.A. Care, DMHC, DHHS, the Comptroller General, or their designees and any other authorized state and federal agencies to inspect, evaluate, and audit any and all books, records, and facilities maintained by the PPG and its providers as they pertain to services rendered under the PPG’s Physician Capitated Services Agreement, at any time during normal business hours, subject to the confidentiality restrictions discussed in the PPG’s Physician Capitated Services Agreement.

The PPG also agrees to require all related entities, contractors, or subcontractors, and downstream entities to agree that:

- DHHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of the related entity(s), contractor(s), or subcontractor(s), and downstream entities involving transactions related to the L.A. Care’s Medicare Advantage – SNP line of business;

- DHHS', the Comptroller General's, or their designee’s right to inspect, evaluate, and audit any pertinent information for any particular contract period will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

11.6.5 Records Retention Term
Medicare Advantage-SNP Line of Business - The PPG’s books and records must be maintained for a minimum of ten (10) years from the end of the fiscal year in which the PPG’s contract with L.A. Care expires or is terminated.

11.6.6 Financial Statements
As required by Section 11.8 above, each PPG must provide L.A. Care with a copy of its Quarterly Financial Statements and Annual Audited Financial Statements. If requested, these financial documents, as well as any other reports required by DMHC, will be made available to DMHC, CMS and any other regulatory agencies.
This section is subject to change pursuant to receipt of supplemental regulations under Title 10.
12.0 CLAIMS
This section covers guidelines for claims processing and other claims related issues for Participating Providers with respect to L.A. Care’s Medicare Advantage-SNP line of business.

12.1 RESPONSIBILITY OF PARTICIPATING PROVIDERS
Participating Physician Groups (PPGs), and hospitals contracted with L.A. Care are responsible for performing certain tasks for claims under the terms of their agreement in the L.A. Care Medicare Program. After reviewing this section, please refer to the “Division of Responsibility” in the agreement between the PPG, and L.A. Care to determine what entity is responsible for specific claims. The “Division of Financial Responsibility,” specifies which health care services are the financial responsibility of L.A. Care, and which are the financial responsibility of the PPG. The PPG is responsible for handling all claims for which it is financially responsible.

12.2 COLLECTION OF CHARGES FROM MEMBERS
Neither the PPG nor any of its providers will, in any event, submit a claim, demand payment, or otherwise collect reimbursement from an L.A. Care member or persons acting on behalf of a member for any services provided pursuant to the PPG’s L.A. Care Services Agreement, except to collect authorized co-payments.

12.3 Coordination Of Benefits (COB)
DEFINITION OF COB:

A. Coordination of Benefits (COB) is the procedure to determine the order of payment responsibility when a Member is covered by more than one health plan or insurer.

B. COB is applied in accordance federal law governing COB including the Order of Determination of payment.

C. L.A. CARE and PPGs are responsible for identifying other health plans that are primary to L.A. CARE and must coordinate benefits for Members in accordance with federal law.

D. L.A. CARE and PPGs must make reasonable efforts to appropriately determine payment of claims for covered services rendered to any Member who is fully or partially covered for the same service under any other State, Federal program, or other entitlement such as a private group or indemnification program.
E. Medicare may be the secondary payer under certain rules as delineated under Title 42, Chapter 7 of the Social Security Act and L.A. Care’s Medicare - Coordination Of Benefits Policy.

PROCEDURE FOR COB RECOVERY:

A. L.A. CARE capitation rates to PPGs as outlined in the L.A. CARE Capitated Agreement, for all Members assigned to them regardless of other insurance coverage.

B. Since all L.A. Care Medicare Advantage SNP members have both Medicare and Medi-Cal (Medi-Medi) coverage, the claim is processed with Medicare as the primary and Medi-Cal as the secondary, following the policies and procedures outlined in the L.A. CARE Medi-Cal Provider Manual, “Coordination of Benefits” section.

C. If the Member has other health coverage in addition to Medicare and Medi-Cal, Medicare may be secondary under certain rules for coordination of benefits as outlined below.

D. If the Member has other primary health care coverage, the claim is adjudicated at the lesser of the Medicare allowable or the primary payer allowable. L.A. CARE adjudicates covered services as primary if they are not covered by the other health coverage. The provider of service must submit such claims with a denial letter or explanation of benefits from the other health coverage.
The COB claim determination period is based on the period of time the Member is enrolled with L.A. CARE. If the Member is not enrolled with L.A. CARE on the date of service, COB is not applicable.

L.A. CARE has the right to obtain and release COB information and may do so without the Member’s or Authorized Representative’s consent. Members must provide an insurer with any information needed to make COB determinations and to pay claims.

When coordinating benefits, Medicare Secondary Payer rules apply. Under those rules, the Medicare Advantage plan is secondary under the following conditions:

- **Elderly Workers Employer Group Health Plan** – These 65 year old or older members are covered by an employer Group Health Plan (GHP) with 20 or more employees or have a spouse who is covered by an Employer Group Health Plan. The spouse’s age is not material to the determination of primary coverage only the qualification of the GHP.

- **Disabled Beneficiaries Employer Group Health Plan** – These members are eligible for Medicare based on disability and are under the age of 65 years and are covered by a Large Group Health Plan (LGHP) through their own or a family member’s employment. Large Group Health Plans are defined by at least one of the employers having 100 or more employees.

- **Beneficiaries with End Stage Renal Disease (ESRD) and an Employer Group Health Plan** – The rules for these members are complex; please see the Medicare Secondary Payer Manual (Publication # 100-05) on the CMS website for detailed information affecting the rules for members with ESRD.

- **Federal Black Lung Program** - The Black Lung Program was set up under the Department of Labor to assist coal miners with pulmonary and respiratory diseases that resulted from their employment. The Black Lung Program is billed for all services that relate to either respiratory or pulmonary diseases. The Medicare managed care plan is the primary payer for all other cares and service needs.
• Veterans Administration Coverage - Care and services authorized by Veteran's Administration are payable in full by the VA. Claims from one government program cannot be reimbursed by another government program. The Medicare managed care plan may supplement VA payment when the member files a claim for Part B services that were not fully reimbursable by the VA or for any member copayments made to a VA facility.

E. Medicare Secondary Payer rules supersede other federal and state law governing the coordination of benefits.

F. Providers may retain any amounts collected through COB, in addition to any capitation received.

12.4 Third-Party Liability (TPL)
This policy applies to all L.A. CARE Medicare Advantage Members. PPGs may make a claim for recovery of the value of covered services rendered to a Medicare Advantage Member in cases involving the tort liability of a third party or casualty liability insurance, including Workers’ Compensation and uninsured motorist’s coverage.

PROCEDURE FOR TPL RECOVERY:

A. If the Payer becomes aware of a claim involving Third Party Liability (TPL), the Payer must pursue recovery of any monies paid in accordance with state and federal guidelines.

B. The Payer must notify the insurance plan and/or attorney of record of its intent to recover the amounts paid in connection with the injury or illness caused by the third party or employer. The Payer must provide copies of all related claims if requested.

C. The Payer should regularly follow-up with all involved parties every 30 days until resolution is complete.

D. The Payer should attempt to recover the full amount of claims already paid as well as the amount necessary to pay all anticipated future medical expense.
12.5 CLAIMS SUBMISSION

Claims submitted by the PPG or its contracted providers must be complete with all required information to ensure timely processing and payment as stipulated in the provider's contract.

12.5.1 Billing

All paper claims must be submitted on CMS 1500 form for professional services and UB-04 forms for facility services.

12.5.2 Claim Filing Limit

The provider shall bill using appropriate forms and in a manner acceptable to L.A. Care or the PPG within the filing limit specified in the provider’s contract. If not specified in the provider contract, the filing limit for Medicare claims will apply.

12.5.3.1 In general, physician and ancillary service claims for MA-SNP members will be submitted to the PPG. Inpatient hospital claims and claims for DME and ambulance services for MA-SNP members will be submitted to L.A. Care. In order to determine who is responsible for paying a claim, please refer to Exhibit B, the Division of Financial Responsibility, in your contract with L.A. Care. The Division of Financial Responsibility specifies what entity is responsible for paying each category of claim.

12.5.3.2 If you have a question about where to send a claim, please call L.A. Care’s Provider Information Line. You will access our Interactive Voice Recognition (IVR) system that will guide you to one of our Provider Network Representatives that can assist.

12.5.3.3 For all claims for which L.A. Care is financially responsible, please mail the claims to:

   L.A. Care Health Plan  
   Attn: Claims Dept.  
   P.O. Box 811580  
   Los Angeles, CA 90081

12.5.4 Claim Status Inquiries

Please be advised that you may inquire about the status of a claim, including the date of receipt, for which L.A. Care is financially responsible by calling 1-866-LACARE6.
12.6 **CLAIMS PROCESSING**

A. All claims submitted to the PPG must be processed (paid or denied) or forwarded in accordance with all federal and state laws and regulations and the L.A. CARE contract.

B. All PPGs are delegated the responsibility of claims processing for the services identified as PPG’s responsibility in the Division of Financial Responsibility exhibit of the L.A. Care Service Agreement and are subject to review by L.A. CARE. L.A. CARE provides oversight of the PPGs by monitoring, reviewing and measuring claims processing systems and payment appeals to ensure timely and accurate claims processing and appeal resolution.

C. Contracted providers of service are required to submit claims in accordance with the provisions outlined in their contract with the Payer. If the contract is silent on a timeframe for submission, or the provider of service is non-contracted, the provider of service has 1 year from the date of service to submit a claim.

D. Misdirected claims must be forwarded to the appropriate financially responsible entity within 10 working days of receipt.

E. PPGs must pay 95% of clean claims for non-contracted providers rendering services to Medicare Advantage Members within 30 calendar days of receipt of the claim. All other claims for non-contracted providers must be paid or denied within 60 calendar days. Claims for contracted providers must be paid within contractual timeframes.

F. If the Payer pays clean claims from non-contracted providers after 30 days, it must pay interest in accordance with federal guidelines and at the Prompt Payment Act Interest Rate published in the Federal Register and on the United States Treasury website.

G. PPGs are expected to identify and recover overpayments resulting from a payment error or when it has been determined that the provider of service or Member was liable for the services, in accordance with federal regulations.

H. PPGs must establish and maintain a process that addresses the receipt, handling and disposition of a payment appeal in accordance with federal or state regulations and contractual guidelines. All payment appeals must be resolved within 60 calendar days of receipt of the appeal.
12.7 PROCEDURE FOR MEDICARE CLAIMS PROCESSING:

A. PPGs must have written procedures for claims processing that are available for review. In addition, PPGs must disclose claims filing directions, fee schedules and payment appeal processes via contract, written notification, Explanation of Benefits (EOB) or Remittance Advice (RA) at the time of payment, denial or adjustment, and/or via a website, as applicable. These written procedures and disclosures must comply with state, federal and L.A. CARE contractual standards and requirements. Such disclosures must also be made available upon request to providers of service, L.A. CARE or a regulatory agency.

B. PPGs’ claims processing systems must identify and track all claims and payment appeals by line of business and/or program and be able to produce claims and appeals related reports as outlined in Section 12.7.2, “Initial Claims Payment Appeals.”

C. Contracted providers of service must be given no lesser period to submit claims than the timeframe stipulated in the contract to submit a claim.

D. Non-contracted providers of service and contracted providers of service whose contract is silent on a submission timeframe are allowed up to 1 year from the date of service to submit a claim.
   1. Claims received after that deadline may be denied.
   2. Claims received after the filing deadline are reconsidered for payment only when the provider of service has submitted an explanation of the circumstances surrounding the late filing, or L.A. CARE or the PPG is responsible due to an administrative error.
   3. If a claim is denied for untimely filing, the provider of service may file an appeal as outlined in Section 12.7.2, “Initial Claims Payment Appeals” and the claim may be reconsidered for payment upon proof of and demonstration of good cause for the delay.

E. PPGs must redirect claims that are not their financial responsibility to the appropriate responsible party within 10 working days of receipt.
   1. If the Member cannot be identified or the financially responsible entity is not affiliated with the Payer’s network, the claim may be denied and/or returned to the provider of service advising the billing provider to verify eligibility assignment and to bill the appropriate responsible party.
   2. All redirected claims must be tracked and reported as outlined in “Claims and Payment Appeal Reporting.”

F. Clean claims are those claims and attachments or other documentation that include all reasonably relevant information necessary to determine Payer liability and for which no further information is required from the
provider of service or a third party to develop the claim. To be considered a clean claim, the claim should be prepared in accordance with the National Uniform Billing Committee standards and should include, but is not limited to the following information:

1. A claim form that contains:
   a. A description of the service rendered using valid CPT, ICD9, HCPCS, and/or Revenue codes, the number of days or units for each service line, the place of service code, the type of service code and charge for each listed service.
   b. Other claim specific information as dictated by Medicare for provider of service type (i.e., Hospital, lab, etc.).
   c. Member (patient) demographic information, which must at a minimum include the Member’s last name and first name and date of birth.
   d. Provider of service name, address, tax identification number; Medicare Health Insurance Claim Number (HICN), and Providers NPI.
   e. Information pertaining to COB, if applicable.
   f. Date(s) of service.
   g. Amount billed.
   h. Signature of Member or person authorized to sign on behalf of Member.
   i. Signature of person submitting claim.

2. Other documentation necessary to adjudicate the claim, such as medical or emergency room reports, claims itemization or detailed invoice, medical necessity documentation, other insurance payment information and referring provider information (or copy of referral) as applicable.

3. Prior authorization documentation, such as an L.A Care authorization number, a copy of the authorization form or referral form attached to the claim for services on which authorization is required.

G If a claim is missing required information, as defined in Procedure above, or additional information in necessary order to complete the claim, the claim must be developed as follows:

1. The Payer must send a written notice to the provider of service requesting the missing information or other reasonably relevant information necessary to determine Payer liability within 30 calendar days after the date of receipt. If the Payer is requesting
additional reasonably relevant information, the Payer must include a written explanation of the necessity for the request.

2. If the Payer does not receive the requested information from a provider of service within 45 calendar days after it receives the claim, the Payer must review the claim and make a decision to pay or deny the claim based on available information. That payment or denial must be issued within 60 calendar days of original receipt of the claim.

3. Upon receipt of the requested information, the Payer must pay the amount due on the claim within 30 calendar days from receipt of the additional information from a non-contracted provider, or within contractual timeframes if the provider of service is contracted.

4. If the Payer denies a claim on the basis of a failure to submit requested medical records or other information reasonably necessary to determine Payer liability, as outlined in Procedure F (2)-(4), the Payer must process any appeal from the denial of such claim in accordance with the appeals process outlined in “Initial Claims Payment Appeals”.

5. If the Provider fails to submit requested required information as defined in Procedure G (1), or the information is invalid or incomplete, the claim can be rejected or denied.

H. PPGs must establish processes for claim payment without a requirement for prior authorization for the following covered services rendered to a Medicare Member by a non-contracted provider of service:

1. Ambulance services dispatched through 911 or its local equivalent where other means of transportation may endanger the Member’s Health.

2. Emergency services

3. Urgently needed services

4. Post-stabilization care services

5. Renal dialysis services

6. Covered services that the Payer denied that were determined through the appeals process to be services to which the Member was entitled.

I. PPGs must coordinate benefits and follow Medicare as Secondary Payer rules as outlined in the “Coordination of Benefits” Section. Claims submitted for secondary payment must follow the submission timeframes stated in Procedure D, from the date the primary Payer’s notice of payment or denial is received by the provider of service in order to be considered timely.
J. Claims received from contracted providers of service must be appropriately paid or denied within contractual timeframes. Clean claims from non-contracted providers of service rendering services to Medicare Members must be paid within 30 calendar days of receipt, or within 60 calendar days for all other claims.

1. This measurement begins on the initial date of receipt of the claim anywhere within the contracted network (i.e. the earliest date stamp) and ends when the check or denial is mailed to the provider of service, regardless of when the check is dated.

2. The payment date used to meet timeliness standards is the actual date the check is mailed, deposited into the provider of service’s account or transferred electronically, regardless of the date on the check.

3. The date of receipt is the date the claim is first received by an entity within the plan’s network even if that party is not financially responsible for that particular claim as indicated by its date stamp on the claim. Claims with multiple date stamps should be deemed priority and processed immediately.

4. “All other claims” are denied claims or those (unclean) claims that require investigation or additional information from the provider of service to develop the claim. This includes but is not limited to requests for additional information from the physician/supplier or other external source such as routine data omitted from the claim, medical information, or information to resolve discrepancies.

K. If the PPG fails to pay a clean claim from a non-contracted provider of service within 30 calendar days after receipt, the PPG must pay interest at the rate used for such late payments, as stated in federal regulations beginning on the first calendar day following 30 calendar days from the date of receipt. Interest accrues from that date until the date the check is mailed.

L. Denial Letters must be mailed to the provider of service within timeframes stated in Procedure J for paying or denying a claim. The PPG should access the Medicare Advantage Pre-Service Denial Reason Matrix on the INDUSTRY COLLABORATION EFFORT (ICE) website and conform to the approved language found there. The date of denial notification is the date the denial notice is actually mailed to the provider of service.

1. Any claim that is denied must include an accurate and clear written explanation of the actions taken. Both the provider of service and Member must be notified of the denial if there is member liability for the claim or a portion of the claim.

2. All denial notifications and the EOB and/or RA to the provider of service must include mandated language and be properly formatted.
in accordance with Medicare specifications. At a minimum, the denial notification must:

a. Use approved notice language in a readable and understandable format

b. State the specific reason for the denial

c. Inform the Member of his or her right to reconsideration of the payment determination

d. For payment denials, the standard reconsideration process as well as the rest of the appeal process as outlined in “Initial Claims Payment Appeals,” “2nd Level Claims Payment Appeals” and “Member Appeal Resolution Process (Standard and Fast Track)”

e. Comply with any other notice requirements specified by CMS.

3. The denial notification must incorporate appropriate denial reason language.

M. If a Payer determines that a claim has been overpaid, the Payer may attempt to recover the overpayment and send a written notice to the provider of service.

1. Individual overpayments are those overpayments resulting from incorrect payment to the provider for physician/supplier services, including but not limited to duplicate payments, payments to the wrong provider of service, processing errors.

2. The written notice must clearly identify the claim, the name of the Member, the date of service and a clear explanation of the basis upon which the Payer believes the amount paid was in excess of the amount due, including interest and penalties.

4. Providers of service must respond to the request with a corrected billing, an appeal or a refund in accordance with federal guidelines or within 30 days of the date of the request. PPGs may retract the overpayment under certain circumstances outlined in federal guidelines. Payer may send a second written request and continue to follow-up with the provider of service to recover the money.

N. PPGs must establish processes that address the receipt, handling and disposition of a payment appeal in accordance with federal or state regulations and contractual guidelines, as outlined in “Initial Claims Payment Appeals”.

O. L.A. CARE’s Claims Department is available from 8:00am - 5:00pm, Monday through Friday at (866) 522-2736 to assist and answer any questions related to claims processing.
P. The responsibility for claims payment as outlined above continues until all claims have been paid/denied for services rendered during the timeframe a Capitated Agreement existed.

Q. In the event the Payer fails to meet L.A. CARE claims processing standards as indicated above, L.A. CARE may elect to pay these claims on behalf of the Payer by deducting such payment from the Provider's monthly capitation check.

R. The 14-Day letter process is applied when there are unpaid claims and/or claims inquiries.

12.7.1 PROCEDURE FOR RESPONDING TO A 10 DAY LETTER:

A. The 10-Day letter is a tool used by L.A. CARE to process appeals or disputes from members’ providers of service related to claims issues involving alleged lack of payment or denial from the payer.

B. L.A. CARE's 10-Day letter process is sent to providers of service under the following circumstances:

1. A provider of service (both contracted and non-contracted) notifies L.A. CARE that no status has been provided on a claim submitted to the appropriate payer for over 60 days, or

2. L.A. CARE identifies a claim that has not been paid appropriately within the claims processing timeframes.

3. A member is being billed for covered services or has filed a grievance.

C. The 10-Day letter requests information on the status of the claim, as outlined in Procedure G below. The Payer must complete this form and return it to L.A. CARE within 10 days from the date of the letter. A copy of the claim from the provider of service is included with the 10-Day letter sent by L.A. CARE to the Payer.

D. PPGs must provide L.A. CARE the following information in their response regarding the claim: the date the claim was originally received, if it was paid or denied, the date paid or denied, the amount paid, check number and/or the reason for the denial.

E. The following are examples of unacceptable responses to the 14-day letter:
1. Not Payer’s Delegated Responsibility (L.A. CARE confirms financial responsibility prior to 10-day notification).

2. Member Not Eligible (L.A. CARE confirms eligibility prior to 10-day notification).

3. Not Authorized (it is inappropriate to deny a claim due to “No Authorization” as medical review must be performed prior to denial).

F. In the event the Payer fails to provide an acceptable written response to L.A. CARE within 10 days or the requested information is returned incomplete, L.A. CARE pays the provider of service directly using the prevailing Medicare fee schedule outlined below and deducts the amount paid from the Payer’s monthly capitation check.

1. The Medicare limiting charge for unassigned claims by non-participating providers.

2. Non-par amounts for assigned claims by non-participating providers.

3. The par amount for participating providers.

J. Claims capitation deductions are outlined on a detail report that is sent with the capitation payment.

12.7.2 PROCEDURE FOR INITIAL CLAIM APPEALS:

A. Inquiries regarding the status of a claim or requests for intervention by L.A. CARE on behalf of the billing provider in an attempt to get an initial adjudication decision (payment or denial) made on a claim by the Payer are not considered appeals and are handled in accordance with the procedure outlined in “10-Day Letters” Section.

B. Payment appeals relate to the initial determination of a payment decision or denial and are primarily complaints concerning an adverse organizational determination denying a request for payment.

1. Any appeal involving PCP P4P reimbursements should be filed in accordance with the guidelines provided in “Pay For Performance”.

2. Any provider appeal not involving payment should be filed in accordance with the guidelines provided in “Appeal Resolution Process for Providers of Service: Initial Appeal Resolution”.

3. Grievances and appeals are separate and distinct. If the documentation submitted is considered to be a grievance, PPGs must resolve it in accordance with their grievance policies and
procedures as outlined in “Appeal Resolution Process for Providers of Service: Initial Appeal Resolution” or using the “Member Grievance Resolution Process”.

C. Members, their authorized representative or providers of service acting on behalf of a Member and non-contracted providers of service must submit all payment appeals in writing to the Payer within 60 calendar days from the date of a denial or other adverse payment determination from the Payer. The denial may be in the form of a written adverse determination from the Payer or an Explanation of Benefits (EOB) or Remittance Advice (RA) Justification and supporting documentation must be provided with the written appeal, as outlined in Procedure F below.

D. Non-contracted providers of service may file an appeal on his or her own behalf if the provider of service furnished a covered service to the Member and completes a waiver of liability statement that states that the provider of service will not bill the Member for covered services regardless of the outcome of the payment appeal.

E. Payers may accept a request for reconsideration of an appeal filed after 60 calendar days if the Member, the Member’s authorized representative or non-contracted provider of service submits a written request for an extension of the timeframe for good cause.

F. Written payment appeals must be submitted to the Payer in accordance with the appeal process guidelines issued by the Payer.

1. For payment appeals involving L.A. CARE as the Payer, appeals must be sent to:

   Grievance and Appeals Coordination Unit
   P.O. Box 811610 Los Angeles, CA 90081

2. Written payment appeals to L.A. Care must include:
   a) The Medicare health insurance claim number
   b) Specific service(s) and/or item(s) for which reconsideration is being requested and the specific date(s) of service
   c) The name and signature of the party or the representative of the party filing the appeal
   d) A clear explanation of why the appealing party disagrees with Payer’s initial determination and should include supporting documentation the appealing party feels should be considering when making the reconsideration
   1) If the appeal involves a denied emergency claim, the documentation should include a copy of the Member’s emergency room records, notification of the
emergency room visit and a copy of the notice of determination or EOB.

2) If the appeal involves an ambulance claim, the documentation should include a copy of the transport record, a copy of the Member’s emergency room or hospitalization records relating to the ambulance trip, including records from the triage or medical departments as applicable and a copy of the notice of determination or EOB.

3) If the appeal involves co-payment charges or co-payment reimbursement, the supporting documentation should include a copy of the Member’s medical record from the corresponding hospital, emergency room or provider of service office, a copy of the utilization records if the Member was admitted, a copy of the notification of the emergency room visit or admission, and a copy of the notice of determination or EOB.

3. If supporting documentation is not available or the Payer does not have enough information to make a determination on the appeal, the Payer may send a request for additional information to the provider of service. If the provider of service fails to provide requested information within 5 calendar days of the request, the Payer must make a determination on the information available.

G. Payers must research the appeal and if it meets the criteria for a payment appeal, the Payer must send a written acknowledgement letter, an authorization for release of protected health information, and a self-addressed stamped envelope to the Member, the authorized representative or non-contracted provider of service who submitted the request, within 5 working days of the request.

H. Payers must make every effort to investigate and take into consideration all information on file or received from the provider of service. The Payer may request additional information or discuss the issue with the involved provider of service as needed to make a determination.

I. PPGs must send written notice of the resolution, including pertinent facts and an explanation of the reason for the determination, within 60 calendar days of the receipt of the payment appeal. The notification must be sent to both the Member and appealing party, with a copy to L.A. CARE.

1. Written notification of affirmative (uphold) determinations, whether in whole or in part, must be written in a manner easily understood by the Member and include:

a. A clear statement indicating the extent to which the reconsideration is favorable or unfavorable;
b. A summary of the facts, including, as appropriate, a summary of the clinical or scientific evidence used in making the re-determination;

c. An explanation of how pertinent laws, regulations, coverage rules and CMS policy applies to the facts of the case;

d. A summary of the rationale for the re-determination in clear, understandable language;

e. The procedures for obtaining additional information concerning determinations, such as specific provisions of the policy, manual or regulation used in making the determination

f. Any other requirements specified by CMS.

2. Failure to respond to the request for reconsideration with a determination within the specified timeframe must consider the failure as an affirmation of the adverse decision and the Payer must forward the request to the CMS Independent Review Entity (IRE) for review in accordance with Medicare requirements, within 60 calendar days after receiving the request for reconsideration.

J. If the written determination results in payment, payment must be made within 60 calendar days of receipt of the payment appeal, which is concurrently with the written determination. There is no interest due on payments made as a result of an appeal.

K. If the determination is to affirm or uphold the initial payment determination, the Payer must send a written determination to the Member and appealing party informing them of the decision and immediately forward the appeal and determination and supporting documentation to the IRE for final review in accordance with Medicare guidelines.

1. The information must be forwarded to the IRE within 5 calendar days of the determination, or within 60 calendar days of receipt of the appeal from the appealing party, whichever occurs first.

2. The IRE will make a decision on the payment appeal in accordance with is CMS contracted timeframes.

3. The IRE may request additional information, and upon receipt of such information, L.A. CARE and/or the Payer must make every effort to provide the requested information within the timeframe specified by the IRE.

4. If the IRE upholds the original adverse determination, the IRE will notify the Member and other parties to the appeal in writing of such decision following CMS guidelines.

5. If the IRE reverses or partially reverses the original adverse determination, the IRE notifies the Payer and L.A. CARE. The
payer in turn must notify the Member and the provider of service of the decision, with a copy to L.A. CARE.

6. If payment is required as a result of the IRE, the IRE notifies the Payer of the requirement to pay the claim. Payment must be issued within 30 calendar days of receipt of the decision by the IRE. No interest is due on favorable payment determinations made by the IRE.

L. If the appealing party is not satisfied with the decision of the IRE, and the projected value of the disputed service after reconsideration meets or exceeds the minimum requirements provided in the IRE’s decision, the appealing party may request a review by an Administrative Law Judge (ALJ) within 60 calendar days of receipt of the decision from the IRE, as outlined in “Member Appeal Resolution Process (Standard and Fast-Track”).

M. Subsequently, any party dissatisfied with the outcome of the Administration Law Judge Hearing, may request a Medicare Appeals Council review as outlined in “Member Appeal Resolution Process If still dissatisfied with the outcome, any party may request judicial review as outlined in “Member Appeal Resolution Process (Standard and Fast-Track)”.

N. If L.A. CARE receives an initial payment appeal directly for which another Payer is financially responsible, L.A. CARE will forward the appeal or grievance to the Payer for resolution, as applicable and notify the involved parties.

O. At any point in the process, the appealing party may bypass L.A. CARE or the Payer and submit an appeal directly to the IRE, in accordance with CMS guidelines. Additionally, any party to the appeal may withdraw the appeal at any point in the appeal process.

P. Members or providers of service not satisfied with the initial determination by the Payer where the determination is related to medical necessity, utilization management or pre-service referral denials or modifications may submit a written appeal to L.A. CARE within 60 calendar days, for review as outlined in L.A. CARE Policy # UM-041, “Appeals or Reconsideration”.

Q. No retaliation can be made against a Member or provider of service who submits an appeal in good faith.

R. Copies of all appeals and related documentation must be retained for at least ten years. A minimum of the last two years must be easily accessible and available within five days of request from L.A. CARE or regulatory agency.
S. Payers must track and report all appeals received in accordance with “Claims and Payment Appeals Reporting.”

T. L.A. CARE tracks, trends and analyzes appeals data, taking into account information from all other sources, including PPGs, and presents such information to the L.A. CARE Governing Board with recommendations for intervention, as appropriate.

12.7.2.1 Grievance disposition letters issued by PPGs must fully describe the grievance and grievance appeal process. This must include a description of timelines as well as higher levels of consideration, including L.A. Care.

Grievance and Appeals Coordination Unit
P.O. Box 811610
Los Angeles, CA. 90081

12.7.3 Disputes Between Contracted Relationships

A. IPA’s, PCPs and/or L.A. CARE are responsible for authorizing medical care.

B. In the event that a particular service is not available at the assigned Hospital the PPG must coordinate with the Hospital, if capitated, or L.A. CARE for contracted non-capitated Hospitals, to provide care for the Member at a mutually agreed upon facility.

C. In the event of an emergency the PPG must inform the Hospital, if capitated, or L.A. CARE for contracted non-capitated Hospitals, that care is being rendered at another facility.

D. Members cannot be transferred when admissions are due to lack of specialty coverage, access standard timeframe issues or when the Member refuses to be transferred.

PROCEDURE FOR DISPUTE RESOLUTION:

A. In the event an authorization for Hospital services is provided by a PPG representative that is in breach of the above policy, the following may occur:

1. Hospital/L.A. CARE reviews its incoming claims and identifies PPG contract violations that do not meet the above criteria such as:

   A. Authorized hospital services provided at a non-contracted facility.

   B. Authorized hospital services provided at another contracted facility that could have been provided at the assigned facility.
C. Authorized ER services for non-emergent care. Appropriately licensed medical staff must perform review for medical appropriateness.

2. If the Hospital, or L.A. CARE as applicable, was not notified or not amenable to these arrangements, the Hospital or L.A. CARE may deny payment of these authorized services.

3. Upon denial, the Hospital or L.A. CARE must send a copy of the claim to the PPG for payment with a denial letter explaining the reasons for the denial. If denied by the Hospital a copy of the denial letter, claim, records and all supporting documentation should also be sent to L.A. CARE at the following address:

   **L.A. Care Health Plan**  
   **Attention: Claims Department**  
   **P.O. Box 811580**  
   **Los Angeles, CA 90081**

4. Hospitals may send the provider of service a letter informing them that the claim has been forwarded to the IPA for payment, however a denial should not be sent to the practitioner.

5. The IPA must pay the claim for these hospital services unless the IPA feels the services provided were emergent or that the service was justified. In the event of the latter the IPA should submit the claim with the appropriate supporting documentation to L.A. CARE at the above address with a letter of appeal explaining their position. The appeal must be submitted to L.A. CARE within 60 days of the denial or payment.

6. L.A. CARE will follow the procedures outlined in Section 12.7.2 “Initial Claims Payment Appeals,” in determining the appropriateness of the appeal and whose financial responsibility it is to pay the claim.

7. Payment will be issued by the responsible party as outlined in “Initial Claims Payment Appeals.”
SAMPLE CLAIMS DENIAL NOTICE (see ICE website for most recent language requirements)

{Provider Name}
{Provider Mailing Address}

Member: {Member Name}
Member No: {Sub ID – Suffix}
Date of Service: {From – To Service Dates}
Claim No: {Claim ID}
Claim Amount: {Charged Amount}

NOTICE OF DENIAL OF PAYMENT

Dear {Provider Name}:

We have received your claim for the above-referenced member. This claim has been denied for the following reason:

A) Contracted providers

(1) Medical Records Requested – not received/ Contracted Prov – CONT 06
Medical records requested were not received. In order to determine financial liability or medical necessity, medical records are required to assist in a clinical determination. As these records have not been received, this claim in not payable by L. A. Care Health Plan. You are a contracted provider with (PMG / IPA) and you are not allowed to balance bill the member for these services. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.

(2) Outpatient Services (Office visits, lab and diagnostic imaging) – CONT-01
According to our records, there is no authorization for the services rendered. Contracted providers are required to provide documentation or other evidence that the member was advised prior to the services being rendered that they may be financially responsible for such services. You are a contracted provider with (PGM / IPA) and you are not allowed to balance bill the member for these services. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.
(3) Contracted Hospital or Provider Services (non-emergent – no triage call) – CONT-02
Emergency services are services needed immediately due to sudden illness, injury, or prudent layperson perception, and additional time spent to reach (PMG / IPA) would have meant risk of permanent damage to the member's health. The services you provided do not meet this definition and therefore required that you obtain prior authorization or provide documented proof the member was advised prior to services being rendered that they may be financially liable for such services. As a contracted provider, you are precluded from billing the member for these services. THE MEMBER IS NOT RESPONSIBLE FOR THE PAYMENT OF THIS CLAIM.

(4) Contracted Facility (delay in care resulted in unnecessary days) CONT -03
Medical Management has reviewed the care provided and determined that a delay in services provided resulted in unnecessary inpatient days listed above. As a contracted provider, you are not allowed to balance bill the member for these non-covered services. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.

(5) In – area Emergency Services (non-emergent) – (presenting circumstances fail test) – ERIA -01
Medical records do not support that the presenting symptoms meet the below definition of emergency. An emergency service is a service needed immediately due to acute symptoms (including pain) which a prudent layperson feels could result in serious jeopardy to their health. Additional time spent to reach an HMO provider would mean risking permanent damage to your health.

(6) Required Claim Data missing or Spoiled – (A required data element or one of the nine specified data emoluments is missing or Spoiled and the Contracted provider has not responded to the Plan’s request for the missing data) - CONT- 04 & CONT-05
The information submitted to us was missing one or more essential items of information required under 42 CFR 422.257(d) paragraphs (1) and (4). You have not responded to our request(s) for that information. Because the federal time limit for us to obtain that information has expired, we remain unable to process the claim and must send you this notice. BY CONTRACTUAL AGREEMENT, YOU MAY NOT BILL THE MEMBER.

Unless otherwise specified, the missing or deficient items include one or more of the following items listed below this paragraph that is not to the highest level of specificity or in accordance with currently valid Medicare codes. If you submit a complete claim to us that includes the information requested not later than the one- to two-year time limit allowed under Medicare law and regulations, we will process this claim.

[CMS -1500: CONT-04]_____ [or] [UB-04: CONT-05]__________.

Patient's Name (2) Patient Name (12)
Sex (3) Sex (15)
Birth Date (3) Birthdate (14)
I.D. No. (HIC or SSN) (1a) HIC or SSN (60)
Dates of Service (24A) From and Through Dates (6)
Diagnosis Code (24E) Principal Diagnosis Code (67)
B) Non-Contracted Provider Denial language -

(1) Missing required data –missing or Spoiled (Medicare guidelines)

[This page presents an approach to developing these problem claims when they are received from non-contracting providers. Please note that unlike for contracting provider claims on the preceding page, non-contracting provider claims cannot initially be denied for lack of complete, correct CMS required encounter data elements. CMS required data elements includes submission of a complete claim including complete diagnosis coding required for submission of risk adjustment information to CMS. Such incomplete claims from non-contracted providers are defined as non-clean and should be developed for up to 60 calendar days. If the claim data remains incomplete after requesting complete information, the claim should be denied on day 60 for incomplete information.]

Medicare requires us to report more complete information than you provided on this claim. Your claim as submitted is missing one or more essential items of information or has codes that are not sufficiently specific or do not conform to national standards (e.g., are incomplete, invalid or out of date). 42 CFR 422.257(d) paragraphs (1) and (4) require Medicare Advantage organizations to submit complete, conforming encounter data from paid claims. Unless otherwise specified, the missing or deficient items include one or more of the items listed below this paragraph that is not to the highest level of specificity or in accordance with currently valid Medicare codes. Until you provide us with the requested information, THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS INCOMPLETE CLAIM and should not be billed.

(2) In-Area Emergency Services (non-emergent) (presenting circumstances fail test) – ERIA -04 (cc: member)

Medical records do not support that the presenting symptoms meet the below definition of emergency. An emergency service is a service needed immediately due to acute symptoms (including pain) which a prudent layperson feels could result in serious jeopardy to their health. Additional time spent to reach an HMO provider would mean risking permanent damage to your health. Use of non-Plan providers in non-emergency situations is not payable by L. A. Care Health Plan.

(3) Medical Records requested and not received -NON -01 (cc: Member)

Medical records requested were not received. In order to determine financial liability or medical necessity, medical records are required to assist in a clinical determination. As these records have not been received, this claim is not payable by L. A. Care Health Plan.

C) Contracted and non-contracted providers denial language (Could be utilized by both)

C1) Eligibility
(1) Provider Eligibility with Plan – ELIG-01
The date you received medical services on the above claim was prior to your effective date of eligibility with L. A. Care Health Plan. Please submit your claim to Medicare or the HMO with whom you were eligible as of the date services were rendered.

(2) In-between Eligibility – ELIG-04
The date of service is between your eligibility for L. A. Care Health Plan. Please submit your claim to Medicare or the HMO with whom you were eligible as of the date services were rendered.

(3) Postdates Eligibility with Plan – Elig-02
The date you received medical services on the above claim was after your effective date of disenrollment with L. A. Care Health Plan. Please submit your claim to Medicare or the HMO with whom you were eligible as of the date services were rendered

(4) Service Postdates Member's death – ELIG-03
Our records show the date of service was after the date of death.

C2) Emergency and Urgently Needed Services

(5) In-Area Emergency Services (records not received) – ERIA-02
Medical records requested were never received. An emergency service is a service needed immediately due to acute symptoms (including pain) which a prudent layperson feels could result in serious jeopardy to their health. Additional time spent to reach an HMO provider would mean risking permanent damage to your health. The services received and circumstances do not meet these requirements based on the information available.

(6) In-area (Partial denial of inappropriate services) ERIA-03
Services delivered as emergency care were not consistent with presenting symptoms or emergency diagnosis

(7) Out-of-area Emergency and Urgently Needed Services (not urgently needed) – EROA-01
Emergency/urgent services are covered outside of the service area if necessary to prevent deterioration of health due to unforeseen illness while temporarily out of the service area. The services received were not emergent/urgent and were not authorized.

(8) Out-of-Area Emergency and urgently needed Services (records not received) – EROA-02
Emergent / urgent services are covered outside of the service area if necessary to prevent deterioration of health due to unforeseen illness while temporarily out of the service area. Medical records requested were never received. The services received cannot be determined to meet these requirements based on the information available.

C3) Maximum Allowable Benefit

(10) Inpatient Psychiatric – MAPY-01
Inpatient psychiatric care is covered according to Medicare guidelines and is limited to 190 days per lifetime in a Medicare certified psychiatric hospital. Our records indicate you reached 190 lifetime days on {date}.

(11) Podiatry (non-Medicare covered) – MAPO-01
The maximum calendar year additional podiatry benefit is {#} visits per year. Our records indicate you reached that limit on {date}. The maximum benefit was paid at that time.

(12) Prescription Drugs (non-Medicare covered) – MARX-01
The maximum calendar year benefit allowance for outpatient prescription drugs is ${______}. Our records indicate you reached that limit on {date}. The maximum benefit was paid at that time.

(13) Skilled Nursing Facility – MASN-01
Skilled Nursing Facilities are covered by L. A. Care Health Plan up to 100 days per benefit period. Our records indicate that on {date}, you reached your 100 day benefit maximum for this benefit period.

(14) Miscellaneous – MAMI-01
Insert other specific benefits with annual maximums.

C4) Not a covered Benefit

(15) Ambulance (not medically necessary) – NCAM-01
Ambulance transportation is covered if you could not have used another means of transportation without endangering your health. The transport you received does not meet this criterion.

(16) Ambulance (no patient transport) – NCAM-02
As you were not transported by ambulance, the services are not covered by Medicare or L. A. Care Health Plan.

(17) Assistant Surgeon (Medicare guidelines) – NCAS-01
Medicare does not pay for an assistant surgeon for this procedure/surgery. Payment for the assistant surgeon is denied by L. A. Care Health Plan. The member has no financial responsibility for these services.

(18) Bundling (Medicare Guidelines) – NCBU-01
Medicare does not pay separately for this service. Payment is included in another service the member has received. The member has no financial liability and should not be billed for these services.

(19) Chiropractic (Medicare guidelines) NCCH-01
Medicare coverage for chiropractic care requires that you be diagnosed with subluxation of the spine. The services received do not meet this criterion and are not covered by Medicare or L. A. Care Health Plan.

(20) Cosmetic – NCCO-01
The procedure you received is considered a cosmetic procedure. Cosmetic procedures are not a benefit covered by Medicare or L. A. Care Health Plan for post accident repair/reconstruction. Please refer to your Health Plan's member materials for benefit guidelines.

(21) Dental Services – NCDS-01
Dental services are not a benefit covered under Medicare or L. A. Care Health Plan except for surgery related to the jaw or any structure related to the jaw or any facial bone. Please refer to your Health Plan's member materials for benefit guidelines.

(22) DME- Durable Medical Equipment (does not meet Medicare DME criteria) – NCDM-01
Medicare defines durable medical equipment as an item that is medical in nature, can withstand repeated use, and is used in the home. The item received does not meet these requirements and is not payable by Medicare or L. A. Care Health Plan.

(23) DME- Durable Medical equipment (not authorized) –NCDM-02
The durable medical equipment received was not prescribed/authorized by your primary care physician. Services not authorized, unless emergent or urgently needed out of the area, are not payable by L. A. Care Health Plan.

(24) Hearing Aids – NCHA-01
Hearing Aids are not a benefit covered under Medicare or L. A. Care Health Plan.

(25) Home Health (does not meet skilled guidelines) –NCHH-01
Home health services must include intermittent skilled care (skilled nursing, PT, or speech therapy) to qualify under Medicare guidelines. The services received were not skilled care and are not payable by Medicare or L. A. Care Health Plan.

(26) Home Health (member not homebound) – NCHH-02
Home health care must meet Medicare guidelines, which require that you are confined to your home. You are not homebound and consequently the home health services received are not payable by Medicare or L. A. Care Health Plan.

(27) Home Health (not authorized) – NCHH-03
The home health services you received were not authorized by your primary care physician. Services not authorized, unless emergent or urgently needed out of the area, are not payable by L. A. Care Health Plan.

(29) Non Medicare/FDA Approved Drugs or Devices – NCRX-02
{_________} is not approved by Medicare/the FDA and is excluded from coverage by L. A. Care Health Plan. Please refer to your Health Plan's member materials for benefit guidelines.

(30) Not Authorized In-Area (if ER/Emergent, use emergency denial message) – NCNA-01
When you enrolled in a Medicare Advantage Plan, you selected a Primary Care Physician to coordinate/authorize your medical care. The services received were not authorized and are not payable by {L. A. Care Health Plan}. 
(31) Over the counter Drugs – NCRX-03
The drugs/medication received is available over the counter without a prescription and are not a benefit covered by {L. A. Care Health Plan}. Please refer to your Health Plan’s member materials for benefit guidelines.

(32) Personal comfort items – NCPC-01
The {______} you were provided is considered a personal comfort item and is not a covered benefit under Medicare or {L. A. Care Health Plan}. Please refer to your Health Plan’s member materials for benefit guidelines.

(33) Podiatry – NCPO-01
Podiatry services for routine foot care, such as toe nail trimming, or corn/callus removal are not a benefit covered under Medicare or {L. A. Care Health Plan}. Please refer to your Health Plan’s member materials for benefit guidelines.

(34) Shoe Orthotics – NCSO-01
Shoe orthotics, including inserts and modifications, are only covered by Medicare or {L. A. Care Health Plan} for diabetics or when the shoe is an integral part of a leg brace. Please refer to your Health Plan’s member materials for benefit guidelines.

(35) Skilled Nursing Facility – (custodial care or not daily SNF care) – NCSN-01
Medicare guidelines require that skilled nursing facility care be needed daily, as certified by your physician. The services received were custodial in nature and/or not required daily. They are not covered by Medicare or {L. A. Care Health Plan}.

(36) Skilled Nursing Facility (not authorized) – NCSN-02
The skilled nursing facility services you received were not authorized by your primary care physician. Services not authorized, unless emergent or urgently needed out of the area, are not a covered benefit under {L. A. Care Health Plan}.

(37) Miscellaneous – NCMI-01
{SPECIFIC Item(s)} is not a Medicare covered benefit and excluded from coverage under {L. A. Care Health Plan}. Please refer to your Health Plan’s member materials for benefit guidelines.

C5) Coordination of Benefits
(1) Requested information not received from member –COB-01
Our records indicate that you may have other insurance coverage. Coordination of benefits information (primary insurance carrier information) was requested from you and has not been received. In order to determine financial liability this information is required. As this information has not been received, this claim in not payable by [Health Plan].

If you believe this determination is incorrect, you have the right to request for reconsideration. You must submit your request in writing within 60 days from the date of this notice and include the additional information which will substantiate your request for reconsideration to:

L. A. Care Health Plan
Appeals and Grievance Department
12.0 Claims – Medicare Advantage-SNP Line of Business

This section covers guidelines for claims processing and other claims related issues for Participating Providers with respect to L.A. Care’s Medicare Advantage-SNP line of business.

12.1 RESPONSIBILITY OF PARTICIPATING PROVIDERS

Participating Physician Groups (PPGs), and hospitals contracted with L.A. Care are responsible to perform certain tasks for claims under the terms of their agreement in the L.A. Care Medicare Program. After reviewing this section, please refer to the “Division of Responsibility” in the agreement between the PPG, and L.A. Care to determine what entity is responsible for specific claims. The “Division of Financial Responsibility,” specifies which health care services are the financial responsibility of L.A. Care, and which are the financial responsibility of the PPG. The PPG is responsible for handling all claims for those services it is financially responsible.

12.2 COLLECTION OF CHARGES FROM MEMBERS

Neither the PPG nor any of its providers will in any event submit a claim or demand or otherwise collect reimbursement from an L.A. Care member or persons acting on behalf of a member for any services provided pursuant to the PPG’s L.A. Care Services Agreement, except to collect any authorized co-payments.

12.6 Coordination Of Benefits (COB)

DEFINITION OF COB:

F. Coordination of Benefits (COB) is the procedure to determine the order of payment responsibility when a Member is covered by more than one health plan or insurer.

G. COB is applied in accordance federal law governing COB including the Order of Determination of payment.

H. L.A. CARE and PPGs are responsible for identifying other health plans that are primary to L.A. CARE and must coordinate benefits for Members in accordance with federal law.
I. L.A. CARE and PPGs must make reasonable efforts to appropriately determine payment of claims for covered services rendered to any Member who is fully or partially covered for the same service under any other state, federal program, or other entitlement such as a private group or indemnification program.

J. Medicare may be the secondary payer under certain rules as delineated under Title 42, Chapter 7 of the Social Security Act and L.A. Care’s Medicare - Coordination Of Benefits Policy.

**PROCEDURE FOR COB RECOVERY:**

E. L.A. CARE pays PPGs capitation rates as outlined in the L.A. CARE Capitated Agreement, for all Members assigned to them regardless of other insurance coverage.

F. Since all L.A. Care Medicare Advantage SNP members have both Medicare and Medi-Cal (Medi-Medi) the claim is processed with Medicare as the primary and Medi-Cal as the secondary, following the policies and procedures outlined in the L.A. CARE Medi-Cal Provider Manual, “Coordination of Benefits”.

G. If the Member has other health coverage in addition to Medicare and Medi-Cal, Medicare may be secondary under certain rules for coordination of benefit, as outlined below.

H. If the Member has other primary health care coverage, the claim is adjudicated at the lesser of the Medicare allowable or the primary payer allowable. L.A. CARE adjudicates covered services as primary if they are not covered by the other health coverage. The provider of service must submit such claims with a denial letter or explanation of benefits from the other health coverage.
The COB claim determination period is based on the period of time the Member is enrolled with L.A. CARE. If the Member is not enrolled with L.A. CARE on the date of service, COB is not applicable.

L.A. CARE has the right to obtain and release COB information and may do so without the Member's or Authorized Representative's consent. Members must provide an insurer with any information needed to make COB determinations and to pay claims.

When coordinating benefits, Medicare Secondary Payer rules apply. Under those rules, the Medicare Advantage plan is secondary under the following conditions:

- Elderly Workers Employer Group Health Plan - This 65 year old or older member is covered by an employer Group Health Plan (GHP) with 20 or more employees or is the spouse of a person covered by an Employer Group Health Plan. The spouse's age is not material to the determination of primary coverage only the qualification of the GHP.

- Disabled Beneficiaries Employer Group Health Plan – These members are eligible for Medicare based on disability and are under the age of 65 years and are covered by a Large Group Health Plan (LGHP) through either their own or family member's employment. Large Group Health Plans are defined by at least one of the employers having 100 or more employees.

- Beneficiaries with End Stage Renal Disease (ESRD) and an Employer Group Health Plan – The rules for these members are complex, please see the Medicare Secondary Payer Manual (Publication # 100-05) on the CMS website for detailed information affecting the rules for members with ESRD.

- Federal Black Lung Program - The Black Lung Program was set up under the Department of Labor to assist coal miners with pulmonary and respiratory diseases that resulted from their employment. The Black Lung Program is billed for all services that relate to either respiratory or pulmonary diseases. The Medicare managed care plan is the primary payer for all other cares and service needs.

- Veterans Administration Coverage - Care and services authorized by Veteran's Administration are payable in full by the VA. Claims from one government program cannot be reimbursed by another government program. The Medicare managed care plan may supplement VA payment when the member files a claim for Part B.
services that were not fully reimbursable by the VA or for any member copayments made to a VA facility.

E. Medicare Secondary Payer rules supersede other federal and state law governing the coordination of benefits.

F. Providers may retain any amounts collected through COB, in addition to any capitation received.

12.7 Third-Party Liability (TPL)
This policy applies to all L.A. CARE Medicare Advantage Members. PPGs may make a claim for recovery of the value of covered services rendered to a Medicare Advantage Member in cases involving the tort liability of a third party or casualty liability insurance, including Workers’ Compensation and uninsured motorist’s coverage.

**PROCEDURE FOR TPL RECOVERY:**

E. If the Payer becomes aware of a claim involving Third Party Liability (TPL), the Payer must pursue recovery of any monies paid in accordance with state and federal guidelines.

F. The Payer must notify the insurance plan and/or attorney of record of its intent to recover the amounts paid in connection with the injury or illness caused by the third party or employer. The Payer must provide copies of all related claims if requested.

G. The Payer should regularly follow-up with all involved parties every 30 days until resolution is complete.

H. The Payer should attempt to recover the full amount of claims already paid as well as the amount necessary to pay all anticipated future medical expense.
12.8 CLAIMS SUBMISSION

Claims submitted by the PPG or its contracted providers must be complete with all required information to ensure timely processing and payment as stipulated in the provider's contract.

12.5.1 Billing
All paper claims must be submitted on CMS 1500 form for professional services and UB-04 forms for facility services.

12.5.2 Claim Filing Limit
The provider shall bill using appropriate forms and in a manner acceptable to L.A. Care or the PPG within the filing limit specified in the provider's contract. If not specified in the provider contract, the filing limit for Medicare claims will apply.

12.5.3.1 In general, physician and ancillary service claims for MA-SNP members will be submitted to the PPG. Inpatient hospital claims and claims for DME and ambulance services for MA-SNP members will be submitted to L.A. Care. In order to determine who is responsible for paying a claim, please refer to Exhibit B, the Division of Financial Responsibility, in your contract with L.A. Care. The Division of Financial Responsibility specifies what entity is responsible for paying each category of claim.

12.5.3.2 If you have a question about where to send a claim, please call L.A. Care’s Provider Information Line. You will access our Interactive Voice Recognition (IVR) system that will guide you to one of our Provider Network Representatives that can assist.

12.5.3.3 For all claims for which L.A. Care is financially responsible, please mail the claims to:

L.A. Care Health Plan
Attn: Claims Dept.
P.O. Box 811580
Los Angeles, CA 90081

12.5.4 Claim Status Inquiries
Please be advised that you may inquire about the status of a claim, including the date of receipt, for which L.A. Care is financially responsible by calling 1-866-LACARE6.
12.6 CLAIMS PROCESSING

I. All claims submitted to the PPG must be processed (paid or denied) or forwarded in accordance with all federal and state laws and regulations and the L.A. CARE contract.

J. All PPGs are delegated the responsibility of claims processing for the services identified as PPG’s responsibility in the Division of Financial Responsibility exhibit of the L.A. Care Service Agreement and are subject to review by L.A. CARE. L.A. CARE provides oversight of the PPGs by monitoring, reviewing and measuring claims processing systems and payment appeals to ensure timely and accurate claims processing and appeal resolution.

K. Contracted providers of service are required to submit claims in accordance with the provisions outlined in their contract with the Payer. If the contract is silent on a timeframe for submission, or the provider of service is non-contracted, the provider of service has 1 year from the date of service to submit a claim.

L. Misdirected claims must be forwarded to the appropriate financially responsible entity within 10 working days of receipt.

M. PPGs must pay 95% of clean claims for non-contracted providers rendering services to Medicare Advantage Members within 30 calendar days of receipt of the claim. All other claims for non-contracted providers must be paid or denied within 60 calendar days. Claims for contracted providers must be paid within contractual timeframes.

N. If the Payer pays clean claims from non-contracted providers after 30 days, it must pay interest in accordance with federal guidelines and at the Prompt Payment Act Interest Rate published in the Federal Register and on the United States Treasury website.

O. PPGs are expected to identify and recover overpayments resulting from a payment error or when it has been determined that the provider of service or Member was liable for the services, in accordance with federal regulations.

P. PPGs must establish and maintain a process that addresses the receipt, handling and disposition of a payment appeal in accordance with federal or state regulations and contractual guidelines. All payment appeals must be resolved within 60 calendar days of receipt of the appeal.
12.7 PROCEDURE FOR MEDICARE CLAIMS PROCESSING:

B. PPGs must have written procedures for claims processing that are available for review. In addition, PPGs must disclose claims filing directions, fee schedules and payment appeal processes via contract, written notification, Explanation of Benefits (EOB) or Remittance Advice (RA) at the time of payment, denial or adjustment, and/or via a website, as applicable. These written procedures and disclosures must comply with state, federal and L.A. CARE contractual standards and requirements. Such disclosures must also be made available upon request to providers of service, L.A. CARE or a regulatory agency.

C. PPGs’ claims processing systems must identify and track all claims and payment appeals by line of business and/or program and be able to produce claims and appeals related reports as outlined in Section 12.7.2, “Initial Claims Payment Appeals.”

E. Contracted providers of service must be given no lesser period to submit claims than the timeframe stipulated in the contract to submit a claim.

F. Non-contracted providers of service and contracted providers of service whose contract is silent on a submission timeframe are allowed up to 1 year from the date of service to submit a claim.

4. Claims received after that deadline may be denied.

5. Claims received after the filing deadline are reconsidered for payment only when the provider of service has submitted an explanation of the circumstances surrounding the late filing, or L.A. CARE or the PPG is responsible due to an administrative error.

6. If a claim is denied for untimely filing, the provider of service may file an appeal as outlined in Section 12.7.2, “Initial Claims Payment Appeals” and the claim may be reconsidered for payment upon proof of and demonstration of good cause for the delay.

E. PPGs must redirect claims that are not their financial responsibility to the appropriate responsible party within 10 working days of receipt.

3. If the Member cannot be identified or the financially responsible entity is not affiliated with the Payer’s network, the claim may be denied and/or returned to the provider of service advising the billing provider to verify eligibility assignment and to bill the appropriate responsible party.

4. All redirected claims must be tracked and reported as outlined in “Claims and Payment Appeal Reporting.”

F. Clean claims are those claims and attachments or other documentation that include all reasonably relevant information necessary to determine Payer liability and for which no further information is required from the provider of service or a third party to develop the claim. To be considered
a clean claim the claim should be prepared in accordance with the National Uniform Billing Committee standards and should include, but is not limited to the following information:

4. A claim form that contains:
   a. A description of the service rendered using valid CPT, ICD9, HCPCS, and/or Revenue codes, the number of days or units for each service line, the place of service code, the type of service code and charge for each listed service.
   b. Other claim specific information as dictated by Medicare for provider of service type (i.e., Hospital, lab, etc.).
   c. Member (patient) demographic information, which must at a minimum include the Member’s last name and first name and date of birth.
   d. Provider of service name, address, tax identification number; Medicare Health Insurance Claim Number (HICN), and Providers NPI.
   e. Information pertaining to COB, if applicable.
   f. Date(s) of service.
   g. Amount billed.
   h. Signature of Member or person authorized to sign on behalf of Member.
   i. Signature of person submitting claim.

5. Other documentation necessary to adjudicate the claim, such as medical or emergency room reports, claims itemization or detailed invoice, medical necessity documentation, other insurance payment information and referring provider information (or copy of referral) as applicable.

6. Prior authorization documentation, such as an L.A Care authorization number, a copy of the authorization form or referral form attached to the claim for services on which authorization is required.

G If a claim is missing required information, as defined in Procedure above, or additional information in necessary order to complete the claim, the claim must be developed as follows:

6. The Payer must send a written notice to the provider of service requesting the missing information or other reasonably relevant information necessary to determine Payer liability within 30 calendar days after the date of receipt. If the Payer is requesting additional reasonably relevant information, the Payer must include a written explanation of the necessity for the request.
7. If the Payer does not receive the requested information from a provider of service within 45 calendar days after it receives the claim, the Payer must review the claim and make a decision to pay or deny the claim based on available information. That payment or denial must be issued within 60 calendar days of original receipt of the claim.

8. Upon receipt of the requested information, the Payer must pay the amount due on the claim within 30 calendar days from receipt of the additional information from a non-contracted provider, or within contractual timeframes if the provider of service is contracted.

9. If the Payer denies a claim on the basis of a failure to submit requested medical records or other information reasonably necessary to determine Payer liability, as outlined in Procedure F (2)-(4), the Payer must process any appeal from the denial of such claim in accordance with the appeals process outlined in "Initial Claims Payment Appeals".

10. If the Provider fails to submit requested required information as defined in Procedure G (1), or the information is invalid or incomplete, the claim can be rejected or denied.

H. PPGs must establish processes for claim payment without a requirement for prior authorization for the following covered services rendered to a Medicare Member by a non-contracted provider of service:

7. Ambulance services dispatched through 911 or its local equivalent where other means of transportation may endanger the Member's Health.

8. Emergency services

9. Urgently needed services

10. Post-stabilization care services

11. Renal dialysis services

12. Covered services that the Payer denied that were determined through the appeals process to be services to which the Member was entitled.

K. PPGs must coordinate benefits and follow Medicare as Secondary Payer rules as outlined in the “Coordination of Benefits” Section. Claims submitted for secondary payment must follow the submission timeframes stated in Procedure D, from the date the primary Payer’s notice of payment or denial is received by the provider of service in order to be considered timely.

L. Claims received from contracted providers of service must be appropriately paid or denied within contractual timeframes. Clean claims
from non-contracted providers of service rendering services to Medicare Members must be paid within 30 calendar days of receipt, or within 60 calendar days for all other claims.

5. This measurement begins on the initial date of receipt of the claim anywhere within the contracted network (i.e. the earliest date stamp) and ends when the check or denial is mailed to the provider of service, regardless of when the check is dated.

6. The payment date used to meet timeliness standards is the actual date the check is mailed, deposited into the provider of service’s account or transferred electronically, regardless of the date on the check.

7. The date of receipt is the date the claim is first received by an entity within the plan’s network even if that party is not financially responsible for that particular claim as indicated by its date stamp on the claim. **Claims with multiple date stamps should be deemed priority and processed immediately.**

8. “All other claims” are denied claims or those (unclean) claims that require investigation or additional information from the provider of service to develop the claim. This includes but is not limited to requests for additional information from the physician/supplier or other external source such as routine data omitted from the claim, medical information, or information to resolve discrepancies.

L. If the PPG fails to pay a clean claim from a non-contracted provider of service within 30 calendar days after receipt, the PPG must pay interest at the rate used for such late payments, as stated in federal regulations beginning on the first calendar day following 30 calendar days from the date of receipt. Interest accrues from that date until the date the check is mailed.

L. Denial Letters must be mailed to the provider of service within timeframes stated in Procedure J for paying or denying a claim. The PPG should access the Medicare Advantage Pre-Service Denial Reason Matrix on the INDUSTRY COLLABORATION EFFORT (ICE) website and conform to the approved language found there. The date of denial notification is the date the denial notice is actually mailed to the provider of service.

4. Any claim that is denied must include an accurate and clear written explanation of the actions taken. Both the provider of service and Member must be notified of the denial if there is member liability for the claim or a portion of the claim.

5. All denial notifications and the EOB and/or RA to the provider of service must include mandated language and be properly formatted in accordance with Medicare specifications. At a minimum, the denial notification must:
a. Use approved notice language in a readable and understandable format
b. State the specific reason for the denial
c. Inform the Member of his or her right to reconsideration of the payment determination
d. For payment denials, the standard reconsideration process as well as the rest of the appeal process as outlined in “Initial Claims Payment Appeals,” “2nd Level Claims Payment Appeals” and “Member Appeal Resolution Process (Standard and Fast Track)”
e. Comply with any other notice requirements specified by CMS.

6. The denial notification must incorporate appropriate denial reason language.

N. If a Payer determines that a claim has been overpaid, the Payer may attempt to recover the overpayment and send a written notice to the provider of service.

3. Individual overpayments are those overpayments resulting from incorrect payment to the provider for physician/supplier services, including but not limited to duplicate payments, payments to the wrong provider of service, processing errors.

4. The written notice must clearly identify the claim, the name of the Member, the date of service and a clear explanation of the basis upon which the Payer believes the amount paid was in excess of the amount due, including interest and penalties.

5. Providers of service must respond to the request with a corrected billing, an appeal or a refund in accordance with federal guidelines or within 30 days of the date of the request. PPGs may retract the overpayment under certain circumstances outlined in federal guidelines. Payer may send a second written request and continue to follow-up with the provider of service to recover the money.

O. PPGs must establish processes that address the receipt, handling and disposition of a payment appeal in accordance with federal or state regulations and contractual guidelines, as outlined in “Initial Claims Payment Appeals”.

R. L.A. CARE’s Claims Department is available from 8:00am - 5:00pm, Monday through Friday at (866) 522-2736 to assist and answer any questions related to claims processing.

S. The responsibility for claims payment as outlined above continues until all claims have been paid/denied for services rendered during the timeframe a Capitated Agreement existed.
T. In the event the Payer fails to meet L.A. CARE claims processing standards as indicated above, L.A. CARE may elect to pay these claims on behalf of the Payer by deducting such payment from the Provider’s monthly capitation check.

R The 14-Day letter process is applied when there are unpaid claims and/or claims inquiries.

12.7.1 PROCEDURE FOR RESPONDING TO A 10 DAY LETTER:

G. The 10-Day letter is a tool used by L.A. CARE to process appeals or disputes from members’ providers of service related to claims issues involving alleged lack of payment or denial from the payer.

H. L.A. CARE’s 10-Day letter process is sent to providers of service under the following circumstances:

4. A provider of service (both contracted and non-contracted) notifies L.A. CARE that no status has been provided on a claim submitted to the appropriate payer for over 60 days, or

5. L.A. CARE identifies a claim that has not been paid appropriately within the claims processing timeframes.

6. A member is being billed for covered services or has filed a grievance

I. The 10-Day letter requests information on the status of the claim, as outlined in Procedure G below. The Payer must complete this form and return it to L.A. CARE within 10 days from the date of the letter. A copy of the claim from the provider of service is included with the 10-Day letter sent by L.A. CARE to the Payer.

J. PPGs must provide L.A. CARE the following information in their response regarding the claim: the date the claim was originally received, if it was paid or denied, the date paid or denied, the amount paid, check number and/or the reason for the denial.

K. The following are examples of unacceptable responses to the 14-day letter:

5. Member Not Eligible (L.A. CARE confirms eligibility prior to 10-day notification).

6. Not Authorized (it is inappropriate to deny a claim due to “No Authorization” as medical review must be performed prior to denial).

L. In the event the Payer fails to provide an acceptable written response to L.A. CARE within 10 days or the requested information is returned incomplete, L.A. CARE pays the provider of service directly using the prevailing Medicare fee schedule outlined below and deducts the amount paid from the Payer’s monthly capitation check.

4. The Medicare limiting charge for unassigned claims by non-participating providers.

5. Non-par amounts for assigned claims by non-participating providers.

6. The par amount for participating providers.

K. Claims capitation deductions are outlined on a detail report that is sent with the capitation payment.

12.7.2 PROCEDURE FOR INITIAL CLAIM APPEALS:

F. Inquiries regarding the status of a claim or requests for intervention by L.A. CARE on behalf of the billing provider in an attempt to get an initial adjudication decision (payment or denial) made on a claim by the Payer are not considered appeals and are handled in accordance with the procedure outlined in “10-Day Letters” Section.

G. Payment appeals relate to the initial determination of a payment decision or denial and are primarily complaints concerning an adverse organizational determination denying a request for payment.

4. Any appeal involving PCP P4P reimbursements should be filed in accordance with the guidelines provided in “Pay For Performance”.

5. Any provider appeal not involving payment should be filed in accordance with the guidelines provided in “Appeal Resolution Process for Providers of Service: Initial Appeal Resolution”.

6. Grievances and appeals are separate and distinct. If the documentation submitted is considered to be a grievance, PPGs must resolve it in accordance with their grievance policies and procedures as outlined in “Appeal Resolution Process for Providers of Service: Initial Appeal Resolution” or using the “Member Grievance Resolution Process”.

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H. Members, their authorized representative or providers of service acting on behalf of a Member and non-contracted providers of service must submit all payment appeals in writing to the Payer within 60 calendar days from the date of a denial or other adverse payment determination from the Payer. The denial may be in the form of a written adverse determination from the Payer or an Explanation of Benefits (EOB) or Remittance Advice (RA) Justification and supporting documentation must be provided with the written appeal, as outlined in Procedure F below.

I. Non-contracted providers of service may file an appeal on his or her own behalf if the provider of service furnished a covered service to the Member and completes a waiver of liability statement that states that the provider of service will not bill the Member for covered services regardless of the outcome of the payment appeal.

J. Payers may accept a request for reconsideration of an appeal filed after 60 calendar days if the Member, the Member’s authorized representative or non-contracted provider of service submits a written request for an extension of the timeframe for good cause.

G. Written payment appeals must be submitted to the Payer in accordance with the appeal process guidelines issued by the Payer.

3. For payment appeals involving L.A. CARE as the Payer, appeals must be sent to:

   **Grievance and Appeals Coordination Unit**
   **P.O. Box 811610**
   **Los Angeles, CA 90081**

4. Written payment appeals to L.A. Care must include:

   e) The Medicare health insurance claim number
   f) Specific service(s) and/or item(s) for which reconsideration is being requested and the specific date(s) of service
   g) The name and signature of the party or the representative of the party filing the appeal
   h) A clear explanation of why the appealing party disagrees with Payer’s initial determination and should include supporting documentation the appealing party feels should be considering when making the reconsideration

4) If the appeal involves a denied emergency claim, the documentation should include a copy of the Member’s emergency room records, notification of the emergency room visit and a copy of the notice of determination or EOB.
5) If the appeal involves an ambulance claim, the documentation should include a copy of the transport record, a copy of the Member's emergency room or hospitalization records relating to the ambulance trip, including records from the triage or medical departments as applicable and a copy of the notice of determination or EOB.

6) If the appeal involves co-payment charges or co-payment reimbursement, the supporting documentation should include a copy of the Member's medical record from the corresponding hospital, emergency room or provider of service office, a copy of the utilization records if the Member was admitted, a copy of the notification of the emergency room visit or admission, and a copy of the notice of determination or EOB.

4. If supporting documentation is not available or the Payer does not have enough information to make a determination on the appeal, the Payer may send a request for additional information to the provider of service. If the provider of service fails to provide requested information within 5 calendar days of the request, the Payer must make a determination on the information available.

G. Payers must research the appeal and if it meets the criteria for a payment appeal, the Payer must send a written acknowledgement letter, an authorization for release of protected health information, and a self-addressed stamped envelope to the Member, the authorized representative or non-contracted provider of service who submitted the request, within 5 working days of the request.

H. Payers must make every effort to investigate and take into consideration all information on file or received from the provider of service. The Payer may request additional information or discuss the issue with the involved provider of service as needed to make a determination.

I. PPGs must send written notice of the resolution, including pertinent facts and an explanation of the reason for the determination, within 60 calendar days of the receipt of the payment appeal. The notification must be sent to both the Member and appealing party, with a copy to L.A. CARE.

3. Written notification of affirmative (uphold) determinations, whether in whole or in part, must be written in a manner easily understood by the Member and include:
   a. A clear statement indicating the extent to which the reconsideration is favorable or unfavorable;
   b. A summary of the facts, including, as appropriate, a summary of the clinical or scientific evidence used in making
the re-determination;
c. An explanation of how pertinent laws, regulations, coverage rules and CMS policy applies to the facts of the case;
d. A summary of the rationale for the re-determination in clear, understandable language;
e. The procedures for obtaining additional information concerning determinations, such as specific provisions of the policy, manual or regulation used in making the determination
f. Any other requirements specified by CMS.

4. Failure to respond to the request for reconsideration with a determination within the specified timeframe must consider the failure as an affirmation of the adverse decision and the Payer must forward the request to the CMS Independent Review Entity (IRE) for review in accordance with Medicare requirements, within 60 calendar days after receiving the request for reconsideration.

U. If the written determination results in payment, payment must be made within 60 calendar days of receipt of the payment appeal, which is concurrently with the written determination. There is no interest due on payments made as a result of an appeal.

V. If the determination is to affirm or uphold the initial payment determination, the Payer must send a written determination to the Member and appealing party informing them of the decision and immediately forward the appeal and determination and supporting documentation to the IRE for final review in accordance with Medicare guidelines.

7. The information must be forwarded to the IRE within 5 calendar days of the determination, or within 60 calendar days of receipt of the appeal from the appealing party, whichever occurs first.

8. The IRE will make a decision on the payment appeal in accordance with its CMS contracted timeframes.

9. The IRE may request additional information, and upon receipt of such information, L.A. CARE and/or the Payer must make every effort to provide the requested information within the timeframe specified by the IRE.

10. If the IRE upholds the original adverse determination, the IRE will notify the Member and other parties to the appeal in writing of such decision following CMS guidelines.

11. If the IRE reverses or partially reverses the original adverse determination, the IRE notifies the Payer and L.A. CARE. The payer in turn must notify the Member and the provider of service of the decision, with a copy to L.A. CARE.
12. If payment is required as a result of the IRE, the IRE notifies the Payer of the requirement to pay the claim. Payment must be issued within 30 calendar days of receipt of the decision by the IRE. No interest is due on favorable payment determinations made by the IRE.

W. If the appealing party is not satisfied with the decision of the IRE, and the projected value of the disputed service after reconsideration meets or exceeds the minimum requirements provided in the IRE’s decision, the appealing party may request a review by an Administrative Law Judge (ALJ) within 60 calendar days of receipt of the decision from the IRE, as outlined in “Member Appeal Resolution Process (Standard and Fast-Track”).

X. Subsequently, any party dissatisfied with the outcome of the Administration Law Judge Hearing, may request a Medicare Appeals Council review as outlined in “Member Appeal Resolution Process If still dissatisfied with the outcome, any party may request judicial review as outlined in “Member Appeal Resolution Process (Standard and Fast-Track”).

Y. If L.A. CARE receives an initial payment appeal directly for which another Payer is financially responsible, L.A. CARE will forward the appeal or grievance to the Payer for resolution, as applicable and notify the involved parties.

Z. At any point in the process, the appealing party may bypass L.A. CARE or the Payer and submit an appeal directly to the IRE, in accordance with CMS guidelines. Additionally, any party to the appeal may withdraw the appeal at any point in the appeal process.

AA. Members or providers of service not satisfied with the initial determination by the Payer where the determination is related to medical necessity, utilization management or pre-service referral denials or modifications may submit a written appeal to L.A. CARE within 60 calendar days, for review as outlined in L.A. CARE Policy # UM-041, “Appeals or Reconsideration”.

BB. No retaliation can be made against a Member or provider of service who submits an appeal in good faith.

CC. Copies of all appeals and related documentation must be retained for at least ten years. A minimum of the last two years must be easily accessible and available within five days of request from L.A. CARE or regulatory agency.

DD. Payers must track and report all appeals received in accordance with “Claims and Payment Appeals Reporting.”
EE. L.A. CARE tracks, trends and analyzes appeals data, taking into account information from all other sources, including PPGs, and presents such information to the L.A. CARE Governing Board with recommendations for intervention, as appropriate.

12.7.2.1 Grievance disposition letters issued by PPGs must fully describe the grievance and grievance appeal process. This must include a description of timelines as well as higher levels of consideration, including L.A. Care.

Grievance and Appeals Coordination Unit
P.O. Box 811610
Los Angeles, CA. 90081

12.7.3 Disputes Between Contracted Relationships

E. IPA’s, PCPs and/or L.A. CARE are responsible for authorizing medical care.

F. In the event that a particular service is not available at the assigned Hospital the PPG must coordinate with the Hospital, if capitated, or L.A. CARE for contracted non-capitated Hospitals, to provide care for the Member at a mutually agreed upon facility.

G. In the event of an emergency the PPG must inform the Hospital, if capitated, or L.A. CARE for contracted non-capitated Hospitals, that care is being rendered at another facility.

H. Members cannot be transferred when admissions are due to lack of specialty coverage, access standard timeframe issues or when the Member refuses to be transferred.

PROCEDURE FOR DISPUTE RESOLUTION:

B. In the event an authorization for Hospital services is provided by a PPG representative that is in breach of the above policy, the following may occur:

1. Hospital/L.A. CARE reviews its incoming claims and identifies PPG contract violations that do not meet the above criteria such as:

D. Authorized hospital services provided at a non-contracted facility.

E. Authorized hospital services provided at another contracted facility that could have been provided at the assigned facility.
F. Authorized ER services for non-emergent care. Appropriately licensed medical staff must perform review for medical appropriateness.

2. If the Hospital, or L.A. CARE as applicable, was not notified or not amenable to these arrangements, the Hospital or L.A. CARE may deny payment of these authorized services.

3. Upon denial, the Hospital or L.A. CARE must send a copy of the claim to the PPG for payment with a denial letter explaining the reasons for the denial. If denied by the Hospital a copy of the denial letter, claim, records and all supporting documentation should also be sent to L.A. CARE at the following address:

   **L.A. Care Health Plan**
   **Attention: Claims Department**
   **P.O. Box 811580**
   **Los Angeles, CA 90081**

4. Hospitals may send the provider of service a letter informing them that the claim has been forwarded to the IPA for payment, however a denial should not be sent to the practitioner.

5. The IPA must pay the claim for these hospital services unless the IPA feels the services provided were emergent or that the service was justified. In the event of the latter the IPA should submit the claim with the appropriate supporting documentation to L.A. CARE at the above address with a letter of appeal explaining their position. The appeal must be submitted to L.A. CARE within 60 days of the denial or payment.

6. L.A. CARE will follow the procedures outlined in Section 12.7.2 “Initial Claims Payment Appeals,” in determining the appropriateness of the appeal and whose financial responsibility it is to pay the claim.

7. Payment will be issued by the responsible party as outlined in “Initial Claims Payment Appeals.”
Claims Attachment

SAMPLE CLAIMS DENIAL NOTICE (see ICE website for most recent language requirements)

{Provider Name}
{Provider Mailing Address}

Member: {Member Name}
Member No: {Sub ID – Suffix}
Date of Service: {From – To Service Dates}
Claim No: {Claim ID}
Claim Amount: {Charged Amount}

NOTICE OF DENIAL OF PAYMENT

Dear {Provider Name}:

We have received your claim for the above-referenced member. This claim has been denied for the following reason:

A) Contracted providers

(2) Medical Records Requested – not received/ Contracted Prov – CONT 06
Medical records requested were not received. In order to determine financial liability or medical necessity, medical records are required to assist in a clinical determination. As these records have not been received, this claim is not payable by L. A. Care Health Plan. You are a contracted provider with (PMG / IPA) and you are not allowed to balance bill the member for these services. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.

(2) Outpatient Services (Office visits, lab and diagnostic imaging) – CONT-01
According to our records, there is no authorization for the services rendered. Contracted providers are required to provide documentation or other evidence that the member was advised prior to the services being rendered that they may be financially responsible for such services. You are a
contracted provider with (PGM / IPA) and you are not allowed to balance bill the member for these services. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.

(3) Contracted Hospital or Provider Services (non-emergent – no triage call) – CONT-02
Emergency services are services needed immediately due to sudden illness, injury, or prudent layperson perception, and additional time spent to reach (PMG / IPA) would have meant risk of permanent damage to the member's health. The services you provided do not meet this definition and therefore required that you obtain prior authorization or provide documented proof the member was advised prior to services being rendered that they may be financially liable for such services. As a contracted provider, you are precluded from billing the member for these services. THE MEMBER IS NOT RESPONSIBLE FOR THE PAYMENT OF THIS CLAIM.

(4) Contracted Facility (delay in care resulted in unnecessary days) CONT-03
Medical Management has reviewed the care provided and determined that a delay in services provided resulted in unnecessary inpatient days listed above. As a contracted provider, you are not allowed to balance bill the member for these non-covered services. THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS CLAIM.

(5) In – area Emergency Services (non-emergent) – (presenting circumstances fail test) – ERIA-01
Medical records do not support that the presenting symptoms meet the below definition of emergency. An emergency service is a service needed immediately due to acute symptoms (including pain) which a prudent layperson feels could result in serious jeopardy to their health. Additional time spent to reach an HMO provider would mean risking permanent damage to your health.

(6) Required Claim Data missing or Spoiled – (A required data element or one of the nine specified data emoluments is missing or Spoiled and the Contracted provider has not responded to the Plan’s request for the missing data) - CONT-04 & CONT-05
The information submitted to us was missing one or more essential items of information required under 42 CFR 422.257(d) paragraphs (1) and (4). You have not responded to our request(s) for that information. Because the federal time limit for us to obtain that information has expired, we remain unable to process the claim and must send you this notice. BY CONTRACTUAL AGREEMENT, YOU MAY NOT BILL THE MEMBER.

Unless otherwise specified, the missing or deficient items include one or more of the following items listed below this paragraph that is not to the highest level of specificity or in accordance with currently valid Medicare codes. If you submit a complete claim to us that includes the information requested not later than the one- to two-year time limit allowed under Medicare law and regulations, we will process this claim.

[CMS -1500: CONT-04] [or] [UB-04: CONT-05]

Patient's Name (2) Patient Name (12)
Sex (3) Sex (15)
Birth Date (3) Birthdate (14)
I.D. No. (HIC or SSN) (1a) HIC or SSN (60)
### B) Non-Contracted Provider Denial Language

(2) **Missing required data – missing or Spoiled (Medicare guidelines)**  
[This page presents an approach to developing these problem claims when they are received from non-contracting providers. Please note that unlike for contracting provider claims on the preceding page, non-contracting provider claims cannot initially be denied for lack of complete, correct CMS required encounter data elements. CMS required data elements includes submission of a complete claim including complete diagnosis coding required for submission of risk adjustment information to CMS. Such incomplete claims from non-contracted providers are defined as non-clean and should be developed for up to 60 calendar days. If the claim data remains incomplete after requesting complete information, the claim should be denied on day 60 for incomplete information.]

Medicare requires us to report more complete information than you provided on this claim. Your claim as submitted is missing one or more essential items of information or has codes that are not sufficiently specific or do not conform to national standards (e.g., are incomplete, invalid or out of date). 42 CFR 422.257(d) paragraphs (1) and (4) require Medicare Advantage organizations to submit complete, conforming encounter data from paid claims. Unless otherwise specified, the missing or deficient items include one or more of the items listed below this paragraph that is not to the highest level of specificity or in accordance with currently valid Medicare codes. Until you provide us with the requested information, THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THIS INCOMPLETE CLAIM and should not be billed.

(2) **In-Area Emergency Services (non-emergent) (presenting circumstances fail test) – ERIA -04 (cc: member)**

Medical records do not support that the presenting symptoms meet the below definition of emergency. An emergency service is a service needed immediately due to acute symptoms (including pain) which a prudent layperson feels could result in serious jeopardy to their health. Additional time spent to reach an HMO provider would mean risking permanent damage to your health. Use of non-Plan providers in non-emergency situations is not payable by L. A. Care Health Plan.

(3) **Medical Records requested and not received -NON -01 (cc: Member)**

Medical records requested were not received. In order to determine financial liability or medical necessity, medical records are required to assist in a clinical determination. As these records have not been received, this claim is not payable by L. A. Care Health Plan.
C) Contracted and non-contracted providers denial language (Could be utilized by both)

C1) Eligibility

(1) Provider Eligibility with Plan – ELIG-01
The date you received medical services on the above claim was prior to your effective date of eligibility with L. A. Care Health Plan. Please submit your claim to Medicare or the HMO with whom you were eligible as of the date services were rendered.

(2) In-between Eligibility – ELIG-04
The date of service is between your eligibility for L. A. Care Health Plan. Please submit your claim to Medicare or the HMO with whom you were eligible as of the date services were rendered.

(3) Postdates Eligibility with Plan – Elig-02
The date you received medical services on the above claim was after your effective date of disenrollment with L. A. Care Health Plan. Please submit your claim to Medicare or the HMO with whom you were eligible as of the date services were rendered.

(4) Service Postdates Member's death – ELIG-03
Our records show the date of service was after the date of death.

C2) Emergency and Urgently Needed Services

(5) In-Area Emergency Services (records not received) – ERIA-02
Medical records requested were never received. An emergency service is a service needed immediately due to acute symptoms (including pain) which a prudent layperson feels could result in serious jeopardy to their health. Additional time spent to reach an HMO provider would mean risking permanent damage to your health. The services received and circumstances do not meet these requirements based on the information available.

(6) In-area (Partial denial of inappropriate services) ERIA-03
Services delivered as emergency care were not consistent with presenting symptoms or emergency diagnosis.

(7) Out-of-area Emergency and Urgently Needed Services (not urgently needed) – EROA-01
Emergency/urgent services are covered outside of the service area if necessary to prevent deterioration of health due to unforeseen illness while temporarily out of the service area. The services received were not emergent/urgent and were not authorized.

(8) Out-of-Area Emergency and urgently needed Services (records not received) – EROA-02
Emergent / urgent services are covered outside of the service area if necessary to prevent deterioration of health due to unforeseen illness while temporarily out of the service area. Medical records requested were never received. The services received cannot be determined to meet these requirements based on the information available.
C3) Maximum Allowable Benefit

(10) Inpatient Psychiatric – MAPY-01
Inpatient psychiatric care is covered according to Medicare guidelines and is limited to 190 days per lifetime in a Medicare certified psychiatric hospital. Our records indicate you reached 190 lifetime days on {date}.

(11) Podiatry (non-Medicare covered) – MAPO-01
The maximum calendar year additional podiatry benefit is {#} visits per year. Our records indicate you reached that limit on {date}. The maximum benefit was paid at that time.

(12) Prescription Drugs (non-Medicare covered) – MARX-01
The maximum calendar year benefit allowance for outpatient prescription drugs is ${______}. Our records indicate you reached that limit on {date}. The maximum benefit was paid at that time.

(13) Skilled Nursing Facility – MASN-01
Skilled Nursing Facilities are covered by L. A. Care Health Plan up to 100 days per benefit period. Our records indicate that on {date}, you reached your 100 day benefit maximum for this benefit period.

(14) Miscellaneous – MAMI-01
Insert other specific benefits with annual maximums.

C4) Not a covered Benefit

(15) Ambulance (not medically necessary) – NCAM-01
Ambulance transportation is covered if you could not have used another means of transportation without endangering your health. The transport you received does not meet this criterion.

(16) Ambulance (no patient transport) – NCAM-02
As you were not transported by ambulance, the services are not covered by Medicare or L. A. Care Health Plan.

(17) Assistant Surgeon (Medicare guidelines) – NCAS-01
Medicare does not pay for an assistant surgeon for this procedure/surgery. Payment for the assistant surgeon is denied by L. A. Care Health Plan. The member has no financial responsibility for these services.

(18) Bundling (Medicare Guidelines) – NCBU-01
Medicare does not pay separately for this service. Payment is included in another service the member has received. The member has no financial liability and should not be billed for these services.

(19) Chiropractic (Medicare guidelines) NCCH-01
Medicare coverage for chiropractic care requires that you be diagnosed with subluxation of the spine. The services received do not meet this criterion and are not covered by Medicare or L. A. Care Health Plan.
(20) Cosmetic – NCCO-01
The procedure you received is considered a cosmetic procedure. Cosmetic procedures are not a benefit covered by Medicare or L. A. Care Health Plan for post accident repair/reconstruction. Please refer to your Health Plan's member materials for benefit guidelines.

(21) Dental Services – NCDS-01
Dental services are not a benefit covered under Medicare or L. A. Care Health Plan except for surgery related to the jaw or any structure related to the jaw or any facial bone. Please refer to your Health Plan's member materials for benefit guidelines.

(22) DME- Durable Medical Equipment (does not meet Medicare DME criteria) – NCDM-01
Medicare defines durable medical equipment as an item that is medical in nature, can withstand repeated use, and is used in the home. The item received does not meet these requirements and is not payable by Medicare or L. A. Care Health Plan.

(23) DME- Durable Medical equipment (not authorized) –NCDM-02
The durable medical equipment received was not prescribed/authorized by your primary care physician. Services not authorized, unless emergent or urgently needed out of the area, are not payable by L. A. Care Health Plan.

(24) Hearing Aids – NCHA-01
Hearing Aids are not a benefit covered under Medicare or L. A. Care Health Plan.

(25) Home Health (does not meet skilled guidelines) –NCHH-01
Home health services must include intermittent skilled care (skilled nursing, PT, or speech therapy) to qualify under Medicare guidelines. The services received were not skilled care and are not payable by Medicare or L. A. Care Health Plan.

(26) Home Health (member not homebound) – NCHH-02
Home health care must meet Medicare guidelines, which require that you are confined to your home. You are not homebound and consequently the home health services received are not payable by Medicare or L. A. Care Health Plan.

(27) Home Health (not authorized) – NCHH-03
The home health services you received were not authorized by your primary care physician. Services not authorized, unless emergent or urgently needed out of the area, are not payable by L. A. Care Health Plan.

(29) Non Medicare/FDA Approved Drugs or Devices – NCRX-02
{_________} is not approved by Medicare/the FDA and is excluded from coverage by L. A. Care Health Plan. Please refer to your Health Plan’s member materials for benefit guidelines.

(30) Not Authorized In-Area (if ER/Emergent, use emergency denial message) – NCNA-01
When you enrolled in a Medicare Advantage Plan, you selected a Primary Care Physician to coordinate/authorize your medical care. The services received were not authorized and are not payable by {L. A. Care Health Plan}.

(31) Over the counter Drugs – NCRX-03
The drugs/medication received is available over the counter without a prescription and are not a benefit covered by {L. A. Care Health Plan}. Please refer to your Health Plan’s member materials for benefit guidelines.

(32) Personal comfort items – NCPC-01
The {______} you were provided is considered a personal comfort item and is not a covered benefit under Medicare or {L. A. Care Health Plan}. Please refer to your Health Plan’s member materials for benefit guidelines.

(33) Podiatry – NCPO-01
Podiatry services for routine foot care, such as toe nail trimming, or corn/callus removal are not a benefit covered under Medicare or {L. A. Care Health Plan}. Please refer to your Health Plan's member materials for benefit guidelines.

(34) Shoe Orthotics – NCSO-01
Shoe orthotics, including inserts and modifications, are only covered by Medicare or {L. A. Care Health Plan} for diabetics or when the shoe is an integral part of a leg brace. Please refer to your Health Plan's member materials for benefit guidelines.

(35) Skilled Nursing Facility – (custodial care or not daily SNF care) – NCSN-01
Medicare guidelines require that skilled nursing facility care be needed daily, as certified by your physician. The services received were custodial in nature and/or not required daily. They are not covered by Medicare or {L. A. Care Health Plan}.

(36) Skilled Nursing Facility (not authorized) – NCSN-02
The skilled nursing facility services you received were not authorized by your primary care physician. Services not authorized, unless emergent or urgently needed out of the area, are not a covered benefit under {L. A. Care Health Plan}.

(37) Miscellaneous – NCMI-01
{SPECIFIC Item(s)} is not a Medicare covered benefit and excluded from coverage under {L. A. Care Health Plan}. Please refer to your Health Plan's member materials for benefit guidelines.

C5) Coordination of Benefits
(1) Requested information not received from member –COB-01
Our records indicate that you may have other insurance coverage. Coordination of benefits information (primary insurance carrier information) was requested from you and has not been received. In order to determine financial liability this information is required. As this information has not been received, this claim in not payable by [Health Plan].
13.0 MARKETING – Medicare Advantage-SNP Line of Business

13.1 PURPOSE:

The purpose of this Policy & Procedure is to ensure that all Medicare Marketing materials used by L.A. Care Health Plan, and our contracted Providers, have been approved by the Centers for Medicare and Medicaid Services (CMS).

13.2 POLICY:

L.A. Care Health Plan shall establish Marketing standards by which L.A. Care Health Plan and its Providers may engage in Marketing Activities related to L.A. Care Health Plan’s Medicare Advantage (HMO SNP) product in accordance with the Centers for Medicare & Medicaid (CMS) marketing guidelines set forth in the Medicare Managed Care Manual.

L.A. Care may impose sanctions on a Provider in accordance with the terms of this policy or the contracted Provider agreement for any violation of this policy or the marketing guidelines set forth in the Medicare Managed Care Manual.

Nothing in this policy shall affect a Provider’s obligation to communicate with L.A. Care or a member pursuant to contractual, statutory, regulatory, or L.A. Care policy requirements.

13.3 DEFINITION(S):

CMS – Centers for Medicare & Medicaid, the oversight agency governing the Medicare program, including marketing.
**Co-Branding** – Co-branding is defined as a relationship between two or more separate legal entities, one of which is an organization that sponsors a Medicare plan. The organization displays the name(s) or brand(s) of the co-branding entity or entities on its marketing materials to signify a business arrangement. Co-branding arrangements allow an organization and its co-branding partner(s) to promote enrollment into the plan. Co-branding relationships are entered into independent of the contract that the organization has with CMS.

**Provider Promotional Activities** – Activities that a provider may perform to educate potential enrollees or to assist potential enrollees in enrollment.

**Marketing** - Steering, or attempting to steer, a potential enrollee towards a plan, or limited number of plans, and for which the individual or entity performing marketing activities expects compensation directly or indirectly from the plan for such marketing activities. “Assisting in enrollment” and “education” do not constitute marketing. Marketing activities are limited to those activities permitted in the Medicare Marketing Guidelines.

**Marketing Materials** – Marketing materials include any informational materials that perform one or more of the following actions:

a. Promote an organization.
b. Provide enrollment information for an organization.
c. Explain the benefits of enrollment in an organization.
d. Describe the rules that apply to enrollees in an organization.
e. Explain how Medicare services are covered under an organization, including conditions that apply to such coverage.
f. Communicate with the individual on various membership operational policies, rules, and procedures.

**Member** – Medicare beneficiary either enrolled in Managed Care or not.

**Provider** – Physicians, physician groups, clinics, hospitals and others.

### 13.4 PROCEDURE/S:

#### 13.4.1 Promotional Activities

L.A. Care Health Plan, or a contracted Provider may engage in Promotional Activities related to L.A. Care Health Plan’s Medicare Advantage product in accordance with the terms and conditions of...
this policy and the CMS Marketing guidelines set forth in the Medicare Managed Care Manual.

13.4.2 Permitted Activities:

- Providers may enter into discussions with their patients when the patient is asking for information or advice from the provider regarding their Medicare options, as long as the provider gives the patient objective information.
- Providers may distribute plan materials or make them available in their office, provided that materials are distributed or made available for all plans with whom the provider contracts.
- Providers may display posters or other materials announcing their plan contractual arrangements, provided they do so for all plans with whom the provider contracts.
- Providers may provide the names of plans with whom they contract.
- Providers may provide information on and assistance with applying for the low-income subsidy.
- Providers may provide objective information on ALL plan sponsors’ specific plan formularies, based on a particular patient’s medications and health care needs.
- Providers may provide objective information regarding ALL plan sponsors’ specific plans being offered, such as covered benefits, cost sharing, and utilization management tools.
- Providers may distribute all Prescription Drug Plans’ marketing materials with whom the provider contracts.
- Providers may refer their patients to other sources of information, such as the SHIPS, L.A. Care Field Representatives, contracted Agents, the State Medicaid Office, and local Social Security Office, CMS’s website at http://www.medicare.gov/ or 1-800-MEDICARE.
- Providers may print out and share information with patients from CMS’s website.
- Providers may distribute the “Medicare and You” Handbook or a printed copy of “Medicare Options Compare” from the CMS website.
- Providers may distribute other CMS documents or materials that provide comparative and descriptive information of a broad nature about plans.
- A new L.A. Care provider may announce the new affiliation to their patients. This announcement to patients of the new affiliation with L.A. Care which only names L.A. Care and not the provider’s other affiliations may only occur once if the
announcement is made by direct mail or email. Any additional direct mail or email communications regarding affiliations must name all plans with whom the provider contracts.

- Any affiliation materials that describe L.A. Care in any way (including, but not limited to, plan benefits and formularies) must be submitted to L.A. Care, who must obtain approval from CMS for the materials. Materials that list the provider’s plan affiliations and only include the plan names and contact information do not need CMS approval.

- Providers may distribute printed information provided by a plan that compares the benefits of all the different plans with which they contract.
  
  - These materials may not highlight or rank order specific plans.
  
  - The materials must only include objective information.
  
  - The materials must have the concurrence of all plans listed in the materials.
  
  - The materials must be approved by CMS. (These materials are not subject to File and Use provisions.)

- Providers may provide links on the provider group website to enrollment applications, or they may provide downloadable enrollment applications. The links and/or downloadable applications must be for all plans with whom the provider contracts.

- Providers may provide a link on their website to the CMS Online Enrollment Center.

L.A. Care shall consider a health education material and wellness promotion as Marketing Materials if such material is:

a. Used in any way to promote L.A. Care or a Provider;

b. Used to explain benefits; or

c. Contains any commercial message or beneficiary notification information.

L.A. Care shall consider the Internet as both Marketing Materials and Promotional Activities.

a. The Internet consists of, but may not be limited to, electronic transfer, transmittal, dissemination, and distribution through the organization’s Web site.
b. L.A. Care or a Provider shall follow approval procedures set forth in this policy for all Marketing Materials and Promotional Activities conducted through the internet.

13.4.2 Marketing Standards

All Marketing Materials and Promotional Activities shall meet the following standards.

All Marketing Materials and Marketing Activities shall comply with the CMS Marketing Guidelines set forth in the Medicare Managed Care Manual. The CMS guidelines pertain to, but are not limited to, the following types of Marketing Materials and Promotional Activities:

a. Advertising and pre-enrollment materials;
b. Post-enrollment materials;
c. Outreach to members;
d. Promotional activities/events; and
e. Other marketing activities.

Marketing materials shall not contain false, misleading, or ambiguous information. L.A. Care and a Provider shall make every effort to write Marketing Materials at a reading level no greater than (6th) grade and be both culturally and linguistically appropriate.

13.4.3 All Marketing materials shall clearly label with the following:

a. The year on which they were last updated;
b. The source of any representations, endorsements, or awards referred to in the Marketing Materials; and
c. The entity responsible for producing the Marketing Materials.

13.4.4 L.A. Care Logo

L.A. Care reserves the right to review and ensure correct usage of the L.A. care logo including the contents of the material that contains the L.A. Care logo.

L.A. Care must review and approve the use of the L.A. Care logo prior to publishing.

13.5 APPROVAL PROCESS:

A Provider shall submit all Marketing Materials and Promotional Activities to L.A. Care through the Provider Network Relations department for review and CMS approval at least forty-five (45)
calendar days prior to using such Marketing Materials or engaging in such Promotional Activities.

The exception to the 45 days is if Provider uses CMS model language without modification in Marketing Materials, L.A. Care shall submit the Marketing Materials to CMS at least ten (10) calendar days prior to using the Marketing Materials.

Mail or facsimile to:

L.A. Care Health Plan  
Attn: Provider Network Operations Department  
1055 West 7th Street  
Los Angeles, CA 90017  
Fax: 213.438.5732

Documentation of proposed Marketing Materials and Promotional Activities shall include:

a. A draft in final layout of the proposed Marketing Materials or description of the proposed Activities;

b. A draft of translated versions of the proposed Marketing Materials with a letter attesting that the translated material conveys the same information and level of detail as the English material; and

c. The total cost of the proposed Marketing Materials or Promotional Activities.

If, upon review, L.A. Care does not object to a Provider’s Marketing Materials and Promotional Activities, L.A. Care shall send a written notice to the Provider within ten (10) business days after receipt of all documentation indicating L.A. Care’s review of the documentation and intent to submit the proposed Marketing Materials and Promotional Activities to CMS.

If, upon review, L.A. Care objects to a Provider’s Marketing Materials or Promotional Activities, L.A. Care shall send a notice to the Provider that describes its objections in detail.

a. The Provider may resubmit revisions of the Marketing Materials or Promotional Activities and all applicable documentation to L.A. Care within five (5) business days after receipt of L.A. Care’s Notice.
b. L.A. Care shall review the resubmitted documentation and shall respond to the Provider within five (5) business days after receipt.

c. If approved, L.A. Care shall submit the proposed Marketing Materials or Promotional Activities to CMS.

d. If a Provider fails to resubmit revisions of Marketing Materials or Promotional Activities within five (5) working days after receipt of L.A. Care’s review, the Provider shall submit such materials as new Marketing Materials or Promotional Activities.

A Provider shall NOT use Marketing Materials or engage in Promotional Activities prior to receipt of L.A. Care’s written notice of CMS approval.

L.A. Care shall notify the Physician Group or Provider that proposed Marketing Materials or Promotional Activities have been approved by CMS within five (5) working days after receipt of CMS approval.

L.A. Care shall consider Marketing Materials and Promotional Activities approved if CMS fails to respond to L.A. Care’s request to approve Marketing Materials or Promotional Activities within 45 working days.

13.6 PROHIBITED ACTIVITIES:

Engaging in prohibited activities as set forth in the Medicare Managed Care Manual and L.A. Care’s policies. Use of Marketing Materials or engaging in Promotional Activities without prior written approval from L.A. Care and CMS; and use of logos or other identifying information used by a government or public agency, including L.A. Care without prior authorization to include but not limited to:

- Offering sales/appointment forms.
- Accepting enrollment applications for L.A. Care Health Plan Medicare Advantage (HMO SNP).
- Directing, urging or attempting to persuade potential enrollees to enroll in a specific plan based on financial or other interests.
- Mailing marketing materials on behalf of L.A. Care.
- Offering anything of value to induce L.A. Care Health Plan Medicare Advantage (HMO SNP) enrollees to select them as their provider.
Offering inducements to persuade potential enrollees to enroll in L.A. Care Health Plan Medicare Advantage (HMO SNP).

Distribute L.A. Care Health Plan Medicare Advantage (HMO SNP) information while conducting a health screening.

Accept any compensation directly or indirectly from L.A. Care Health Plan Medicare Advantage (HMO SNP) Field Representative or contracted Agents for enrollment activities.

Providers may not give the Field Representatives or contracted Agents patient names, addresses, or phone numbers for the solicitation of enrollment.

Failure to Comply

L.A. Care may impose Sanctions on a Provider for any violation of the terms and conditions of this policy and the CMS marketing guidelines set forth in the Medicare Managed Care Manual. L.A. Care may impose Sanctions including, but not limited to:

- Financial penalties;
- Immediate suspension of use of all Marketing Materials and Promotional Activities for a period not to exceed six (6) months;
- Imposition of an enrollment cap or membership cap and Contract termination.

14.0 ENCOUNTER DATA

Participating Physician Groups (PPGs) are responsible for gathering, processing, and submitting encounter data on all L.A. Care members.

Encounter Data is the primary source of information about the delivery of services provided by practitioners to L.A. Care members. When PPGs contracted with L.A. Care submit encounter data that is timely, accurate, and complete, L.A. Care staff is able to track utilized services and analyze the validity of capitation rates. This is a very important source of information for determining needed changes and improvements in health related programs administered at L.A. Care. L.A. Care will also use encounter data for monitoring and oversight functions including HEDIS reporting and meeting various regulatory requirements.

L.A. Care has contracted with Diversified Data Design (DDD), a data clearinghouse company, to assist PPGs with the proper formatting timely and accurate submission of encounter data. PPGs must submit encounter data directly to Diversified Data Design.
14.1 REQUIREMENTS

PPGs are required to submit all requested encounter data, including data for services provided under the capitated arrangement, for L.A. Care members. Encounter data is required to be submitted within sixty (60) business days after the end of the month in which the encounter occurred.

The encounter data must be submitted in an electronic format in accordance with the encounter data specifications established by Diversified Data Design. If the PPG is unable to submit data electronically, a hard copy of the CMS 1500 can be sent to DDD.

When a PPG uses Diversified Data Design to process its encounter data, Diversified Data Design will convert the PPG’s encounter data into the appropriate format to meet L.A. Care’s specifications.

The PPG must submit encounter data on a monthly basis. Services must use current valid CPT codes and ICD9 diagnosis codes.

PPGs must use Diversified Data Design’s services under the below mentioned terms and conditions free of charge. L.A. Care will reimburse Diversified Data Design for services rendered to all contracted PPGs. Listed below is Diversified Data Design’s contact information.

Diversified Data Design
5875 Green Valley Circle
Culver City, CA 90230
(310) 973-2880
Contact: Noelle Clark Porter or Horace Clark

14.2 USE OF DIVERSIFIED DATA DESIGN SERVICES

PPGs are required to:

- Submit data to Diversified Data Design within the parameters required by Diversified Data Design.
- Submit data to Diversified Data Design within timeframes to ensure routine and timely submission of encounter data to L.A. Care.
- Provide a completed encounter data batch cover sheet, which is designed to facilitate an accurate accounting of encounter data submissions, to Provider Network Operations’ Business Analyst concurrently with the submission to Diversified Data Design.
15.0 COMPLIANCE

L.A. Care Health Plan (“L. A. Care”) is committed to establishing and maintaining its business operations in compliance with ethical standards, contractual obligations, and all-applicable federal and state statutes, regulations and rules pertaining to the Medicare Advantage and Prescription Drug (“MA-PD”) program. L.A. Care’s compliance commitment extends to its own internal business operations, as well as its oversight and monitoring responsibilities relating to its business partners.

L. A. Care has tailored its Compliance Program to fit the unique environment of the organization. Moreover, the Compliance Program is dynamic; L.A. Care regularly reviews and enhances the Compliance Program to meet evolving compliance needs (i.e., business or legal areas of risk) as well as changes in state and federal laws and regulations.

Additionally, L.A. Care’s Compliance Program is designed to ensure the provision of quality health care services to all L.A. Care members. This is achieved through a variety of compliance activities. L.A. Care’s Compliance Program activities include:

- Oversight and monitoring of delegated entities.
- Training and Education.
- Fraud, Waste & Abuse prevention, detection, and investigations.
- Preserving Member Rights concerning Privacy and Confidentiality.
- Ongoing monitoring of quality health care services.
- Education of PPGs about MA-PD program rules and other health care compliance requirements.

15.1 GOAL AND OBJECTIVES

GOAL

The goal of L.A. Care’s Compliance Program is to ensure that all L.A. Care health plan members receive appropriate and quality health care services through the provider network in compliance with all applicable California and federal rules and regulations including the Centers for Medicare and Medicaid Services (“CMS”) requirements as well as L.A. Care contractual requirements.

L.A. Care’s Compliance Program:
- Provides oversight and ongoing monitoring of delegated responsibilities of L.A. Care’s provider network.
Requires the implementation of corrective actions by the PPGs to address deficiencies concerning provision of health care services or L.A. Care performance standards

- Establishes policies and procedures to identify, investigate, and resolve potential or actual fraud & abuse activities.
- Establishes education/training opportunities and other available resources to assist PPGs in becoming compliant with HIPAA requirements and Member Rights concerning Privacy and Confidentiality.
- Establishes education/training opportunities and other available resources to assist PPGs in achieving and maintaining compliance with CMS MA-PD requirements.
- Establishes education/training opportunities to assist PPGs with compliance concerns and issues regarding fraud, waste, and abuse.
- Provides L. A. Care’s latest Code of Conduct online training program at

http://www.lachp.org/compliance/coc_2010_ppg.nsf/coc_login

(When taking the online training, please log-in with your name, as well as the name of the organization before beginning).

15.2 AUTHORITY AND RESPONSIBILITY

L.A. Care’s Compliance Program strives to ensure compliance with federal and State of California rules and regulations affecting the administration of the MA-PD program. This includes, but is not limited to, the following requirements as applicable to each PPG’s contract with L.A. Care:

- Requirements set forth by CMS as described in the Medicare Managed Care Manual and other guidance or communications.
- Rules and regulations promulgated by and for the Department of Managed Health Care ("DMHC") and the Department of Health Care Services ("DHCS").
- All applicable federal rules and regulations that apply to the provision of health care services.
- Federal and State of California governing law and legal rulings.
- Terms and conditions as set forth in L.A. Care’s contracts with CMS and DHCS.
- Requirements established by L.A. Care and implemented with the PPG as stated in the PPG’s contract with L.A. Care.
15.3 DELEGATION OF COMPLIANCE & AUDIT PROGRAM

L.A. Care does not delegate its Compliance Program responsibilities to a PPG. L.A. Care staff works with PPG staff to administer compliance activities and implement corrective actions to rectify deficiencies. PPG staff is encouraged to work with L.A. Care compliance staff to ensure compliance with all L.A. Care performance standards.

15.4 AUDIT & OVERSIGHT ACTIVITIES

To ensure that all L.A. Care health plan members receive appropriate health care services, L.A. Care staff performs an annual audit of contract responsibilities and services delegated by L.A. Care to PPG. L.A. Care’s audit program for delegated PPGs includes, but is not limited to, the following activities:

- Annual on-site visit to delegated PPGs to ensure that all delegated responsibilities and services are in compliance with MA-PD program requirements. The annual evaluation will be a comprehensive assessment of the delegate’s performance, including both compliance with applicable standards and the extent to which the delegate’s activities promote L.A. Care’s overall goals and objectives for the delegated function. If any problems or deficiencies are identified, the evaluation will specify any necessary corrective action and include procedures for assuring that the corrective action is implemented.

- Ad-hoc on-site visits to review PPG activities to ensure compliance with program requirements.

- Ongoing monitoring through review of periodic reports and data required as outlined in the delegation agreement.

- Review of all PPG books and records and information as may be necessary to demonstrate PPG compliance with federal, California, and L.A. Care contractual requirements. Records include, but are not limited to, financial records and books of accounts, all medical records, medical charts and prescription files, and any other documentation pertaining to medical and non-medical services rendered to members, and such other information as reasonably requested by L.A. Care.
15.5 PPG COMPLIANCE RESPONSIBILITIES

PPG agrees to comply with Medicare laws, regulations, and CMS instructions and agrees to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records a minimum of 10 years.

PPG shall ensure all their related entities, contractors, or subcontractors, and downstream entities involved in transactions related to L.A. Care’s MA-PD program maintain and provide access to all pertinent contracts, books, documents, papers, and records necessary for compliance with state and federal requirements.

PPG shall require all related entities, contractors, or subcontractors, and downstream entities to agree to comply with Medicare laws, regulations, and CMS instructions and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records a minimum of 10 years.

PPG shall require its managers, officers and directors responsible for the administration or delivery of Part C or Part D benefits to sign a conflict of interest statement, attestation, or certification at the time of hire and annually thereafter certifying that the manager, officer or director is free from any conflict of interest in administering or delivering Part C and Part D benefits.

Upon contracting with a downstream entity, and related entities, PPG will require a signed certification that these entities will require its managers, officers and directors responsible for the administration or delivery of Part C or Part D benefits to sign a conflict of interest statement, attestation, or certification at the time of hire and annually thereafter certifying that the manager, officer or director is free from any conflict of interest in administering or delivering Part C and Part D benefits.

PPG shall conduct annual general and specialized compliance training for their employees. PPG must submit documentation of general and specialized compliance training to L.A. Care’s Compliance Officer annually.

L.A. Care’s SPECIAL INVESTIGATION UNIT -L.A. Care’s Compliance Program includes measures to detect, correct, and prevent fraud, waste, and abuse (“FWA”). L.A. Care’s Special Investigation Unit (“SIU”) was created to provide oversight of FWA prevention efforts and help reduce fraudulent activities in L.A. Care’s network.
Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Abuse is defined as practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the federal Medicaid and Medicare programs.

The goal of the SIU is to protect and preserve the integrity and availability of health care resources for our Members, stakeholders, and business partners by maintaining a comprehensive program integrity plan. Anti-fraud activities will be coordinated between L.A. Care and its PPGs, hospitals and ancillary providers.

15.6.1 Reporting Potentially Fraudulent Activities

The SIU is set up to handle all types of potentially fraudulent activities. Staff monitors activities ranging from claims to health care services provided to members. Written or verbal allegations of fraudulent activities are forwarded to L.A. Care’s Regulatory Affairs & Compliance Department for follow-up.

Potentially fraudulent activities can be reported by calling L.A. Care’s Compliance Helpline at 1-800-400-4889 or via the internet at www.lacare.ethicspoint.com. The Compliance Helpline is available 24 hours a day, 7 days a week. You may also call L.A. Care’s Compliance Officer directly at 213-694-1250, ext. 4292. If, for whatever reason, you are not able to report a potential fraud case by calling these phone numbers, please call L.A. Care’s Provider Inquiry Line at 866-522-2736.

A written letter regarding potentially fraudulent activities can also be mailed to L.A. Care at:

Compliance Officer, Regulatory Affairs & Compliance
C/o Special Investigation Unit (SIU)
1055 W. Seventh Street, 10th Floor
Los Angeles, CA  90017

Referral Requirements
Regardless of what method you choose to use to report fraud or abuse to us, you should include the following:

- Name of Person Reporting Fraud (Optional, but highly recommended)
- Name, Address, License or Insurance ID of Subject (if known)
- Nature of Complaint
Date of Incident(s)
Supporting Documentation (Optional)

All cases identified as fraud or abuse are reported to the appropriate law enforcement and/or regulatory agency.

15.6.2 COMMUNICATION OF L.A. CARE’S FRAUD & ABUSE DETECTION EFFORTS

L.A. Care uses various means to educate its provider network and membership about its fraud & abuse detection efforts. Information about L.A. Care’s fraud & abuse detection activities is communicated in some of the following ways: provider bulletins; provider mailings; provider trainings; member newsletters; New Member Handbook and other sources which may include L.A. Care’s Regional Community Advisory Committee meetings.

Additionally, all L.A. Care contracted PPGs must ensure the PPG employees and contracted downstream and related entities participate and complete L.A. Care’s training regarding fraud, waste, and abuse on an annual basis. Providers that have met FWA certification standards through enrollment as a Medicare provider are deemed to have met FWA training and educational requirements. Non-deemed Providers may also be waived from this training if able to provide evidence of participation in a similar training program through another health plan or a professional association or industry group accepted by L.A. Care.


15.7 THE FEDERAL FALSE CLAIMS ACT

The federal False Claims Act permits a person who learns of fraud against the United States Government to file a lawsuit on behalf of the government against the person or business that committed the fraud. If the action is successful, the person filing the lawsuit or "plaintiff" is rewarded with a percentage of the recovery.

Who can be a plaintiff?
If the fraud has not previously been publicly disclosed, any person may bring a lawsuit called a "qui tam action" regardless of whether he or she has "direct" or first-hand knowledge of the fraud. Thus, where there has been no public disclosure, an employee who learns from a colleague of fraud, the employer or another employee at work may bring a qui tam action, even if the qui tam plaintiff personally has no first-hand knowledge.
What types of fraud qualify?
When a person deliberately uses a misrepresentation or other deceitful means to obtain something to which he or she is not otherwise entitled, that person has committed fraud. This usually -- although not always -- involves money. However, under the False Claims Act, fraud has a much wider and more inclusive meaning.

Under the Act, the defendant need not have actually known that the information it provided to the government was false. It is sufficient that the defendant supplied the information to the government either: (I) in "deliberate ignorance" of the truth or falsity of the information; or (ii) in "reckless disregard" of the truth or falsity of the information.

Thus, if a defendant should have known that its representations to the government were not true or accurate, but did not bother to check, such recklessness may constitute a violation of the Act. Likewise, if a defendant deliberately ignores information which may reveal the falsity of the information submitted to the government, such "deliberate ignorance" may constitute a violation of the Act.

What protection is there for a plaintiff who brings an action?
The False Claims Act provides protection to employees, agents or contractors who are retaliated against by an employer because of their participation in a qui tam action. The protection is available to any employee, agent or contractor who is fired, demoted, threatened, harassed or otherwise discriminated against by his or her employer because the employee, agent or contractor investigates, files or participates in a qui tam action.

This "whistleblower" protection includes reinstatement and damages of double the amount of lost wages if the employee, agent, or contractor is fired, and any other damages sustained if the employee, agent or contractor is otherwise discriminated against.

15.8 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA") FOR MEDI-CAL AND MEDICARE PROGRAMS
HIPAA stands for the Health Insurance Portability & Accountability Act of 1996. The Act included a section re Title II, entitled Administrative Simplification, requiring:

- Improved efficiency in healthcare delivery by standardizing electronic data interchange, and
- Protection of confidentiality and information security of health data through setting and enforcing standards.
More specifically, HIPAA called upon the Department of Health and Human Services ("DHHS") to publish rules that ensure:

- Standardization of electronic patient health, administrative and financial data.
- Unique health identifiers for individuals, employers, health plans and health care providers.
- Privacy and Information Security standards protecting the confidentiality and integrity of "individually identifiable health information," past, present or future.

Overall, HIPAA has meant sweeping changes in most healthcare transaction and administrative information systems.

15.8.1 Security Rule

The Security Rule requires covered entities to ensure the confidentiality, integrity, and availability of all electronic protected health information ("ePHI") the covered entity creates, receives, maintains, or transmits. It also requires entities to protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI, protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required by the Privacy Rule, and ensure compliance by their workforce. Required safeguards include application of appropriate policies and procedures, safeguarding physical access to ePHI, and ensuring that technical security measures are in place to protect networks, computers and other electronic devices.

The Security Standard is intended to be scalable; in other words, it does not require specific technologies to be used such as encryption technology. Covered entities may elect solutions that are appropriate to their operations, as long as the selected solutions are supported by a thorough security assessment and risk analysis.

15.8.2 Privacy Rule

The Privacy Rule is intended to protect the privacy of all individually identifiable health information in the hands of covered entities, regardless of whether the information is or has been in electronic form. The Privacy standards:

- Give patients rights to access their medical records, restrict access by others, request changes, and to learn how patient’s health information has been accessed.
Restrict most disclosures of protected health information to the minimum amount of information needed for healthcare treatment, payment and healthcare operations.

Provide the right of all patients to be formally notified of covered entities' privacy practices.

Enable patients to decide if they will authorize disclosure of their protected health information ("PHI") for uses other than treatment, payment or healthcare operations.

Establish new criminal and civil sanctions for improper use or disclosure of PHI.

Establish new requirements for access to records by researchers and others.

Establish business associate agreements with business partners and vendors that safeguard their use and disclosure of PHI.

Implement a comprehensive compliance program, including
  o Conducting an impact assessment to determine gaps between existing information practices and policies and HIPAA requirements.
  o Reviewing functions and activities of the organization’s business partners to determine where Business Associate Agreements are required.
  o Developing and implementing enterprise-wise privacy policies and procedures to implement the regulations.
  o Assigning a Privacy Officer who will administer and oversee the organizational privacy program and enforce compliance.
  o Training all members of the workforce on HIPAA and organizational privacy policies.
  o Updating systems to ensure they provide adequate protection of patient information data.

15.8.3 Transaction and Code Sets Standards

According to CMS, electronic transactions are activities involving the transfer of healthcare information for specific purposes. Under the HIPAA regulations, if a health care provider engages in one of the identified transactions, they must comply with the standard for that transaction. HIPAA requires every provider who does business electronically to use the same healthcare transactions, code sets and identifiers. HIPAA has identified ten standard transactions for Electronic Data Interchange ("EDI") for the transmission of healthcare data. Claims and encounter information, payment and remittance advice, and claims status and inquiry are several diagnosis and clinical procedures on claims and encounter forms. The HCPCS, CPT-4 and ICD-9 codes, with which providers are familiar, are examples of code sets for procedures and diagnoses.

15.9 The Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH")
The Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH") made a number of significant changes to HIPAA. The following are the most significant changes impacting covered entities such as Providers;

Breach Notification Rules

Prior to HITECH, the HIPAA Privacy Rule required a Provider only to “mitigate” harmful effects known to the Provider from an improper release of Protected Health Information ("PHI"). HITECH has expanded what a Provider must do in the event of the “breach” of the security or privacy of an individual's PHI, requiring both the patient involved, and media outlets in certain cases, to be notified of the breach. HITECH also created requirements that apply directly to a Provider's business associates ("BA") in the event of such a breach.

How do the New Breach Notification Regulations Apply?

The Regulations only apply to “unsecured” PHI. PHI that is “secured” is not subject to the Regulations, which means that the requirements discussed below do not apply to such secured PHI.

For PHI to be secured, it must be either “encrypted” in accordance with standards specified under the HIPAA Security Rule or the media on which the PHI is stored must be destroyed in one of several ways.

PHI that does not meet these standards is “unsecured.” The Regulations are triggered in the event of a “breach,” which means a use or disclosure of PHI that is not permitted under the Privacy Rule.

What Must a Covered Entity or Business Associate do if a Breach Occurs?

The Provider must provide written notification to the affected individuals within a 60-day period following the discovery of the breach. If a BA learns of a breach, it is required to notify the Provider so that the Provider can notify the individuals involved. The 60-day timeframe begins when the Provider, in the exercise of reasonable diligence, should have known of the breach.

In addition to notifying affected individuals, the following items are important

- If a breach affects more than 500 people, Providers must inform the media about the breach.
- Providers are also required to provide notice to Department of Health and Human Services ("DHHS"), which will publicize the breach on its web site.
- For breaches affecting less than 500 people, Providers are required to keep an annual log of any breaches and provide a log to DHHS within 60 days of the start of the next calendar year.
Business Associates Directly Regulated Under HIPAA

Business associates have historically had to comply with certain HIPAA requirements solely as a result of their agreements with Providers. If a BA breached its obligations, it would only be liable to the Provider under that contract and it would not be subject to direct oversight or penalties by DHHS. HITECH has increased the stakes for compliance for BAs.

As a result of this change, BAs are subject to a host of new obligations:

- In addition to the breach notification obligations, they are directly subject to parts of the HIPAA Security Rule requiring the use of technical, physical and administrative safeguards to ensure the confidentiality of electronic PHI.
- Understanding the requirements of the Security Rule, what types of safeguards are acceptable and how the safeguards should be implemented will be required of the BAs.
- BAs must directly comply with a host of standards found in the Privacy Rule, including using and disclosing PHI only as permitted under the Privacy Rule and,
- Providers can be penalized directly by DHHS and other enforcement agencies.

Enhanced Enforcement Options and Increased Penalties for Noncompliance

HITECH significantly expanded options for HIPAA enforcement. For example, State Attorney Generals have been empowered, since February, 2009, to bring civil actions against persons who violate HIPAA if the Attorney General believes the violation threatens state residents. DHHS will also be conducting audits of Providers and BAs to ensure their compliance with the Privacy and Security Rules.

In addition, HITECH increased the penalties against Providers and BAs for violating HIPAA.

- HITECH expanded regulators' ability to impose criminal penalties for violating HIPAA.
- HITECH imposed increased penalties. For example, while the maximum fine that could be imposed for identical violations in a one year period was $25,000 under the previous rule, HITECH permits fines of up to $1.5 million for identical violations within the same year. The enhanced civil penalties are now linked to the Provider's level of culpability.
- HITECH has eliminated certain defenses that could be raised in the past against HIPAA violations. No longer can parties avoid penalties
by claiming that they did not have actual or constructive knowledge of the violation. Together with the new obligations discussed above, these enhanced penalties have increased the risks of noncompliance.

Other Notable Points about HITECH

- HITECH has expanded the disclosures for which Providers must maintain an accounting to include disclosures for treatment, payment and health care operations, if the disclosures for those purposes are made through an electronic health record.
- Providers will be required to agree to an individual's restriction on disclosures of their PHI to a health plan if the disclosure is for payment or health care operations purposes and it pertains solely to services for which the Provider involved was paid in full out-of-pocket.
- Significantly less leeway exists for Providers to engage in marketing or fundraising activities.

15.10 PRIVACY AND INFORMATION SECURITY RELATED RESOURCES & WEB SITES

U.S. Department of Health & Human Services- Office of Civil Rights
http://www.hhs.gov/ocr/hipaa/

Centers for Medicare & Medicaid Services (CMS)
http://www.cms.hhs.gov/hipaageninfo/01_overview.asp?

California Department of Health Care Services
www.privacy.ca.gov

Privacy Rights Clearinghouse
http://www.privacyrights.org/

National Committee on Vital and Health Statistics
http://www.ncvhs.hhs.gov/

Workgroup for Electronic Data Exchange
http://www.wedi.org

National Institutes of Health
http://privacyruleandresearch.nih.gov/
16.0 PHARMACY

PART D PRESCRIPTION DRUG COVERAGE – MEDICARE ADVANTAGE-SNP

This chapter describes the key aspects of the Part D Prescription Drug benefit offered under L.A. Care Health Plan Medicare Advantage HMO SNP.

16.1 Pharmacy Benefits

L.A. Care, through its pharmacy benefits manager (PBM), has contracted with a comprehensive network of pharmacies located throughout the Service Area. Additionally, MA-PD members may fill prescriptions by utilizing a mail order pharmacy. L.A. Care has made arrangements with a PBM (Pharmacy Benefit Manager) to manage these pharmacy services for these MA-PD members.

16.2 Systems Support for L.A. Care and its Participating Pharmacies

The PBM has developed sophisticated systems to work efficiently with L.A. Care and its Participating Pharmacies to safeguard the health of MA-PD members and to facilitate access to appropriate pharmacy and therapeutic services.

a) MA-PD member Eligibility, as well as MA-PD member identifying information, is verified on-line, in real time by the customer services representatives

b) Formulary Compliance is monitored and facilitated through the identification of alternative medications or dosages

c) Drug Interaction(s) with potentially adverse outcomes are noted and brought to the attention of prescribing providers

16.3 Clinician’s Support for L.A. Care

The PBM dedicates a support staff to work with L.A. Care and its Providers on identifying the best strategies for prescribing and dispensing pharmaceuticals considering quality, cost, and MA-PD member needs.
The PBM’s support staff works closely with the Plan’s Pharmacy Director, Clinical Pharmacists and Medical Director to:

1) Administer the Pharmacy Benefits
2) Recommend improvements based on the experience of L.A. Care, as well as trends and innovations found throughout the managed care industry

16.4 L.A. Care’s Drug Formulary for Part D
The Drug Formulary for Part D represents the efforts by the PBM’s Pharmacy and Therapeutics (P&T) Committee to provide physicians, other prescribers and pharmacists with a method for evaluating the various drug products available.

The medical treatment of MA-PD members is frequently related to the practical application of drug therapy. Due to the vast availability of medication therapy and treatment modalities, a reasonable program of drug product selection and drug usage has been developed. The goal of the Drug Formulary is to enhance the physician’s/other prescriber’s abilities to provide optimal cost effective drug therapy for our MA-PD members.

The development, maintenance, and improvement of this process are evolutionary and require constant attention. This is accomplished by the PBM’s P&T and Formulary Committee for Part D. The Formulary is continuously reviewed and revised, as a necessary part of a Quality Improvement. To accommodate the necessary changes of this document, formulary updates are regularly posted on L.A. Care’s website, www.lacare.org/members/medicareadvantageplan/medicarepartd. Additionally, an updated electronic version of this formulary is always available online at: http://www.lacare.org/members/medicareadvantage/helpfulinformation. L.A. Care’s Customer Services Department may also be contacted regarding Formulary updates at (888) 839-9909. Physicians/other prescribers utilizing this Drug Formulary are encouraged to review the information.

The PBM’s P&T Committee use the following criteria in the evaluation of drug selection for the Drug Formulary:

a) Drug safety profile
b) Drug efficacy
c) Comparison of relevant drug benefits to current formulary agents of similar use, while minimizing duplications
d) Equitable cost and outcomes of the total cost of product and medical care
e) If drug needs authorization or is not in formulary an exception may be requested. This may be requested on the Medicare Prescription Drug Coverage Determination request form which is posted on L.A. Care’s website: www.lacare.org/members/medicareadvantageplan/helpfulinformation.

The Drug Formulary is a list of covered and preferred drug therapies for L.A. Care Health Plan Medicare Advantage HMO SNP Members. Drugs are listed by their generic names and/or most common proprietary (branded) name. The Formulary is arranged by medical condition and alphabetical listing. Some branded drugs listed are for reference use only, and do not denote coverage; covered branded drugs are listed entirely in capital lettering. Any drug not found in this Drug Formulary listing or in any Formulary updates published by L.A. Care shall be considered a Non-Formulary drug.

L.A. Care’s Drug Formulary does not provide information regarding the specific coverage and limitations an individual MA-PD member may have. Many MA-PD members have specific Benefit inclusions, exclusions, Co-payments, or a lack of coverage, which are not reflected in the Formulary.

The Drug Formulary applies only to Outpatient drugs provided to MA-PD members, and may not apply to medications used in Inpatient settings or to medications that require special handling and/or administration by a Participating Provider. If a Member has any specific questions regarding their coverage, they should contact L.A. Care at (888) 839-9909.

16.5 Medicare Part D Formulary Structure

The Medicare Part D Formulary is based on a two-tier structure, which includes Generic drugs (Tier 1) covered at a lower Co-payment, and Brand drugs (Tier 2) at the higher Co-payment amount. Should a MA-PD member need drugs that are restricted by the Drug Formulary, a Medicare Prescription Drug Coverage Determination request form will need to be filled out and fax or mail to the PBM that is on this form.

16.6 L.A. Care’s Policies Regarding Prescriptions

It is the goal of L.A. Care to provide quality care to our MA-PD members by ensuring that medications prescribed by the L.A. Care’s physicians/other prescribers are appropriate for the MA-PD member considering his/her health status and the clinical alternatives that are available. Consequently it is the policy of the L.A. Care that:

1. **Generics will be substituted**, unless the name brand is specified by the physician/other prescriber

2. Higher Co-payments apply to name brand drugs than to generics
3. PBM’s clinicians along with Plan’s clinicians administer the Plan’s guidelines

4. In instances where the guidelines are not sufficiently specific, L.A. Care’s Clinical Pharmacist, Pharmacy Director or Medical Director will be involved in rendering a decision regarding a specific case for a determination.

5. Grievances and Appeals by MA-PD members and/or physicians/other prescribers relative to pharmacy services, are handled by L.A. Care, as for all other Benefits

16.7 Coverage determination
The Coverage Determination made by L.A. Care is the starting point for dealing with requests MA-PD members may have about covering or paying for a Part D prescription drug. If the MA-PD members’ physicians, other prescribers or pharmacists inform them that a certain prescription drug is not covered, our MA-PD members or their physicians/other prescribers should contact L.A. Care and ask how to obtain a Coverage Determination. Requests for a Coverage Determination or exception may be submitted on Medicare Prescription Drug Coverage Determination request form via fax or mail that is on this form. With this Coverage Determination decision, L.A. Care does explain whether we will provide the prescription drug requested or pay for a prescription drug already received. If L.A. Care denies the request (this is sometimes called an “adverse coverage determination”), our MA-PD members can request for a redetermination of the decision within sixty (60) calendar days. If L.A. Care fails to make a timely coverage determination on a request, it will be automatically forwarded to the independent review entity (IRE) for review. For additional information, please see L.A. Care website: www.lacare.org under Medicare Advantage.

The following are examples of coverage determinations:

1. A MA-PD member requests payment for a prescription drug already received. This is a request for a coverage determination about payment. You can call us at 1-888-839-9909 to get help in making this request.

2. A Part D drug that is not on L.A. Care’s Drug Formulary list. This is a request for a “formulary exception.”
3. Exception is requested for prior authorization, dosage limits, quantity limits, or step therapy requirements. Requesting an exception to a utilization management tool is a type of formulary exception.

16.8 Utilization Management Tools:
a. Prior Authorization: L.A. Care requires prior authorization for certain drugs. This means that a MA-PD member, their physician/other prescriber or authorized representative will need to get approval from us before filling a prescription. If they don't get approval, we may not cover the drug.
b. Quantity Limits: For certain drugs, L.A. Care limits the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will provide up to 60 tablets for every 30 day period per prescription for Namenda.
c. Step Therapy: In some cases, L.A. Care requires a MA-PD member to first try one drug to treat their medical condition before covering another drug for that condition. For example, if Drug A and Drug B both treat their medical condition, L.A. Care may require the provider to prescribe Drug A first. If Drug A does not work for you, then L.A. Care will cover Drug B
d. A MA-PD member requests for a non-preferred drug to be provided at the preferred cost-sharing level. This is a request for a “tiering exception.”
e. Request for reimbursement for a drug obtained at an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided in a physician's/other prescriber's office may be covered by the L.A. Care.

When L.A. Care makes a coverage determination(s), we are determining coverage for Part D prescription drug(s) for our members based on their specific situation(s).

16.9 Time Frames for Coverage Determinations
A decision about whether L.A. Care will cover a Part D prescription drug can be a “standard” coverage determination that is made within the standard timeframe (typically within 72 hours); or it can be a “fast” coverage determination that is made more quickly (typically within 24 hours). A fast decision is sometimes called an “expedited coverage determination.”

A fast or expedited coverage determination may be requested only if the MA-PD member or their physician/other prescriber believe that waiting for a standard decision could seriously harm a MA-PD member's health or ability to function. (Fast decisions apply only to requests for Part D drugs that a MA-PD member has not received yet. MA-PD members cannot get
a fast decision if they are requesting payment for a Part D drug that was already received.)

16.10 Reports on Pharmacy Services Utilization

L.A. Care conducts drug utilization reviews for all of our MA-PD members to make sure that they are receiving safe and appropriate care. These reviews are especially important for MA-PD members who have more than one physician/other prescriber who prescribe their medications. These drug utilization reviews occur each time a prescription may be filled and on a regular basis by reviewing the MA-PD member’s pharmacy records. During these reviews, we look for medication problems such as:

1. Possible medication errors
2. Duplicate drugs that are unnecessary because the MA-PD member are taking another drug to treat the same medical condition
3. Drugs that are inappropriate for their age or gender
4. Possible harmful interactions between drugs you are taking
5. Drug allergies
6. Drug dosage errors

Pursuant to its agreement with L.A. Care, the PBM generates reports about the utilization of pharmacy services by/within the health plan, physicians/other prescribers and selected specialties. This information is analyzed on a retrospective basis in accordance with general industry trends and criteria. Consideration of the specific interests of L.A. Care relative to the health status of its unique membership base and the related prescribing practices of network physicians/other prescribers are also taken into account. L.A. Care will share drug utilization reports with the Preferred Physician Groups (PPGs) on a periodic basis as part of its Quality Improvement process.

16.11 Reimbursement for Pharmacy Services

Reimbursement for pharmacy services is a responsibility of L.A. Care and has budgeted funds based on the actuarial assumptions regarding such costs for the target population.

16.12 Additional Pharmacy Services for MA-PD Members

Mail Order Prescriptions
As a convenience to our MA-PD members, they have the option of obtaining an extended 90-day supply of covered Part D medications through L.A. Care Health Plan’s mail-order program. To receive medications through our mail-order service, they simply complete one of our mail-order forms and mail it in with the physician’s or other prescriber’s prescription to the address on the form. If our MA-PD members need mail order forms, please contact L.A. Care’s Member Services or go to our
website at www.lacare.org/members/medicareadvantageplan/helpfulinformation.

Transition Policy
New MA-PD members to L.A. Care may be taking drugs that are not on our Drug Formulary, or that are subject to certain restrictions, such as prior authorization or step therapy. MA-PD members should talk to their physicians or other prescribers to decide if they should switch to an appropriate drug that we cover or request a formulary exception (which is a type of coverage determination) in order to get coverage for the drug. The exception process is described below. While these new MA-PD members might talk to their physicians/other prescribers to determine the right course of action, we may cover the non-formulary drug in certain cases during the first 90 days of new membership.

For each of the drugs that are not on our formulary or that have coverage restrictions or limits, we will cover a temporary 90-day supply (unless the prescription is written for fewer days) when the new member goes to a participating network pharmacy (and the drug is otherwise a "Part D drug"). After the first 30-day supply, we will provide refills for 60 more days. After 90 days L.A. Care will not pay for these drugs.

If the new MA-PD member is a resident of a long-term care facility, L.A. Care will cover a temporary 31-day transition supply (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days for a new MA-PD member of our plan.

If a new member needs a drug that is not on our formulary or subject to other restrictions, such as step therapy or dosage limits, but the new MA-PD member is past the first 90 days of new membership in our plan, we will cover a 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new MA-PD member pursues a formulary exception.

Medication Therapy Management (MTM) programs
L.A. Care offers Medication Therapy Management (MTM) programs thru the contracted local retail pharmacists at network pharmacies and at no additional cost for our MA-PD members who have two or multiple medical conditions, who are taking many prescription drugs, or who have high drug costs. These MTM programs were developed to help us provide better care for our MA-PD members. For example, these programs help us make sure that our MA-PD members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors. We offer MTM programs for MA-PD members that meet specific criteria. These contracted local retail pharmacists may contact MA-PD members who qualify and their physicians/other prescribers for these MTM programs. We hope you will encourage your patients to utilize the MTM
programs so that we can help manage their medications. MA-PD members do not need to pay anything extra to participate.

**Drug exclusions**

By law, certain types of drugs or categories of drugs are not covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs.” These drugs include:

<table>
<thead>
<tr>
<th>Non-prescription drugs (over-the-counter drugs)*</th>
<th>Drugs when used for anorexia, weight loss, or weight gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs when used to promote fertility</td>
<td>Drugs when used for cosmetic purposes or hair growth</td>
</tr>
<tr>
<td>Drugs when used for the symptomatic relief of cough or colds*</td>
<td>Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations*</td>
</tr>
<tr>
<td>Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale*</td>
<td>Barbiturates and Benzodiazepines*</td>
</tr>
</tbody>
</table>

*These may be covered under the Medi-Cal pharmacy benefit.

NOTE: Due to a change in Medicare regulation, most Medicare Part D Plans will no longer cover erectile dysfunction (ED) drugs like Viagra, Cialis, Levitra, Muse and Caverject after January 1, 2007.

In addition, a Medicare Prescription Drug Plan cannot cover a drug that would be covered under Medicare Part A or Part B