Provider Manual

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KEY CONTACTS

Function	Organization	Phone	Website
Member Services	Sutter Health Plus	(855) 315-5800	*sutterhealthplus.org*
Provider Services	Sutter Health Plus	(855) 315-5800	*sutterhealthplus.org*
TTY	Sutter Health Plus	(855) 830-3500	
Nurse Advice Line	Sutter Health Plus	(855) 836-3500	
Language Assistance	Sutter Health Plus	(855) 315-5800	
Appeals & Grievances	Sutter Health Plus	(855) 315-5800	
Fraud & Abuse	Sutter Health Plus	(855) 315-5800	
Vision Benefit	VSP	(800) 877-7195	*vsp.com*
Acupuncture-Chiropractic Benefit	ACN, dba OptumHealth Physical Health of California	(800) 428-6337	*myoptumhealthphysicalhealthofca.com*
Behavioral Health/Substance Use Disorder Treatment Benefit	U.S. Behavioral Health Plan, California (USBHPC), dba OptumHealth Behavioral Solutions of California (OHBS-CA)	(855) 202-0984	*liveandworkwell.com*
Pharmacy Benefit Manager	Express Scripts®	(877) 787-8661	*express-scripts.com*
Pharmacy – Mail Order	Express Scripts Pharmacy℠	(888) 327-9791	*express-scripts.com*
Pharmacy – Specialty	Accredo®	(877) 787-8661	*express-scripts.com*
Dental Benefit	Delta Dental	(800) 765-6003	*deltadental.com*
California Department of Managed Health Care (DMHC)		(888) 466-2219	*dmhc.ca.gov*

CONTACTS

Acupuncture Services

ACN Group of California, dba OptumHealth Physical Health of California (ACN)

(800) 428-6337
Website: *myoptumhealthphysicalhealthofca.com*

Behavioral Health Services

U.S. Behavioral Health Plan, California (USBHPC), dba OptumHealth Behavioral Solutions of California (OHBS-CA). Submit appeals and grievances to the following address:

OHBS-CA
Attn: Appeals and Grievances Department
P.O. Box 30512
Salt Lake City, UT 84130

(855) 202-0984
Website: *liveandworkwell.com*

Chiropractic Services

ACN Group of California, dba OptumHealth Physical Health of California (ACN)

(800) 428-6337
Website: *myoptumhealthphysicalhealthofca.com*

Claims Submission – Out-of-Area Emergency

Sutter Health Plus
P.O. Box 160385
Sacramento, CA 95816

Complex Case Management – Sutter Care Coordination Program (SCCP)

Affinity Medical Group
(888) 309-2221

Brown & Toland Physicians and Brown & Toland Physicians – East Bay
(415) 972-4454

SCCP Bay
(844) 421-6414

SCCP Valley North
(888) 833-4566

SCCP Valley South
(855) 550-3890

Dental Services

Delta Dental, provided through their network DeltaCare® USA

(800) 422-4234
Website: *deltadentalins.com*

Department of Managed Health Care (DMHC) Help Line

Member Grievances
(888) 466-2219
TDD: (877) 688-9891
Website: *dmhc.ca.gov*

Disease Management

Sutter Health Disease Management

(855) 421-6831

Eligibility Verification

Member Services Department

(855) 315-5800 (M – F, 8 a.m. – 7 p.m.)
Website: *shplus.org/providerportal*

Fraud Reporting

Sutter Health Plus

Attn: Compliance Officer
P.O. Box 160307
Sacramento, CA 95816

(855) 315-5800
TTY: (855) 830-3500
(800) 500-1950 (anonymous Hotline)
Email: *shpcompliance@sutterhealth.org*
Fax: (916) 736-5425 or (855) 759-5425

Health and Wellness

Member Services Department

(855) 315-5800

Hospital Notification

Member Services Department

(855) 315-5800

Interpreter Services

Member Services Department

(855) 315-5800
TTY: (855) 830-3500

Member Grievance Submission

Members submit the SHP Grievance form to:

Sutter Health Plus

Attn: Appeals and Grievances
P.O. Box 160305
Sacramento, CA 95816

(855) 315-5800
TTY: (855) 830-3500
Fax: (855) 759-8755

Member Services

Member Services Department

(855) 315-5800
TTY: (855) 830-3500

Nurse Advice Line 24/7

(855) 836-3500
(855) 315-5800

Pharmacy

Pharmacy Benefit Manager

Express Scripts

(877) 787-8661
Website: *express-scripts.com*

Submit medication prior authorization requests to Express Scripts:

(800) 753-2851
Fax: (877) 251-5896
Online: *express-path.com* or *covermymeds.com* (registration required)

Formulary & Pharmacy Lookup tools:

- *express-scripts.com/shp*
- Select any of the four Guest Member Account links from the home page
  - Formulary – select Price a Medication
  - Pharmacy Locator – select the Find a Pharmacy

Mail Service Pharmacy

Express Scripts Pharmacy

Submit new mail order prescriptions to Express Scripts Pharmacy:

Telephone: (888) 327-9791
Fax: (800) 837-0953
Mail: P.O. Box 66567
St. Louis, MO 63166-6567
Website: *express-scripts.com*

eRx: 4600 North Hanley Road, St. Louis, MO 63134
NCPDP ID #2623735

Specialty Pharmacy

Accredo

(866) 759-1557
Fax: (800) 391-9707
Website: *express-scripts.com*

eRx: 1640 Century Center Parkway, Memphis, TN 38134
NCPDP ID #:4436920

Provider Dispute Submission

Sutter Health Plus
P.O. Box 160366
Sacramento, CA 95816

Provider Search

Website: *sutterhealthplus.org/providersearch*

Provider Services

Member Services Department

(855) 315-5800
TTY: (855) 830-3500

Sutter eHealth Records

Website: *suttereHRLink.org*

Sutter Health Plus

2480 Natomas Park Drive, Ste. 150
Sacramento, CA 95833

(855) 315-5800
TTY (855) 830-3500
Website: *sutterhealthplus.org*
Provider Portal: *shplus.org/providerportal*

Vision Services

VSP

(800) 877-7195
Website: *vsp.com*

INTRODUCTION

The Sutter Health Plus (SHP) Provider Manual describes the policies and operating procedures for SHP delegated subcontractors and their contracting providers. It serves as a reference on operational and clinical policies necessary in the administration of SHP's programs, such as eligibility, contract administration, medical management, quality improvement, and billing and claims information. The SHP Provider Manual supplements the administrative and operational policies of SHP's participating medical groups (PMGs); it does not replace PMG provider manuals or guidance to the PMG's downstream providers.

The SHP Provider Manual provides generalized information on benefits, healthcare goods and services available to SHP HMO members; participating providers must verify eligibility, benefits and cost sharing for an SHP member prior to rendering services.

SHP's participating providers are required to comply with applicable state and federal laws and regulations and SHP's policies and procedures. SHP's operational policies and procedures are available to providers on request. The contents of the SHP Provider Manual are supplemental to the contract between SHP and its providers. If the contents of the SHP Provider Manual conflict with the contract, the contract takes precedence. If the contents of the SHP Provider Manual conflict or are inconsistent with federal or state statutory or regulatory requirements, the provisions of the statutory regulatory requirements prevail.

The information contained in the SHP Provider Manual is current as of the date of its publication. SHP reviews and updates the provider manual at least annually. SHP makes updates to this manual as needed to revise policies and process in response to regulatory and legislative changes or business need. SHP revises the information contained in the manual provider updates or signed letters and distributes by mail, email, fax, or other method in accordance with the provider contract. SHP posts the most current version of the SHP Provider Manual on the provider portal of SHP's website at *shplus.org/providerportal*. Hardcopies of the manual are available on request; however, participating providers are encouraged to access the electronic version of the SHP Provider Manual online for the most current information.

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BENEFITS

Overview

SHP covers medically necessary health care services, equipment and supplies when a participating provider provides, prescribes, authorizes, or directs within the service area in accordance with the member's benefit plan. SHP also provides emergency and urgent care in and out of area without prior authorization. Certain exceptions or limitations apply; refer to the discussion on Exceptions and Limitations in this section. SHP also offers additional optional benefits through benefit riders available for purchase by employer groups.

This section provides basic information on principal coverage and benefits for all SHP members, and exclusions and limitations for various benefits. It also provides more detailed descriptions for certain benefits that may be non-standard or newer in HMO benefit plans, e.g., classification of essential health benefits as defined by the Affordable Care Act, or ACA, or have specific administrative instructions that require consideration by providers or members to access the benefit.

Providers must verify member eligibility and benefit coverage prior to rendering services. Refer to the discussion of Eligibility Verification in the Operations section of this manual for more information and instructions. Providers can access a member's *Evidence of Coverage and Disclosure Form* (*EOC*) and *Health Plan Benefits and Coverage Matrix* (*BCM*) using the Eligibility and Coverage search feature on the SHP Provider Portal, at *shplus.org/providerportal*. Providers can also contact the Member Services Department at (855) 315-5800 for a copy of the member's *EOC* or *BCM*.

Providers can communicate freely with SHP members regarding all of their treatment options, regardless of benefit coverage limitations.

Principal Coverages

SHP covers the following benefits for all SHP members when medically necessary. For additional benefits related to small group and individual plans, refer to the Essential Health Benefits discussion in this section.

- Preventive care services – provided without member cost-share
- Outpatient care
- Ambulance services
- Hospital inpatient care
- Bariatric surgery
- Dental and orthodontic services – limited coverage
- Dialysis care
- Durable medical equipment (DME) for home use
- Health education

- Hearing services
- Home health care
- Hospice care
- Mental health, behavioral health and substance use disorder treatment services
- Ostomy and urological supplies
- Outpatient imaging, laboratory and therapeutic procedures
- Outpatient prescription drugs, supplies, equipment, and supplements
- Outpatient rehabilitation and habilitation services
- Prosthetic and orthotic devices
- Reconstructive surgery
- Services associated with clinical trials
- SHP Nurse Advice Line and USBHPC Intake Line
- Skilled nursing facility (SNF) care
- Transplant services

Essential Health Benefits

The ACA defines 10 categories of benefits as essential health benefits (EHBs), specifying that health plans must cover these benefits for members enrolled through small group or individual plans. The state of California has further defined the categories and outlined specific required services. SHP offers all of the EHB services listed to individual and small group members.[1] SHP offers certain preventive services at no cost to members.

The EHB categories are:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Medically necessary prescription drugs

[1] Most of these services are also covered for members enrolled through most large group plans, with certain exceptions (such as habilitative services, acupuncture services, pediatric vision, and pediatric dental care). Providers must verify coverage prior to rendering services.

For detailed information on EHBs and services, refer to the California Code of Regulations (CCR) Title 28, Chapter 2, Article 7, §1300.67.005 on the Department of Managed Health Care (DMHC) website at *http://wpso.dmhc.ca.gov/regulations/docs/14ccrip.pdf.*

- Mental health and substance use disorder services, including behavioral health treatment
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, and chronic disease management
- Pediatric services, including dental and vision care – for members through the end of the month in which they turn age 19

General Exclusions and Limitations

SHP excludes or limits by the member's benefit plan the following services and all related services:

- Any services or supplies obtained before the member's effective date of coverage or after the member's coverage has ended
- Services, supplies and treatments which are not medically necessary
- Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation, other than a licensed ambulance or psychiatric transport van, even if it is the only way to travel to a participating provider
- Non-emergent services and supplies rendered by non-participating providers unless prior authorized by the PMG or SHP
- Any services or supplies provided by a person who lives in the member's home, or by an immediate relative of the member
- Personal comfort or convenience items, home or automobile modifications or improvements (chair lifts, purifiers)
- Penile prostheses, unless prescribed by a participating physician or mental health provider and determined to be medically necessary treatment for a medical condition or mental health disorder
- Vitamins and mineral supplements, except those noted in the Preventive Care Drugs and Supplies subsection of the Outpatient Prescription Drugs, Supplies, Equipment and Supplements section of the Your Benefits chapter in the member's *EOC*
- Over-the-counter (OTC) medications, supplies or equipment that can be obtained without a prescription, except for aspirin for members of certain ages or with certain conditions, and diabetes and pediatric asthma supplies (this exclusion does not apply to Food and Drug Administration (FDA) approved OTC contraceptive drugs or devices, or OTC medications covered under preventive care recommendations from the U.S. Preventive Services Task Force (USPSTF), when accompanied by a written prescription)
- Services related to the treatment of infertility (this exclusion does not apply if optional infertility benefits are elected by group subscriber or if the member is enrolled in a Plus plan)
- Home birth delivery

- Routine physical exams when the purpose of the exam is to satisfy requirements for obtaining or maintaining insurance, licensing, employment, or for entering school, camp or athletic programs
- Aquatic therapy and other water therapy, except as part of a physical therapy treatment plan
- Chiropractic services and the services of a chiropractor (exclusion does not apply if optional chiropractic benefits are elected by the group subscriber and provided through ACN)
- Cosmetic services intended primarily to alter or reshape normal structures of the body in order to improve appearance
- Custodial care such as assistance with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medicine
- Dental care, including:
    - Items or services in connection with the care, treatment, filling, removal, replacement, or artificial restoration of the teeth or structures directly supporting teeth
    - Treatment of dental abscesses
    - Orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason other than reconstructive treatment of cleft palate, including treatment to alleviate temporomandibular joint disease (TMJ)
    - Any procedure intended to prepare the mouth for dentures or for the more comfortable use of dentures
    - Bridges, dental plates, dental prostheses and dental orthoses, including anesthetic agents or drugs used for the purpose of dental care
    - These dental exclusions do not apply to required pediatric dental services for members.
- Disposable supplies for home use including, but not limited to, bandages, gauze, tape, antiseptics, dressings, ACE-type bandages, diapers, underpads, and other incontinence supplies (this exclusion does not apply to disposable supplies covered under the Durable Medical Equipment for Home Use, Home Health Care, Hospice Care, Ostomy and Urological Supplies, and Outpatient Prescription Drugs, Supplies, Equipment, and Supplements sections of the Your Benefits chapter in the member's *EOC*)
- Experimental and investigational services, except as described in the Experimental and Investigational Services discussion in the Clinical – Operations section of this manual
- Hair loss and hair growth services and supplies
- Care in a licensed intermediate care facility (this exclusion does not apply to covered services under the Durable Medical Equipment for Home Use, Home Health Care and Hospice Care sections of the Your Benefits chapter in the member's *EOC*. This exclusion also does not apply to the provision of mandated mental health services required by state and federal law)

- Non-health care items and services, including, but not limited to, teaching and support services, items and services that increase academic knowledge or skills, educational testing, teaching skills for employment, or vocational purposes
- Eye exams – coverage is limited to:
  - Annual preventive refractive eye exam for all members enrolled through large group plans, provided through VSP
  - Required comprehensive pediatric vision benefits for members (through the end of the month in which they turn age 19) enrolled through individual and small group plans, provided through VSP
- Vision care items and services intended to correct refractive defects of the eye (such as eye surgery or contact lenses to reshape the eye)
- Massage therapy, except as provided as part of an authorized physical therapy treatment plan and covered under hospital inpatient care, outpatient care, home health care, hospice services, or SNF care in the member's *EOC*
- Food supplements or infant formulas, except when medically necessary and covered in the Your Benefits chapter of the member's *EOC*
- Residential and long-term care (LTC) facility services, except as covered as part of hospice care, inpatient mental health and behavioral health care, or substance use disorder treatment services
- Routine foot care items and services that are not medically necessary
- Non-FDA-approved medications, supplements, tests, vaccines, devices, radioactive materials, and any other services – except as obtained as part of emergency or urgent care outside of the U.S., as part of an FDA-authorized procedure, or as part of an approved clinical trial using an investigational application pending FDA approval
- Services provided safely and effectively by a non-licensed or non-certified person when the member's condition does not require services be provided by a licensed health care provider – except for medically necessary behavioral health treatment services for pervasive developmental disorders or autism
- When a service is not covered, all services related to a non-covered service are excluded, except for services otherwise covered to treat complications of the non-covered service
- All services involved in surrogacy, including but not limited to embryo transfers, services and supplies related to donor sperm or sperm preservation for artificial insemination
- Travel and lodging expenses (this exclusion does not apply to reimbursement for travel and lodging expenses provided under the Bariatric Surgery section in the Your Benefits chapter of the member's *EOC*)
- Exercise equipment, gym memberships, fitness trainers and fitness classes

- Dietary supplements or replacement foods used to promote weight loss, such as all liquid diets, purified foods, protein shake diets, vitamin and mineral supplements
- Commercially available weight loss programs that offer group support or specific meals, such as Weight Watchers®, Jenny Craig®, or Nutrisystem®
- Complementary, alternative and integrative medicine, except for acupuncture services when covered as an essential health or optional benefit for certain plans
- Immunizations required for foreign travel or occupational purposes, unless otherwise described in the Preventive Services subsection of the Your Benefits section of the member's *EOC*
- Private duty nursing or shift care
- Services and supplies associated with the donation of organs when the recipient is not a member of SHP
- Services and supplies in connection with the reversal of voluntary sterilization
- Circumcisions performed more than 30 days after the birth of the newborn unless medically necessary and the PMG provides prior authorization

Optional Benefits

SHP offers the following optional benefit riders to employer group purchasers:

- Acupuncture
  - Services provided through ACN Group of California, dba OptumHealth Physical Health of California (ACN)
- Chiropractic care
  - Services provided through ACN
- Dental
  - Services provided through Delta Dental
- Infertility services
- Vision
  - Services provided through VSP

Acupuncture

SHP covers acupuncture services provided by PMG providers for members enrolled through small group and individual plans, and most large groups as part of the EHB. These services are typically for the treatment of nausea or as part of a comprehensive pain management program for chronic pain. PMGs provide these services through its network. Acupuncture services are subject to prior authorization by the PMG.

SHP considers acupuncture medically necessary as part of EHBs in accordance with federal and California law, typically for the following indications:

- Treatment of nausea
- Treatment of chronic pain as part of a comprehensive pain management program

SHP's approved acupuncture medical policy is available on the SHP provider portal at *shplus.org/providerportal*.

Optional Acupuncture Benefits

For members whose employer group has purchased the optional acupuncture benefit, SHP covers acupuncture services when provided by ACN, SHP's acupuncture vendor. These services are subject to prior authorization by ACN.

Some members enrolled through a small group or large group plan have both the EHB core medical benefit through the PMG and the optional benefit policy through ACN. PMGs cannot require these members to access medically necessary EHB acupuncture services through ACN in lieu of providing the services through the PMG's network.

The member may choose, however, to access medically necessary EHB acupuncture services through the PMG's network or the ACN network. The member must obtain other acupuncture services through ACN only. PCPs may guide the member in this choice.

Members should contact ACN for any questions regarding ACN network providers, benefits, limitations and exclusions.

AIDS

SHP, PMGs and participating providers must ensure timely access to HIV/AIDS specialists for members with these diagnoses, and establish standing referrals to specialists when appropriate. Refer to the Standing Referrals to Specialists section under Clinical – Operations for more information.

Allergy Testing, Evaluation and Management

SHP covers allergy testing, evaluation and management when a member's PCP provides or the PCP refers the member to a participating specialist.

Allergy testing and treatment require prior authorization by the PMG.

Ambulance

Emergency Ambulance

SHP covers licensed ambulance services in and out of area without authorization in the following situations:

- There is a medical emergency and a member requires ambulance services

- A member reasonably believes that the medical condition is an emergency medical condition that requires ambulance services
- A treating physician determines that the member must be transported to another facility because their emergency medical condition is not stabilized and the care needed is not available at the treating facility

Out-of-area coverage includes services provided anywhere in the world, including transportation through the 911 emergency response system where available.

Nonemergency Ambulance

SHP covers nonemergency ambulance and psychiatric transport van services if a participating provider determines that a member's condition requires the use of services only a licensed ambulance (or psychiatric transport van) can provide, and that the use of other means of transportation would endanger the member's health. SHP covers these services only when the vehicle transports the member to or from covered services.

For transportation within the service area, the PMG must prior authorize the services. For transportation outside of the service area, SHP must prior authorize the services.

Ambulance Services Exclusion

SHP does not cover transportation by car, taxi, bus, wheelchair van, and any type of transportation other than a licensed ambulance or psychiatric transport van.

Bariatric Surgery

SHP covers bariatric surgery and related services when medically necessary.

To ensure access to qualified bariatric surgeons and facilities, SHP coverage includes certain provisions for transportation and lodging expenses when the member lives 50 miles or further from the referred bariatric facility. SHP covers the following upon prior authorization from the member's PMG:

- Transportation for the member to and from the facility up to $130 per round trip for a maximum of three trips (one pre-surgical visit, the surgery, and one follow-up visit)
- Transportation for one companion to and from the facility up to $130 per round trip for a maximum of two trips (the surgery and one follow-up visit)
- One hotel room, double-occupancy, for the member and one companion not to exceed $100 per day for the pre-surgical visit and the follow-up visit, up to two days per trip
- Hotel accommodations for one companion not to exceed $100 per day while the member is a hospital inpatient during and immediately following surgery, up to four days

The member must submit adequate documentation, including receipts, to the PMG for reimbursement.

SHP does not reimburse the member for any travel or lodging expenses if the PMG or SHP offered the member a referral to a facility within 50 miles from the member's home.

Behavioral and Mental Health and Substance Use Disorder Treatment

SHP covers mental health, behavioral health and substance use disorder treatment services summarized in this section. SHP contracts with U.S. Behavioral Health Plan, California (USBHPC) to administer these covered services.

Mental health, behavioral health and substance use disorder treatment services are those services provided or arranged by USBHPC for the medically necessary treatment of:

- Mental disorders, including but not limited to treatment for the severe mental illness of an adult or child and/or the serious emotional disturbance of a child
- Alcohol and drug problems, also known as chemical dependency, substance use disorder or substance abuse

Participating providers should direct SHP members to contact USBHPC's or SHP's Member Services for coordination and questions regarding coverage for mental health care, behavioral health care or substance use disorder treatment services. Members can contact USBHPC:

Online: *LiveandWorkWell.com*
Telephone: (855) 202-0984

Participating providers can also contact SHP or USBHPC for an *EOC*, which contains a complete description of all behavioral health benefits.

Mental Health and Behavioral Health Care Services for the Diagnosis and Treatment of Mental Disorders

A mental disorder is defined as a mental health condition identified as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM), versions IV and 5, that results in clinically significant distress or impairment of mental, emotional or behavioral functioning.

SHP covers:

- All mental health conditions identified as a mental disorder in the DSM. Mental disorders include, but are not limited to, the following conditions:
  - Severe mental illness of a person of any age – Includes:
    - Schizophrenia
    - Schizoaffective disorder
    - Bipolar disorder (manic-depressive illness)
    - Major depressive disorders
    - Panic disorder
    - Obsessive-compulsive disorder
    - Pervasive developmental disorder or autism
    - Anorexia nervosa
    - Bulimia nervosa
  - A serious emotional disturbance of a child under age 18

- Inpatient mental health services and prescription medication
  - Note: Coverage for prescription medications that are needed for treatment of a mental disorder while an inpatient in a residential treatment center is provided through the outpatient prescription drug benefit, and will be covered when prescribed by a licensed provider for treatment of a mental disorder
- Outpatient
  - Outpatient professional care
  - Behavioral health treatment for autism spectrum disorder
  - Outpatient prescription medications (prescribed by a licensed behavioral health provider for treatment of a mental disorder)
  - Injectable psychotropic medications (prescribed by a licensed behavioral health provider for treatment of a mental disorder)
- Psychological intensive psychiatric treatment programs include but are not limited to:
  - Short-term hospital-based intensive outpatient care (partial hospitalization)
  - Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
  - Short-term treatment in a crisis residential program in a licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis
  - Psychiatric observation for an acute psychiatric crisis

Substance Use Disorder Treatment Services

SHP covers:

- Inpatient
  - Inpatient hospital/facilities services
  - Residential treatment transitional residential recovery
- Outpatient
  - Outpatient treatments for substance use disorder services:
    - Day-treatment programs, including partial hospitalization
    - Intensive outpatient programs
    - Individual and group chemical dependency counseling
    - Medical treatment for withdrawal symptoms
  - Outpatient physician care
  - Outpatient prescription medications

Chiropractic

SHP offers chiropractic services through ACN as an optional benefit for members whose employer has purchased the optional benefit policy. ACN administers and provides chiropractic services through its network of chiropractors. Members can obtain information about chiropractic network providers on the SHP website at *sutterhealthplus.org/providersearch.*

Clinical Trials

SHP covers services associated with approved clinical trials if members meet all of the following requirements:

- The member is diagnosed with cancer or another life-threatening disease or condition
- The member is accepted into a phase I, II, III, or IV clinical trial for cancer or another life-threatening disease or condition
- The member is referred by a participating provider (PCP or specialist), and the PMG or SHP authorizes the referral upon determining that the clinical trial has a meaningful potential to benefit the member
- The services billed are routine member care costs that would be covered under the member's benefit plan if they were not provided in connection with a clinical trial
- The clinical trial has a therapeutic intent and its end points are not defined exclusively to test toxicity
- The clinical trial involves a drug that is exempt under federal regulations from a new drug application, or the clinical trial is approved by either the National Institutes of Health (NIH), the FDA (in the form of an investigational new drug application), the U.S. Department of Defense (DOD), the U.S. Department of Veterans Affairs, the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, and the Centers for Medicare & Medicaid Services (CMS)

The member is responsible for any applicable cost-sharing fees, including copayments and deductibles, for the services related to clinical trials that would otherwise be subject to cost sharing under the member's benefit plan.

SHP does not cover services related to a clinical trial when:

- The services are provided solely to satisfy data collection and analysis needs and are not used in clinical management of the member's medical condition
- The services are customarily provided by the research sponsors free of charge to participants in the clinical trial

SHP's approved clinical trials medical policy is available on the SHP provider portal at *shplus.org/providerportal*.

Dental Services

As part of SHP's medical benefit plans, SHP provides limited coverage for dental and orthodontic services, including:

- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the member's jaw for radiation therapy of cancer in their head or neck if a participating provider provides the services or if the member's PMG authorizes a referral to a dentist
- General anesthesia for dental procedures at a participating provider and the services associated with the anesthesia if all of the following are true:
    - The member is under age seven, or the member is developmentally disabled, or their health is compromised
    - The member's clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
    - The dental procedure would not ordinarily require general anesthesia
- Covered services for cleft palate including dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic services, if:
    - The services are an integral part of a reconstructive surgery for cleft palate that SHP covers under reconstructive surgery
    - A participating provider provides the services or SHP or the PMG authorizes a referral to a non–participating provider who is a dentist or orthodontist
- Emergency medical services to stabilize an acute injury to sound natural teeth, jawbone and surrounding structures after an injury. Dental services beyond emergency medical treatment to stabilize an acute injury are not covered
- Outpatient prescription drugs
- Required pediatric dental services for members through the end of the month in which they turn age 19. SHP contracts with Delta Dental to provide these services

SHP does not cover any other services related to dental procedures, such as the dentist's services.

Optional Dental Coverage

SHP offers dental coverage for members whose employer has purchased the optional benefit policy provided by Delta Dental. Delta dental administers and provides dental services through its network of dentists. Members can locate a participating dental provider on Delta Dental's website at deltadental.com or SHP's website at *sutterhealthplus.org/providersearch*.

Durable Medical Equipment

SHP covers medically necessary durable medical equipment (DME) for use in the member's primary residence. Coverage is limited to the standard item of equipment that adequately meets the member's medical needs. Coverage includes repair or replacement of covered equipment, unless the repair or replacement need is due to loss or misuse.

DME coverage is subject to prior authorization by the member's PMG. The PMG is responsible for the provision of covered medically-necessary DME for a member whose primary residence is outside of the service area but who qualifies for in-area coverage based on the member's work location.

SHP's approved DME medical policy is available on the SHP provider portal at *shplus.org/providerportal*.

Emergency Services

All members may directly access emergency services at the closest emergency room (ER), both inside and outside the SHP service area if they experience an emergency medical condition. An emergency medical condition is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to members' health
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

An emergency medical condition is also active labor, which means there is inadequate time for safe transfer to a participating hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the member or unborn child.

A psychiatric emergency medical condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders members as being either of the following:

- An immediate danger to themselves or others
- Immediately unable to provide for, or utilize, food, shelter or clothing due to the mental disorder

SHP covers initial screening examinations performed by ER staff to determine the medical stability of a patient, regardless of whether the situation results in a true emergency or urgent care situation.

For post-stabilization services, SHP requires notification and prior authorization for coverage of services provided by participating and non-participating facilities following an emergency or urgent care situation once the member's medical condition is stable.

Refer to the Emergency Services discussion in the Clinical – Operations section for more information.

Habilitation Services

SHP covers medically necessary habilitation services for members enrolled through small group and individual plans, and some large group and custom plans, in accordance with ACA requirements for EHB. Participating providers must follow the PMG's policies and process for requesting authorization for habilitation services. PMGs are responsible for evaluating all relevant clinical information and determining medical necessity.

Habilitative services are health care services and devices that help a person to keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age, or services related to pervasive developmental disorder or autism. These services may include individual and group physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and outpatient settings.

Habilitation services and devices used are often the same or similar to rehabilitation services and supplies, such as occupational therapy, physical therapy, speech-language therapy, and behavioral therapies. The professionals and the settings are often the same, and the functional deficits and the improvement in functional outcomes that result from treatment can often be similar. However, habilitation and rehabilitation differ in the reasons members need services and the length of time the services may be required. Rehabilitation services help an individual recover from an illness or injury and to restore previous functioning. Habilitative services are appropriate for individuals with many types of developmental and cognitive conditions that, without such services, would prevent them from acquiring certain skills and functions over the course of their lives, particularly in childhood.

Exclusions

SHP does not cover nor consider certain services habilitative, including but not limited to:

- Respite care
- Day care
- Recreational care
- Residential treatment
- Social services
- Custodial care
- Education services of any kind, including, but not limited to, vocational training

SHP's approved habilitation services medical policy is available on the SHP provider portal at *shplus.org/providerportal*.

Home Health Care

SHP offers limited coverage for home health care service for members who meet the following conditions:

- The member is substantially confined to his or her home or primary residence

- The member's condition requires:
  - Services of a nurse, physical therapist, occupational therapist, or speech therapist; or
  - Behavioral health services provided by persons permitted by state or federal law to provide such services
- Home health aide services are only covered if the member is receiving covered services by one of the home health service provider types listed above
- A participating provider determines that it is feasible to maintain effective supervision and control of the member's care at home and that the services can be safely and effectively provided in the home

Home health care coverage is subject to prior authorization by the member's PMG. The PMG is responsible for the provision of covered medically necessary home health care for a member whose primary residence is outside of the service area but who qualifies for in-area coverage based on the member's work location.

SHP covers only part-time or intermittent home health care, as follows:

- Two-hour incremental visits by a nurse, medical social worker, or physical, occupational, or speech therapist, and four-hour incremental visits by a home health aide
  - Any visit that extends beyond the incremental limit is considered an additional visit
- Up to three visits per day (for all home health visits)
- Up to 100 visits per benefit year (for all home health visits)

Home health services may include the use of other covered benefits, such as:

- Dialysis
- DME for home use
- Ostomy and urological supplies
- Outpatient prescription drugs, supplies, equipment, and supplements
- Prosthetic and orthotic devices

SHP does not cover the following home health care services:

- Care of a type that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training
  - This exclusion does not apply to the provision of behavioral health treatment services that state or federal law permits unlicensed persons to provide
- Care in the home if the home is not a safe and effective treatment setting

Infertility Services

SHP covers infertility services as an optional benefit for members whose employer group has purchased the optional benefit rider, and as an embedded benefit for members of small group Plus plans. For members with the infertility benefit, SHP covers services, supplies and medications for the diagnosis and treatment of involuntary infertility, including consultations, examinations, diagnostic tests, procedures, and drug therapy, subject to certain exclusions and limitations. Participating providers must verify eligibility and coverage prior to rendering infertility-related services and follow the PMG's process for referrals and authorizations for infertility services.

For the purposes of the benefit, SHP defines infertility as:

- For a member under age 35: inability to conceive a pregnancy or carry a pregnancy to a live birth after one year (12 months) of regular intercourse without contraception
- For a member over age 35 or with a history of oligo/amenorrhea, or with known or suspected uterine/tubal disease or endometriosis: inability to conceive a pregnancy or carry a pregnancy to a live birth after six months of regular intercourse without contraception
- Inability to conceive a pregnancy or carry a pregnancy to a live birth after six cycles of artificial donor insemination under medical supervision
- For men and women with other health conditions known to cause infertility, as recognized by licensed physicians

Limitations

The following limitations apply:

- Intrauterine insemination (IUI) is limited to three cycles per member's lifetime
- In-vitro fertilization (IVF) is limited to one per member's lifetime
- For purposes of this infertility benefit, lifetime is defined as the lifetime of the member who is the recipient of infertility services, and includes all treatments provided to the member under any health care coverage plan in which the member participated

Exclusions

SHP excludes the following from its infertility benefit:

- Services and supplies to reverse voluntary infertility, including but not limited to reversals of vasectomy and tubal ligation, or other surgically induced infertility, or to treat infertility following reversal procedures
- Services and supplies related to donor sperm or sperm preservation for artificial insemination
- Surrogacy or gestational carriers if the prenatal and postpartum care is covered by the intended parent(s)
- Frozen embryo transfers, and zygote intrafallopian transfers (ZIFT)

- Intracytoplasmic sperm injection (ICSI)
- Ova sticks
- Ovum transfer/transplants or uterine lavage as part of infertility diagnosis or treatment
- Sperm donor, including the actual collection and storage of the sperm
- Donor sperm in lieu of a partner
- Treatment of female sterility in which a donor ovum would be necessary (e.g., post-menopausal syndrome)
- Experimental and/or investigational diagnostic studies, procedures or drugs used to treat or determine the cause of infertility
- Laboratory medical procedures involving the freezing or storing of sperm, ovum and/or pre-embryos
- Inoculation of women with partner's white cells (considered experimental)

Obesity

SHP covers obesity screening and counseling for members without cost share as part of preventive services. Subject to the delegated PMG's prior authorization requirements, PCPs can refer members for health education counseling and programs offered by the PMG or SHP as indicated, including adult members with a body mass index (BMI) greater than 30 and children six years and older who are at or above 95th percentile for weight.

PMG obesity programs must incorporate the following components in accordance with USPSTF recommendations:

- Behavioral management activities, such as setting weight-loss goals
- Improving diet or nutrition and increasing physical activity
- Addressing barriers to change
- Self-monitoring
- Strategizing how to maintain lifestyle changes

SHP offers a health and wellness program for members, which includes access to:

- A personal health assessment
- Member newsletters with timely and appropriate health and wellness messages
- Telephonic coaching for weight management, accessible by calling SHP's Health Coaching Program at 1-866-961-8513

Obesity treatment programs, such as bariatric surgery or medical monitoring of weight loss, are subject to copayments or coinsurance and deductibles in accordance with the member's plan. Providers must verify eligibility and coverage prior to rendering services.

Preventive Care

SHP covers preventive care services without member copayment. Preventive services are part of the ACA-required EHBs, and include services, screenings and immunization recommended by the USPSTF (and have a rating of A or B), Advisory Committee of Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and the Health Resources Services Administration. These services are subject to change in accordance with new recommendations and ACA requirements.

Covered preventive care services include:

- Alcohol and substance abuse screenings
- Obesity screen and counseling for adults and children age six and older
- Depression screening for adults and adolescents ages 12 to 18
- Developmental screenings to diagnose and assess potential developmental delays
- Family planning counseling, methods and consultations, including all FDA-approved contraceptive methods, tubal ligation, and patient education and counseling
- Colorectal cancer screening
- Health education counseling and programs
- Hearing exams and screenings
- Immunizations administered by a participating provider
- Preventive counseling, such as sexually transmitted disease (STD) prevention counseling
- Routine preventive imaging services, such as the following:
    - Abdominal aortic aneurysm screening
    - Bone density scans
    - Mammograms
- Routine physical maintenance exams, including well-woman exams
- Routine preventive retinal photography screenings
- Maternity and newborn care, including but not limited to:
    - Scheduled prenatal care exams and first postpartum follow-up consultation and exam
    - Alpha-fetoprotein testing
    - Anemia screening
    - Breast feeding supplies, support and counseling
    - Gestational diabetes screening
    - Prenatal diagnosis of genetic disorders of the fetus, including tests for specific genetic disorders for which genetic counseling is available

  - Rh incompatibility screening
- Smoking cessation interventions, including drugs and counseling
- Tuberculosis tests
- Well-child preventive care exams
- Routine preventive laboratory tests and screenings, such as:
  - Cervical cancer screenings
  - Cholesterol tests (lipid panel and profile)
  - Diabetes screening (fasting blood glucose tests)
  - Fecal occult blood tests
  - HIV tests
  - Prostate specific antigen tests
  - Certain STD tests

Transplants

SHP covers transplants of organs, tissue, or bone marrow upon referral from a participating provider to a transplant facility, subject to prior authorization from the member's PMG.

After the referral to a transplant facility, the following applies:

- If either the PMG or the referral facility determines that the member does not satisfy its respective criteria for a transplant, SHP only covers related services rendered prior to the determination
- SHP and its participating providers, hospitals and PMGs are not responsible for finding, furnishing or ensuring the availability of an organ, tissue, or bone marrow donor

Donor and Donation Coverage

SHP covers certain donation-related services for a living donor or an individual identified by the PMG as a potential donor, whether or not the donor is an SHP member. These services must directly relate to a covered transplant for the member. This may include certain services for harvesting the organ, tissue, bone marrow, or stem cell, and for treatment of complications.

SHP covers donation-related services for actual or potential donors (whether or not they are members) in accordance with the following guidelines:

- Donor receives covered services no later than 90 days following the harvest or evaluation service
- Donor receives services inside the United States, with the exception that geographic limitations do not apply to treatment of stem cell harvesting
- Donor receives written authorization for evaluation and harvesting services

- For services to treat complications, SHP covers non-emergency services for the donor subject to prior authorization, or covers the same services in an emergency situation without authorization
- In the event the member's plan membership terminates after the donation or harvest, but before the expiration of the 90-day time limit for services to treat complications, SHP continues to cover medically necessary services for the donor up to 90 days following the harvest or evaluation service

Transplant Services Exclusions

SHP does not cover the following excluded services:

- Treatment of donor complications related to a stem cell registry donation
- HLA blood screening for stem cell donations, for anyone other than the member's siblings, parents, or children
- Services related to post-harvest monitoring for the sole purpose of research or data collection
- Services to treat complications caused by the donor failing to come to a scheduled appointment or leaving a hospital before being discharged by the treating physician

Transplant Network

Members may obtain services through qualified providers within the PMG's network. PMGs also have the option to use SHP's contracted transplant provider network through OptumHealth Care Solutions.

Vision

SHP covers the following vision services without member share of cost:

- Annual preventive refractive eye exam for all members enrolled through large group plans, provided through VSP
- Required comprehensive pediatric vision benefits for pediatric members (through the end of the month in which they turn age 19) enrolled through individual or small group plans

Vision benefits are also available for purchase as a rider by small and large group employer plans. Refer to the discussion of Optional Benefits in this section.

VSP and its network of vision care providers administers and provides vision services. Members may self-refer for vision services. Members and participating providers can locate a VSP provider through the VSP website at vsp.com, on SHP's website at *sutterhealthplus.org/providersearch* or by calling VSP Member Services at (800) 877-7195.

CLINICAL – OPERATIONS

Overview

SHP delegates utilization management (UM) responsibilities for most health services, including prior authorization, concurrent and retrospective review, to its delegated PMGs with the exception of out-of-area urgent or emergent care services and post-stabilization services. PMGs are responsible for establishing UM policies and procedures (P&Ps) that comply with SHP's requirements, and communicating the policies to their contracting providers. SHP requires PMGs to meet SHP's UM standards related to inpatient care, outpatient care, discharge planning, case management, retrospective review, and timeliness of authorizations and denials. SHP's UM standards are updated as necessary to comply with standards established by federal and state regulatory agencies and accreditation entities, such as the National Committee for Quality Assurance (NCQA).

The PMG may establish prior authorization requirements for medically and contractually necessary inpatient and outpatient/ambulatory services unless a provider renders the services under emergency or urgent conditions. Refer to the Prior Authorization Requirements section for more information on SHP requirements and limitations for PMG prior authorization policies.

Clinical Criteria for UM Review Decisions

SHP and its PMGs make authorization determinations based on medical necessity, consistently using established criteria and guidelines supported by clinical principles and processes. Due to the dynamic state of medical/health care practice, each medical decision must be case-specific and based on current medical knowledge and practice, regardless of available practice guidelines. SHP and its PMGs never link authorization decisions to financial incentives or compensation to the person(s) conducting the review.

SHP and its PMGs use the following criteria for UM decisions:

- InterQual® Clinical Decision Support Criteria (Change Healthcare) – SHP and PMGs use these evidence-based clinical decision support criteria to manage patient care appropriately. The four available criteria suites address all levels of medical and behavioral healthcare, as well as ambulatory care planning
- MCG™ Guidelines – These guidelines span the continuum of disease states and care settings including ambulatory, acute, post-acute, home health, chronic condition management, and behavioral health. MCG updates the guidelines annually through a rigorous, evidence-driven editorial process. Quality measures from the Hospital Quality Alliance are also embedded in the guidelines
- Sutter Health Maintenance and Disease Prevention Guidelines – SHP adheres to the Sutter Health Maintenance and Disease Prevention Guidelines for recommended screening examinations, immunizations and counseling topics for healthy individuals.

- Sutter Health developed the guidelines using multiple current sources of clinical reference material, including the USPSTF, Advisory Committee on Immunization Practices (ACIP), the American College of Preventive Medicine (ACPM) and CDC. Sutter Health reviews and updates the guidelines annually
- SHP clinical practice guidelines (CPGs) – SHP adheres to the Sutter Health CPGs. These are evidence-based strategies developed to assist providers in the clinical management of members who are at risk, or may be at risk, for certain conditions, e.g., hypertension, hyperlipidemia and adult Type 2 diabetes. SHP's CPGs are available on the SHP provider portal at *shplus.org/providerportal*
- SHP medical policies – SHP develops specific medical policy and technology assessments for areas of clinical practice that include new or emerging technology, or where there is significant controversy about effectiveness. In preparing medical policies, SHP's chief medical officer (CMO) and registered nurses (RNs) access multiple resources, including current medical literature, CMS guidelines, other nationally recognized guidelines and specialty society position papers, community standards of care, views of expert physicians practicing in relevant clinical areas, Hayes New Technology Assessment Guidelines, and the Agency of Healthcare Research and Quality (AHRQ). The foundations UM medical directors form the peer reviewing body for draft medical policies. These physicians meet during regularly scheduled Sutter Medical Network Population Management Clinical Advisory Team (PMCAT) meetings. Following review and revisions, PMCAT issues recommendations to the SHP Quality Improvement Committee (QIC) for adoption of SHP medical policies. The QIC includes physicians in active clinical practice or who perform a UM or quality improvement role. The QIC issues final approval of medical policies and technology assessments
- CMS National and Local Coverage Determinations – These determinations address medical issues and DME, prosthetics, orthotics and supplies
- SHP medication coverage policies – Express Scripts, SHP's pharmacy benefit manager (PBM), maintains a national Pharmacy &Therapeutics (P&T) Committee to develop, review and adopt medication coverage policies. SHP's P&T Committee, a subcommittee of the QIC, provides oversight of Express Scripts, reviewing medication coverage policies as necessary when SHP or the PMG's standards are inconsistent with the Express Scripts guideline or policy. SHP staff members also participates in Sutter Health's P&T Committee for oversight of facility-based medications and clinical pharmacy programs at the foundations

SHP and PMGs base the UM review decisions on principles of evidence-based medicine and review of currently available clinical information when considering authorization requests for treatment that do not fit standard of care guidelines or modalities that are considered experimental or investigational. This includes review of peer-reviewed published medical literature, the regulatory status of the technology, public health and health research findings and recommendations, guidelines and positions of leading national health professional organizations, and resources such as the Hayes Medical Technology Directory.

Disclosure of UM Review Policies

On request, SHP and PMGs must disclose at no cost the following UM information to members, providers and the public:

- A description of the process by which SHP or the PMG reviews and approves, modifies, delays, or denies, whether prospectively, concurrently or retrospectively, requests by providers concerning the provision of health care services to its members
- UM criteria, guidelines, and policies and procedures for specific procedures or conditions

SHP and PMGs must include the following disclaimer when it discloses such information to the public:

> "The materials provided to you are guidelines used by this plan to authorize, modify or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

Providers can call SHP Member Services to request the UM criteria, guidelines and policies and procedures SHP uses to review, approve, modify, delay, or deny requests for the provision of health care services to its members.

Complex Case Management

SHP delegates complex case management (CCM) to PMGs. CCM provides care coordination for members with high cost, high volume and high-risk health care experiences. CCM is a collaborative process to assess, plan, implement, coordinate, monitor, and evaluate options and services to meet an individual's health needs, provide effective benefit management, and increase member satisfaction. CCM promotes quality outcomes that enhance the physical, psychosocial and spiritual well-being of individuals. Providers can contact the member's PMG case management division to refer a member for CCM. Refer to the Contacts section for the appropriate CCM telephone numbers. Members may self-refer to CCM by contacting SHP, their PMG or their provider.

Continuity of Care

SHP follows California state laws relating to continuity of care (COC) for new members receiving ongoing or current treatment or therapy from non-participating providers at the time of enrollment, and for established members when SHP terminates the contract of the provider or the provider submits his or her termination.

Members qualify to receive continued services from their previous provider for specified time periods for the following conditions:

- Acute condition – an acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and has a limited duration. Completion of covered services are provided for the duration of the acute condition
- Serious chronic condition – a serious chronic condition is a medical condition due to disease, illness or other medical problem or medical disorder that is serious in nature and that persists

without full cure, worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Covered services are provided for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider. Completion of covered services will not exceed 12 months from the termination date of the provider or 12 months from the effective date of coverage for a newly enrolled member

- Pregnancy – during pregnancy and immediately after delivery (postpartum period)
- Terminal illness – care is continued for the duration of the terminal illness
- Newborn/Infant – care of a child under age three (care is continued for up to 12 months)
- Surgery – a previously scheduled surgery or other procedure (e.g., colonoscopy) that is performed within 180 days of the member's effective date or provider termination

SHP allows new members to submit a COC request form up to 30 days before, or 60 days after, their SHP coverage effective date. The following members may be eligible for COC:

1. New SHP small and large group members who are currently receiving active treatment and their treating provider does not accept SHP. New members enrolled in group coverage are not eligible for COC if:
    - They had the choice to continue coverage with their previous health plan or provider and chose to change to SHP
    - They had a choice to enroll in a health plan with an out-of-network option, such as a preferred provider organization (PPO)
2. New SHP individual and family plan members whose prior coverage was terminated because their previous health plan withdrew from the market or discontinued the member's previous benefit plan.
3. Existing SHP members currently receiving active treatment from an SHP provider who leaves or is terminated from our provider network.

SHP reviews the request to determine whether the member is eligible for COC. If eligible for COC, SHP forwards the request to the member's PMG for final authorization and coordination.

SHP transitions members receiving current or ongoing treatment/therapy from a non-participating or terminated provider to a network provider at the appropriate time to avoid potential adverse outcomes. Delegated PMGs are responsible for determining the timing of the transition on a case-by-case basis, ensuring patient safety and appropriateness, taking into consideration applicable state laws, the nature and severity of the member's current condition and treatment plan or therapy being provided, along with currently accepted medical or behavioral health practices.

COC Compensation for Terminated or Out-of-Network Providers

The PMG or SHP compensates a terminating participating provider pursuant to the terms of the terminated provider agreement for the statutorily required period of time when such arrangements are specified in the particular participating provider contract.

The PMG or SHP compensates participating providers who are terminating pursuant to the terms of the terminated provider agreement for the statutorily required period of time when the particular participating provider's contract specifies such arrangements. SHP compensates a non-participating provider and a provider whose terminated contract does not specify that compensation for COC services is compensated under the terms of the terminated contract at the same rate paid to similar participating providers currently providing similar services in the same or a similar geographic area as the terminated or non-participating provider.

The PMG or SHP is not required to cover the continuing services of a terminated or non-participating provider if the provider does not accept the payment rates provided for as described.

If the PMG or SHP and the non-participating or terminated provider are unable to reach agreement on the terms and conditions for the continued treatment of the member, the PMG or SHP does not provide the COC benefit with this provider.

Coordination between Behavioral Health and Medical Providers

SHP provides behavioral health and substance use treatment services through USBHPC and its network of behavioral health providers. USBHPC psychiatrists are available 24 hours a day, 7 days a week to consult with PCPs and PMGs regarding complex cases involving medical and behavioral health issues and comorbidities, psychotropic medication regimens, and emergent or urgent situations. SHP requires that USBHPC and its providers communicate timely with members' PCPs or treating providers to ensure appropriate coordination and COC for members with coexisting medical and behavioral health care needs.

When a member has signed a release of information, USBHPC encourages clinicians to share the results of mental health and substance use evaluation, consultation and treatment with the member's PCP. The PCP can share results by telephone, fax, mail, at the time of intake, during treatment, at the time of discharge or termination of care, and when the member is between levels of care.

SHP requires USBHPC's behavioral health providers to adhere to the following communication standards:

- Send a written report of the assessment and treatment plan to the member's PCP within 30 days when the member reports having, or is on medication for, an existing medical condition
- Upon suspicion of or discovery of an existing medical condition, call the member's PCP within 30 days to initiate appropriate medical intervention and to follow up as appropriate
- Notify the member's PCP in writing within 30 days of any prescribed medications
- Consult with the member's PCP within 30 days for any behavioral health treatment in consideration that requires medical evaluation, such as electroconvulsive therapy
- Communicate in writing within 30 days the results of treatment after the course of treatment is completed
- Maintain records of the communications within the member's medical record

The member can request that the behavioral health provider does not communicate information to his or her PCP. The behavioral health provider must document this request in the member's medical record.

SHP facilitates coordination and COC for these members. SHP's care management (CM) staff assesses various data to identify members with potential coexisting medical and behavioral health care needs, including pharmacy claims, medical and behavioral health encounter data, and case management reports. SHP refers these members to appropriate case management and disease management programs. SHP CM staff may assist in coordinating communication between behavioral health and medical providers or help facilitate access to behavioral health services with USBHPC as needed.

Cultural and Linguistic Services

SHP is committed to removing cultural and language barriers, which have a profound impact on the delivery of health care to all demographics. SHP provides language assistance services, including interpreter services and translation of vital documents, at no cost to SHP's limited-English proficient (LEP) members.

SHP contracts with TransPerfect to provide language services on request by members and providers. TransPerfect staff are trained and competent interpreters who provide interpretation services for over 150 different languages, via telephone for any medical encounter between a member and health care provider. Telephonic interpreter services are available 24 hours a day, 7 days a week, and 365 days a year. Providers and members can request immediate interpreter services by calling the SHP Member Services Department at (855) 315-5800. After normal hours, a caller may select the prompt for Interpreter Services and proceed to request language assistance from the patient services representative.

SHP also provides in-person American Sign Language (ASL) interpreters when the provider or member's PMG does not have an ASL interpreter available, and upon member request. Members can request ASL services by calling SHP Member Services. SHP requires two-business days' notice for non-urgent services.

Participating Provider Responsibilities

SHP requires PMGs and hospitals to maintain policies and procedures related to cultural and linguistic services that specify their methods to ensure the provision of health care services to LEP SHP members.

SHP's participating providers must:

- Not subject people of limited English proficiency to unreasonable delays in the delivery of services
- Not require or encourage members to use family members or friends as interpreters
- Not require members to pay for services of an interpreter
- Not limit participation in a program or activity on the basis of limited English proficiency

- Not provide services to those of limited English proficiency that are not as effective as those provided to others
- Document the language needs (English or preferred language) of the member in the member's medical record
- Document the member's request or refusal of interpreter services in the member's medical record

Providers must communicate with and provide health care services to SHP members in a way that effectively promotes meeting the member's health care needs. This includes, but is not limited to, the use of language interpretation and translation services and/or assistive technology devices that most effectively permits the member to:

- Express his or her needs and concerns
- Understand his or her rights and responsibilities as a member
- Comply with a proposed treatment regimen

Providers must communicate with and provide health care services to SHP members in a way that respects the member's individual cultural norms and traditions. This includes, but is not limited to, the following:

- Culturally appropriate human interaction
- Accommodation of the needs of the members with disabilities
- Recognition of cultural variation in care and disease management traditions

SHP's QIC and subcommittees oversee the SHP provider network to ensure compliance with requirements regarding the provision of cultural and linguistically appropriate services to all SHP members.

Definition of Medical Necessity

Medical necessary health care services are those that SHP determines are:

- Appropriate and necessary for the diagnosis or treatment of a member's medical condition (in accordance with professionally recognized standards of care)
- Not mainly for the convenience of the member or the member's physician or other provider
- The most appropriate supply or level of service for the injury or illness

For hospital admissions, medical necessary means that acute care as an inpatient is necessary due to the kind of services the member is receiving, and that the member cannot receive safe and adequate care as an outpatient or in a less intensive medical setting.

Delegated Utilization Management

SHP delegates certain UM activities to contracting PMGs at SHP's discretion, upon mutual agreement of SHP and the PMG, and upon the PMG satisfactorily meeting pre-delegation audit requirements.

Delegated UM functions include professional services, institutional (facility-based) services, case management, and disease management. SHP delegates UM functions based on a systematic review of the PMG's internal UM program description, work plans, policies and procedures, and upon the PMG's demonstration of compliance with stated policy and procedures, infrastructure to support delegated functions, and ability to provide services to members in accordance with all applicable regulatory requirements. SHP oversees quality of care and service delivered throughout the network. SHP does not delegate quality management activities to PMGs.

Following NCQA accreditation standards, and state and federal regulatory requirements, SHP performs ongoing oversight and audit activities designed to monitor, evaluate, and assist delegated PMGs in UM process improvement.

Delegation Oversight

SHP evaluates a PMG's ability to conduct delegated activities pre-contractually and at least annually thereafter. SHP conducts ongoing oversight of the delegated PMG to ensure compliance with SHP's delegation standards, including all applicable regulations and accreditation requirements, and that services meet professionally recognized standards of practice. SHP retains responsibility for reviewing the overall quality of care and services delivered to SHP members.

SHP's oversight of delegated PMG functions includes, but are not limited to, the following:

- Reviewing, monitoring and evaluating policies, procedures, committee minutes, and reports for delegated activities
- Conducting annual audits using recognized state and federal regulations and nationally recognized quality standards of performance
- Issuing corrective action plans (CAPs) to delegated PMGs as needed when SHP identifies deficiencies, and monitoring completion of CAP actions. SHP auditors are available to assist the delegated PMG in developing CAPs when deficiencies are identified
- Participating in joint operation committee meetings with delegated PMGs to review performance and collaborate on improving UM, operations processes with the goal of achieving appropriate, cost-effective healthcare

SHP conducts meetings and on-site audits for compliance evaluation and issues follow-up CAPs as needed. SHP maintains the right of final determination in all UM medical necessity decisions.

SHP's Delegation Oversight Workgroup (DOW) reviews delegation reports, performs audits, issues CAPs, and addresses concerns related to the delegated UM functions. The workgroup review may include, but is not limited to, member repatriation, denial files, grievances related to any delegated function, possible over- and under-utilization, and the performance of the PMG's UM department in meeting their annual work plan measures.

The DOW provides status reports and escalates issues as needed to the SHP leadership team. The leadership team recommends forwarding of issues to the QIC when necessary. SHP's leadership team also reports activities related to deficiencies to the Quality Assurance Committee (QAC), a subcommittee of the Board of Directors (BOD). The DOW provides reports during quarterly

meetings. The SHP Care Management director may also convene an ad hoc meeting as needed to discuss interventions taken to correct a nonconformance episode.

SHP may revoke a portion of or all delegated functions in the event the delegated PMG fails to develop and successfully execute an acceptable CAP.

Delegation Standards

PMGs with delegated UM responsibilities must adhere to SHP's delegation standards. Delegated PMGs must maintain a UM program consistent with SHP guidelines and provide SHP with a written copy of the program description annually. PMGs must make sufficient documents available for SHP review at least semi-annually and as requested by SHP.

SHP uses a provider delegation assessment tool (PDAT) to evaluate structural elements necessary to maintain an effective UM program. The tool delineates the responsibilities between SHP and the delegated PMG. SHP uses the tool to perform pre-contracting and annual delegation assessments. A copy of the PDAT is available on request by contacting the SHP Care Management Department or by calling the SHP Member Services Department.

Calendar of Required Submissions

Delegated PMGs must provide regular written reports to SHP related to the delegated UM program, in accordance with the following schedule, and on request by SHP:

Type of Report	Frequency
Denial logs or letter	Upon request
UM work plan	Semi-annually
UM program	Annually
UM evaluation	Annually
Patient satisfaction surveys	Annually
Provider satisfaction surveys of the UM process	Annually

Denials and Denial Notification

SHP and delegated PMGs must ensure that a California licensed physician makes decisions to deny, delay or modify request for services based on medical necessity. PMGs are responsible for issuing timely service denial notices to members and requesting providers when appropriate.

PMG's care management staff performing review of authorization requests must refer requests to the medical director when:

- The care management staff cannot determine medical necessity or appropriateness of care
- The proposed treatment includes experimental services or treatments not approved by the FDA
- There is a potential denial of coverage

- The UM staff identifies an alternate place of service and the requesting physician is not in agreement with the plan

SHP and PMG medical directors directly review relevant portions of submitted medical records as well as prepared nurse summaries, applicable clinical and administrative policies, and criteria prior to issuing a determination. Medical directors request additional medical records or perform additional research in peer-reviewed literature as needed to complete reviews, and apply their medical training, experience, and judgment to reach an appropriate determination. If medical directors do not have familiarity with the medical condition or requested service, SHP and PMG medical directors may refer for specialty-matched review or seek guidance from published specialty society position statements.

PMGs must notify members and providers of review outcomes in accordance with the Industry Collaboration Effort (ICE) Utilization Management Timeliness Standards (refer to the discussion of Authorization Timelines for Authorization Decisions and Notifications in this section). ICE bases these standards on multiple factors, including urgency and type of review, and delineates decision-making and notification timeliness requirements. The PMG medical director must be accessible to the requesting provider to discuss the request both during the course of the review and following a denial notification.

SHP recommends that delegated PMGs use the ICE denial template letters, which include elements required by the DMHC for commercial plans. If the PMG elects to use its own denial letters, it must ensure that the denial letter template includes the following elements:

- Decision (review outcome or current status, if delayed)
- Specific reason or rationale used for the decision in language easily understood by the member (eighth grade or lower reading level)
- Citation of clinical criteria, guidelines or benefit language used for the decision
- Alternative treatment recommendations, if available, and a recommendation for members to contact their physician regarding an alternate treatment plan
- Appeal rights, including when, where and how to submit a routine or expedited appeal
- Grievance rights, including the DMHC required statement in 12-point type with contact information bolded as follows:

  "The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(insert health plan's telephone number**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for

emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online."

- A statement indicating a free copy of the actual benefit provision, entire guideline, protocol or other similar criterion on which the denial decision was based is available on request and how members can obtain a copy. The following disclaimer is included in the notice when this information is disclosed to the member, "*The materials provided to you are guidelines to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract*."
- Notice of Translation and Language Assistance Program
- Employee Retirement Income Security Act (ERISA) statement
- Name, address, telephone and fax number of SHP
- For denial notification to providers, the name and telephone number of the health care professional responsible for the denial, delay or modification

Medical Record Documentation Audits

SHP conducts medical record documentation audits on one-third of the PCPs each year. SHP uses the 8 and 30 sampling methodology during the medical record documentation audit. SHP requests 30 records per PCP and reviews eight of the 30 records for compliance with DMHC documentation standards. If all eight are determined to be compliant with standards, SHP determines the PCP to be compliant. If one or more of the initial eight records are out of compliance, then SHP reviews the remaining 22 records.

DMHC Documentation Standards

In alignment with DMHC standards, medical records must include the following documentation:

1. Patient name and identification number on each page.
2. Consultations and progress notes documented as appropriate.
3. Evidence of continuity and coordination of care between primary and specialty physicians.
4. All entries are dated.
5. Medication allergies and adverse drug reactions are present.
6. Idiosyncratic medical problems conspicuously documented.
7. Appropriate past medical history.
8. Pertinent history and physical with clinical findings and evaluation.
9. Evidence of developmental screening during well-child visits beginning at age 18 months, including autism screening.

10. All pertinent diagnoses listed.
11. Evidence that pathology, laboratory and other diagnostic reports are recorded.
12. The health professional documenting is identifiable for every entry.
13. Case management and multidisciplinary team notes are present if applicable.

SHP Care Management reviews and evaluates compliance with the medical record documentation standards every three years for those PCPs scoring 90 percent or above, and every year for those PCPs who fall below the 90 percent threshold until their scores reach 90 percent.

SHP issues the foundation a CAP for each PCP who scores less than 90 percent. The CAP provides detailed information regarding the documentation standards that PCPs did not meet and instructions on how to send CAP responses back to SHP. Foundations must perform necessary corrections within 90 days.

Disease Management Program

SHP delegates to PMGs the responsibility to provide disease management (DM) programs at no cost to SHP members assigned to their group. PMGs must use the Telephonic Disease Management (TDM) program offered through Sutter Health.

SHP collaborates with Sutter Health to offer SHP members the following five telephonic DM programs: asthma, diabetes, high cholesterol, hypertension, and heart failure. These programs assist members living with certain chronic medical conditions through one-on-one support and guidance by specially trained nurses and staff. Members can enroll in more than one program at the same time. The TDM program identifies eligible members through diagnostic information in claims and stratifies members for nurse outreach based on certain trigger conditions known to be markers of high risk, such as elevated HbaA1c levels, ER utilization or persistently elevated blood pressure. The TDM program offers low-risk members access to the program at their own discretion and continually monitors them for high-risk markers in a proactive manner.

Providers and members can initiate the TDM program referral by contacting the Sutter Health Disease Management Program by telephone at (855) 421-6831, Monday through Friday, 8:30 a.m. to 4:30 p.m.

A representative from the program works with the member to provide education and tools to help them understand and manage their condition. An RN case manager works with members to assist with any of the following:

- Understanding their medications
- Understanding test results
- Setting personal goals to improve health
- Answering questions about their medical condition

Emergency Services

All members may directly access emergency services at the closest emergency room (ER), both inside and outside the SHP service area, if they believe they are experiencing a medical or behavioral health emergency. ER access is not subject to prior authorization by SHP or the PMG. SHP and PMGs consider the presenting symptoms of members if they review such services retrospectively, and must take into consideration whether the member's belief was reasonable given the member's age, education, background, and other similar factors.

SHP and PMGs cover emergency services if an authorized representative acting for SHP or the PMG (such as a member's PCP or SHP's Nurse Advice Line) has authorized the provision of ER services or directed the member to go to an ER, even if the medical or behavioral health condition would not normally meet ER criteria.

SHP and PMG cover initial screening examinations performed by ER or urgent care staff to determine the medical stability of a patient, regardless of whether the situation results in a true emergency or urgent care situation.

SHP participating hospitals and urgent care centers must provide discharge instructions to members that include directions to obtain follow-up care from the member's PCP.

Ambulance

SHP or the delegated PMG is responsible for ambulance services, including services dispatched through a 911 or equivalent local emergency dispatch system, when any other means of transportation would put the member's health at risk.

Behavioral and Mental Health and Substance Use Disorder Emergencies

SHP contracts with USBHPC for behavioral and mental health practitioners, programs and facilities to provide services to members that require urgent or emergent mental health care, including crisis intervention, stabilization and psychiatric inpatient hospital services 24 hours a day, 7 days a week.

The care and treatment necessary to relieve or eliminate a psychiatric emergency medical condition may include admission or transfer to a psychiatric unit within a hospital or to a psychiatric hospital if, in the opinion of the treating provider, the transfer would not result in a material deterioration of the patient's condition. A psychiatric emergency medical condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that in the absence of immediate mental health care or behavioral health care services the member would be either of the following:

- An immediate danger to himself or herself or to others
- Immediately unable to provide for, or utilize food, shelter, or clothing due to the mental disorder

Non-participating and out-of-area providers must obtain authorization from USBHPC to provide post-stabilization mental health, behavioral health or substance use disorder treatment services.

Post-Stabilization Services

SHP requires notification and prior authorization for coverage of services provided by participating and non-participating facilities following an emergency or urgent care situation once the member's medical condition is stable.

Participating facilities must notify the PMG to request authorization for in-area post-stabilization services.

In accordance with California statutes, non-participating facilities must notify SHP to request authorization for out-of-area post-stabilization services by calling the SHP Member Services Department at (855) 315-5800, available 24 hours a day, 7 days a week. Member Service representatives forward calls to staff members at Sutter Transfer Centers, SHP Care Management or USBHPC as appropriate to the situation and location of emergency care.

When a non-participating facility requests authorization of post-stabilization care, SHP or the PMG must respond within 30 minutes, in accordance with CA statutes. SHP or the PMG must inform the facility either that they authorize the request for post-stabilization care, or that SHP or the PMG will arrange for prompt transfer of the member to a participating facility. SHP or the PMG must initiate any transfer arrangements when they deem transfer is medically appropriate. If SHP or the PMG does not respond within 30 minutes, the request is deemed authorized, until SHP or the PMG makes other arrangements with the facility or treating provider.

SHP initiates concurrent review upon notification of a post-stabilization hospital admission, or notifies the member's PMG of in-area, out-of-network hospital admissions for PMG review and possible authorization.

If SHP or the PMG and the treating provider disagree regarding the need for necessary medical care following stabilization of the member, SHP or the PMG assume responsibility for the care of the patient, initiating care by a contracting provider within a reasonable amount of time after the disagreement or coordinating transfer to an alternate contracting facility.

If the non-participating facility does not notify SHP or the PMG to request authorization for post-stabilization care, then SHP and the PMG must follow their standard concurrent and retrospective review processes.

Following an ER visit, the member must obtain continuing care or routine follow-up treatment from a network provider. If extenuating circumstances exist when a member is temporarily out of the service area, the member must obtain prior authorization from SHP for out-of-area non-emergent or urgent follow-up care.

Health and Wellness Program

SHP offers health and wellness programs, services and resources designed to engage members in activities that help them improve and maintain their overall health and well-being. Members and PCPs can request educational materials or classes on health topics as needed. Members can also access health and wellness programs offered through the Sutter Health system by obtaining a referral from any health care provider (subject to availability and type of request, as well as geographical, cultural and

language circumstances). Topics covered through SHP programs include diabetes, asthma, hypertension, heart failure, and weight management.

The following programs are available at no cost to SHP members through self-referral, PCP referral, nurse, or health coaching referral:

- Health Coaching Program – SHP's Health Coaching Program offers personalized coaching by trained health coaches, engaging members in effective self-management of their health condition and assisting them to achieve personal wellness goals through promotion of personal accountability. SHP currently offers the following coaching programs – Healthy Weight, Tobacco Cessation and Stress Management. Health coaches conduct all coaching appointments by telephone. During the initial consultation, the member and coach collaborate to determine the best approach to address the member's needs, concerns and preferences. Additional coaching program topics are developed as needed to address members needs
- TDM Program – SHP offers members with asthma, diabetes, heart failure, hypertension, and high cholesterol access to Sutter Health's TDM Program. Specially trained nurses and support staff provide one-on-one support and guidance to members living with chronic diseases. The program is designed to reduce health risks, increase member compliance with their physician's plan of care and prescriptions, and ensure provision of appropriate health status monitoring, including diagnostic testing, in accordance with national clinical standards
- Worksite Wellness Initiatives – SHP offers onsite health and wellness promotion programs, in cooperation with Sutter Health, to participating employer groups. SHP and Sutter Health design programs to improve employee awareness of and participation in healthy lifestyle activities. These activities can include worksite flu clinics, biometric screenings, "lunch and learn" lectures provided by Sutter Health physicians or nurses, and employee fitness challenges

Members also have access to the SHP Health and Wellness site. The site provides health-related tools and resources to help members achieve their personal health and wellness goals. The health and wellness site offers members a personal health assessment (PHA). The PHA is a confidential, easy-to-use questionnaire that asks members about their health history and lifestyle behaviors to give them a personal health risk report.

SHP makes available various publications to educate and encourage members on prevention and appropriate use of health services, including:

- Member Newsletter – SHP develops and distributes a member newsletter twice a year. The newsletter covers topics such as SHP plan information, health issues, timely wellness topics, and Sutter Health events. SHP staff selects topics at the beginning of each year. Wellness topics may correspond with the National Health Observances Calendar

Members and providers can obtain more information about these programs and services by contacting the SHP Member Services Department at (855) 315-5800.

Member Identification and Stratification

SHP has implemented various strategies toward identification of members with potential health issues that may benefit from any of the health and wellness or health management programs.

SHP's Care Management and Pharmacy teams review utilization data monthly for identification of members who may benefit from a program. This includes monthly review of pharmacy data, claims and encounter data. Once SHP identifies a member, SHP initiates the referral to the appropriate program intake coordinator. Members can self-refer to any program. Providers can also refer members for participation in programs.

Monitoring Effectiveness

SHP monitors the effectiveness of the health and wellness programs through a variety of methods:

- Member satisfaction surveys
- Healthcare Effectiveness Data and Information Set (HEDIS®) measure data collection
- Program participation rates and results from targeted member outreach

Health Management Programs

SHP's QIC selects and approves health management programs and clinical studies based on analysis of members' medical care and service needs, including behavioral health. The QIC performs demographic analysis and reviews medical diagnosis and utilization patterns as part of the selection process.

QIC designs health management programs consistent with clinical practice guidelines, UM criteria, and member education materials. The programs include targeted member interventions – SHP targets the most appropriate candidates based using predictive modeling of stratified date.
SHP designs the studies in alignment with current research methods for health services, consults with experts and network physicians, and performs root cause analysis in the selection of interventions.

SHP shares disease and member-specific information as appropriate with PMGs and physicians for COC and evaluates the health management programs for effectiveness and improvement opportunities.

Ambulatory Case Management

SHP provides case management (CM) services in cooperation with its delegated PMGs. SHP and PMG UM clinical staff provide short-term nursing interventions designed to coordinate appropriate and cost-effective care, improve member engagement in healthier behaviors, and enhance the member experience with the health care system.

Complex Case Management

SHP provides structured CCM program services through its delegated PMG's care coordination program. CCM involves intensive engagement of a member who has multiple or complex conditions. The program emphasizes social support and physician engagement to improve overall member health and outcomes.

Hospital Discharge Planning

PMGs are required to work with hospital staff to create an appropriate discharge plan for SHP members, including post-hospital care and member notification of patient rights.

Nurse Advice Line

SHP provides the Nurse Advice Line, available 24 hours a day, 7 days a week, 365 days a year, giving members access to RNs for immediate information about medical issues or questions, and triage of acute medical issues to the appropriate level of care, such as:

- Caring for minor injuries and illnesses at home
- Seeking the most appropriate help based on the medical concern
- Identifying and addressing emergency medical concerns

Members can access the Nurse Advice Line through the SHP Member Services Department telephone number or directly at (855) 836-3500.

Out-of-Network Referrals

SHP and delegated PMGs must ensure that members have access to medically necessary, covered services within timely access standards, which may necessitate the use of out-of-network providers.

SHP has an extensive multi-disciplinary provider network through which members can access the services of contracting providers. However, in the event that a contracting provider is not available, SHP or the PMG must process referrals to non-participating practitioners/providers (NPPP) for medically necessary covered services when required to meet access to care timeliness standards and address specific member needs.

SHP or the PMG authorizes out-of-network requests when:

- There is no qualified specialist available within the network
- Travel to a contracting provider, whether hospital or physician, is contraindicated
- There is no qualified, contracting in-network provider available to provide a second opinion
- An in-network specialist has requested an out-of-network referral due to limitations on his or her practice, or inability to accommodate the member within the access timeliness standards
- The treating provider does not have admitting privileges to an in-network hospital

SHP or the PMG may deny out-of-network requests when an in-network specialist is available within a reasonable driving distance.

Prior Authorization Requirements

Prior authorization requirements help ensure the provision of medically necessary services at the appropriate level of care by an authorized provider (including non-participating providers when necessary). Prior authorization also helps to ensure that SHP covers the services provided under the

member's benefit plan. However, coverage is contingent upon the member's eligibility at the time providers render services, so providers must verify eligibility prior to rendering services. Medically necessary services may be subject to prior authorization requirements established by the PMG.

The following services do not require prior authorization or a PCP referral:

- Emergency and urgent care services – authorization is not required for emergency or urgent care conditions, regardless of whether or not the facility providing the service is a network provider
- On-call physician services – authorization is not required for PCPs' on-call physicians to provide care in their place
- Self-referral services (those that do not require referral from a PCP):
    - Gynecology services (from a participating provider within the member's assigned medical group)
    - Obstetrical services (from a participating provider within the member's assigned medical group)
    - Pediatric dental exam
    - Pediatric vision services
    - Mental health, behavioral health or substance use disorder treatment services
    - Reproductive or sexual health care services for the following:
        - The prevention or treatment of pregnancy, including birth control, emergency contraceptive services, pregnancy tests, prenatal care, abortion, and abortion-related procedures
        - The screening, prevention, testing, diagnosis, and treatment of sexually transmitted infections and sexually transmitted diseases
        - The diagnosis and treatment of sexual assault or rape, including the collection of medical evidence with regard to the alleged rape or sexual assault
        - The screening, prevention, testing, diagnosis, and treatment of HIV

SHP requires prior authorization by SHP or delegated PMGs of requests for non-emergency services referred to a non-network or out-of-area provider.

SHP manages authorization requests for out-of-area emergent hospital admissions and post-stabilization services. Hospitals must request these services by calling the SHP Member Services Department, and selecting the option for hospital notification. Hospital notification is available 24 hours a day, 7 days a week.

PMG Prior Authorization Standards

PMGs may require prior authorization of certain services, such as those that are prone to over-utilization, pose significant risk to the member, have a cost-effective alternative, are within the

scope of practice of a PCP, or in-network providers must deliver. PMGs cannot require prior authorization for emergency or urgent care services.

PMGs must develop, maintain and distribute a prior authorization requirements list to their network providers and office staff. The PMG must ensure that their UM Committee reviews and approves the prior authorization requirements list at least annually. The PMG must announce any changes to the requirements to affected providers. For changes that negatively affect SHP members or the PMG providers, the PMG must provide at least 45 business days' prior notice to the providers of the change.

PMGs are responsible for informing their participating providers of the methods and contact information needed to submit requests for authorization to the PMG. If a provider submits an authorization request through SHP's Member Services Department, an SHP Member Services representative forwards the request to the appropriate PMG, notifies the requesting provider of the routing to the PMG and informs the provider how to follow-up directly with the PMG authorization unit.

Timelines for Authorization Decisions and Notifications

SHP and delegated PMGs adhere to Utilization Management Timeliness Standards for commercial HMO products, established and maintained by ICE. Refer to the table on the following pages for the ICE standards.

Additionally, for medication prior authorization requests, SHP and PMGs must adhere to the following response turnaround timelines:

- Non-urgent requests – response within 72 hours of receipt
- Expedited request for exigent circumstances – response within 24 hours of receipt

For additional information, refer to the Physician-Administered Medications section in the Prescription Drug Program chapter.

Utilization Management Timeliness Standards
(Commercial HMO - California)

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition **not to exceed 72 hours after receipt of the request.**	Practitioner: Within 24 hours of the decision, not to exceed 72 hours of receipt of the request (for approvals and denials). Member: Within 72 hours of receipt of the request (for approval decisions). Document date and time of oral notifications.	Within 72 hours of receipt of the request. **Note:** If oral notification is given within 72 hours of receipt of the request, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
Urgent Pre-Service - Extension Needed • Additional clinical information required	**Additional clinical information required:** Notify member and practitioner within 24 hours of receipt of request & provide 48 hours for submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made within 48 hours of receipt of information. **Note:** Decision must be made in a timely fashion appropriate for the member's condition not to exceed 48 hours after receipt of information.	*Additional information received or incomplete* Practitioner: Within 24 hours of the decision, not to exceed 48 hours after receipt of information (for approvals and denials). Member: Within 48 hours after receipt of information (for approval decisions). Document date and time of oral notifications.	*Additional information received or incomplete* Within 48 hours after receipt of information. **Note:** If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
	Additional information not received: If no additional information is received within the 48 hours given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 48 hours. **Note:** Decision must be made in a timely fashion appropriate for the member's condition not to exceed 48 hours after the deadline for extension has ended.	*Additional information not received* Practitioner: Within 24 hours of the decision, not to exceed 48 hours after the timeframe given to the practitioner & member to supply the information (for approvals & denials). Member: Within 48 hours after the timeframe given to the practitioner and member to supply the information (for approval decisions). Document date and time of oral notifications.	*Additional information not received* Within 48 hours after the timeframe given to the practitioner & member to supply the information. **Note:** If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
Urgent Concurrent - (i.e., inpatient, ongoing/ambulatory services) Request involving both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved and the request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments. **Exceptions:** • If the request is not made at least 24 hours prior to the expiration of prescribed period of time or number of treatments, and request is urgent, default to *Urgent Pre-service* category. • If the request to extend a course of treatment beyond the period of time, or number of treatments previously approved by the Health Plan/PMG/IPA does not involve urgent care, default to *Non –urgent Pre-service* category.	Within 24 hours of receipt of the request.	Practitioner: Within 24 hours of receipt of the request (for approvals and denials). Member: Within 24 hours of receipt of the request (for approval decisions).	Within 24 hours of receipt of the request. **Note:** If oral notification is given within 24 hours of request, written or electronic notification must be given no later than 3 calendar days after the oral notification.

Utilization Management Timeliness Standards
(Commercial HMO - California)

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Standing Referrals to Specialists / Specialty Care Centers **-** All information necessary to make a determination is received	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 3 business days of receipt of request. **NOTE:** Once the determination is made, the referral must be made within 4 business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or designee.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.
Non-urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 5 business days of receipt of request.	Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	Within 2 business days of making the decision.
Non-urgent Pre-Service - Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer	**Additional clinical information required:** Notify member and practitioner within 5 business days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made in a timely fashion as appropriate for member's condition not to exceed 5 business days of receipt of information.	Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	Within 2 business days of making the decision.
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available in a timely fashion as appropriate for member's condition not to exceed an additional 5 business days.		
	Require consultation by an Expert Reviewer: Upon the expiration of the 5 business days or as soon as you become aware that you will not meet the 5 business day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		
	Require consultation by an Expert Reviewer: Decision must be made in a timely fashion as appropriate for the member's condition within 5 business days of obtaining expert review, not to exceed 15 calendar days from the date of the delay notice to the practitioner and member.	*Require consultation by an Expert Reviewer:* Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	*Require consultation by an Expert Reviewer:* Within 2 business days of making the decision.

Utilization Management Timeliness Standards
(Commercial HMO - California)

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Post-Service - All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days of receipt of request.	Practitioner: Within 30 calendar days of receipt of request (for approvals). Member: Within 30 calendar days of receipt of request (for approvals).	Within 30 calendar days of receipt of request.
Post-Service - Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer	**Additional clinical information required:** Notify member and practitioner within 30 calendar days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	Additional information received or incomplete If additional information is received, complete or not, decision must be made within 15 calendar days of receipt of information.	*Additional information received or incomplete* Practitioner: Within 15 calendar days of receipt of information (for approvals). Member: Within 15 calendar days of receipt of information (for approvals).	*Additional information received or incomplete* Within 15 calendar days of receipt of information.
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 15 calendar days.	*Additional information not received* Practitioner: Within 15 calendar days after the timeframe given to the practitioner & member to supply the information (for approvals). Member: Within 15 calendar days after the timeframe given to the practitioner and member to supply the information (for approval decisions).	*Additional information not received* Within 15 calendar days after the timeframe given to the practitioner & member to supply the information.
	Require consultation by an Expert Reviewer: Upon the expiration of the 30 calendar days or as soon as you become aware that you will not meet the 30 calendar day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		
	Require consultation by an Expert Reviewer: Within 15 calendar days from the date of the delay notice.	*Require consultation by an Expert Reviewer:* Practitioner: Within 15 calendar days from the date of the delay notice (for approvals). Member: Within 15 calendar days from the date of the delay notice (for approval decisions).	*Require consultation by an Expert Reviewer:* Within 15 calendar days from the date of the delay notice.
Translation Requests for Non-Standard Vital Documents 1. Urgent (e.g., pre-service pend or denial notifications with immediate medical necessity) 2. Non-Urgent (e.g., post-service pend or denial notifications)	*LAP Services Not Delegated:* All requests are forwarded to the contracted health plan. 1. Request forwarded within one (1) business day of member's request 2. Request forwarded within two (2) business days of member's request		*LAP Services Delegated/Health Plan:* All requested Non-Standard Vital Documents are translated and returned to member within 21 calendar days.

Utilization Management Timeliness Standards
(Commercial HMO - California)

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Prescription Drugs CA Health & Safety Code section 1367.241 (CA SB 282; 2015-2016) **Exigent circumstances" exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function **OR** when an insured is undergoing a current course of treatment using a non-formulary drug.*	▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request	Practitioner: ▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request ***NOTE:** CA SB282 does not specify timeframes for member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes.*	Practitioner: ▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request ***NOTE:** CA SB282 does not specify timeframes for member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes.*

Experimental/Investigational Services

SHP delegates to PMGs the responsibility for review and authorization of requests involving an experimental, investigational or new technology treatment, cancer clinical trials or a rare disease (unless care is provided emergently out-of-area). Delegated PMGs may include the following components in their review criteria for investigational/experimental or new technology treatments:

- Requests for experimental, investigational, new technology, cancer clinical trials or rare disease treatment are reviewed against relevant published literature by appropriate regulatory agencies, as well as against published scientific evidence
- Clinical trials must be for purposes of treatment (not toxicity assessment) and be approved by the National Institutes of Health (NIH), Veterans Administration (VA), FDA as an investigational new drug application, the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, CMS, the Department of Veterans Affairs, a qualified non-governmental research entity identified in the guideline issued by the National Institutes of Health for center support grants, or the Department of Defense (DOD)

PMGs can request that SHP's Care Management Department facilitate review by an independent physician review organization. On request, SHP forwards the request and all relevant clinical information to the independent reviewer, and may solicit up to three independent outside reviewers (experts in the pertinent field) to assist in the review process. SHP also makes available to the PMG the Hayes Technology Assessment for the requested service as appropriate.

PMGs must require the submission of all the following documents with the request for an experimental/investigational service:

- Certification from the member's attending physician, which includes a statement of why the standard therapy available is not beneficial, appropriate, or is ineffective. The attending physician must be a board certified or board eligible physician qualified in the area of practice appropriate to treat the member's condition
- A copy of the member's informed consent form, when appropriate
- A copy of the member's medical and treatment records, including results of tests or studies showing the member's current condition and any treatment the member has received for the condition
- Any other relevant data that indicates the treatment effectiveness

In accordance with standards established by the DMHC, the PMG must respond within five business days to member requests for review of investigational or experimental treatment. The PMG is required to review all requests for these procedures. If the PMG decides not to authorize the treatment, the PMG must issue the denial letter that specifically states the medical and, if applicable, scientific reasons for the denial and any alternative treatment covered by SHP. The PMG must also include an application and instructions for the member to utilize the DMHC Independent Medical Review (IMR) Program.

Terminal Illness

A member with a terminal illness or the member's authorized representative may request a conference with SHP if SHP or a delegated PMG denies coverage of a treatment or service that it deems experimental and a participating plan provider recommends. DMHC defines a terminal illness as an incurable or irreversible condition that has a high probability of causing death within one year or less.

A PMG that denies the request must provide the following to the SHP member within five business days:

- A statement citing the specific medical and scientific reasons for denying coverage
- A description of alternative treatment, services or supplies covered by the member's plan, if any
- A copy of SHP's grievance form and procedures, which includes an opportunity for the terminally ill member to request a conference with SHP

SHP provides the member an opportunity to attend a conference within 30 calendar days of SHP's receipt of the request, or within five business days of SHP's receipt of request if the treating physician determines, after consultation with SHP's CMO, that the effectiveness of the proposed services are materially reduced if not provided at the earliest possible date.

SHP makes a determination within five business days after the conference. If SHP denies the request, SHP provides the member or member's authorized representative with a written denial notification that includes the following information:

- A statement citing the specific medical and scientific reasons for denying coverage
- A description of alternative treatment, services or supplies covered by SHP, if any
- A copy of SHP's grievance form and procedures

Second Opinions

SHP requires its PMGs to provide or authorize a second opinion by an appropriately qualified health care professional, in a timely manner, upon request by a member or a participating health care professional treating a member, or by SHP when deemed necessary during an appeal, grievance or quality of care investigation.

SHP members can ask for a second opinion about a condition that another provider diagnoses or treatment that a physician may recommend. Situations in which a member might request a second opinion include, but are not limited to, the following:

- A member questions the reasonableness or necessity of recommended surgical procedures
- A member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition

- Clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition
- The treatment plan in progress is not improving the medical condition of the member within an appropriate period of time given the diagnosis and plan of care and the member requests a second opinion regarding the diagnosis or continuance of the treatment
- A member has attempted to follow a plan of care and has already discussed serious concerns about the diagnosis or plan of care with the initial provider

Members and providers can initiate requests for a second opinion. Members are not required to obtain a referral in order to seek a second opinion; however, the PMG may require authorization. The member's PMG or PCP may generate a referral for monitoring and tracking purposes. SHP and the member's PMG provide members with information regarding relevant specialists within the SHP network. The member's PCP may make the referral or submit a prior authorization request to the PMG.

Members must obtain prior authorization for a second opinion by a non-network or out-of-area provider. The PMG may deny requests for a second opinion consultation by a non-network provider when there is an appropriately qualified professional of the member's choice available within the PMG or SHP network. The PMG may also require prior authorization for a second opinion by an in-network provider.

The PMG must ensure the provision of a second opinion to the member by an appropriately qualified medical professional, acting within his or her scope of practice and who possesses a clinical background related to the illness or condition associated with the second opinion request. If either SHP or the PMG determines that a participating provider who is appropriately qualified for the member's condition is not available, the PMG must authorize a referral to a non-participating provider for the second opinion. Member costs for a second opinion with an out-of-network provider are the same as the applicable copayments or coinsurance applied when he or she sees an in-network provider. Deductibles and out of pocket maximums apply to second opinion services.

If a second opinion treatment plan differs from initial physician's treatment plan, coverage for a third opinion is available when requested.

The PMG renders determinations for routine second opinion requests in a timely manner appropriate for the nature of the member's condition, not to exceed five business days after the receipt of the request by the PMG, or within a shorter period if required due to the member's medical condition.

If the member faces an imminent and serious threat to their health (including, but not limited to potential loss of life, limb, or other major bodily function) or if a lack of timeliness would be detrimental to the member's ability to regain maximum function, the PMG authorizes or denies the second opinion within 72 hours of receipt of the request, as appropriate to the member's condition and current circumstances.

The provider rendering the second opinion must provide a consultation report, including recommended procedures or tests, to the member and requesting provider. PMGs are responsible for educating contracting providers of this requirement.

Mental Health Second Opinions

SHP's behavioral and mental health plan, USBHPC, handles requests for second opinions for mental and behavioral health services. Members and providers must contact the USBHPC

Customer Service Department to request a second opinion, or to obtain a copy of USBHPC's Second Opinion policy.

Separation of Medical Decisions and Financial Concerns

SHP does not perform economic profiling of PMGs or individual practitioners in a manner that could compromise the separation of medical decisions from fiscal or administrative management. SHP maintains that it bases UM decision-making only on appropriateness of care and service and the existence of coverage. SHP does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for those making UM decisions do not encourage decisions that result in underutilization.

SHP monitors typical UM statistics for quality review and potential quality improvement programs. However, SHP does not use these statistics in any way to select or choose providers, de-select, terminate or not use providers, or influence payment to any of the PMGs or practicing individual practitioners.

SHP's PMGs do not perform economic profiling on their providers in a manner that could compromise the separation of medical decisions from fiscal or administrative management. To ensure compliance with this policy, SHP queries each of its PMGs upon contracting to determine if the group performs economic profiling. SHP also determines during the annual PMG UM audit if there has been a change in the group's position regarding economic profiling, which includes reviewing the group's policies and procedures. If there has been a change, SHP requires the group to provide a copy of the individual economic profiling information for each of the individual providers they profile. In addition, SHP monitors provider dispute issues and complaints to detect and identify any potential disputes or concerns that might identify providers PMGs are profiling.

SHP, as a condition of contracting, requires that PMGs that do perform and maintain economic profiles of individual providers provide (on request) a copy of individual economic profiling information to the individual providers who they profile as described in the procedure below.

- No SHP Management or Staff Incentives – SHP does not provide incentives, financial or otherwise, for UM decision makers, or care management staff, employed or otherwise controlled by SHP to encourage decisions or the creation of policies that knowingly would result in individual or systemic underutilization of medically necessary services to which a member is entitled. Medical decisions are made by qualified and licensed individuals and with the use evidence-based criteria supported by clinical principles and processes
- No Physician Incentives – SHP does not penalize physicians for authorizing medically necessary services to which a member is entitled or referrals for such medically necessary services. Contracts between SHP and its provider network do not contain any incentives for a provider to deny medically necessary services to which a member is entitled. SHP does not pressure or encourage physicians or other providers to render care beyond the scope of the provider's license and training
- No Hospital Incentives – SHP does not penalize any hospital for such hospital's decision to extend or not extend privileges to a provider for reasons related to the provider's provision of medically necessary care

Open Clinical Dialogue

Providers can have candid discussions with SHP members regarding appropriate or medically necessary treatment options regardless of cost or benefit coverage limitations.

Standing Referral to a Specialist

SHP and its PMGs must have and follow a procedure providing member access to specialized care over a prolonged period for a life-threatening, degenerative or disabling condition. A standing referral allows a member to receive ongoing treatment from a specialist over a pre-designated period without having to obtain prior authorization for each subsequent visit or treatment rendered by that specialist.

The PMG issues a standing referral upon agreement among the member's PCP, the specialist or specialty care center, and the PMG medical director or clinical designee that the member needs continuing care. These entities also agree on a treatment plan describing the course of treatment. The PMG may limit the number of visits to the specialist, limit the period of time it authorizes the visits, and require that the specialist provide the member's PCP with regular reports on the health care provided to the member.

The PMG must make determinations and notifications for standing referrals within the time frames established in the ICE Utilization Management Timeliness Standards appropriate to the member's condition. The PMG must make a decision in a timely fashion appropriate to the member's condition, not to exceed three business days of receipt of request when the PMG receives all appropriate medical records and other items of information necessary to make the determination. If the treating specialist or specialty care center requires a referral, the PMG must issue the referral within four business days of the date they receive the proposed treatment plan (if any). The PMG is not required to refer a member to an out-of-network specialist unless there is no specialist available within network who is appropriate to provide treatment to the member, as determined by the PCP in consultation with the PMG medical director and as documented in the treatment plan.

HIV/AIDS Specialist Referrals

SHP, PMGs and participating providers must ensure timely access to HIV/AIDS specialists for members with these diagnoses, particularly in the form of standing referrals when appropriate. SHP lists specialists designated as having expertise in treating HIV/AIDS as HIV Disease Specialists in the SHP Provider Directory. These physicians are accredited or designated as HIV/AIDS experts in the field by a federal or state government agency or by a voluntary national health organization.

COMPLIANCE

SHP's compliance program integrates ethical, legal and regulatory guidance to foster an environment in which employees, participating providers, vendors, and contractors are empowered and encouraged to ask questions, report concerns and to reinforce Sutter Health's commitment to ethical values. SHP and its participating providers are required to adhere to all state and federal health care regulations, including those for preventing and reporting fraud and providing access to care for all members. SHP and its participating providers must also adhere to standards for ethical business conduct, which includes conducting regular trainings and reporting suspected instances of non-compliance.

SHP and Sutter Health, its parent organization, provide access to the Sutter Health Compliance Department as a resource to participating providers for compliance-related questions and reporting.

Access for Patients with Disabilities

SHP and its participating providers do not discriminate against members who have physical disabilities. The Americans with Disabilities Act of 1990 (ADA) requires that places of public accommodation, including hospitals and medical offices, provide auxiliary aids and services (e.g., an interpreter for deaf members) to disabled members. SHP and Sutter Health's compliance program helps to ensure patients with disabilities have full access to necessary medical services. Participating providers must ensure member access to accessible spaces, equipment, and alternative communication methods. Providers must adjust procedures to ensure that they properly examine, treat and diagnose all patients.

Anti-Fraud

The SHP anti-fraud program serves to prevent, detect and correct instances of fraud, thereby reducing costs to SHP, providers, members, and others caused by fraudulent activities. The anti-fraud program also serves to protect consumers in the delivery of health care services through the timely detection, investigation and prosecution of suspected fraud in accordance with Section 1348 of the Knox-Keene Act, and applicable federal and state regulations.

SHP documents and investigates all reports of potential fraud and abuse. SHP reports findings to the DMHC and other appropriate investigative and law enforcement agencies whether or not the fraud and abuse allegation is resolved internally.

Participating providers must comply with all federal and state regulations prohibiting fraudulent behavior.

SHP requires providers to:

- Record clear and accurate documentation of all services rendered in a timely manner as close as possible to the date of service
- Report any vendor offering discounts, free services or cash in exchange for referrals
- Refuse to certify the need for medical supplies for members not seen and/or examined
- Specify the diagnosis when ordering a particular service (e.g., lab test)

- Know and adhere to the PMG's billing policies and procedures
- Verify the identity of members since insurance cards can be borrowed, stolen and fabricated
- Carefully scrutinize requests for controlled substances, particularly with new members

SHP prohibits providers from:

- Signing blank certification forms used by suppliers to justify payment for home oxygen, wheelchairs and other medical equipment
- Balance billing or charging members for costs covered services other than the member's cost-sharing responsibility
- Offering members gifts or money to receive treatment or services
- Offering members free services, equipment or supplies in exchange for use of an SHP member identification (ID) number
- Providing members unnecessary treatment or services
- Submitting false claims (refer to the False Claims Act discussion in this section for additional information)

Providers who suspect health care fraud must report any suspicions to their organization's compliance officer and/or the SHP Compliance Officer. Providers may submit reports of suspicions or concerns involving an SHP member or provider to SHP's Compliance Officer in writing, via telephone or secure email. Providers can report anonymously to the SHP Compliance Hotline, available 24 hours a day, 7 days a week. An independent company operates the hotline. SHP employees do not staff the hotline.

Submit reports of suspected fraud as follows:

Mail:	Sutter Health Plus Attn: Compliance Officer P.O. Box 160307 Sacramento, CA 95816
Telephonic:	(855) 315-5800 (TTY (855) 830-3500) (800) 500-1950 (anonymous Hotline)
Email:	*shpcompliance@sutterhealth.org*
Fax:	(916) 736-5425 or (855) 759-5425

Providers must not send protected health information (PHI) through unsecured email.

Caring for Limited English Proficiency, Hearing, Speech, Cognitive, and Visually Impaired Patients

SHP, Sutter Health and its participating providers must provide equal access to high quality services to all patients. SHP and its participating provider must provide, at no cost to the member, language assistance to limited English proficient (LEP) members, and effective communication methods for persons with hearing and visual impairments.

If an LEP patient needs an interpreter, participating providers may use either a bilingual staff member who has demonstrated competency as an interpreter, telephonic interpreter services available through SHP's Member Services Department, or in-person interpreter services as provided by the member's PMG.

Effective communication methods for persons with a visual, hearing, speech or cognitive impairment may mean the use of auxiliary aids or services, such as an assistive listening system, a qualified American Sign Language (ASL) interpreter, a qualified oral interpreter, or computer-assisted real time transcription. It may also entail the use of materials in alternative formats, such as Braille, large print, audio recordings, or computer disks pictographs.

Providers should not use family members as interpreters except in an emergency or when the patient refuses the offer of an interpreter and insists the family member interpret. In this case, the treating provider must document the member's refusal of the interpreter in the patient record. Providers must never use children as interpreters.

Refer to the Operations – Clinical section for more information on cultural and linguistic requirements and services available through SHP for LEP members.

False Claims Act (FCA)

The False Claims Act is a federal law that prohibits submission of false claims to government and commercial insurance programs. A false claim is any attempt to obtain payment by knowingly presenting false or misleading information related to claims. Criminal penalties for submitting false claims include imprisonment and criminal fines. The government may decide to pursue civil remedies and collect up to three times the amount lost with penalties ranging from $5,500 to $11,000 for each false claim. Whistleblowers who alert the government to false claims may receive a percentage of the money recovered as a reward. SHP provides detailed information to its employees, contractors and agents regarding the FCA and comparable state anti-fraud statutes, including whistleblower protections.

California has specific criminal statutes for those who knowingly make or cause to be made a false or fraudulent claim for payment to non-governmental insurers such as SHP.

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OPERATIONS

Balance Billing

State and federal law prohibits SHP participating providers from billing a member for any fees for rendered services covered under the member's benefit plan. Participating providers must advise members prior to rendering services of any member payment responsibility, such as copayments and deductibles for covered services.

Providers may bill a member for non-covered services when they notify the member in advance that the services they are providing are not covered, and the member agrees in writing that the provider should render the non-covered services.

Capitation Reports

SHP provides its capitated PMGs and capitated hospitals with an electronic capitation report on a monthly basis in accordance with the SHP contract.

Claims

Billing and Submission

Providers must use correct coding to ensure prompt, accurate processing of claims. Participating providers must follow the claims submission process established by the member's PMG. The PMG claims process should include the use of CMS-1500 forms UB-04 (CMS-1450) form and industry standard coding sets, such as CPT, HCPCS, ICD-10, and revenue codes. SHP includes the claims submission address on the member's identification (ID) card.

Providers must submit claims within 180 calendar days of the date of service for services rendered. SHP denies claims submitted more than 180 days after the date of service.

SHP reserves the right to request clinical records before or after claim payment to identify possible fraudulent or abusive billing practices, as well as any other inappropriate billing practice not consistent or compliant with the American Medical Association (AMA) CPT codes or guidelines, provided there is evidence such an investigation is warranted.

Claims Coding Policies

SHP and its capitated PMGs use nationally recognized payment policies and coding guidelines, including but not limited to CPT Coding Guidelines, ICD-10 CM Guidance, HCPCS Manual, Correct Coding Initiatives (CCI), and Evaluation and Management (E&M) Guidelines. SHP and its delegated PMGs must notify affected providers of implementation of any non-standard coding methodologies used to adjudicate claims at least 45 business days prior to implementation.

Claims Denial

PMGs and capitated hospitals are required to notify the member and provider in writing within 45 business days when they deny a claim if the member has any financial responsibility for the

charges. They may not send member denial notices if the member is not financially liable for the services. Claim denial letters must specify:

- Date of denial notice
- Member's name
- Provider's name
- Specific service
- Date of service
- Denied amount
- Member responsibility amount
- Reason for the denial – Claim denials for members must include a claim denial message. Use the ICE Commercial HMO Claim Denial Reasons Guide located under Approved Documents on the ICE website at *iceforhealth.org/library.asp*
- Provider and member appeals process and information, including plan name, address and telephone number for appeals. For disputes, include the DMHC Required Statement (refer to the Denials and Denial Notification discussion in the Clinical - Operations section for the DMHC statement and instructions)

PMGs are encouraged to use the ICE Claim Denial letters located under Approved ICE Documents on the ICE website at *iceforhealth.org/library.asp.*

Claims Reimbursement

SHP, its PMGs and capitated hospitals are required to reimburse each complete claim or portion of each claim as soon as possible, but no later than 45 business days after receipt of the complete claim. A PMG or hospital may contest or deny a claim or portion of a claim by notifying the provider in writing within 45 business days after receipt of the claim that they contest or deny the claim. The PMG or hospital notice must identify the portion of the claim they are contesting by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that the PMG or hospital sends denying a claim must identify the portion of the claim they are denying, and the specific reasons for the denial.

If the PMG or hospital contests a claim or portion of a claim on the basis that the PMG or hospital has not received information reasonably necessary to determine payer liability for the claim, the PMG or hospital has 45 business days after receipt of this additional information to complete reconsideration of the claim. If the PMG or hospital does not reimburse the claim they are reconsidering within the respective 45 business days after their receipt of the additional information, the PMG or hospital must pay interest or late charges.

Disclosure of Fee Schedules and Claims Payment Policies

SHP’s delegated PMGs must disclose the fee schedules and claims payment policies, including non-standard claims coding methodologies, and global payment policies to downstream contracting

providers upon initial contracting, annually on or before the contract anniversary date, and upon request by the providers.

Copayments

Participating providers must collect copayments for professional services when they provide services. If a provider cannot collect the copayment immediately, the provider must send a bill to the member for payment at a later date.

Participating providers may not collect a copayment for a missed appointment. Providers have the option of having the member transferred to another participating provider after three missed appointments.

Participating providers may not collect a copayment for preventive services, including services and screenings recommended by the USPSTF, immunizations recommended by the Advisory Committee on Immunization Practices (ACIP), Bright Futures Guidelines recommended by the American Academy of Pediatrics (AAP), and Guidelines for Women's Preventive Services recommended by the Independent Institute of Medicine (IOM). A provider that collects a copayment in error must reimburse the member the copayment amount.

A service rendered by any provider type other than the member's assigned PCP may have a separate and different copayment amount. The specialist visit copayment is required each time the member receives services from the specialist (not limited to the first visit only). Providers may also verify the member's copayment amount as part of eligibility verification by contacting the SHP Member Services Department, or by accessing the member's *Benefits and Coverage Matrix* (*BCM*) on the provider portal of the SHP website.

Coordination of Benefits

SHP and its delegated PMGs must apply coordination of benefits (COB) processes whenever a member has health coverage under more than one plan. The purpose of coordinating benefits is to pay for covered expenses, avoid duplicate payments for the same claims, and ensure that the total benefit paid does not exceed 100 percent of the covered expenses incurred.

SHP and its delegated PMGs must follow state and federal law and regulations, including the Order of Benefit Determination established by the National Association of Insurance Commissions, when processing claims payments. Participating providers may contact SHP for its order of benefit determination rules.

Eligibility

Participating providers must verify member eligibility prior to rendering services to ensure current eligibility, coverage and applicable member cost sharing responsibility.

The eligibility guarantee, described in the upcoming Eligibility Guarantee section, does not apply if the provider does not verify eligibility with SHP for members who are receiving continuing services within 30 days after the initial visit. If a member is ineligible due to a retroactive addition or cancellation, SHP adjusts the delegated PMG's capitation accordingly.

Steps for Determining Eligibility

Participating providers must verify eligibility using one of the following methods:

- Call the SHP Member Services Department at (855) 315-5800 between 8 a.m. and 7 p.m., Monday through Friday
- Check online using the Member Eligibility & Coverage Search tool on the provider portal of the SHP website:
  - Visit the SHP provider portal at *shplus.org/providerportal*. Advance registration is required. To register, select the New User Register Here link on the landing page. SHP issues registration approvals within two to three business days
  - Log in using your user name and password
  - On the main page, under the Member Eligibility & Coverage Search section, enter the member ID number, or the member's last name, first name and date of birth. Then select *Search*
  - On the Search Results page, select the member's name
  - Verify the member's eligibility status and coverage effective date

Member's coverage status can change at any time; therefore, providers should request and copy the member's identification card and additional proof of identification, such as a photo ID. Providers must verify continued plan participation for each visit.

Eligibility Guarantee

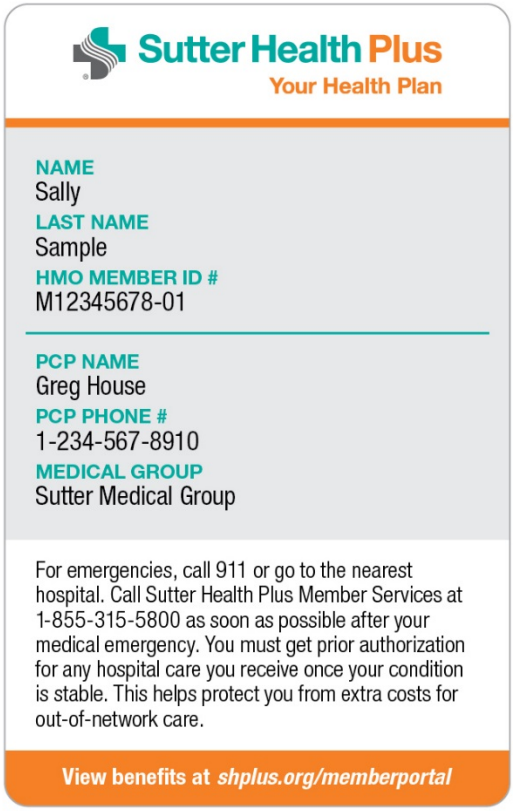
SHP and its delegated PMGs reimburse all expenses incurred for covered services performed in good faith by a participating provider to an individual who SHP finds later to have been ineligible on the date of service and whose enrollment SHP has retroactively terminated. Eligibility guarantee does not apply if the individual has coverage with another health plan at the time of service.

Eligibility Reports

SHP provides its capitated PMGs and capitated hospitals with electronic eligibility reports at least monthly within 12 calendar days of the first of the month. SHP's capitated PMGs are responsible for using this information and developing relevant reports (such as hospital, group and PCP eligibility reports) to their downstream providers.

ID Cards

SHP issues member ID cards upon enrollment. The ID card contains pertinent information for members and providers regarding the member's plan, coverage and contacts. Participating providers should request and copy the member's ID card; however, a member's provision of an ID card does not guarantee eligibility, so providers must verify eligibility prior to rendering services.



Emergency Claims Processing

For out-of-area emergency services rendered to SHP members, SHP is responsible for processing the claims. SHP's submission address for out-of-area emergency claims for SHP members is:

Mail: Sutter Health Plus
P.O. Box 160385
Sacramento, CA 95816

Encounters

Capitated PMGs, hospitals and ancillary providers are required to provide complete encounter data about professional and facility services rendered to SHP members. These services include office visits, X-rays, laboratory tests, surgical procedures, anesthesia, physician visits to the hospital, inpatient, outpatient, emergency room, or SNF services, and all professional referral services. Delegated PMGs must provide encounter data weekly. Encounter data submissions must include all member-paid cost-share amounts, such as copayments, coinsurance and deductibles, applicable to the member's benefit. In addition, PMGs must correct and resubmit any rejected encounter data in order for complete information and correct member-paid cost-share amounts to be captured and accumulated.

Member Terminations and Transfers

Member Terminations for Cause

If an SHP member commits fraud or an intentional misrepresentation of material fact in connection with membership, SHP or any participating provider, SHP may terminate their membership by sending written notice to the subscriber. The termination is effective on the date specified in the SHP termination notice.

PCP Request for Member Transfer/Disenrollment

A participating PCP may request removal of a member from his/her panel in cases when the physician feels an SHP member is not following accepted standards set by the physician's office to maintain an effective treatment plan or satisfactory patient/physician relationship. This may be due to the member's noncompliance, disruptive behavior, or non-payment of copayments or other fees (when applicable), or the physician's inability to manage the member's care.

The following are acceptable reasons for a member transfer/disenrollment:

- The member is abusive to the PCP or staff, exhibiting disruptive, unruly, threatening, or uncooperative behavior
- The member misuses or loans his/her membership card to another person
- The member fails to follow prescribed treatment plans and repeatedly disregards the physician's medical advice
- The member repeatedly fails to keep appointments and does not notify the provider office 24 hours in advance

- The member fails to remit copayments or other fees
- The practitioner is unable to establish a mutually beneficial relationship with the member

The physician must make serious efforts to maintain the doctor/patient relationship at every opportunity before requesting disenrollment of a member for cause. The physician must encourage the member to work cooperatively to directly resolve the situation. The physician must document all attempts to resolve the problem.

The physician and the PMG must ascertain that the member's behavior is not due to a physical illness, mental illness, or treatment such as prescribed medications.

If attempts to establish or maintain a productive physician/patient relationship are unsuccessful, the PMG may request that SHP disenroll the member from the PCP's panel. The PMG must notify SHP of the member disenrollment at least 30 calendar days in advance of the disenrollment effective date. The PMG must include documentation with the request to SHP demonstrating the cause for disenrollment and all efforts taken to resolve the issues.

PMGs can submit member transfer and disenrollment requests by email to *shpenrollmentmailbox@sutterhealth.org* or by fax to (916) 736-5426.

Upon receipt of PMG notification of member disenrollment, SHP notifies the member of his/her disenrollment from current PCP's panel, and provides the member with instructions on selecting a new PCP.

The PMG must also notify the member in writing of the disenrollment at least 30 calendar days in advance of the disenrollment effective date. The letter must include the reason(s) for disenrollment, effective date of disenrollment, information on choosing a new physician (instruction to call SHP), and any appeal rights offered.

The PCP and PMG continue to be responsible for the member's care until the effective date of the transfer. Upon request from the member, the disenrolling physician must forward a copy of the patient's medical records to the new physician or member within 10 calendar days.

Out-of-Pocket Maximum

The annual out-of-pocket maximum (OOPM) is the maximum amount a member is liable to pay each year for most covered services. When the member reaches the applicable OOPM the member is not required to pay any additional cost-sharing fees, such as copayments, coinsurance or deductibles, for the remainder of the plan service year.

SHP complies with state and federal laws that establish parity and cost-share coordination requirements for mental health care and substance use disorder treatment services. SHP accounts for both mental health and non-mental health services when calculating amounts paid towards deductibles and OOPMs.

When verifying eligibility and benefits, participating providers must also verify whether a member has met his or her OOPM to determine whether any copayment is due at the time of service.

This information is available on the provider portal of the SHP website, by using the Member Eligibility and Coverage Search feature, or by contacting SHP Member Services.

PCP Assignment and Selection

Members must select a PCP and a PMG during the enrollment process. SHP and its PMGs must provide access to a PCP within 30 minutes or 15 miles from the member's home or place of work in compliance with access to care standards.* Members may designate a different PCP or choose a different PMG for each family member. For each member who does not select a PCP at the time of enrollment, SHP auto-assigns a PCP. SHP considers several factors in PCP assignment, including:

- Distance – PCP must be within a 15-mile radius from the member's home or work
- Language preferences – the PCP or qualified medical interpreter on the PCP's staff speaks the member's preferred language
- Age – the member is matched with an age-applicable specialty, such as a pediatrician for pediatric age members
- Family member assignment – multiple family members are assigned to the same PCP as available and appropriate

Any member may change his/her PCP or PMG by notifying SHP. Change requests are effective the first of the following month. SHP considers requests for retroactive PCP changes on a case-by-case basis. Providers may contact SHP Member Services to request consideration of a retroactive change.

*Note that SHP and its participating PMGs may institute alternative access standards, as approved by the DMHC. Members residing in certain ZIP codes may need to travel, as indicated in the Alternative Geographic Access Standards list, to access a participating PCP or to receive non-emergency hospital services. Refer to the Alternative Geographic Access Standards list in the Appendices chapter.

Physician and Facility Updates, Additions or Deletes

Addition of New Physicians, Providers or Facilities

SHP's delegated PMGs are responsible for credentialing and peer review activities. SHP performs annual delegation oversight activities to ensure PMG credentialing processes are compliant with DMHC and NCQA standards.

SHP requires delegated PMGs to provide quarterly files of newly credentialed and recredentialed providers including physician, ancillary and facility providers. SHP requests at a minimum a 90-day notice of new providers in the network, in order to update the provider directory, the claims and the authorization system.

Closures and Terminations

PMGs are required to notify the SHP Network Management department in writing at least 90 days in advance of the date that a provider does the following:

- Closes the medical practice
- Terminates the relationship with the PMG

SHP requires PMGs to include instructions to SHP on member reassignment, including the receiving PCPs, the effective date of the reassignment and the date of the termination.

SHP notifies affected members 30 days in advance, whenever possible, of a PCP termination. SHP sends the notification by mail, and includes instructions on selecting a new PCP.

For acute care facility terminations, the PMG or hospital is required to notify SHP 120 days prior to the termination date. SHP notifies affected members 60 days in advance.

SHP may allow a member to continue using a terminated provider when:

- A member had been receiving care for an acute or chronic condition, in which case care by the terminated provider is covered for 90 days or longer, if necessary, for safe transfer of the member
- A member is pregnant, in which case care by the terminated provider is covered until postpartum services related to the delivery are completed or longer, if necessary, for a safe transfer of the member

The terminated provider is subject to the same contractual terms and conditions imposed prior to termination until medical care to the member is completed. These terms and conditions include, but are not limited to:

- Credentialing
- Hospital privileging
- Utilization review
- Peer review
- Compensation

Conditions of PCP Office Closures

PCPs may close their practices to new SHP members while remaining open to members of other insured or managed health care plans, provided certain conditions are met:

- The PCP must establish and subsequently meet a certain numerical or percentage threshold beyond which he or she no longer accepts new SHP members
- The number of SHP members assigned to the PCP exceeds the number of patients who are members of any other single insured or managed health care plan at the time the PCP wants to close his or her practice to SHP members
- The PCP’s PMG continues to have at least 85 percent of its PCP panel open for SHP member access

If a patient of the PCP is a member of another health care plan and joins SHP, the PCP must continue to accept the member even if his or her practice is not accepting new SHP members.

PCPs must provide SHP with any documentation or information reasonably requested to demonstrate to SHP that they are meeting the above conditions prior to closing the practice to new SHP members.

A PCP may close his or her practice to all new patients from all insurance or health plans at any time.

Facility and Satellite Additions

If a facility expands its capacity by adding new or satellite facilities, or new physicians or other subcontracting providers, the facility must notify SHP in writing at least 90 days before the addition. SHP has the right, in its sole discretion, to determine whether the new or satellite facilities, or the new physicians are acceptable to SHP.

Member Notification for Specialist Termination

Delegated PMGs must have a written policy regarding member notification when a specialist terminates his or her contract to ensure continuity of care. The written policy must include the following elements:

- PMGs must notify SHP 90 days prior to a specialist terminating
- PMGs must identify members who have regularly seen the terminating specialist or have an open authorization to receive services from the terminating specialist
- PMGs must notify identified members in writing immediately upon the specialist's termination notice, but no later than 30 calendar days prior to the effective date of the specialist's termination
- PMGs must help members transition to a new specialist within the PMG's network of participating providers

If a member with an acute care condition has questions or concerns regarding the continuation of services from the terminating specialist, advise the member to call the SHP Member Services Department.

Practice Updates

PMGs must notify SHP within five business days when either of the following occurs to a provider's panel status:

- Provider is no longer accepting new patients
- Provider who was previously not accepting new patients is now accepting new patients

The PMG must provide SHP with provider updates to the following within 10 business days of the change:

- Provider name
- Physician type (PCP or specialist)
- Physician specialty type
- Hospital affiliation, including ambulatory surgery center affiliations
- Board certification

- Tax identification number (TIN) or entity affiliation (W-9 required)
- Group name or affiliation
- Physical or billing address
- Telephone and fax number
- Language spoken by provider and languages spoken by qualified medical interpreters on provider's staff

When submitting updates to SHP, the PMG must give an effective date for the change. Failure to notify SHP prior to these changes could result in a misrepresentation of provider information in SHP's printed or online directory.

When applicable, SHP is responsible for notifying members and issuing new ID cards for demographic changes.

Provider Directory Elements

Providers Included in the SHP Directory

SHP includes the following physicians and clinicians in the directory:

- Physicians, surgeons, nurse practitioners, physician assistants, acupuncturists, podiatrists, lactation consultants, dieticians, neuropsychologists, and nurse midwives

SHP includes the following facilities and ancillary providers in the directory:

- Acute hospitals, ambulatory surgery centers, audiology, dialysis, durable medical equipment suppliers, home health, hospice, inpatient rehabilitation, laboratories, occupational, physical and speech therapy, orthotics and prosthetics, radiology and imaging, SNFs and LTC, sleep medicine, urgent care clinics, and Walk-In Care sites

Alternative Name

In addition to collecting and displaying the provider's name in its provider directories, SHP may also list an alternative name preferred by and as specified by the provider. SHP displays the alternative name in parentheses after the provider's legal name.

The DMHC defines a provider's name as the name listed on the provider's professional license issued by the State of California. SHP will continue to collect and display the provider's legal name as it appears on his or her Social Security card, driver's license or other government issued ID, in accordance with CMS requirements and SHP policy.

Panel Status

SHP uses one or more of the following panel status designations for individual providers:

- Accepting new patients
- Accepting existing patients
- Not accepting new patients

- Available by referral only (SHP uses for specialty physicians and advance practice clinicians, with the exception of OB/GYNs, gynecologists and nurse midwives)
- Available through a hospital or facility (SHP uses for facility-based specialists)

SHP collects updates to alternative names and panel status designations through the SHP demographic change process and the annual directory review.

Provider Directory Requirements

Investigation of Reported Inaccuracies

PMGs must assist SHP in promptly investigating all reported provider directory inaccuracies. SHP will notify PMGs within five business days when SHP receives a notice indicating that information listed in its provider directory is inaccurate.

PMGs must respond to SHP within 15 business days of SHP's initial notification. PMGs must either verify the accuracy of the information in SHP's directory or provide SHP updated information (as applicable). Timelines may be shorter if a member reports the inaccuracy through a formal member grievance. If timelines are shorter, SHP includes the expedited timeframe in its initial outreach to PMGs.

Provider Responsibility to Inform Members How to Report Inaccuracies

If SHP lists a provider who is not accepting new patients in its directory as open to new patients, and an SHP member or potential member contacts the provider seeking to become a new patient, the provider must direct the member or potential member to SHP Member Services for additional assistance in finding an available provider. The provider must also direct the member or potential member to the DMHC to report any inaccuracy in SHP's directory. Providers can direct members to call the DMHC at (888) 466-2219.

Annual Review of SHP Provider Directories

PMGs must conduct an annual review of its contracting provider network to ensure that demographic information used in SHP provider directories is accurate and complete. PMGs must actively respond for each provider in the network that information is accurate or with the details of changes required.

SHP notifies PMGs of the annual review through an SHP provider update. The update includes an Excel spreadsheet for PMGs to complete and instructions on how to return the spreadsheet to SHP. PMGs must include employed and downstream physicians/clinicians and facility/ancillary providers on the templates. SHP reviews the information the PMGs submit against the provider information currently in our directory and sends a data discrepancy report back to PMGs.

PMGs must investigate and reconcile discrepancies and respond to SHP within 30 business days. SHP updates the directory using the information provided after this final review. If PMGs do not respond and confirm within 30 business days, SHP will contact PMGs within 15 business days to attempt to verify the information. If PMGs fail to respond to SHP's request for verification within the allotted timeframe, SHP pursues removing the provider from its directories. SHP notifies PMGs 10

business days in advance of removing the provider from its directory. This allows PMGs time to respond to SHP with the necessary information.

Provider Dispute Resolution

Participating providers must follow the claims provider dispute resolution (PDR) process established by their PMG to contest the payment or denial of a claim. SHP offers a second-level dispute process for participating providers dissatisfied with the dispute resolution from the PMG. Delegated PMGs must inform participating providers on the claims dispute mechanisms available, including the option to submit a second-level dispute to SHP if they are dissatisfied with the PMG's initial determination, including instructions and submission forms.

For a second-level dispute of a PMG-processed claim, participating providers must complete the *SHP Provider Dispute Resolution* form and mail to SHP. The form is located in the Forms section of this manual and available electronically on the SHP provider portal. Providers may call the SHP Member Services Department at (855) 315-5800 for questions or concerns.

Providers must submit the completed PDR form and mail to:

Sutter Health Plus
P.O. Box 160366
Sacramento, CA 95816

Providers must submit a dispute to SHP within 365 days of the most recent determination or action for the claim, and must include specific information needed to complete the review of the dispute. SHP acknowledges receipt of PDRs sent by mail within 15 business days of the date of receipt by SHP. SHP sends requests for additional information required for resolution in writing within 15 business days of receipt. Providers must submit an amended dispute that includes the missing information within 30 business days following receipt of the request for additional information. SHP makes a determination and notifies the provider within 45 business days after the receipt of the dispute or the amended dispute.

If SHP determines that the disputed claim amount is the financial responsibility of the capitated PMG in accordance with contractual Division of Financial Responsibility (DOFR), SHP notifies the capitated PMG of the determination, and allows 10 working days for the capitated PMG to either make payment on the claim or provide a written explanation to SHP of non-payment. If SHP reimburses a disputed claim, SHP may recover the amount and any interest via an itemized capitation deduction.

SHP does not perform a capitation deduction for services that the capitated PMG contends it has appropriately denied or paid to the provider. In such cases, SHP meets with the capitated PMG to resolve the dispute.

Provider Surveys

SHP conducts three annual provider surveys — After-Hours Access, Appointment Availability and Provider Satisfaction — as required by the DMHC Timely Access Regulations. SHP reports results to the DMHC annually. PMG and provider office cooperation with these surveys is essential.

- After-Hours Access Survey – this survey verifies that SHP members who seek medical care after hours receive appropriate instructions on how to access emergency care and urgently needed services, and that triage or screening wait time for non-urgent care does not exceed 30 minutes. SHP or its contracting vendor call random PCPs' offices between the hours of 6 p.m. and 8 a.m. to conduct the survey
- Appointment Availability Survey – SHP is required to ensure members receive health care services in a timely manner appropriate for the nature of the member's condition, consistent with good professional practice. DMHC determines what provider type health plans survey each year, including specialist physicians and ancillary providers. SHP or its contracting vendor conducts the survey on a random sample of physicians or provider offices in accordance with DMHC methodology
- Provider Satisfaction Survey – SHP is required to assess provider satisfaction with patient access to health care services. SHP or it contracting vendor distributes the survey to a random sample of physicians

PMGs can refer to the Quality Improvement section for after-hours access requirements and appointment availability standards. The full Timely Access Regulation standards are located on the DMHC website at dmhc.ca.gov.

SHP may conduct additional surveys as directed by the DMHC or to address deficiencies identified during the survey process. SHP may impose CAPs on PMGs that do not meet access standards.

Third-Party Liability

If an SHP member injures himself or herself through an act or omission of another person, the participating provider must provide benefits in accordance with the member's *EOC.* If the injured member is entitled to recovery, SHP and the participating provider rendering services to the member are entitled to recover and retain the value of the services provided from any amounts received by the member from third-party sources.

Providers must establish procedures for identifying members who have work-related injuries or illnesses or who have other coverage, including auto insurance, which may be coordinated with SHP coverage. Providers must make best efforts to notify SHP whenever they have reason to believe a member may be entitled to coverage under any other insurance plan, including Medicare, and must assist SHP in obtaining COB information when a member holds such other coverage.

SHP expects providers to make best efforts to identify and notify SHP of any facts that may relate to auto, workers' compensation, or third-party injury or illness, and to execute and provide documents that may reasonably be required or appropriate for the purpose of SHP pursuing reimbursement or payment from other payers.

PRESCRIPTION DRUG PROGRAM

SHP's pharmacy benefits provide coverage of all FDA-approved medically necessary outpatient medications, the administration of those medications, and diabetic supplies. SHP administers pharmacy benefits through Express Scripts, who maintains the SHP formulary, performs medication management services (including prior authorization), and provides mail order fulfillment for maintenance medications through Express Scripts Pharmacy. This section provides information on pharmacy benefits and limitations, and administrative procedures.

Compounded Medications

SHP limits coverage of compounded medications to those that are medically necessary, that contain at least one prescription-required medication as the primary ingredient, and for which no commercial alternative is available. The requested prescription-required primary ingredient must be FDA-approved and be prescribed for FDA-approved indications. SHP does not cover compounded products with bulk chemicals not approved by the FDA.

SHP considers compounded medications Tier 3 medications on the SHP formulary and may require prior authorization for coverage. All compounded prescriptions with a cost greater than $150 require prior authorization.

Continuity of Care

SHP provides COC for covered medications for new members who have an active prescription of a medication that requires prior authorization. SHP provides coverage for up to a 90-day supply for a member who has been regularly taking the medication for at least 30 days prior to eligibility. The member's participating physician must submit a medication prior authorization request that specifies "continuity of care."

Subsequent refills or requests for medication require review for medical necessity. The member's prescribing physician must submit a prior authorization request with relevant clinical information for approval of coverage beyond the supply originally approved for COC.

Diabetic Supplies

SHP covers the following diabetic testing equipment, meters and supplies as part of the pharmacy benefits:

- Blood glucose meters – available by prescription though participating pharmacies, including:
  - TRUE METRIX® – also available at no cost to members by contacting (866) 788-9618, or by supplying the pharmacy with the following information:
    - BIN – 015251
    - PCN – PRX2000
    - Identification number – HB224289455
    - Group code number – TRUEPORT22

  - OneTouch Ultra® and OneTouch Verio® – also available at no cost to members by contacting (800) 668-7148 and supplying offer code 573EXP333
- Diabetes test supplies, such as:
  - Blood glucose test strips
  - Ketone test strips
  - Lancets
  - Urine glucose strips
- Insulin administration devices, such as:
  - Pen delivery devices
  - Disposable needles and syringes
  - Visual aids required to ensure proper dosage (excluding eyewear) – such as insulin syringe scale magnifier and needle guides

SHP covers insulin pumps and supplies to operate the pump under a member's medical benefit for durable medical equipment.

Aid in Dying

SHP supports a compassionate process for our terminally ill, mentally capable adult members who have a prognosis of six months or less to live. SHP members have the option to request from their physician a medication they can self-administer, if they so choose, to die peacefully and painlessly in their sleep to relieve suffering and shorten a difficult dying process.

SHP provides aid-in-dying medications through the SHP pharmacy benefit for qualified members who meet all requirements outlined in the California End of Life Option Act, ABX2-15 (chaptered 2015). Providers and pharmacists who want information about specific aid-in-dying medication regimens and how to obtain the medications can contact SHP's pharmacist Patrick Robinson, RPh, MBA, at *robinsp1@sutterhealth.org*.

Exclusions and Limitations

The following exclusions and limitations apply to all SHP plans:

- Generic substitution is required in lieu of brand name medications, with some exceptions, unless one of the following applies:
  - A generic equivalent is not available
  - The member has used the generic version without clinical success
  - The prescribing physician indicates "do not substitute" or "dispense as written (DAW)"
    - Members must pay the generic copayment plus the difference between the brand and generic medication if prescribing physician requests DAW

  - The DAW difference payment does not apply to the member's deductible or out-of-pocket maximum amounts
  - If a member or prescribing physician wants the medication at the standard copayment then the prescribing physician must submit a prior authorization request to Express Scripts supporting medical necessity for brand over generic

- Quantity limits for covered prescription medications include:
  - A 30-day supply when fulfilled through a participating pharmacy
  - A 30-day supply of specialty medications
  - Up to a 100-day supply (depending on benefit plan) when fulfilled through Express Scripts Pharmacy, Express Scripts mail order pharmacy program
- Medications that are not medically necessary are not covered
- Medications for the treatment of impotence and/or sexual dysfunction and/or hypoactive sexual desire disorder must be medically necessary and the prescribing physician must submit documentation of a confirmed diagnosis to Express Scripts for review
  - Prescription medications may be subject to quantity limitations. Physicians can refer to the SHP Formulary for more information
- Experimental or investigational medications are excluded, with the following possible exceptions:
  - Medications for life-threatening or seriously debilitating conditions when approved through an independent medical review
  - Medications provided as a part of a clinical trial approved by the participating medical group (PMG)
  - Medically necessary investigational medications that have been submitted to the FDA for approval, are under review by the FDA and approved by SHP
  - Medically necessary medications provided in an emergency in a foreign country where the medication is allowed are covered
- Drugs required for foreign travel are excluded, unless they are prior authorized for medical necessity
- Drugs prescribed solely for cosmetic purposes are not covered, including agents for wrinkles, hair growth or other health/beauty aids
- Medications for weight loss and dietary/nutritional aids or supplements are excluded, whether prescribed or over the counter, with the exception of:
  - Medically-necessary medications to treat morbid obesity – subject to prior authorization
  - Authorization may be contingent on demonstration of the member's prior or concurrent enrollment in a comprehensive weight loss program

  - Medications or dietary/nutritional supplements prescribed for phenylketonuria (PKU), which are covered under the medical benefit
- Vitamins and dietary/nutritional supplements are excluded, with the exception of:
  - Prescribed prenatal vitamins and fluoride supplements
  - Formulas, medical food or dietary/nutritional supplements prescribed for PKU, which are covered under the medical benefit
- Replacement of medications that are lost or stolen are not covered
- Special request non-standard packaging, such as unit dose packaging, is not covered
  - Compounded products are excluded if there is a medically appropriate SHP formulary alternative or the compounded medication does not contain at least one prescription medication. SHP does not cover bulk chemicals not approved by the FDA used in compounded products. SHP is not liable for any claim or demand on account of damages arising out of or in any manner connected with the manufacturing, compounding, dispensing, or use of any covered prescription medication
- Drugs prescribed to shorten the duration of the common cold are not covered
- Enhancement medications prescribed solely for the treatment of hair loss, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance are not covered
  - This exclusion does not apply to FDA-approved prescription medications for mental performance when used to treat diagnosed mental illness, or medical conditions affecting memory, including, but not limited to treatment of the conditions or symptoms of dementia or Alzheimer's disease
- Over-the-counter (OTC) medications are not covered
  - SHP does not exclude an entire class of medications when one medication within the class becomes available over the counter
    - This exclusion does not apply to insulin and insulin syringes with needles for diabetics, OTC FDA-approved contraceptive medications or devices, or the specific preventive medications when accompanied by a written prescription (refer to the Preventive Medication Without Cost-Sharing section in this chapter for a list)
- Drugs prescribed by non-contracted providers, for non-covered procedures, and/or not authorized by SHP or the PMG. This excludes medications dispensed or prescribed as part of emergency services

SHP Formulary

SHP contracts with Express Scripts for pharmacy management services, including the maintenance of SHP's comprehensive drug formulary. The SHP formulary includes all medications approved by the FDA, and adds new medications following FDA approval.

Providers can search the complete SHP formulary:

- Through an electronic health record (EHR) system, such as Epic
  - Epic users search using the Formulary and Benefits transaction
- Online using Price a Medication on the Express Scripts custom website for SHP
  - Go to *express-scripts.com/shp*
  - Select any of the four Guest Member Account links from the home page
  - Select the Price a Medication
- Using the printable formulary – available on the SHP Provider Portal at *shplus.org/providerportal* in the Forms and Resources section

Pharmacy and Therapeutics Committee

The Express Scripts Pharmacy and Therapeutics (P&T) Committee regularly evaluates medications to determine changes, additions or deletions to the SHP formulary, and to ensure rational and cost-effective use of pharmaceutical agents. The P&T Committee reviews all medications for the efficacy, quality, safety, similar alternatives, and cost of the medication in determining tier placement, limitations and prior authorization requirements. Participating providers may request consideration of changes to the SHP formulary, including additional medications and modifications to guidelines or limitations, such as medication-specific quantity limits or age restrictions. Providers may submit these requests through the SHP pharmacist, CMO or SHP P&T Committee.

The SHP P&T Committee oversees policies, activities and decisions made by Express Scripts regarding formulary changes and prior authorization criteria for medications. The SHP CMO chairs the P&T Committee. An SHP clinical pharmacist leads the committee and is responsible for conducting technology assessments and evaluating prior authorization criteria for review and approval during P&T committee meetings. The P&T Committee also reviews specific medication grievance and appeal data for consideration of modifications to the formulary or prior authorization process, and communicates these decisions to Express Scripts and the SHP QIC.

Mail Order Program for Maintenance Medications

SHP offers a mail order prescription program through Express Scripts Pharmacy, the mail order pharmacy contracting with Express Scripts. Mail order pharmacy is available as a convenient and cost-effective alternative for refills of maintenance medications, those prescribed for use longer than 60 days (including contraceptives and glucose test strips). Members have the option to use the mail order program to obtain refills of a 3-month supply (up to a 100-day supply) of covered maintenance medications, rather than a 30-day supply through a participating pharmacy. The member cost-share responsibility for the 3-month mail order supply is equivalent to two copayments that the member would pay for two one-month prescriptions obtain through a retail pharmacy.

Providers can submit prescriptions for mail service through Express Scripts Pharmacy using one of the following methods:

- Electronic prescription (eRx) – select Express Scripts Pharmacy — 4600 North Hanley Road, St. Louis, MO 63134 — to submit through an electronic health record system, such as Epic
  - Use NCPDP2623735
- Fax – fax new prescription to at (800) 837-09591 – providers must have the member's ID number to fax a prescription
- Telephone – call Express Scripts at (888) 327-9771
- Mail – send the Express Scripts Home Delivery Order form to Express Scripts at P.O. Box 66567, St. Louis, MO 63166-6567
  - The form is available on the SHP website at *sutterhealthplus.org*, under the Member tab, in the Forms and Resources section

Note that specialty medications are not available through Express Scripts Pharmacy mail order service, but must be obtained through the specialty pharmacy vendor, Accredo. Refer to the Specialty Pharmacy section in this chapter for information.

Off-Label Medication Use

A medication prescribed for a non-FDA-approved indication (off-label use) is subject to clinical review and prior authorization for coverage. A participating provider may prescribe a medication for an off-label use for life-threatening condition or chronic, seriously debilitating conditions.

Medications eligible for off-label prior approval include those that are FDA-approved for some indication and recognized by one of the following:

- The American Hospital Formulary Service Drug Information
- One of the following compendia, if recognized by the CMS as part of an anticancer chemotherapeutic regimen:
  - The Elsevier Gold Standard's Clinical Pharmacology
  - The National Comprehensive Cancer Network Drug and Biologics Compendium
  - The Thomson Micromedex DrugDex
  - At least two articles from major peer-reviewed medical journals that present data supporting the proposed use as safe and effective, unless there is clear and convincing contradictory evidence in a similar journal

Pharmacy Network

SHP has a robust pharmacy network, including most major pharmacy retail chains and independent pharmacies, the Express Scripts Pharmacy mail order pharmacy and Accredo. Members and providers can Search the pharmacy network using Find a Pharmacy on the Express Scripts custom website for SHP at *express-scripts.com/shp*.

Physician-Administered Medications

SHP covers medications that require administration by a physician or other clinician (such as a home health nurse) as a medical benefit, rather than as an outpatient prescription drug benefit administered by Express Scripts on behalf of SHP. These include chemotherapy, home infusion and injectable medications (other than self-injectables). The PMG is responsible for review and approval of prior authorization requests for these medications.

Chemotherapy

SHP covers chemotherapy when a participating provider provides it in an inpatient hospital setting, at the physician office, other outpatient settings, or in the member's home.

FDA-approved chemotherapy and oncology medications used outside of standard protocols or off-label for a malignancy or indication are subject to prior authorization. SHP may cover upon presentation of evidence that indicates the medication used in treatment for a particular cancer is a professionally recognized standard of care. Cancer clinical trials may be available to members and are subject to prior authorization.

Home Infusion Therapy

SHP covers home infusion therapy for acute or chronic conditions that respond to treatment safely and effectively in the home. The member’s treating physician must prescribe home infusion services as part of a home health care plan. The member does not need to be homebound to be eligible to receive home infusion therapy. These services are subject to prior authorization by the PMG, and a licensed network pharmacy or home health agency must provide.

SHP provides intravenous medications, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as an intravenous or intraspinal-infusion) as a maximum 30-day supply per fulfillment, as well as the supplies and equipment required for their administration.

Injectables

SHP covers injectable medications, including self-injectables. SHP covers injectables administered by a health care professional as a medical benefit. SHP covers self-injectables administered by the patient or family as a pharmacy benefit, however SHP handles in-office administration exceptions on a case-by-case basis.

SHP covers injectable psychotropic medications when prescribed for treatment of a mental disorder by a mental health practitioner participating through the USBHPC network.

Prior Authorization Requests and Turnaround Times

Providers are subject to PMGs prior authorization requirements and processes for physician-administered medications.

The PMG must adhere to the following response turnaround times for medication prior authorization requests:

- Non-urgent requests – response within 72 hours of receipt

- Expedited request for exigent circumstances – response within 24 hours of receipt
  - Exigent circumstances are when one of the following are true:
    - A member is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function
    - A member is undergoing a current course of treatment using a non-formulary drug

If the PMG does not respond within the required timeframes, the prior authorization request is deemed to have been approved.

Physician Self-Treatment

SHP does not cover physician self-treatment, or treatment of immediate family members, rendered in a nonemergency situation, including medication prescriptions. Physician self-treatment occurs when physicians provide their own medical services, including prescribing their own medication, ordering their own laboratory tests and self-referring for their own services.

Preventive Care Medications and Supplies without Cost-Sharing

SHP covers the following medications and supplies under the outpatient pharmacy benefit when prescribed by a participating provider:

- Aspirin for members of a certain age or with certain conditions
- Bowel preparation drugs for colonoscopy screening for members of a certain age
- Breast cancer drugs raloxifene or tamoxifen for members of a certain age and at increased risk for the first occurrence of breast cancer, after risk assessment and counseling
- Certain immunizations for routine use in children, adolescents and adults as recommended by the Advisory Committee on Immunization Practices (ACIP) of the CDC
- FDA-approved contraceptive drugs, devices and other products, including OTC. Note that where the FDA has approved more than one therapeutically equivalent of a contraceptive drug, device or product, SHP covers at least one version of each contraceptive drug, device or product at no member cost share
- Folic acid supplements for women who are pregnant or considering pregnancy
- Iron supplements for infants
- Manual breast pumps for postpartum lactation support
- Selective statin therapy for certain ages and disease risk factors
- Smoking cessation products, both prescription and OTC agents
- Vitamins in conjunction with fluoride for children

Additional information is available in the Preventive Care discussion in the Benefits section.

Prior Authorization Process for Prescription Medications

Certain medications are subject to prior authorization (PA) for coverage. Providers can identify medications with PA restrictions within the SHP formulary maintained by Express Scripts. Express Scripts is responsible for the PA process, including the evaluation and implementation of PA requirements, and authorization request reviews and approvals.

Providers must submit medication PA requests to Express Scripts, using one of the following methods:

- Web requests – *express-path.com* or *covermymeds.com* (registration required)
- Fax requests – fax the California standardized Prescription Drug Prior Authorization or Step Therapy Exception Request Form to (877) 251-5896
- Telephone requests – call (800) 753-2851

The California standardized Prescription Drug Prior Authorization or Step Therapy Exception Request Form is available in the Forms section of this manual with the Express Scripts contact numbers pre-populated. It is also available on the SHP Provider Portal at *shplus.org/providerportal*, in the Forms and Resources section.

Note that physician-administered medications offered under the medical benefit are subject to prior authorization by the PMG. Refer to the Physician-Administered Medication section for information.

Prior Authorization for Medications

SHP requires prior authorization for specialty and many non-preferred medications.

If SHP moves a medication actively prescribed for a member to a higher tier on the SHP formulary or makes it subject to prior authorization for medical necessity, SHP continues the member's coverage for the medication without prior authorization and at the same copayment until we provide the member with at least a 60-day advance notice.

Off-Label Use

SHP requires prior authorization of formulary medications prescribed for non-FDA-approved indications (off-label use). Refer to the prior discussion of Off-Label Medication Use in this section for more information.

Opiate Quantity Thresholds

Providers may need to submit a prior authorization request to support medical necessity for some classes, categories, doses, or combinations of opiate medications when the quantity dispensed for the last 90 days is above a threshold considered unsafe in the clinical judgement of the dispensing pharmacist.

Turnaround Times for PA Requests

Express Scripts processes medication PA requests in a timeframe appropriate for the member's condition, not to exceed 72 hours of receipt, dependent upon inclusion of all applicable information with the request.

For urgent and emergency situations occurring after standard business hours, on weekend or holidays, SHP automatically authorizes pharmacies to dispense an emergency supply of medically necessary medications, in a quantity sufficient to last until Express Scripts can process the PA request on the next business day (and the member can reasonably access a participating pharmacy).

For exigent circumstances, a prescribing physician may request an expedited review from SHP for a medication coverage authorization. SHP makes the determination and notifies the prescribing physician of the decision no later than 24 hours of receipt of the request. For non-formulary medications, exceptions granted based on exigent circumstances remain in effect for the duration of the exigency. Exigent circumstances are when one of the following are true:

- A member is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function
- A member is undergoing a current course of treatment using a non-formulary drug

If Express Scripts does not respond within the required timeframes, the prior authorization request is deemed to have been approved.

Prescriptions from Non-Participating Providers

SHP covers medications prescribed by non-participating providers in the following circumstances (unless a participating provider determines that the item is not medically necessary or the medication is for a sexual dysfunction disorder):

- When prescribed by a dental provider for dental care
- When prescribed by the non-participating provider rendering services on written referral prior authorized by SHP or the member's medical group
- When prescribed by a non-participating provider as part of covered emergency services, post-stabilization care or out-of-area urgent care

Specialty Medications

SHP covers specialty medications, up to a 30-day supply per prescription. Specialty medications may have one or more of the following characteristics:

- Used for therapy of chronic or complex disease
- Require specialized patient training and coordination of care (services, supplies, or devices) prior to therapy initiation or during therapy
- Require unique patient compliance and safety monitoring
- Require unique handling, shipping and storage
- Present the potential for significant waste due to the high cost of the medication

Members must obtain specialty medications through Accredo, the sole specialty pharmacy provider for all specialty medications.

Accredo Specialty Pharmacy Services

Express Scripts contracts with Accredo as the sole specialty pharmacy vendor. Accredo provides mail order fulfillment of specialty prescription medications to the member's home or place of business. Accredo also provides member programs and services, including access to specialty-trained pharmacists and nurses 24 hours a day, 7 days a week and online tools to help members manage their specialty drugs.

Providers can submit prescriptions for specialty medications using one of the following methods:

- Electronic prescription (eRx) – select Accredo — 1640 Century Center Parkway, Memphis, TN 38134 — to submit through an electronic health record system, such as Epic
  - Use NCPDP #:4436920
- Fax requests – fax to (800) 391-9707
- Telephone requests – call Accredo at (877) 759-1557

Step Therapy

SHP's Step Therapy Program, approved by the SHP P&T Committee, requires that providers attempt the use of safer or more cost-effective medications in the member's treatment plan, and evaluate for safety and efficacy, before SHP covers other less safe or more expensive medications with the same indications. Formulary or non-formulary drugs may be included in a step therapy program. The SHP formulary indicates which medications require step therapy.

Express Scripts reviews prior authorization requests for step therapy medications on a case-by-case basis. Express Scripts adheres to medication-specific criteria established the SHP's P&T committee, including criteria for exceptions to step-therapy requirements when clinically appropriate, in approval of authorization requests. In addition, SHP and Express Scripts consider continuity of care for new members in active treatment regimens — SHP exempts a member from the step therapy requirement if a provider appropriately prescribed the member's medication and it is safe and effective for the member's medical condition.

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PRIVACY

SHP maintains privacy and confidentiality standards for member records and member health care information. SHP requires participating providers to fully comply with all applicable state and federal regulations regarding confidentiality of health information, including but not limited to the Privacy and Security regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It is important that privacy regulations do not affect member treatment or quality of care. To that end, SHP providers should be aware that, absent specific authorization from the member, HIPAA allows for the exchange of information needed for treatment, payment and health care operations. Examples that are applicable to the relationship between SHP and providers include, but are not limited to, the following:

Payment: the exchange of information needed to ensure appropriate payment is made for services provided to members, including fulfilling authorization requirements, rendering payment, and conducting retrospective audits.

Health Care Operations: the collection of information for quality assessment and improvement activities. This includes HEDIS audits, medical record reviews, the investigation of grievances, quality of care issues and/or suspected fraud and abuse; the exchange of information that enables the coordination of medical care for an SHP member by SHP's team of care managers; and/or the provision of information to providers concerning their members' utilization of medical services.

SHP informs members of their privacy rights, including how SHP uses their information, by distributing the Notice of Privacy Practices. Providers with questions or concerns about SHP's privacy practices can call the SHP Privacy Officer. Providers can access up-to-date HIPAA Notice of Privacy Practices on the SHP website at *sutterhealthplus.org*. This includes an explanation of members' rights to access, request confidential communication, request privacy protection, restricted use and disclosure, and receiving an accounting of disclosures of protected health information.

SHP Confidentiality Policy

SHP and its contracting healthcare practitioners and provider facilities are responsible for having policies and procedures to ensure confidentiality consistent with California State H.S.C §1364.5(c)(1),and including, but not limited to Federal laws and regulations, and NCQA, Utilization Review Accreditation Committee (URAC) and The Joint Commission (TJC) accreditation standards. SHP staff, participating providers and those providing services to SHP members are responsible for protecting confidential information and records and for preserving the privacy of members, providers, practitioners, and staff.

SHP informs prospective and current members and its practitioners and providers of SHP's policies and practices related to the confidentiality of personal information, including the collection, use, and disclosure of confidential information. SHP and its providers protect the confidentiality of medical information and inform patients or members and subscribers that any disclosure of medical information beyond the provisions of the law is prohibited.

SHP notifies members of its privacy practices at the time of enrollment and annually thereafter. Additionally, SHP shares information through member newsletters and on SHP's website, direct

mailings and distribution of the Member Rights and Responsibilities statement annually. On request, SHP provides members with information on SHP's privacy and confidentiality policies and procedures.

SHP's Member Rights and Responsibilities relating to member care, information, and conduct are available for providers in the Forms section of this manual. PMGs and their downstream providers can also access them on the provider portal under Provider Forms and Resources > Member Rights and Responsibilities. Understanding the member rights and responsibilities helps providers ensure SHP members get the care and service they need.

All SHP contracts, including, but not limited to, subscriber, provider and vendor contracts, contain provisions regarding maintaining confidentiality of medical information consistent with federal and state laws and regulations. SHP makes PMGs aware of SHP's policies and procedures related to confidentiality with the expectation that processes are in place at the provider sites to ensure compliance to those policies.

SHP requires the expressed written approval of the appropriate parties, the member and or their representative, prior to disclosure of confidential personally identifiable member information. SHP prohibits the use and disclosure of such information except when it is required for the performance of one's work for SHP or when SHP specifically authorizes it. Information used or disclosed in the normal course of doing business is limited to that which is necessary to complete the task. SHP prohibits further disclosure of information to a person or entity that is not engaged in providing direct health care services to the member, or is not their provider of health care services, unless the member authorizes it or it is permitted by law.

Additionally SHP prohibits, unless otherwise permitted by law:

- Unauthorized selling, sharing, or use of medical information for a purpose other than the provision of healthcare services
- Disclosure to a third party of the test results for a genetic characteristic in a manner that would identify or provide identifying characteristics of the person to whom the test results applied without the written authorization by the applicant or their legal representative
- Disclosure of information following termination of employment or a business relationship unless specifically waived in writing by an authorized party
- The sharing of explicit or implicit member information with employers, whether fully insured or self-insured, except when the disclosure is required by law

SHP's QIC has authority and responsibility for the development and implementation of confidentiality policies and the review of internal and external practices related to the collection, use, and disclosure of medical and personally identifiable member, provider, and employee information. QIC approves or disapprove the use and disclosure of identifiable information, levels of access, involvement in research projects, and other security measures related to protecting confidential information. QIC and the Compliance subcommittee are responsible for addressing risks to the confidentiality and security of personal, medical and business information. SHP updates its policies and procedures dealing with confidentiality issues as needed and on an annual basis. The QIC approves policies and procedures and shares with the PMGs.

QUALITY IMPROVEMENT

Access to Care and Availability Standards

Access to Care

SHP designs its network and services to provide 24-hour access to all members for their health care needs. SHP ensures adequate access to providers and health care facilities including, but not limited to, primary care, specialty care, inpatient care, behavioral health care, urgent care, ancillary services, and emergency care. SHP's network of PCPs ensures that members can access primary health care services within 15 miles or 30 minutes from their primary residence or workplace, and access high-volume specialty services providers within 30 miles from the member's primary residence or workplace. SHP and its delegated PMGs must ensure that 85 percent of PCPs are accepting new SHP members.

The DMHC closely monitors network adequacy for HMO plans. SHP is required to attentively monitor and address access-related grievances, open and closed primary care practices, and to perform an annual access to care network survey in accordance with DMHC requirements. SHP may impose CAPs on delegated PMGs that do not meet access standards.

Alternate Geographic Access Standards

SHP may institute alternative access standards, as approved by the DMHC. Members residing in certain ZIP codes may need to travel to access a participating PCP or to receive non-emergency hospital services. Refer to the Alternative Geographic Access Standards list in the Appendices chapter.

Appointment and Wait Time Standards

In accordance with DMHC timely access regulations, SHP and its delegated PMGs must provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the member's condition consistent with good professional practice. Participating provider offices must have a procedure in place for scheduling appointments that ensures adherence to the following appointment access standards.

Table 1: SHP Appointment Access Standards

Access Type	Standard
Access to non-urgent appointments for primary care - regular and routine care (PCP)	Appointment offered within 10 business days from time of request
Access to urgent care services that do not require prior authorization (PCP) (includes appointment with a physician, nurse practitioner or physician's assistant in office)	Appointment offered within, and not to exceed, 48 hours from time of request
Access to after-hours care (PCP)	Ability to contact on-call physician after-hours within 30 minutes for urgent issues
	Appropriate after hours Emergency instructions
Access to non-urgent care appointments with specialist	Appointment offered within 15 business days from time of request
Access to urgent care services that require prior authorization (specialist and other)	Appointment offered within 96 hours from time of request
Non-urgent appointment with a mental health provider (who is not a physician)	Appointment is offered within 10 business days from the time of request
Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness or other heath condition	Appointment offered within 15 business days from time of request

Participating providers may extend the applicable waiting time for a particular appointment if the following occurs. The referring or treating licensed health care provider or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, determines and notes in the

relevant record that a longer waiting time will not have a detrimental impact on the health of the member.

SHP and delegated PMGs must regularly monitor provider compliance with the standards, review measures and indicators of access issues, including member complaints and grievances, potential quality issues (PQIs), member satisfaction surveys, medical record reviews, disenrollment information, PCP transfers, and annual access surveys. PMGs are responsible for monitoring data provided by SHP regarding their providers' adherence to the standards, and impose corrective actions if providers do not comply.

SHP Nurse Advice Line

SHP offers 24-hour member access to RNs via telephone who help answer member's questions or triage the member with an acute medical issue to the appropriate level of care. This is not intended to replace providers' requirements to provide on-call and after-hours coverage. Members can contact the Nurse Advice Line at (855) 836-3500, 24 hours a day, 7 days a week, 365 days a year.

Appeals and Grievances

SHP and its delegated PMGs offer processes for members and providers who are dissatisfied with plan and PMG decisions regarding service requests or payment disputes, or with quality of care or services. Members and providers may submit an appeal, a grievance or a dispute, depending on the issue.

SHP does not delegate the appeals and grievance process to its PMGs. Participating providers must forward to SHP any member grievances submitted or verbalized to the provider. SHP's processes include peer-review-protected evaluations on the matters raised.

PMGs delegated for claims payment are also responsible for first-level claims disputes, but must make participating providers aware of SHP's second-level claims dispute process. Refer to the Claims Dispute discussion in the Operations section of this manual for more information.

For service requests denied by a PMG, SHP does not consider a peer-to-peer discussion that results in a reconsideration an appeal. The PMGs can manage these through its current process.

Definitions

SHP defines these as the following:

Appeal – A request for reconsideration of a previous decision or adverse determination of a request for a health care service, supply or device for a member. A member may submit an appeal verbally or in writing. The member's authorized representative or the member's participating provider can also submit an appeal on behalf of the member.

Dispute – A request for reconsideration of the processing of a claim that resulted in a denial or modification of the payment for a rendered service. A provider must submit a dispute in writing.

Grievance – An expression of dissatisfaction regarding any aspect of an organization's or participating provider's operations, activities, behavior, quality of care, or quality of service. A member, member's authorized representative or a provider can submit a grievance verbally or in writing.

Inquiry – A request for clarification, without an expression of dissatisfaction or request for reconsideration. A member or provider may submit an inquiry verbally or in writing.

Member Appeals and Grievances

SHP has established a comprehensive process for members to communicate difficulties and concerns regarding their health care and to receive a timely response through SHP's appeals and grievance process.

A member can file an appeal or grievance for any issue. A member may ask his or her physician or an authorized representative to assist them with filing an appeal on their behalf. The appeal or grievance must explain the member's issue, such as the reasons why they believe a decision was in error or why they are dissatisfied about covered services received. Members may submit appeals and grievances online, in writing or by telephone. The member must submit the appeal or grievance within 180 days of the date of the incident that caused the dissatisfaction.

Members can submit the grievance in one of the following ways:

Mail: Sutter Health Plus
Attn: Appeals and Grievances
P.O. Box 160305
Sacramento, CA 95816

Online: *sutterhealthplus.org*

Telephonic: (855) 315-5800 (TTY (855) 830-3500)

SHP has a Grievance form, located in the Forms section of this manual, and available electronically to members and providers via the SHP website at *sutterhealthplus.org,* in the Forms and Resources section. SHP's PMGs must ensure that the SHP Grievance form is available at all participating provider locations. For a provider or person other than the member to submit a grievance on the member's behalf, the member must sign and submit to SHP the Appointment of Representative for Appeals and Grievances form. Members can obtain the form by contacting SHP Member Services or on the member portal of the SHP website.

Upon receipt of an appeal or grievance, SHP's appeals and grievances team, including licensed nurses, researches the issue in collaboration with the PMG as appropriate, gathering and reviewing documentation from all providers associated with the matter.

If a member submits or verbalizes an appeal or grievance to a participating provider, the participating provider must fax the appeal or grievance to the SHP Appeals and Grievance Department within one business day. SHP's process includes peer-review-protected evaluations. The provider must submit a copy of the denial and relevant clinical information with appeal requests.

If the issue identified includes clinical judgment and/or medical necessity determination, SHP's CMO, medical director or clinical designee reviews the case for appropriateness of the original medical determination, and makes the final decision to uphold or modify the original determination. SHP may request additional documentation or directly contact the providers involved in the case.

SHP's CMO may also request a review by a board-certified specialty matched peer reviewer to evaluate the denial.

SHP sends written notification of the appeals or grievance review outcome to the submitting member and/or provider within a maximum of 30 days of the submission in accordance with the following turnaround time standards. If SHP upholds a denial, even in part, SHP includes appropriate appeal rights language in the member letter in compliance with DMHC requirements.

SHP performs additional review when it identifies PQIs during the investigation process. SHP's CMO works with the PMG's medical director for consideration of a credentialing/peer review investigation. SHP tracks and trends all PQIs to identify patterns for future credentialing consideration.

Turnaround Timelines

SHP adheres to the following grievance resolution process and timelines to assure timely grievance management that complies with all required standards:

Routine Appeal/Grievance

1. SHP sends an acknowledgement letter to the member within five calendar days of receipt of the appeal or grievance. The letter includes:
    - Acknowledgment the grievance has been received
    - The date of receipt
    - The telephone number, name and address of the SHP representative who may be contacted about the grievance
2. SHP requests additional information needed from a PMG or practitioners within five calendar days of the receipt of the appeal or grievance
3. Providers have at a minimum of 5 up to a maximum of 15 calendar days to respond to SHP's requests for information
4. SHP makes a decision and notifies the member in writing no later than 30 calendar days from the date of receipt of the appeal or grievance. The resolution letter provides a clear and concise explanation of SHP's decision concerning the appeal or grievance

Expedited Grievance/Appeal

Expedited appeals and grievances include those involving an imminent and serious threat to the health of the patient, including but not limited to severe pain, potential loss of life, limb or major bodily function.

Members or their authorized representatives can request that SHP expedite the member's appeal or grievance. These requests are reviewed by an RN for appropriateness of the expedited time frame. If the request is for a continuation of an expiring course of treatment and the member or representative makes the request at least 24 hours before the treatment expires, SHP covers the continuing treatment until SHP makes a determination on the appeal.

1. SHP calls the member to acknowledge receipt of the appeal or grievance. The telephone call includes the following information:
    - Acknowledgment the grievance has been received
    - The date of receipt
    - The telephone number, name and address of the SHP representative who may be contacted about the grievance
2. SHP requests any additional information that may be needed from a PMG or provider on the same date of the receipt of the appeal or grievance
3. Providers must respond to SHP's request for information within 36 hours
4. SHP makes a decision and notifies the member verbally and in writing no later than 72 hours from the date of receipt of the appeal or grievance. The resolution letter provides a clear and concise explanation of SHP's decision concerning the appeal or grievance
5. SHP notifies the provider or the PMG's UM department telephonically of the determination when the determination requires action by the provider or PMG

Behavioral and Mental Health Appeals and Grievances

Members must submit appeals and grievance for behavioral health services to SHP's behavioral health vendor, USBHPC, dba OptumHealth Behavioral Solutions of California (OHBS-CA), as follows:

Mail: OHBS-CA
Attn: Appeals and Grievances Department
P.O. Box 30512
Salt Lake City, UT 84130

Online: *liveandworkwell.com*

Telephonic: (855) 202-0984

Additional Appeals and Grievances Recourse

In addition to the SHP appeals and grievances processes, members have access to the following to help resolve concerns and complaints:

- DMHC Help Center
- Independent Medical Review (DMHC determines whether a member's concern qualifies for an IMR)
- Voluntary mediation

DMHC Help Center

The member may contact the DMHC directly at any time at (888) 466-2219, TDD (877) 688-9891 without first filing a grievance with SHP. The member can contact the DMHC if they have an issue that involves an imminent and serious threat to their health (such

as severe pain or potential loss of life, limb, or major bodily function) or a grievance that has remained unresolved for more than 30 days.

Complaint forms and instructions are available at the DMHC's website listed below. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to the member.

DMHC website: *dmhc.ca.gov*

Independent Medical Reviews

Members may be eligible for an independent medical review (IMR). The IMR process provides the member with an impartial review of medical decisions made by a health plan or its delegated medical groups related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. IMR application forms and instructions are available at the DMHC's website (*dmhc.ca.gov*).

Credentialing Program

SHP delegates credentialing and recredentialing activities to PMGs following review and approval of the PMG's credentialing program. SHP conducts annual oversight audits of delegated PMGs.

SHP maintains a Credentialing subcommittee that is responsible for:

- Overseeing the health plan's credentialing program and the delegated functions of credentialing to ensure that SHP's credentialing requirements are met
- Evaluating the geographic aspects of availability and accessibility
- Conducting an annual review and revision of the standards for delegation of credentialing to the PMGs

Delegated PMGs must adhere to SHP's credentialing requirements, and follow NCQA credentialing and recredentialing requirements, performing recredentialing activities at least every three years or more frequently if SHP identifies a quality event as potentially significant. The PMG's credentialing process must include the following elements:

1. Review and evaluation of each initial practitioner and facility application and/or reapplication, review of primary source information, facility site evaluation (as applicable) and peer review investigation of outlier cases for credentialing and/or recredentialing
2. Review and evaluation of each practitioner and facility reapplication, primary source information, facility site evaluation and chart audits (as applicable), peer review investigation, and quality management and utilization management (UM) data for recredentialing purposes. Recredentialing occurs every three years from the last committee approval date
3. Review any reported incidents regarding a practitioner and/or facility credentials or professional status identified through:
    a. Negative state licensing board reports
    b. Negative National Practitioner Data Bank (NPDB) reports

   c. Negative Federation of State Medical Board (FSMB) reports
   d. Negative California Association of Nursing Homes Report (CANHR)
   e. Restriction of institutional privileges
   f. Sanctions or exclusions from Medicare listed by the Office of the Inspector General (OIG)
4. Referral of any appropriate issues to the QIC or Peer Review Committee (PRC) for further investigation and action
5. Review and approval of the credentialing and recredentialing program annually
6. Review of any SHP Credentialing Department audits
7. Monitoring of practitioner and facility compliance with Credentialing Department and/or Credentialing Committee request
8. For practitioner and facilities requiring specific monitoring, i.e., the excluded list, credentialing is performed and monitored in compliance with state, federal, health plan, and regulatory agency requirements

Medical Records

SHP has established medical record standards for confidentiality of records, documentation standards, medical record keeping systems and availability of medical records. Delegation oversight includes demonstration that the medical group has medical records standards and ensures training and supervision of their employed and contracting physicians. The delegated PMG must ensure that controls are in place to assure information from various sources across SHP and its provider network stay confidential and are not inadvertently or purposefully disclosed, lost, altered, tampered with, destroyed, or misused in any manner.

Quality Improvement Program

The SHP Quality Improvement (QI) program is designed to objectively and systematically monitor and evaluate the quality, appropriateness and outcome of services, the structure and processes by which they are delivered to SHP members and to continuously pursue opportunities for improvement and problem resolution.

The scope of the QI program encompasses both quality of care, quality of services and utilization of resources. SHP utilizes the following committee structures to meet DMHC and NCQA requirements. The committees demonstrate to regulators that SHP has oversight of delegated groups and hospitals and documents all necessary quality improvement, corrective action and related delegated functions.

SHP Committees Structures

The following is a description of the QIC and its seven subcommittees:

Quality Improvement Committee

The QIC encompasses all other subcommittees, workgroups and health plan clinical functions and receives "Report Summary to Committee" documentation of the subcommittee and workgroup activities. The QIC is a multi-disciplinary panel and includes representation from PMGs, independent practice associations (IPAs) and affiliated physicians as well as behavioral health care practitioners. SHP may use specialist practitioners outside of the QIC to review and evaluate cases on behalf of the QIC.

Peer Review Committee

The SHP Peer Review Committee (PRC) provides a forum for qualified physicians and other health professionals to investigate, discuss and take action on concerns about quality of care arising from a variety of sources, including member appeals, grievances and provider concerns. The PRC provides the formal mechanism for fair hearing processes to evaluate quality of care and/or service issues and clinical performance rendered by practitioners to ensure they meet acceptable professional community standards.

SHP delegates credentialing and peer review activities to its affiliated PMGs. The PRC ensures the PMGs peer review processes are compliant with California Business Code and PMGs document activities by working collaboratively with SHP's delegation oversight staff. The PRC monitors any corrective action related to the delegated PMG's peer review process to conclusion.

As a health care service plan in the state of California, SHP is a peer review body. As such, SHP is required to file certain reports with state agencies and to comply with fair hearing requirements. The PRC provides the structure for fulfilling these requirements.

The PRC is responsible for the following key components of a comprehensive peer review program:

- Development and maintenance of the SHP policies and procedures for conducting peer review
- Receipt, review, and adjudication of cases referred to PRC in accordance with California Business Code (CBC) Sections 805 and 809
- Report to the QIC a summary of the number and types of cases that are reviewed, while maintaining the confidentiality and privileges against discovery afforded to peer review activities by California law

Medical Policy/Technology Assessment Subcommittee

The Medical Policy/Technology Assessment subcommittee provides a forum to review medical policy and technology assessments as prepared by the SHP medical policy RN and CMO.

Prior to committee meetings, the PMCAT convenes subject matter experts, generally UM medical directors, who review and recommend the guidelines for approval. The workgroup ensures all restrictions and indications are contained within the draft policy, and ensures that the draft policy development took into consideration all appropriate peer-reviewed published research, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), specialty society position statements, and community standards of care. In developing guidelines, the SHP CMO and medical policy RN also refer to various resources including Hayes Technology Assessments, medication compendia, and Up-To-Date.

Pharmacy and Therapeutics Committee

The SHP Pharmacy and Therapeutics (P&T) Committee oversees Express Scripts decisions about medication additions and deletions to the SHP formulary, and reviews and approves the Express Scripts prior authorization criteria for medications. The P&T Committee, chaired by the CMO, includes the SHP pharmacist who prepares technology assessments and prior authorization criteria for review and approval during P&T committee meetings. The P&T Committee also reviews any specific medication grievance and appeal data for consideration of modifications to the formulary or Prior Authorization process and communicates these decisions to Express Scripts and the QIC. Following the P&T Committee, the SHP pharmacist prepares the Report Summary to Committee for the SHP QIC quarterly.

SHP actively participates on the Sutter Health P&T committee to ensure that appropriate and effective medications are included on the Sutter Health formulary, and that all medically necessary medications are available to SHP members through Sutter Health inpatient and outpatient facilities. The SHP CMO serves as a voting member of the Sutter Health P&T Committee.

Utilization Management Committee

The purpose of the UM Committee is to provide a standardized forum for SHP to review utilization metrics, best practices and track utilization data from delegated PMGs and hospitals. The SHP UM Committee is responsible for setting appropriate utilization targets, for monitoring performance of the PMGs and hospitals against these targets, and for providing timely feedback regarding performance variation. The UM Committee identifies opportunities for PMG improvement and guides the development of quality improvement projects that track transitions and coordination of care to improve health care experience, and the cost-effectiveness of health care services. The UM Committee interfaces with other QI subcommittees as necessary to collaborate with initiatives and improvement programs to ensure that access, availability, medical group performance, member satisfaction, quality of care, and individual needs are considered.

Delegation Oversight Committee

The SHP Delegation Oversight Committee (DOC) is responsible for oversight of the SHP DOW, which conducts pre-delegation audits, annual delegation audits, assigning corrective action as necessary and monitoring resolution of corrective action plans. SHP adopts the Industry Collaborative Effort (ICE) audit tools (as available) and requires that delegated PMGs meet the

NCQA standards for quality, access, utilization, and member experience, as indicated in the audit tools. The DOC interfaces with the other QI subcommittees to ensure that access, availability, medical group performance, member satisfaction, quality of care, and individual needs are considered.

Credentialing Committee

The SHP Credentialing Committee's purpose is to oversee the credentialing of providers that directly contract with SHP, including institutional providers, and to oversee the credentialing process of the delegated PMGs. This committee approves credentialing policies, participates in peer review activities as indicated and makes final recommendations regarding credentialing decisions.

The Credentialing Committee oversees SHP's credentialing and recredentialing program and the delegated functions of credentialing to assure that SHP meets credentialing requirements.

The committee reviews the results of the annual credentialing audit of the delegated PMGs, recommending corrective action if applicable, and monitors corrective action to resolution. The Credentialing Committee works collaboratively with the Delegation Oversight Committee and staff to ensure credentialing functions meet DMHC and NCQA standards.

The committee prepares and forwards to the Peer Review Committee any concerns of a quality, scope of practice, or performance nature that are uncovered during the process of credentialing or recredentialing.

QI Program Goals and Objectives

The following are the QI program goals and objectives:

- To continuously improve member experience through the following activities:
  - Analysis of member experience drivers using data sources as they become available for this population. The QI program uses Consumer Assessment of Healthcare Providers and Systems (CAHPS®), SHP member and provider surveys, clinical programs, grievance data, and PQIs to identify and target improvement opportunities for SHP, PMGs, foundations, and providers
  - Applying continuous quality improvement methodology to study design and to improve reporting and outcomes of key services and initiatives and metrics, e.g., first call customer service resolution, claims processing and improved clarity of information
- To maximize effectiveness of clinical quality improvement and preventive health activities in order to improve the health status of members by:
  - Identifying members with highly complex conditions using claims, encounters, pharmacy, and self-reported member data
  - Identifying members with gaps in care
  - Referring members to case and disease management when needed
  - PCP referral and member self-referral into the Health Coaching Program

- Using HEDIS data to target opportunities to improve member health status
- Producing opportunity reports for foundation providers to improve timely performance of key quality indicators
- Enhancing analysis and clinical program design
- Supporting safe and appropriate use of medications through clinical utilization management
  - Drug Utilization Review (DUR) to recognize drug interactions and excessive and inappropriate utilization
  - Prior authorization program to support safe and appropriate use of medications
  - Retrospective drug utilization evaluation (DUE)
  - Step-Therapy program to support utilization of first line, high-value drug choices
  - Safety mailings

HEDIS®

HEDIS is the set of performance measures that assesses SHP's, its delegated subcontractors and their contracting providers' effectiveness in rendering quality care.

Individuals and other entities use HEDIS results.

- Individual consumers use HEDIS results to make choices as to what health plan and providers they will access to meet their health care needs
- Many employer groups consider HEDIS scores and results when considering health plan options for employees
- Health plans, including SHP, must report HEDIS annually as a requirement for health plan accreditation under NCQA

SHP gathers data for HEDIS from February through May each year. SHP or its NCQA certified vendor will contact the PMG's affiliated foundation when it needs to review or copy any medical records required for HEDIS. Unless otherwise agreed on, SHP requires medical records be sent within five business days of the initial request to allow time to abstract the records and request additional information from other providers, if needed.

FORMS

The following section contains the operational forms mentioned throughout the provider manual. These forms are also available electronically on the SHP website at *sutterhealthplus.org*.

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Sutter Health Plus
Your Health Plan

Provider Dispute Resolution Request

Please complete all sections of the form. Be specific when completing the description of dispute and expected outcome. You can provide additional information to support the dispute. Do not include a copy of a claim that was previously processed.

To inquire about the status of this dispute, contact Sutter Health Plus Member Services at 1-855-315-5800, 8 a.m. to 7 p.m., Monday through Friday.

Mail the completed form to:

Sutter Health Plus
P. O. Box 160366
Sacramento CA, 95816

*Required fields

Section A: Provider Information			
*Provider Name:		*Provider Tax ID:	Medicare ID:
Street Address (please include suite number):			
City:		State:	ZIP:
Telephone:			
Provider Type: ☐ MD ☐ Mental Health Professional ☐ Mental Health Institutional ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____ (please specify type of "other")			
Section B: Patient Information			
Member ID:		Group Number:	
Last Name:	First Name:		MI:
Street Address (please include apartment number):			
City:		State:	ZIP:
Date of Birth:			

Sutter Health Plus
Your Health Plan

Section C: Claims Information	
Claim ID number (if multiple claims, use attached spreadsheet): Number of claims:___	Service "from/to" date (*required for claim, billing and reimbursement of overpayment disputes):
Original claim amount billed:	Original claim amount paid:

Dispute Type

☐ Claim

☐ Seeking resolution of a billing determination

☐ Appeal of medical necessity / utilization management decision

☐ Contract dispute

☐ Disputing request for reimbursement of overpayment

☐ Other:_____

*Description of dispute and provider's position:

Expected outcome:

Contact Name and Title Phone

Signature Date Fax

Sutter Health Plus
Your Health Plan

No.	* Patient Name Last	First	Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

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PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/Medical Group Name: Express Scripts for Sutter Health Plus **Plan/Medical Group Phone#:** (877) 787-8661

Plan/Medical Group Fax#: (877) 328-9660 **Non-Urgent** ☐ **Exigent Circumstances** ☐

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request. **Information contained in this form is Protected Health Information under HIPAA.**

Patient Information

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm): _____ Weight (lb/kg): _____	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
Requestor (if different than prescriber):		Office Contact Person:	
NPI Number (individual):		Phone Number:	
DEA Number (if required):		Fax Number (in HIPAA compliant area):	
Email Address:			

Medication / Medical and Dispensing Information

Medication Name:

☐ New Therapy ☐ Renewal ☐ Step Therapy Exception Request

If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?

☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____

☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location:	☐ Patient's Home	☐ Long Term Care
☐ Physician's Office	☐ Home Care Agency	☐ Other (explain):_____
☐ Ambulatory Infusion Center	☐ Outpatient Hospital Care	_____

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step therapy exception request.

1. Has the patient tried any other medications for this condition? ☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	**ICD-10:**

3. <u>Required clinical information</u> - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification:_____ **Date**:_____

Plan/Insurer Use Only: Date/Time Request Received by Plan/Insurer:_____ Date/Time of Decision_____

Fax Number (_____)_____

☐ Approved ☐ Denied Comments/Information Requested: _____

Sutter Health Plus
Your Health Plan

Grievance Form

If you have encountered any difficulties or have had any concerns with Sutter Health Plus or a Sutter Health Plus provider, please give us a chance to help. You may submit a formal complaint or grievance at any time.

Note: You are not required to use this form to file a grievance or complaint. If you prefer, you may telephone Sutter Health Plus at 1-855-315-5800 (TTY users call 1-855-830-3500) to file your complaint or grievance.

If you wish to use this form to start the grievance process, fill out the form below. Describe the situation in detail, including the specific details of the problem such as where and when it happened, and what you believe Sutter Health Plus can do to resolve the concern.

Member Name:	
Date of Birth:	**Sutter Health Plus ID #:**
Address:	
Phone #:	
E-mail Address:	
Name of Person Filing the Grievance & Relationship (if other than member):	
Best way to reach you:	**Best Hours:**

Details of your complaint: (Please be as specific as possible with dates, times and the nature of the problem. Include the names, if any, of anyone in Sutter Health Plus or the provider office with whom you discussed this. Use the other side of this form or additional sheets if you need more room.)

_____

_____

_____

If you have received a denial for treatment, services, or supplies deemed experimental and have an incurable or irreversible condition that has a high probability of causing death within one year or less (terminal illness), and you would like to request a conference as part of the grievance system, please place a check mark in the space below.

Yes, I have a terminal illness and am requesting a conference: _____

_____ _____

Signature **Date**

Please send your completed Grievance Form to:

Sutter Health Plus
Attn: Grievance & Appeals
PO Box 160305
Sacramento, California 95816

Fax: 1-916-736-5422 (Toll-Free 1-855-759-8755)

Phone - Member Services: 1-855-315-5800 (TTY 1-855-830-3500)

Note: If this case involves an imminent and serious threat to the member including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, please telephone Sutter Health Plus at: 1-855-315-5800 (TTY users call 1-855-830-3500) to file your complaint or grievance. You may also call the California Department of Managed Health Care at: 1-888-HMO-2219 or use the TDD line (1-877-688-9891).

NOTICE TO THE MEMBER OR YOUR REPRESENTATIVE:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against Sutter Health Plus, you should first telephone Sutter Health Plus at **1-855-315-5800** (**TTY 1-855-830-3500**) and use the Sutter Health Plus grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Sutter Health Plus, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

IMPORTANTE: ¿Puede leer esta forma? Si no puede, podemos pedir que alguien le ayude a leerla. También es posible obtener esta forma en su idioma. Para recibir ayuda gratuita, llame enseguida al departamento de Servicio a los miembros de Sutter Health Plus al 1-855-315-5800.

Grievance Process Overview

POLICY:

Sutter Health Plus wants members to be satisfied with their health care and has established a formal process for addressing member concerns and complaints, and appeals or requests for review of a coverage decision. This process provides members with a uniform and equitable treatment of their complaint/grievance and a prompt response.

All member information will be handled in a confidential manner according to Sutter Health Plus policies and procedures and in compliance with applicable laws and regulations related to confidentiality of patient information. Sutter Health Plus does not and will not discriminate against any member who has initiated the filing of a complaint/grievance.

Sutter Health Plus will ensure that all members have access to and can fully participate in the grievance system by providing assistance to those with limited English proficiency or with visual or other communicative impairment. Such assistance shall include, but is not limited to, translation of grievance procedures, forms and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devises that aid disabled individuals to communicate.

DEFINITION OF A GRIEVANCE:

A grievance is a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration, or appeal made by a member or the member's representative. When the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Members have up to 180 calendar days from the date of an incident or dispute, or from the date the member receives a denial letter, to submit a grievance to Sutter Health Plus.

FILE YOUR GRIEVANCE:

A member may file a grievance or have a representative file a grievance. A member may appoint any individual (such as, a relative, friend, advocate, an attorney, or any physician) to act as the member's representative and file a grievance on his/her behalf. Members must appoint a representative in writing. Also, a representative (surrogate) may be authorized by a court to act in accordance with State law to file a grievance for a member.

- You can file your grievance by contacting the Member Services Department toll free at:

  Sutter Health Plus
  1-855-315-5800
  (TTY 1-855-830-3500)

A trained Member Services Representative will try to answer questions or resolve the expressed concerns/issues during the call, but if Member Services cannot resolve the situation, ask the representative for more information about how to file a grievance.

- If you prefer, you may mail your grievance or submit the Grievance Form in writing to:

  Sutter Health Plus
  Attn: Grievance Department
  PO Box 160305
  Sacramento, California 95816

  Fax: 1-916-736-5422 (Toll-Free 1-855-759-8755)

  Please include a complete discussion of your questions or situation and your reasons for dissatisfaction. If you would like assistance in filing a grievance, please call Member Services and a representative will assist you in completing the Grievance Form or explain how to write your letter. They will also be happy to take the information over the phone verbally.

- You can fill out a grievance form available at your provider's office.

- You can submit the Grievance Form online at: www.sutterhealthplus.org

Please tell us if this case involves an imminent and serious threat to the member including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function.

Grievances related to Mental Health or Chemical Dependency Detoxification Benefits

U.S. Behavioral Health Plan, California (USBHPC) administers all levels of review under Sutter Health Plus Grievance Process for complaints regarding mental health or chemical dependency/detoxification services. If you have an inquiry or concern regarding your mental health or chemical dependency/detoxification benefits, you should first call USBHPC Customer Service Department at 1-855-202-0984. Every effort will be made to resolve your inquiry or concern through the Customer Service Department.

You may submit a verbal or written grievance to USBHPC Grievance Unit at:

Mail:	USBHPC Attn: Appeals Department P.O. Box 2839 San Francisco, CA 94126
On-line:	LiveandWorkWell.com
Telephonic:	1-855-202-0984

Grievance forms and filing information are available through the USBHPC Customer Service Department.

EXEMPT GRIEVANCE REVIEW:

If you telephone us with a grievance which is not a coverage dispute, disputed health care service involving a medical necessity decision, or a matter involving an experimental or investigational treatment, Sutter Health Plus will try to process the grievance through our exempt grievance process. This means we will attempt to resolve the grievance within one business day without sending you any additional letters or paperwork.

STANDARD GRIEVANCE REVIEW:

Sutter Health Plus will send an acknowledgment letter to the Member within five (5) calendar days of receipt of a standard grievance (a non-exempt grievance). We will fully investigate your grievance, including all aspects of medical care involved. If the grievance involves a quality of care issue or involves medical decision-making, it is reviewed by the Sutter Health Plus Care Management Department, under the direction of the Vice President of Care Management.

For standard grievances, a determination is rendered and the resolution sent in writing to the member within thirty (30) calendar days of our receipt of your grievance. The written notification of the disposition of the grievance sent to the member will include an explanation of the contractual or clinical rationale for the decision.

EXPEDITED GRIEVANCE REVIEW:

The grievance system includes an expedited review process for urgent grievances. A grievance is expedited when a delay in decision-making would pose an imminent and serious threat to the health of the member including, but not limited to, potential loss of life, limb, or major bodily function. If you qualify for an expedited review, you may make a request for expedited review by contacting Central Health Plan or by filing a complaint with the California Department of Managed Care (DMHC) (see FURTHER APPEAL RIGHTS below).

The Expedited Grievance process is initiated using one of the methods listed under “FILE YOUR GRIEVANCE.” Calling the Member Services Department is the recommended method for requesting an expedited review.

Upon receipt of a grievance, the grievance is logged and all necessary information is collected in order to review and render a decision. After an appropriate clinical peer reviewer has reviewed all of the information and determined the case involves an imminent and serious threat to the member, including but not limited to, severe pain, the potential loss of life, limb, or major bodily function, a written disposition is sent in writing to the member and practitioner within three (3) calendar days of our receipt of the grievance. The letter contains all clinical rational used in making the decision.

If you make a request for expedited review and it is determined that you do not qualify for an expedited review, your grievance will be reviewed in the standard 30-day grievance process. You will be notified by mail if you do not qualify for expedited review.

FURTHER APPEAL RIGHTS:

You may be able to pursue one or more of the following appeal processes, depending on your situation. If you need assistance in determining your appeal rights, please contact the Member Services Department.

1. File a complaint with the DMHC.

   The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against Sutter Health Plus, you should first telephone Sutter Health Plus **at 1-855-315-5800** (**TTY 1-855-830-3500**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Sutter Health Plus, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free **telephone number (1-888-HMO-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

2. Request Independent Medical Review.

   The independent medical review (IMR) process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. Sutter Health Plus must provide you with an IMR application form with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the plan regarding the disputed health care service.

Eligibility

(a) Disputed Health Care Service. You may request an IMR of disputed health care services from the DMHC if you believe that health care services have been improperly denied, modified, or delayed by Sutter Health Plus or one of its contracting providers. A "Disputed Health Care Service" is any health care service eligible for coverage and payment under your subscriber contract that has been denied, modified, or delayed by Sutter Health Plus or one of its delegates, in whole or part on findings that the proposed services were not medically necessary. Your application for IMR will be reviewed by the DMHC to confirm the conditions of eligibility set forth below are satisfied:

i. The member's provider has recommended a health care service as medically necessary, OR the member has received an urgent care or emergency service that a provider determined was medically necessary, OR the member, in the absence of such a recommendation or the receipt of urgent care or emergency services, has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the member seeks independent review.

ii. The Disputed Health Care Service has been denied, modified, or delayed by Sutter Health Plus or its delegated entity, based in whole or in part, on a decision that it is not medically necessary.

iii. The member filed a grievance with the Sutter Health Plus or delegate and the disputed decision is upheld or the grievance remains unresolved past 30 days. If your grievance requires expedited review, you may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that you follow the Sutter Health Plus grievance process in extraordinary and compelling cases.

iv. You apply for an IMR within six (6) months after Sutter Health Plus sends you a written response to your grievance, unless the DMHC determines that circumstances prevented timely submission.

(b) Investigational/Experimental Treatment. Sutter Health Plus excludes from coverage services, medication or procedures, which are considered investigational and/or experimental treatment and which are not accepted as standard medical practice for the treatment of a condition or illness. You may request an IMR from DMHC if Sutter Health Plus or its delegate denies a treatment, service or supply on the basis that it is experimental or investigational. Your application for IMR will be reviewed by the DMHC to confirm the conditions of eligibility set forth below are satisfied:

i. The member has a Life-threatening or Seriously Debilitating Condition. "Life-threatening" means either a disease or condition where the likelihood of death is high unless the course of the disease is interrupted, or a disease or condition with potentially fatal outcomes, where the end point of clinical intervention is survival. "Seriously

Debilitating" means a disease or condition that causes major irreversible morbidity.

ii. The member's physician has certified that standard therapies are or have not been effective in improving the member's condition, or would not be medically appropriate for the member, or there is no more beneficial standard therapy covered by Sutter Health Plus than the therapy proposed for the member.

iii. Either the member's physician, contracted with Sutter Health Plus, who has recommended the denied course of treatment that he/she certified in writing is likely to be more beneficial to the Member than any available standard therapies, will include a statement of the evidence relied upon in his/her recommendation; or the member, or his/her physician who is a licensed, board-certified or board-eligible physician not contracted with Sutter Health Plus, but qualified to practice in the specialty appropriate to treat the Member's condition, has requested a therapy that, based on two documents from the medical and scientific evidence is likely to be more beneficial for the Member than any available standard therapy.

iv. The member has been denied coverage by Sutter Health Plus for a drug, device, procedure, or other therapy recommended or requested pursuant to paragraph (b)(iii) above.

v. The specified denied therapy is one that would be a covered service, except for the Sutter Health Plus determination that the therapy is experimental or investigational for the given condition.

Process

To request an IMR, you may call the DMHC's toll-free telephone number (1-888-HMO-2219) or a TDD line (1-877-688-9891) for the hearing and speech impaired, or obtain IMR application forms and instructions online at the DMHC's Internet Web site http://www.hmohelp.ca.gov.

The DMHC will review your application and send you a letter within seven (7) days telling you if you qualify for IMR. If your case is eligible for IMR, when all your information, including relevant medical records, is received by DMHC, the dispute will be submitted to a medical specialist at a review agency who will make an independent determination of whether or not the care is medically necessary. Sutter Health Plus will to gather all medical records and necessary documentation relevant to the member's condition and will forward all information to the review agency within three (3) business days from the date of we receive notice from DMHC of the IMR request for standard requests or within one (1) calendar day for an expedited IMR.

You will receive a copy of the assessment made in your case. If the IMR determines the service is medically necessary, Sutter Health Plus will provide the health care service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within 30 calendar days of receipt of your application and supporting documentation. For urgent cases involving an Expedited Grievance, the IMR organization must provide its determination within three (3) calendar days.

3. Binding Arbitration

If you continue to be dissatisfied with the results of the grievance process and wish to pursue the matter further, you must submit your claim or controversy to binding arbitration within sixty (60) days of completion of the grievance process. The arbitration procedure is governed by the American Arbitration Association rules. Copies of these rules and other forms and information about arbitration are available by calling the American Arbitration Association at (415) 981-3901 or by contacting Member Services.

All interested parties, including Members, specifically agree to use Sutter Health Plus arbitration procedure in place of any rights they otherwise would have to submit any controversy or dispute to a court or jury. For a complete description of how to initiate arbitration, please refer to your subscriber agreement.

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APPENDICES

The following section contains various reference documents mentioned throughout the manual.

Appendix A: Sutter Health Plus Service Area

The SHP Service Area includes the following ZIP codes by county:

- Alameda County: All ZIP Codes
- Contra Costa County: All ZIP Codes
- El Dorado County (partial): 95614, 95635, 95651, 95664, 95672, 95682, 95762
- Placer County (partial): 95602, 95603, 95648, 95650, 95658, 95661, 95663, 95677, 95678, 95681, 95703, 95713, 95722, 95746, 95747, 95765
- Sacramento County: All ZIP Codes
- San Francisco County: All ZIP Codes
- San Joaquin County: All ZIP Codes
- San Mateo County: All ZIP Codes
- Santa Clara County (partial): 94022, 94024, 94040, 94041, 94043, 94085, 94086, 94087, 94089, 94301, 94303, 94304, 94305, 94306, 95002, 95008, 95014, 95030, 95032, 95033, 95035, 95050, 95051, 95053, 95054, 95070, 95110, 95112, 95113, 95116, 95117, 95118, 95122, 95124, 95125, 95126, 95128, 95129, 95130, 95131, 95133, 95134, 95192
- Santa Cruz County: All ZIP Codes
- Stanislaus County: All ZIP Codes
- Solano County: All ZIP Codes
- Sonoma County (partial): 94926, 94927, 94928, 94931, 94951, 94952, 94953, 94954, 94955, 94972, 94975, 94999, 95401, 95402, 95403, 95404, 95405, 95406, 95407, 95409, 95419, 95421, 95425, 95430, 95436, 95439, 95441, 95442, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471, 95472, 95473, 95486, 95492
- Sutter County (partial): 95645, 95668, 95659
- Yolo County: All ZIP Codes

Appendix B: Alternate Geographic Access Standards

Many participating providers are concentrated in the more populous areas of the counties within the SHP service area. Members residing in certain ZIP codes may need to travel to access a participating PCP and to receive non-emergency hospital services.

PCPs and Hospitals	
15 – 30 Miles	
Contra Costa County:	**San Joaquin County Continued:**
94523 – Pleasant Hill (Hospital) 19 miles	95690 – Walnut Grove (Hospital) 26 miles
El Dorado County:	95868 – Thornton (Hospital) 25 miles
95682 – Shingle Springs (Hospital) 28 Miles	**San Mateo County:**
95762 – El Dorado Hills (Hospital) 24 Miles	94021 – Loma Mar (Hospital) 25 miles
Sacramento County:	94060 – Pescadero (Hospital) 29 miles
95615 – Courtland (Hospital) 28 Miles	94060 – Pescadero (PCP) 29 miles
95624 – Elk Grove (Hospital) 19 Miles	**Santa Clara County:**
95632 – Galt (Hospital) 26 Miles	95035 – Milpitas (Hospital) 19 miles
95639 – Hood (Hospital) 18 Miles	**Santa Cruz County:**
95641 – Isleton (Hospital) 28 miles	95005 – Ben Lomond (Hospital) 18 miles
95680 – Ryde (Hospital) 27 Miles	96006 – Boulder Creek (PCP) 23 miles
95683 – Sloughhouse (Hospital) 28 Miles	95060 – Santa Cruz (PCP) 17 miles
95693 – Wilton (Hospital) 29 Miles	95060 – Santa Cruz (Hospital) 22 miles
95757 – Elk Grove (Hospital) 20 Miles	**Solano County:**
95759 – Elk Grove (Hospital) 18 Miles	94533 – Fairfield (Hospital) 27 Miles
95829 – Sacramento (Hospital) 19 Miles	94534 – Fairfield (Hospital) 23 Miles
95638 – Herald (PCP) 25 Miles	94571 – Rio Vista (Hospital) 22 Miles
San Joaquin County:	94585 – Suisan City (Hospital) 25 Miles
95215 – Stockton (Hospital) 18 miles	95625 – Elmira (Hospital) 23 Miles
95219 – Stockton (Hospital) 19 miles	95687 – Vacaville (Hospital) 28 Miles
95220 – Acampo (Hospital) 26 miles	95688 – Vacaville (Hospital) 28 Miles
95227 – Clements (Hospital) 27 miles	95690 – Walnut Grove (Hospital) 28 Miles
95236 – Linden (Hospital) 28 miles	95694 – Winters (Hospital) 21 Miles
95237 – Lockford (Hospital) 24 miles	95696 – Vacaville (Hospital) 27 Miles
95240 – Lodi (Hospital) 22 miles	**Sonoma County:**
95242 – Lodi (Hospital) 22 miles	94931 – Cotati (Hospital) 17 Miles
95253 – Victor (Hospital) 18 miles	94952 – Petaluma (Hospital) 23 Miles
95336 – Manteca (Hospital) 20 miles	94585 – Suisun City (Hospital) 25 Miles
95366 – Ripon (Hospital) 19 miles	
95632 – Galt (Hospital) 25 miles	

PCPs and Hospitals	
15 – 30 Miles Continued	
Sonoma County Continued:	**Stanislaus County Continued:**
94954 – Petaluma (Hospital) 19 Miles	95230 – Farmington (Hospital) 25 Miles
94999 – Petaluma (Hospital) 18 Miles	95329 – La Grange (Hospital) 30 Miles
94972 – Valley Ford (Hospital) 24 Miles	95381 – Turlock (Hospital) 20 Miles
95404 – Santa Rosa (Hospital) 18 Miles	95382 – Turlock (Hospital) 21 Miles
95442 – Glen Ellen (Hospital) 25 Miles	95386 – Waterford (Hospital) 24 Miles
95448 – Healdsburg (Hospital) 26 Miles	95387 – Westley (Hospital) 22 Miles
Stanislaus County:	**Sutter County:**
95313 – Crows Landing (Hospital) 26 Miles	95659 – Nicolaus (Hospital) 27 Miles
95316 – Denair (Hospital) 26 Miles	**Yolo County:**
95323 – Hickman (Hospital) 28 Miles	95612 – Clarksburg (Hospital) 25 Miles
95360 – Newman (Hospital) 30 Miles	95627 – Esparto (Hospital) 26 Miles
95361 – Oakdale (Hospital) 21 Miles	95645 – Knights Landing (Hospital) 29 Miles
95380 – Turlock (Hospital) 25 Miles	95653 – Madison (Hospital) 24 Miles

Greater Than 30 Miles	
Sacramento County:	**Yolo County:**
95638 – Herald (Hospital) 36 Miles	95606 – Brooks (Hospital) 49 Miles
95690 – Walnut Grove (Hospital) 32 Miles	95607 – Capay (Hospital) 33 Miles
Sonoma County:	95637 – Guinda (Hospital) 42 Miles
95421 – Cazadero (Hospital) 38 Miles	95698 – Zamora (Hospital) 31 Miles
95425 – Cloverdale (Hospital) 40 Miles	95937 – Dunnigan (Hospital) 44 Miles
95441 – Geyserville (Hospital) 39 Miles	95606 – Brooks (PCP) 41 Miles
95450 – Jenner (Hospital) 35 Miles	95637 – Guinda (PCP) 34 Miles
Stanislaus County:	95679 – Rumsey (PCP) 42 Miles
95322 – Gustine (Hospital) 34 Miles	95679 – Rumsey (Hospital) 46 Miles
95363 – Patterson (Hospital) 32 Miles	95937 – Dunnigan (PCP) 36 Miles
Sutter County:	
95645 – Knights Landing (Hospital) 33 Miles	

Appendix C: Sutter Health Plus Member Rights and Responsibilities

SHP's Member Rights and Responsibilities outline the member's rights as well as the member's responsibilities.

What Are My Rights?

Member rights may exercise their rights without regard to age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status or the source of payment or utilization of services. SHP's member rights include but are not limited to the following:

- To be provided information about SHP organization and its services, providers and practitioners, managed care requirements, processes used to measure quality and improve member satisfaction, and your rights and responsibilities as a member
- To be treated with respect and recognition of your dignity and right to privacy
- To actively participate with providers in making decisions about your health care, to the extent permitted by law, including the right to refuse treatment or leave a hospital setting against the advice of the attending physician
- To expect candid discussion of appropriate, or medically necessary, treatment options regardless of cost or benefit coverage
- To voice a complaint or to appeal a decision to SHP about the organization or the care it provides, and to expect that a process is in place to assure timely resolution of the issue
- To make recommendations regarding SHP's Member Rights and Responsibilities policies
- To know the name of the provider who has primary responsibility for coordinating your care and the names and professional relationships of others who may provide services, including the practitioner's education, certification or accreditation, licensure status, number of years in practice and experience performing certain procedures
- To receive information about your illness, the course of treatment and prospects for recovery in terms that can be easily understood
- To receive information about proposed treatments or procedures to the extent necessary for you to make an informed consent to either receive or refuse a course of treatment or procedure. Except in emergencies, this information shall include: a description of the procedure or treatment, medically significant risks associated with it, alternate courses of treatment or non-treatment including the risks involved with each and the name of the person who will carry out a planned procedure
- To confidential treatment and privacy of all communications and records pertaining to care you received in any health care setting. Written permission will be obtained before medical records are made available to persons not directly concerned with your care, except as permitted by law or as necessary in the administration of SHP. SHP's policies related to privacy and confidentiality are available to you upon request

- To full consideration of privacy and confidentiality around your plan for medical care, case discussion, consultation, examination and treatment, including the right to be advised of the reason an individual is present while care is being delivered
- To reasonable continuity of care along with advance knowledge of the time and location of an appointment, as well as the name of the provider scheduled to provide your care
- To be advised if the provider proposes to engage in or perform human experimentation within the course of care or treatment and to refuse to participate in such research projects if desired
- To be informed of continuing health care requirements following discharge from a hospital or provider office
- To examine and receive an explanation of bills for services regardless of the source of payment
- To have these member rights apply to a person with legal responsibility for making medical care decisions on your behalf. This person may be your provider
- To have access to your personal medical records
- To formulate advance directives for health care

What Are My Responsibilities?

It is the expectation of SHP and its providers that members adhere to the following member responsibilities to facilitate the provision of high-level quality of care and service to members.

Your member responsibilities include but are not limited to the following:

- To know, understand and abide by the terms, conditions, and provisions set forth by SHP as your health plan. (The *Evidence of Coverage and Disclosure Form* (*EOC*) contains this information)
- To supply SHP and its providers and practitioners (to the extent possible) the information they need to provide care and service to you. This includes informing SHP's Member Services when a change in residence occurs or other circumstances arise that may affect entitlement to coverage or eligibility
- To select a primary care physician (PCP) who will have primary responsibility for coordination of your care and to establish a relationship with that PCP
- To learn about your medical condition and health problems and to participate in developing mutually agreed upon treatment goals with your practitioner, to the degree possible
- To follow preventive health guidelines, prescribed treatment plans and guidelines/instructions that you have agreed to with your health care professionals and to provide to those professionals information relevant to your care
- To schedule appointments as needed or indicated, to notify the participating provider when it is necessary to cancel an appointment and to reschedule cancelled appointments if indicated
- To show consideration and respect to the providers and their staff and to other patients

- To express grievances regarding SHP, or the care or service received through one of SHP's providers, to SHP Member Services for investigation through SHP's grievance process

To facilitate greater communication between patients and providers, SHP will:

- Upon the request of a member, disclose to consumers factors, such as methods of compensation, ownership of or interest in health care facilities, that can influence advice or treatment decisions
- Ensure that provider contracts do not contain any so-called "gag clauses" or other contractual mechanisms that restrict the health care provider's ability to communicate with or advise patients about medically necessary treatment options

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DEFINITIONS

Appeal: A request for reconsideration of a previous decision or adverse determination of a request for a health care service, supply or device for a member. A member, the member's representative, or the member's participating provider may submit an appeal verbally or in writing.

Benefit Year: This is the 12-month period during which the member's or employer group's plan of coverage is effective, which may be either a calendar year (start date of January 1) or a plan year (start date varies based on employer group's contract).

Charges: The participating provider's contracted rates or the actual charges payable for covered services, whichever is less. Actual charges payable to non-participating providers shall not exceed usual, customary and reasonable charges as determined by SHP.

Child: An adopted, step, or recognized natural or any child for whom the employee has assumed a parent-child relationship. This is by intentional assumption of parental status, or assumption of parental duties by the employee, as certified by the employee at the time of enrollment of the child, and annually thereafter up to the age of 26 unless the child is disabled. A disabled child is one who at the time of attaining age 26, is incapable of self-support because of a physical or mental disability which existed continuously from a date prior to attainment of age 26 until termination of such incapacity.

Coinsurance: A percentage of charges the member must pay when the member receives a covered service.

Copayment: A specific dollar amount that the member must pay when the member receives a covered service.

Cost Sharing: The amount the member is required to pay for a covered service (e.g., deductibles, copayments or coinsurance).

Covered Services: Those medically necessary health care services and supplies, which a member is entitled to receive subject to the exclusions and limitations.

Deductible: The amount the member must pay in a benefit year for certain covered services before SHP will cover those covered services at the applicable copayment or coinsurance in that benefit year.

Delegated Entity: Delegated entity means an entity to which SHP, or another payer contracted with SHP, has delegated some or all of its contractual obligations, including but not limited to authorization of services, billing or claims payment.

Dependent: The spouse, domestic partner, or child of an SHP subscriber, who works or resides within the service area and who is eligible for enrollment as a dependent in the health plan. This also includes the spouse or registered domestic partner, or child of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition.

Dispute: A request for reconsideration of the processing of a claim that resulted in a denial or modification of the payment for a rendered service. A provider must submit a dispute in writing.

Downstream Provider: Downstream provider means a healthcare provider who or which has a contract with medical foundation to render services to members.

Emergency Medical Condition: A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to members' health
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

An emergency medical condition is also active labor, which means there is inadequate time for safe transfer to a participating hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the member or unborn child.

A psychiatric emergency medical condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that is renders members as being either of the following:

- An immediate danger to themselves or others
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder

Emergency Services: All of the following with respect to an emergency medical condition:

- A medical screening exam that is within the capability of the emergency department of a hospital, including services such as imaging and laboratory, routinely available to the emergency department to evaluate the emergency medical condition Within the capabilities of the staff and facilities available at the hospital, medically necessary examination and treatment required to stabilize the patient
- An additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility

Essential Health Benefits (EHBs): A set of health care service categories identified by the Patient Protection and Affordable Care Act that certain health plans must cover as of 2014.

Evidence of Coverage: The *Evidence of Coverage and Disclosure Form* (*EOC*) document which describes the health care coverage under SHP's group subscriber contract with the member's employer group.

Exchange: The California Health Benefit Exchange created by Section 100500 of the Government Code, known as Covered California

Family: A subscriber and all of his or her dependents.

Grievance: An expression of dissatisfaction regarding any aspect of an organization's or participating provider's operations, activities, behavior, quality of care, or quality of service. A member or provider may submit a grievance verbally or in writing.

Group: The entity, usually an employer, with which SHP has entered into the group subscriber contract.

Group Subscriber Contract: The contract between the member's group and SHP that establishes the covered services members.

Health Plan: Sutter Health Plus Inc., a California not-for-profit corporation.

Inquiry: A request for clarification, without an expression of dissatisfaction or request for reconsideration. A member or provider may submit an inquiry verbally or in writing.

Medical Foundation: Medical foundation means a medical foundation organized under California Health and Safety Code section 1206(1) that provides or arranges for the provision of health care to its patients through one or more contracted medical groups or physicians.

Medical Group: A group of physicians and other providers who do business together who have entered into a written agreement with SHP to provide or arrange for the provision of covered services and to whom a member is assigned for purposes of primary medical management.

Medical Services: Professional services of physicians and other health care professionals, including medical, surgical, diagnostic, therapeutic and preventive services, which are performed, prescribed or directed by a participating physician or health care professional otherwise authorized under California law to practice his or her profession in the State of California.

Medically Necessary: Means that which SHP determines:

- Is appropriate and necessary for the diagnosis or treatment of the member's medical condition, in accordance with professionally recognized standards of care
- Is not mainly for the convenience of the member or the member's physician or other provider
- Is the most appropriate supply or level of service for the injury or illness

For hospital admissions, this means that acute care as an inpatient is necessary due to the kind of services the member is receiving, and that the member cannot receive safe and adequate care as an outpatient or in a less intensive medical setting.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Member: Means a subscriber or qualified dependent family member who is entitled to receive covered services.

Out-of-Area Urgent Care: Medically necessary services to prevent serious deterioration of the member (or the member's unborn child) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:

- The member is temporarily outside the SHP Service Area
- The member reasonably believes that the member (or the member's unborn child's) health would seriously deteriorate if the member delayed treatment until he or she returned to SHP's service area

Participating Hospital: Means a duly licensed hospital, which at the time care is provided to a member, has a contract in effect with SHP or a participating medical group to provide Hospital services to members. The covered services which some Participating Hospitals may provide to members are limited by SHP's utilization review and quality assurance policies or by SHP's contract with the hospital.

Participating Medical Group (PMG): PMG is a medical foundation or a medical group or IPA under a contract with a medical foundation or aligned IPA that provides or arranges for the provision of professional medical services to members through its contracted medical providers.

Participating Pharmacy: Means a pharmacy under contract with SHP, authorized to dispense covered prescription medications to members who are entitled to receive them.

Participating Physician: A physician, who, at the time care is provided to a member, has a contract in effect with SHP or a PMG to provide covered services to members.

Participating Practitioner: A psychiatrist, psychologist, or other allied behavioral health care professional who is qualified and duly licensed, certified or otherwise authorized under California law to practice his or her profession under the laws of the State of California. And, one who has entered into a written agreement with USBHPC to provide mental health, behavioral health or substance use disorder treatment services to members.

Participating Provider: A PMG, participating physician, participating hospital, other licensed health professional, or licensed health facility or other health professional otherwise authorized under California law to practice his or her profession in the State of California, who or which, at the time care is provided to a member, has a contract in effect with SHP to provide covered services to members.

Participating Qualified Autism Service Provider: Either of the following:

- A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified
- A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the California Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee

Participating Qualified Autism Service Professional: An individual who meets all of the following criteria:

- Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider
- Is supervised by a participating qualified autism service provider
- Provides treatment pursuant to a treatment plan developed and approved by the participating qualified autism service provider
- Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program
- Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the California Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the California Government Code
- Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan

Participating Qualified Autism Service Paraprofessional: An unlicensed and uncertified individual who meets all of the following criteria:

- Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the participating qualified autism service provider
- Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations
- Has adequate education, training, and experience, as certified by a participating qualified autism service provider or an entity or group that employees qualified autism service providers
- Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan

Post-Stabilization Care: Medically necessary services related to an emergency medical condition received after a treating physician determines that the member's condition is stable.

PPACA: The Patient Protection and Affordable Care Act and any rules, regulations, or guidance issued thereunder.

Premiums: The payment fee to be paid by or on behalf of members in order to be entitled to receive the covered services provided for in the *EOC*.

Preventive Care Services: Services that do one or more of the following:

- Protect against disease, such as in the use of immunizations

- Promote health, such as counseling on tobacco use
- Detect disease in its earliest stages before noticeable symptoms develop, such as screening for breast cancer

Primary Care Physician (PCP): A participating physician who:

- Practices in the area of family practice, internal medicine, pediatrics, general practice or obstetrics/gynecology
- Acts as the coordinator of care, including such responsibilities as supervising continuity of care, record keeping and initiating referrals to specialist physicians for members who select such a PCP
- Is designated as a PCP by the medical group

Residential Treatment Center: A residential facility that provides services in connection with the diagnosis and treatment of behavioral health conditions including, but not limited to substance abuse disorders and which is licensed, certified, or approved as such by the appropriate state agency

Service Area: The geographic area in which SHP is licensed to offer health care coverage. Refer to the Service Area description in the Appendices chapter for a list ZIP codes and counties comprising the SHP Service Area

Skilled Nursing Facility (SNF): A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and has a license by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. A "SNF" can also be a unit or section within another facility (e.g., a hospital) as long as it continues to meet this definition.

Stabilize: To provide the medical treatment of the emergency medical condition that is necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "stabilize" means to deliver (including the placenta).

Subscriber: A member who is eligible for membership on his or her own behalf and not by virtue of dependent status and who meets the eligibility requirements as a subscriber.

Urgent Care: Medically necessary services for a condition that requires prompt medical attention but is not an emergency medical condition.