Scripps | Scripps Health Plan

Provider Operations Manual

For Contracted Professionals, Facilities & Ancillary Providers

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Key Contacts

Hours of Operation: Monday- Friday from 8:00am – 5:00pm

Mailing Addresses:

Scripps Health Plan
10790 Rancho Bernardo Road 4S-300
San Diego, California 92127

Provider Dispute Resolution
P.O. Box 1928
La Jolla, California 92038

Claims
P.O. Box 2529
La Jolla, California 92038

Member Services
P.O. Box 2749
La Jolla, California 92038

Claims	
Claims Status Inquiry	**844-337-3700**
Claims Fax	**858-260-5852**
Provider Disputes Inquiry	**844-337-3700**
Provider Disputes Fax	**858-260-5878**
Contracts and Provider Relations	**ProviderRelations@ScrippsHealth.org**
Irene Evans, Contract Manager	**858-927-5400**
Loretta Moody, Provider Relations	**858-927-5425**
Rosalia Munaco-Gonzalez, Provider Relations	**858-927-5391**
Adriana Cuellar, Provider Relations	**858-927-5853**
Bhavini Kapadia, Provider Relations	**858-927-5421**
Annette Carter, Provider Data Updates	**858-927-5427**
Elvia Cabrera, Scripps Care Link Access	**858-927-5452**
Melanie Molina, Provider Data Updates	**858-927-5426**
Ruby Paragas, Payer Relations	**858-927-5361**
Credentialing	
Phone Number	**858-678-7939**
Credentialing Fax	**858-260-5843**
Customer Service	**CustomerService@ScrippsHealth.org**
Phone Number	**844-337-3700**
TTY line (for the hearing impaired)	**888-515-4065**
Customer Service Fax	**858-964-3102**
Enrollment Inquiry	**844-337-3700**

Key Contacts

Enrollment Fax Number	**858-964-3102**
Appeals & Grievances	**SHPSAppealsandGrievancesDG@ScrippsHealth.org**
Phone Number	**858-927-5907**
Fax (Routine)	**858-260-5879**
Fax (Emergent)	**858-964-3100**
Delegation Oversight	**SHPDelegationOversight@ScrippsHealth.org**
Phone Number	**858-927-5887**
Fax	**858-964-3139**
Utilization Management	
Referral Inquiry	**844-337-3700**
Referral Fax (Routine)	**858-260-5877**
Referral Fax (Emergent)	**858-964-3104**
Referral Fax (Out of Area) Fax	**858-260-5859**
Benefit Carve Out Provider Organizations	
American Specialty Health Plans of CA (Acupuncture/Chiropractic)	**800-678-9133**
Cigna Behavioral Health	**800-866-6534**
MedImpact (Pharmacy Benefit Manager)	**844-282-5343**
Compliance & Privacy	**SHPSCompliance@ScrippsHealth.org**
Compliance Officer	**858-927-5360**
Privacy	**858-927-5461**
Scripps Patient Safety Alertline	**888-424-2387**
Website	**www.ScrippsHealthPlan.com**

Mission

Scripps strives to provide superior health services in a caring environment and to make a positive, measurable difference in the health of individuals in the communities we serve.

We devote our resources to delivering quality, safe, cost effective, socially responsible health care services.

We advance clinical research, community health education, education of physicians and health care professionals and sponsor graduate medical education. We collaborate with others to deliver the continuum of care that improves the health of our community.

Vision

Scripps Health will continue to be the leading health care delivery system in the greater San Diego community, as evidenced by the highest clinical quality, patient safety, and patient, physician and employee satisfaction. This will be achieved through unending focus on patient-centered and compassionate care, cost-effective operations, research, advanced technology and innovation.

Values

We provide the highest quality of service

Scripps is committed to putting the patient first and quality is our passion. In the new world of health care, we want to anticipate the causes of illness and encourage healthy behavior for all who rely on us for service. We teach and encourage patients to participate in their care and to make well-informed decisions. We will be their advocate when they are most vulnerable. We measure our success by our patients' satisfaction, their return to health and well-being, and our compassionate care for dying patients, their families and friends.

We demonstrate complete respect for the rights of every individual

Scripps honors the dignity of all persons, and we show this by our actions toward one another and those we serve. We embrace the diversity that allows us to draw on the talents of one another. We respect and honor the cultural, ethnic and religious beliefs and practices of our patients in a manner consistent with the highest standards of care. All this is done in a compassionate setting. Our goal is to create a healing environment in partnership with all caregivers who are committed to serving our patients.

We care for our patients every day in a responsible and efficient manner

Scripps serves as a major community health care resource for San Diego County and, as such, we are accountable for the human, financial and ecological resources entrusted to our care as we promote healing and wholeness. We begin from a base of excellence and collaborate with co-workers, physicians, patients, and other providers to find new and creative ways to improve the delivery of health care services. All members of our community will have access to timely, affordable and appropriate care.

I. Provider Services & Resources

Customer Service

Scripps Health Plan's (SHP) Customer Service Department provides assistance to Providers and their staff, Members and their advocates/designees and others seeking information from Scripps Health Plan. Customer Service Representatives can be reached toll-free at (844) 337-3700 or TTY (888) 515-4065 or by email at CustomerService@ScrippsHealth.org.

Our friendly, well-informed, Customer Service Representatives are available Monday through Friday from 8:00 a.m. to 5:00 p.m. Pacific Standard Time. Customer Service Representatives assist callers by answering questions regarding an array of issues, including:

- Health Plan policies and procedures
- Prior Authorization guidelines, inquiries and responsibilities
- Criteria used to make medically necessary determinations
- Provider Dispute Resolution inquiries, status, and procedures
- Financial responsibility for claims payment
- Provider claim and authorization status
- Member eligibility verification
- Member benefit and copays
- Network and Medical Group affiliations
- Provider demographic changes
- Appeal and Grievance complaint intake

Provider Relations

The Provider Relations & Contracting Department is available during normal business hours and may be contacted through the Customer Service line by calling (844) 337-3700, or via email ProviderRelations@ScrippsHealth.org performs the following services for SHP:

- Contract Analysis and Capitation Payment Inquiries
- Complex Claim and Utilization Management Issue Resolution
- Contract Analysis
- Contract Negotiation, Implementation and Interpretation
- Enrollment Issue Resolution
- Provider Education
- Liaison between Contracted Providers and other SHP Departments
- Maintenance of Provider Directories and Provider demographics

Scripps EHR – Epic Scripps Care Link

Scripps Clinic Medical Group (SCMG) and Scripps Coastal Medical Center (SCMC) providers have direct access to review and submit claims and referrals or verify eligibility through their Epic system access. Epic also supports an external Provider Portal, Scripps Care Link, allowing access to Network Providers to view and submit referrals, view claims and verify eligibility. For additional information on accessing Scripps Care Link, contact Provider Relations at (858) 927-5452 or via email, ProviderRelations@ScrippsHealth.org. If you have any questions about an authorization, contact Customer Service at (844) 337-3700.

Provider Directory

SHP's online and printed Provider Directories include a Provider Profile for each contracted provider, to assist Members and consumers in making informed decisions about health plan network options. The following items are included in SHP's directories:

- Provider Name
- Practice location (or locations)
- Phone & Fax numbers
- Office Email address (if made available to patients, must be HIPAA compliant)
- Type of practitioner; Primary Care, Specialist, Allied Health Professionals
- National Provider Identification (NPI) Number
- California license number and type of license.
- Specialty, including board certification(s), if any.
- Affiliated Medical Group (MG) through which the Provider is contracted to see Members
- Contracted Hospitals where the Provider has admitting privileges
- Whether a Provider is accepting new patients
- Any spoken Non-English Language(s)

The online Provider Directory of SHP's Network Providers can be found on our website, by visiting www.ScrippsHealthPlan.com/physicians/find

Medical Group Providers are required to update their directory information at least annually, semi-annually for individually contracted providers. To report inaccuracies in the provider directory, call us at (844) 337-3700, submit the inaccuracy online https://www.scrippshealthplan.com/provider-directory-changes or send an email to ProviderRelations@ScrippsHealth.org.

Pharmacy, Mental Health & Acupuncture/Chiropractic Services

Pharmacies: SHP delegates Pharmacy network management to SHP's Pharmacy Benefit Manager (PBM), MedImpact. Network Pharmacies are included in the printed directory and a link to the pharmacy search tool is displayed on SHP's website.

Acupuncturists and Chiropractors: SHP delegates American Specialty Health Plans of California, Inc (ASH) for the credentialing and publishing of provider data information for acupuncturists and chiropractors. ASH's Provider Network is included in the printed directory and a link to ASH's provider search tool is displayed on SHP's website.

Mental Health and Substance Use Disorder Providers: SHP delegates Cigna Behavioral Health of CA (CBH) for the credentialing and publishing of provider data information for mental health and substance use disorder providers. CBH's Provider Network is included in the printed directory and a link to CBH's provider search tool is displayed on SHP's website. CBH's Mental Health provider network includes individual practitioners (Psychiatrist, Psychologist, Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT) or Qualified Autism Service Providers, Professionals and Paraprofessionals) and institutional providers (acute psychiatric facilities, psychiatric units in acute care hospitals, residential care, partial hospitalization and detox programs).

Providing Culturally & Linguistically Competent Care

Everything we do is to promote the health and well-being of our Members, and without regard to one's social or economic background. Cultural and Linguistic Competence is the ability of health care providers and organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the health care encounter.

Provider Access to Language Services

State and federal law* requires that health plans establish a Language Assistance Program (LAP) for Limited English Proficient (LEP) Members. Under the law, contracted providers are required to assist Members in accessing language services made available by each health plan. Providers can access a qualified medical language interpreter for office appointments or any other Member encounter by contacting Customer Service by calling (844) 337-3700 or TTY (888) 515-4065. Scripps Clinic & Scripps Coastal Medical Center providers also have access to interpreter services through in-office Blue Phones. SHP provides translation of vital documents, denial notices, appeal letters and any other plan documents.

**CA H&SC Sect. 1367.04 and 28 CCR 1300.67.04; ACA Sect. 1157*

Interpreter Services

Providers can request interpreters for Members whose primary language is not English by calling our Customer Service team. Representatives have access to qualified medical interpreters in over 100+ languages – including American Sign Language interpreters. Face-to-face interpreter service requests must be submitted at least **five (5) days** prior to the appointment date. Please note that even with prior notice, interpreters for face-to-face services may not be available for all languages. Should an interpreter not be available for face-to-face services, health plans can also make arrangements for telephone interpreting services. Be prepared to provide the following information to connect you with the most appropriate resource:

- Member information including: Name, Member ID, and Date of Birth
- Age, Gender, Country of Origin and Regional Dialect information *to help interpreters provide culturally appropriate interpretation*
- Provider information including: Appointment Date & Time, Office location, Provider Name, and type of appointment (e.g., OB/GYN, post-acute stay, follow-up, preventive care, etc.)
- For Phone Interpretation: Phone Number – this is the number the interpreter will call your office for a scheduled appointment

Translation Services

SHP issues certain Utilization Management and Claims documents that fall within the scope of language access regulations and include a DMHC approved notice of translation services in fifteen (15) languages. This notice accompanies the following SHP produced non-standardized vital documents:

1. Member websites and online applications
2. Enrollment Documents and Member Welcome Guides
3. Formularies and Preferred Drug Lists
4. Evidence of Coverage (EOC) forms and Summary of Benefits and Coverage (SBC)
5. UM Denial notifications, *including denial, modification or delay in service*
6. UM Delay notifications *for additional information or expert review*
7. Claims denial notifications *for Member liability*

8. Explanation of Benefit (EOB) notices
9. Appeals, Grievance and Independent Medical Review (IMR) forms and notices
10. Letters that require a response from the Member
11. Provider termination letters

To request Interpreter or Translation services for a Scripps Health Plan Member, contact a Customer Service Representative by calling (844) 337-3700 or TTY (888) 515-4065 or by email at CustomerService@ScrippsHealth.org.

Promoting appropriate Language Assistance in Provider Offices

The first step in assessing a patient's language needs is to ask.

Office staff should ask patients, "what is your preferred language?" during registration or when scheduling an appointment. Providers should consider the use of an "I Speak . . ." poster or card and maintain language preferences in patient medical records. Providers may also consider leaving after-hours messages in the predominant non-English language of their patients.

When using a Phone or Live Interpreter, remember to speak to the patient directly, at an even pace and in short sentences. Avoid run-on or complicated sentences, sentence fragments, idiomatic expressions, or asking multiple questions at one time. Unless insisted upon by the patient, it is never okay to rely on friends or family members *(especially minor children)* for interpretation. Free Provider Cultural & Linguistic Resources are available on the ICE website, including a *Provider Toolkit for Caring for Diverse Populations*:
https://www.iceforhealth.org/library/documents/ICE_Provider_Tool_Kit_March_2017.pdf

Member Rights and Responsibilities

Scripps Health Plan is committed to treating members in a manner that respects their rights. We also have certain expectations of Members' responsibilities. Upon enrollment, Members are given a Welcome Letter which contains the list of member rights and responsibilities.

As a member, you have the Right to:

1. Receive considerate and courteous care, with respect for your right to personal privacy and dignity;
2. Receive information about all health services available to you, including a clear explanation of how to obtain them;
3. Receive information about your rights and responsibilities;
4. Receive information about your Scripps Health Plan, the services we offer you, the physicians and other practitioners available to care for you;
5. Select a PCP and expect his/ her team of health workers to provide or arrange for all the care that you need;
6. Have reasonable access to appropriate medical services;
7. Participate actively with your physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment;
8. A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage;
9. Receive from your physician an understanding of your medical condition and any proposed appropriate or medically necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment;
10. Receive preventive health services;
11. Know and understand your medical condition, treatment plan, expected outcome and the effects these have on your daily living;
12. Have confidential health records, except when disclosure is required by law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your PCP;
13. Communicate with and receive information from Customer Service in a language you can understand;
14. Know about any transfer to another hospital, including information as to why the transfer is necessary and any alternatives available;
15. Obtain a referral from your PCP for a second opinion;
16. Be fully informed about the Scripps Health Plan grievances procedure and understand how to use it without fear of interruption of health care;
17. Voice complaints about the Scripps Health Plan or the care provided to you; and
18. Participate in establishing public policy of Scripps Health Plan, as outlined in your Evidence of Coverage and Disclosure Form or Health Service Agreement; and
19. Make recommendations regarding Scripps Health Plan Member rights and responsibilities policy.

You, as a Scripps Health Plan Member, have the Responsibility to:

1. Carefully read all Scripps Health Plan materials immediately after you are enrolled so you understand how to use your benefits and how to minimize your out of pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Scripps Health Plan membership as explained in the Evidence of Coverage and Disclosure Form or Health Service Agreement;
2. Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed;
3. Provide, to the extent possible, information that your physician, and/or the Plan need to provide appropriate care for you;
4. Understand your health problems and take an active role in making health care decisions with your medical care provider, whenever possible.
5. Follow the treatment plans and instructions you and your physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations;
6. Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given;
7. Make and keep medical appointments and inform the Plan physician ahead of time when you must cancel;
8. Communicate openly with the PCP you choose so you can develop a strong partnership based on trust and cooperation;
9. Offer suggestions to improve Scripps Health Plan;
10. Help Scripps Health Plan to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health plan coverage;
11. Notify Scripps Health Plan as soon as possible if you are billed inappropriately or if you have any complaints;
12. Select a PCP for your newborn before birth, when possible, and notify Scripps Health Plan as soon as you have made this selection;
13. Treat all Plan personnel respectfully and courteously as partners in good health care;
14. Pay your dues, copayments and charges for non-covered services on time; and
15. For all mental health and substance abuse services, follow the treatment plans and instructions agreed to by you and the MHSA and obtain prior authorization for all nonemergency mental health and substance abuse services.

Primary Care Physician Selection

SHP members are required to select a Primary Care Physician (PCP) to manage and coordinate their medical needs. Members in the same family may select the same or different PCPs in the following disciplines; Medical Doctor (MD) (an internist, family practitioner, pediatrician, or general practitioner), or a Doctor of Osteopathy (DO). Female members may select an Obstetrician/ Gynecologist (OB/GYN) as their PCP. If a member does not select a PCP at enrollment, SHP will assign a PCP based on the following factors:

- The member's residence
- The member's language preference
- The member's age
- The existence of established relationships and family linkages

Members are notified by mail of the SHP assigned PCP and of the right to select a different PCP by contacting SHP Customer Service. Assignment of a PCP becomes effective on the first day of the following month. For example, if the member calls to select a PCP on March 16th, the assignment to that PCP becomes effective on April 1. Exceptions may be made on a case-by-case basis. The member is sent a health plan identification card upon enrollment and thereafter whenever a PCP change is made. The identification card includes the PCP, the PCP's telephone number, the assigned Plan Medical Group, copay and other important information.

SHP encourages members to find a PCP they are comfortable with and stay with that PCP. This way the member and doctor can establish a relationship and the doctor will be familiar with the member's medical history. However, members can change PCPs at any time.

PCP changes will be made based on the request from the member or the member's parent or guardian. PCP changes cannot be made by a Provider or the Provider's office staff without authorization from the member, but they can be made from the Provider's office if the member confirms the change by telephone.

Communication to Providers

SHP communicates changes or updates to policies, procedures, and regulatory requirements to providers via:

- This Provider Manual, which is provided upon initial contracting with SHP, and for which updates are posted online at www.ScrippsHealthPlan.com
- Directly via Mail, email or fax
- Via communication with the Plan Medical Group (PMG) to distribute information to their affiliated physicians.

SHP provides required notification to providers about:

- The policy requiring an appropriate physician advisor to be available to discuss all Utilization Management (UM) denial decisions based upon medical necessity.
- The contact information of the medical reviewer responsible for issuing a denial, as indicated in the provider denial letter.
- The opportunity to discuss a behavioral or non-behavioral health care UM denial decision with a physician or other appropriate reviewer.
- The method of obtaining UM Criteria, and updates or changes to UM criteria

II. Medical Management Program

Utilization Management

The purpose of the UM Program is to maintain a comprehensive, coordinated process, which promotes and monitors the effective utilization of health care resources within the SHP health care delivery system. Activities of the UM Program include prospective (before), concurrent (during), and retrospective (after) review of healthcare services including coordination of appropriate discharge planning. SHP may delegate UM activities to qualified entities that meet specific regulatory requirements.

The Medical Management Committee ("MMC") is responsible for the ongoing monitoring, evaluation, and improvement of the UM Program. This committee is also responsible for monitoring clinical practices, evaluation of provider utilization, and monitoring and trending of provider appeals and grievance determinations. SHP's Chief Medical Officer, or designee, chairs this committee.

Authorization review is performed by each PMG Chief Medical Officer or assigned physician advisor. Each specialty department head is responsible to provide expert review consultation upon request. Other responsibilities of the department heads includes business unit-specific review and analysis of business unit-specific UM performance indicator monitoring in conjunction with the MMC and the Chief Medical Officer, or designee.

SHP and its delegated entities require all authorization requests to be screened by qualified health professionals using decision-making criteria that are objective and based on accepted medical evidence. Medical necessity criteria must be reviewed annually and updated as appropriate. Medical necessity criteria must be available to Providers and members upon request. Services not meeting standard medical necessity criteria are forwarded to the Chief Medical Officer or designee for review. Activities within the scope of the UM Program include the following:

- Referral Management
- Prior Authorization
- Concurrent Review
- Retrospective Review
- Discharge Planning
- Second Clinical Opinions
- Emergent Care
- Out of Area coordination of care and repatriation
- Continuity of Care and transition of care when medically appropriate
- UM Key Service and Administrative Performance Indicators
- New Medical Technology review and determination
- Complex Case Management
  Disease Management

Please note that you may contact the Customer Service department in order to obtain a copy of the medical criteria used to make a determination or if you have any general questions regarding UM criteria. For questions on a specific case, contact the physician listed on the denial letter or the Medical Director for the member's PMG.

Scripps Clinic Medical Group
Dan Dworsky, M.D. (858) 554-8374
Scripps Coastal Medical Center – North Division
Anthony F. Chong, FAAFP (858) 678-6652
Scripps Coastal Medical Center – South Division
Anthony F. Chong, FAAFP (858) 678-6652
Scripps Coastal Medical Center – Escondido Division
Anthony F. Chong, FAAFP (858) 678-6652

Prior Authorization

Prior Authorization is the process of evaluating medical services prior to scheduling to determine Medical Necessity, appropriateness, and benefit coverage. Services requiring Prior Authorization should not be scheduled until a Provider receives approval from SHP or its delegated entity. SHP reserves the right to deny payment for authorized services if it is determined that inaccurate information was provided to support the Authorization request. Requests should be submitted by the requesting provider via the applicable referral management system. Requests must be accompanied by all pertinent medical records and supporting documents to avoid unnecessary delays. The following medical information should accompany all requests, as appropriate, to ensure that consulting physicians have clinical information prior to a patient visit:

- Medical history related to the diagnosis
- Results of any diagnostic tests previously performed (including lab and radiology reports)
- Consultation reports related to the diagnosis from other physicians
- Information on referrals pending for other Providers.

Prior Authorization is NOT required for:

- Emergency services
- Family planning services
- Preventive care, like immunizations and annual physicals
- Basic prenatal care
- Sexually transmitted disease (STD) services
- Human immunodeficiency virus (HIV) testing

Experimental/investigational services are not a Covered Benefit. Providers may submit a completed Prior Authorization Request to SHP to determine whether a requested service is considered experimental or investigational.

Referral and Prior Authorization Process

Prior Authorization requests for medical services, referrals and notifications to SHP should be submitted online via Epic's referral and eligibility portal. If you are not yet signed-up for this easy-to-use and secure Internet resource, please contact SHP Provider Relations at (858) 927-5452 or via email, ProviderRelations@ScrippsHealth.org. Prior Authorization requests may also be faxed:

- Emergent fax number - (858) 964-3104
- Routine fax number – (858) 260-5877

Contacting UM Staff

SHP staff is available 8 a.m. to 5 p.m. Monday through Friday to answer questions from Providers and Members regarding Utilization Management issues. After office hours, Providers may call SHP Customer Service at (844) 337-3700 to be transferred to the Scripps Central Transfer Center for Urgent medical requests. For Urgent prescription drug requests, Providers may call MedImpact at (844) 282-5343. For Urgent behavioral health issues, Providers may call Cigna Behavioral at (800) 866-6534.

Prior Authorization is NOT required for:

- Emergency services
- Family planning services
- Preventive care, such as immunizations and annual physicals
- Basic prenatal care
- Sexually transmitted disease (STD) services
- Human immunodeficiency virus (HIV) testing

Referral for Inpatient & Outpatient Services

Hospitals are required to notify SHP within one working day following any inpatient admission (including delivery of a newborn), in order for hospital services to be covered. Prior authorization is also required for inpatient or outpatient surgery. Retroactive authorization requests for non-emergent services rendered will not be approved. Please check with SHP's Utilization Management department if you have questions regarding prior authorization guidelines.

Emergent care does not require prior authorization for services, however NOTIFICATION IS REQUIRED

The following Inpatient and Outpatient services and procedures require Prior Authorization (PA):

Elective Inpatient Admissions

Includes admission to Acute Care Hospitals, Inpatient Psychiatric Facilities, Long Term Acute Care Hospitals, Acute Rehabilitation Facilities, Skilled Nursing Facilities, and Hospices.

Out of Area Services

Non-emergent treatment or services provided outside of San Diego County are not covered and require authorization prior to providing care.

Outpatient Services

- Acupuncture
- Ambulance: non-emergency air or ground transportation
- Advanced Diagnostic Imaging
- Bariatric surgery and care
- Cardiac Rehabilitation
- Chemotherapy
- Chiropractic Services
- Cosmetic procedures and surgery
- Cyberknife Surgery (see above, ***Inpatient***)
- Dental (medical treatment of the teeth, gums, jaw joints or jaw bones are covered)
- Dermatologic Procedures
  - Dermabrasion and chemical peel
  - Chemical exfoliation and electrolysis
  - Laser skin treatment
  - Skin injections and implants
- Durable Medical Equipment (DME)
- Experimental / Investigational Services, Clinical Trials and New Technologies
- Genetic Testing (except for advanced maternal age mothers who require MateniT21 testing, Scripps labs must be used)
- Hearing Aids
- Home Health Services & Home Infusion
- Infertility Services (GIFT, ZIFT, and in vitro fertilization is NOT covered)
- Infusion Therapy
- Injectables
- Integrated Medicine Clinic referrals
- Intensity Modulated Radiation Therapy (IMRT)
- Maxillofacial Procedures (as covered)
- Neuro & Spinal cord stimulators
- Occupational Therapy
- Out of network referrals to specialists
- Orthotics
- Outpatient Surgery (including procedures performed at an ambulatory surgery center or outpatient dept. of a hospital)
- Pain management
- Physical Therapy
- Prosthetics
- Proton Therapy
- Pulmonary Rehabilitation
- Radiation Therapy
- Reconstructive Surgery (to correct or repair abnormal structures of the body caused by congenital development defects, trauma, infection, tumors or disease, in order to improve function, or create a normal appearance, to the extent possible)
- Second Opinions, out of network
- Speech Therapy
- Stereotactic Radiosurgery and Stereotactic Body Radiotherapy (SBRT)
- Transgender surgery and services
- Transplant surgery & services

Outpatient Mental Health & Substance Use Disorder Services

Cigna Behavioral Health provides authorization for MH/SUD services, Contact Cigna Behavioral Health at (800) 866-6534. PA is not required for MH/SUD office visits

- Electroconvulsive Therapy (ECT)
- In-Home Behavioral Health Treatment for PDD (Autism)
- Intensive Outpatient Treatment
- Neuro-Psych evaluations
- Non-emergent psychiatric transport
- Outpatient Psychiatric Observation
- Partial Hospitalization
- Psychological Testing
- Transcranial Magnetic Stimulation

Emergent Inpatient Admissions

SHP requires notification of all emergent inpatient admissions by the close of the next business day (when emergent admissions occur on weekends or holidays). For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the Emergency Department. Notification of admission is required to verify eligibility and to authorize continued care – including level of care, and initiate concurrent review and discharge planning. SHP requires that notification includes member demographic information, facility information, date of admission and clinical information sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting notification and medical necessity requirements or failure to include all of the needed documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient admission. Emergent admission notification can be electronically provided via fax at 858-260-5876.

SHP Authorization and Referral Responsibilities

SHP and its delegated entities are required to provide prompt and timely decisions on prior authorization requests appropriate for the nature of the Member's condition.
Below is a table of turnaround times based on regulations.

Standard Requests: SHPS must make a decision as expeditiously as the member's health condition requires and the decision cannot exceed the state and federal timelines, with a possible extension.
Urgent Requests: When a provider indicates or determines that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, SHPS must make a decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after the receipt of the request for service.
Extension: Extensions may be taken by SHPS when there is not sufficient information to make a determination and it is in the member's best interest to take more time to make the determination.

CATEGORY	COMMERCIAL TIMEFRAMES
Standard requests	Within five (5) working days of receipt
Urgent (Expedited)	Within seventy-two (72) hours of receipt
Extension for Urgent Requests	As expeditiously as possible, not to exceed an additional thirty (30) days
Extension for Standard	Up to forty-five (45) calendar days when it is in the member's best interest to obtain additional information that would support the request.
Retrospective	Within thirty (30) calendar days of receipt of all necessary information
Standard Pharmacy	Within two (2) working days of receipt of request
Expedited Pharmacy	Within twenty-four (24) hours from the receipt of request
Concurrent Review	Within five (5) working days of notification

Clinical Guidelines (Review Criteria)

SHP utilizes the following nationally developed clinical guidelines and criteria based on professionally recognized standards of practice, reviewed by actively practicing physicians, and adopted and approved by the MMC in making referral and authorization decisions. Guidelines are listed in order of priority:

Outpatient	Inpatient	Preventive Care
• MCG • SHP Clinical guidelines • Hayes Technology Investigational and Experimental	• MCG • SHP Clinical guidelines • Hayes Technology for Experimental and Investigational	The Guide to Clinical Preventive Services – USPS Task Force

MCG, Hayes Technology, and SHP clinical care guidelines are based upon established national guidelines, where available, scientific literature and prudent practice. Guidelines are peer reviewed and developed by consensus. MCG guidelines will be reviewed and adapted/adopted by SHP's Medical Management Committee for use as appropriate within SHP's health care delivery system.

Based on the guidelines produced, the MMC will develop medical criteria and performance measures for the monitoring and evaluation of care provided to members. The MMC may appoint multi-disciplinary sub-committees to develop guidelines and criteria when SHP clinical guidelines, or MCG do not have specific criteria. These sub-committees will have representation consistent with services provided and provider panel membership. Contracted providers may request copies of UM guidelines or other review criteria used by SHP in the course of UM activities by calling the Customer Service Department at (844) 337-3700.

Mental Health Services

Mental health and chemical dependency benefits are administered through the Cigna Behavioral Health network of behavioral health providers. A referral from the member's primary care physician is not required. To locate a participating provider, please visit www.cignabehavioral.com. Under the Members section, click "*Find a Therapist/Psychiatrist/Hospital*" to see a complete listing of mental health providers or call (800) 866-6534, 24 hours a day, 7 days a week, or TTY: 711.

Cigna Behavioral Health
Attention: Claims
P.O. Box 188022
Chattanooga, TN 37422

The development and/or review of clinical guidelines are an ongoing responsibility of the MMC, whose membership is composed of participating physicians. These criteria and guidelines are subject to annual review and revision, as applicable, by the MMC to ensure that they are consistent with current literature and national guidelines as well as the outcomes and experience of SHP.

Pharmacy

SHP provides coverage for all medically necessary outpatient prescription drugs through use of a formulary to define preferred drugs and require prior authorization for non-preferred drugs. Prescription drugs may only be prescribed by licensed physicians, licensed physician assistants, licensed nurse practitioners, dentists, licensed behavioral health practitioners in accordance with their credentials and licensure. Prescriptions should be written to allow generic substitution whenever possible and signatures on prescriptions should be legible, and electronically submitted when possible. SHP's Prescription Drug Plan is managed by MedImpact and overseen by SHP's Pharmacy & Therapeutics Committee. For inquiries related to your patient's pharmacy benefits, or prior authorization requirements, please call MedImpact directly.

MedImpact
Phone: (844) 282-5343, TTY 711
10181 Scripps Gateway Ct
San Diego, CA 92131

Many questions regarding prescription drug benefits may be answered by visiting MedImpact's website at **www.MedImpact.com**. SHP's Prescription Drug Formulary and Preferred Drug List are reviewed quarterly by the Pharmacy & Therapeutics Committee and are available on SHP's website at www.ScrippsHealthPlan.com/Provider-Information/ select *"Clinical Support Services."*

Specialty Medications: Specialty medications include, but are not limited to, many oral chemotherapeutic, multiple sclerosis and injectable agents. Specialty medications are provided for by:

Scripps Green Outpatient Pharmacy
Phone: (858) 964-1101
Fax: (858) 554-2544

MedImpact Direct Specialty
Phone: (877) 391-1103
Fax: (888) 807-5716

Medical Necessity Determination Process

UM staff obtains and reviews any necessary clinical information and uses clinical guidelines and criteria approved by the MMC and based on professionally recognized standards of practice in addition to his/her clinical expertise to determine the medical necessity of proposed care. The UM staff will consider the following factors when applying criteria to a given individual: age, co-morbidities, complications, progress of treatment, psycho-social situation, and home environment (when applicable).

Characteristics of the local delivery system available to members such as skilled nursing or sub-acute care facilities and home care to support the patient following hospital discharge and the ability of local hospitals to provide all recommended services within the estimated length of stay must be considered.

If the UM staff is not able to approve the proposed care based on the available information, the case is referred to the appropriate Chief Medical Officer/Physician Advisor for review and determination of medical necessity. When expert review is indicated, the Chief Medical Officer/Physician Advisor will consult with an appropriate specialist not involved in providing the member's care. SHP strictly adheres to the following policy when reviewing service authorization requests and/or request for payment for services:

- UM decision making is based only on appropriateness of care and service and existence of coverage.
- The organization does not reward practitioners or other individuals for issuing denials of coverage or service.
- Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization.

Elective Inpatient Admission Authorization

Pre-admission authorization involves an assessment of the medical necessity (evaluation of the proposed treatment plan, appropriateness of setting, and level of care) for a member's admission to a hospital prior to the admission.

This process is initiated by the member's PCP or other treating physician, preferably ten (10) business days prior to an elective admission. SHP will use established clinical criteria based on professionally recognized standards of practice to review the proposed admission and if considered appropriate, the admission will be authorized. Admission authorizations are subject to the following guidelines and limitations:

1. The admitting facility should verify authorization of all elective admissions with SHP prior to admitting a SHP member to that facility.
2. All authorizations are subject to a member's eligibility at the time services are rendered; this includes retrospective review for medical necessity.
3. Outpatient pre-admission test results may be required prior to an elective admission.
4. If the proposed admission does not meet SHP's established criteria for admission, the case will be referred to the Chief Medical Officer or UM Physician Reviewers for review and final determination.

Experimental/Investigational Services, Clinical Trials, & New Medical Technology

It is the policy of Scripps Health Plan to provide a mechanism for determining new medical technology benefits which include drugs, procedures, devices and other therapeutic interventions. Unless otherwise specified by the Chief Medical Officer, new medical technologies shall meet the following requirements to be considered for review:

- The technology must have final approval from the appropriate government agency.
- Clinical evidence must support the efficacy of the technology with regard to the patient's condition or disease. Peer Reviewed literature and relevant clinical studies shall be considered to support clinical efficacy.
- The technology must be for the purposes of improving a patient's overall health outcome.
- There is no existing modality for treatment which is a suitable alternative for patient's condition.
- The new technology is available outside the investigational or clinical research setting.
    1. New technologies covered by Medicare shall be deemed as meeting established criteria.
    2. SHP uses Hayes Medical Technologies reports and clinical reviews of new, experimental and investigational technologies when assessing a new technologies request.
    3. Requests for certification of new medical technologies or new uses of existing technologies will be based upon:
        a. Clinical & scientific research;
        b. Published studies and findings in peer-reviewed medical literature; and
        c. Made in accordance with current standard of care or ethical considerations.
    4. Upon request by members or providers, the requester shall be asked to supply literature that supports the therapy requested. The Medical Director and/or Utilization Management and Quality Improvement Committee (UMQIC) will perform an in-depth review of literature provided by the requesting party, and perform additional literature search, as required. Professionals or specialists with expertise related to the technology shall be utilized to evaluate the information.

Denial of Experimental Treatment for Terminally Ill Members

A terminal illness is defined as an incurable or irreversible condition that has a high probability of causing death within one year or less. Life threatening diseases or conditions is defined as the likelihood of death is high unless the course of the disease is interrupted and diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival. Seriously debilitating diseases or conditions are defined as causing major irreversible morbidity. If an authorization or referral is being requested for coverage of investigational/experimental treatment, services, or supplies, the case will be immediately forwarded to the Physician Reviewer for consideration within 1 working day.

Denial Determination

A SHP Physician Advisor must review the request and any available clinical information, prior to issuance of any denial based on lack of medical necessity. As a part of the review, the Chief Medical Officer/Physician Advisor may discuss the case with the attending or requesting physician. Denials of service based on medical necessity will always be issued by a physician reviewer. Denial notifications to providers include the name and phone number of the physician responsible for the decision should you wish to discuss the specific SHP UM criteria used to render a determination.

A written denial notice is mailed within twenty four (24) hours of the decision to the requesting physician, the enrollee or enrollee's legal guardian, if applicable. Denial Determinations for emergent services will be given to the requesting physician, and member when applicable, verbally or via fax, immediately upon completion of the review. Written notification of determination will follow within twenty four (24) hours. It is the policy of SHP to notify all members and providers of the routine and expedited appeal process for the denied authorization request. If you believe the denial determination is incorrect, you have the right to appeal on behalf of the member. Appeals should be submitted within sixty (60) days of the denial notice.

SHP is required to process an appeal within thirty (30) days of receipt. In some cases, an expedited seventy two (72) hours appeal is appropriate when the delay in the decision making might pose an imminent and serious threat to the member's health, including but not limited to potential loss of life, limb, or major bodily function. Physicians may request an expedited appeal orally or in writing, as provided for in the initial denial notice – appeal rights. Information for appeals is also available through SHP's Appeals & Grievance team, on our website at www.ScrippsHealthPlan.com, through the Customer Service Department, or from the applicable Medical Director.

SHP is required to process an appeal within thirty (30) days of receipt. In some cases, an expedited appeal is appropriate when the time necessary in routine decision making may pose an imminent or serious threat to the member's health or well-being, including but not limited to potential loss of life, limb, or major bodily function or severe pain. Physicians may request an expedited appeal orally or in writing, as provided for in the initial denial notice, *appeal rights*. Information for appeals is also available by contacting SHP's Appeals & Grievance team, through the Customer Service Department.

Denial letters to Members and Providers include mandatory notifications regarding factors leading to the denial or modification. All Member and Provider Denial Letters include:

- Clear and concise explanation of the reasons for the denial or modification of the originally requested service;
- Clinical reasons for the Plan's decision to deny, delay, or modify health care services.
- How the Member (or Member's Provider) may appeal the adverse determination or submit a grievance to SHP;
- How the Member (or Member's Provider) may request an Independent Medical Review (IMR) in cases where the member believes that health care services have been improperly denied, modified, or delayed by SHP, or by one of its UM delegates.

All written communications to a Physician or other health care provider of a denial, delay, or modification of a request shall include the following information:

- The name of the health care professional responsible for the denial, delay, or modification;
- The direct telephone number or an extension of the healthcare professional responsible for the denial, delay, or modification to allow the requesting Physician or health care provider to easily contact them.

Member Appeals & Grievances

SHP's Compliance Program includes oversight of the process through which members ask questions and resolve issues. Members will often address their questions or concerns directly with their provider, who may resolve the issue without SHP's intervention. If the provider is not able to resolve a question or problem, the member should be advised of their right to file a Grievance and instructed to contact SHP Customer Service at 844-337-3700.

A **grievance** is an indication that a member is dissatisfied with an aspect of his/her health care and/or the delivery of care.

An **appeal** is a request to re-evaluate an adverse decision or determination made by the Plan or any of its authorized Subcontractors (medical groups & delegated services). Sometimes a concern is not automatically classified as a "grievance" or an "appeal". If a member disagrees with a service denial or benefit policy, that's an appeal. If a member is dissatisfied with or concerned about the quality of the health care services he/she is receiving, that's a grievance. When it is not obvious our teams are trained to listen for clues. The member does not have to label their complaint as a formal grievance, please refer the member to our Customer Service team or follow the instructions listed below.

Appeals and Grievances received by SHP may include complaints about the quality of health care services received or an appeal of service denials. Members (or their designees) may call Customer Service or submit their Appeal or Grievance in writing, online or by fax:

Scripps Health Plan
Attention: Appeals & Grievances
10790 Rancho Bernardo Road; 4S-300
San Diego, California 92127
www.ScrippsHealthPlan.com
Phone: (844) 337-3700
Fax: (858) 260-5879

If the member prefers, he/she can complete the Grievance Form available on our website: www.ScrippsHealthPlan.com. Providers are required to make Grievance Forms available to members upon request see Exhibit C Grievance Resolution Program. Forms are also available by contacting SHP at (844) 337-3700.

SHP will make best efforts to facilitate the resolution of the member's concern. Members are encouraged to discuss their questions and concerns with the providers involved in their care. When the provider is unable resolve the concern, the matter will be transferred to the SHP's Appeals & Grievances Department.

SHP will acknowledge receipt of the Appeal or Grievance within five (5) calendar days, and will send the member a decision letter within thirty (30) calendar days. If the Appeal or Grievance involves an imminent and serious threat to the member's health, including but not limited to, severe pain, potential loss of life, limb, or major bodily function, SHP will provide a response within (72) hours. For an Appeal of a denied prescription drug or therapeutic, Members and Providers are notified of the decision within (72) hours, and within (24) hours for emergent circumstances. In most cases, providers involved in the member's care will be contacted by SHP to request medical records or other information needed to research the member's Appeal or Grievance. It is important to respond promptly to such requests, in order to ensure that Appeals and Grievances are resolved within the timelines standards established by state regulations.

SHP understands that there may be many sides to every issue, so it is very important for providers to respond timely to inquiries about member Appeals or Grievances. SHP uses responses from providers to identify opportunities to educate members regarding realistic expectations of access, office wait times, appropriate patient–physician and patient–office staff interaction, etc. The responses also provide opportunities for SHP to work more closely with providers on interactions that are interpreted by members to be problematic and to develop ways to improve processes.

Grievances that are clinical in nature are reviewed by a physician or other appropriately licensed professional and the outcomes are forwarded to the Credentialing Review Panel. The Credentialing Review Panel reviews Grievances for appropriateness of the resolution and to identify any trends. The Credentialing Review Panel will determine if additional follow-up with the provider is needed. If the Committee determines patient care was impacted, the case is also reviewed during the re-credentialing process.

Independent Medical Review (IMR)

Care that is denied, delayed or modified by SHP or a delegated entity may be eligible for an Independent Medical Review (IMR). If the case is eligible for IMR, information about the case will be submitted to a medical specialist not affiliated with SHP who will review the information provided and make an independent determination. If the IMR specialist so determines, SHP will provide coverage for the previously denied or modified health care service.

The IMR process is in addition to any other procedures or remedies that may be available to the member. A decision not to participate in the IMR process may cause the member to forfeit any statutory right to pursue legal action against SHP regarding the care that was requested. Members pay no application or processing fees of any kind for IMR. Members have the right to provide information in support of the request for IMR. For cases that are not urgent, the IMR organization designated by the Department of Managed Health Care (DMHC) will provide its determination within thirty (30) days of receipt of the application and supporting documents. For urgent cases

involving an imminent and serious threat to health, including but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of health, the IMR organization will provide its determination within seven (7) days. At the request of the IMR expert, the deadline can be extended by up to three (3) days if there is a delay in obtaining all necessary documentation.

Denial of a Health Care Service as Not Medically Necessary

Members may request an IMR if the member believes that health care services have been improperly denied, modified, or delayed by SHP. A "disputed health care service" is any health care service eligible for coverage that has been denied, modified, or delayed, in whole or in part, because the service has been deemed not medically necessary.

SHP will provide the member with instructions on the IMR process with any appeal findings letter that denies, modifies, or delays health care services because the service is not medically necessary. To request an IMR, the member should return the application to the DMHC. The application for IMR will be reviewed by the DMHC to determine whether the case meets all of the following conditions:

1. The provider has recommended a health care service as medically necessary;
2. The member received an urgent or emergency service that a provider determined was medically necessary, or the member was seen by a provider for the diagnosis or treatment of the medical condition for which the IMR is requested;
3. The disputed health care service has been denied, modified, or delayed by SHP or a provider, based in whole or in part on a decision that the health care service is not medically necessary
4. The member filed an appeal with SHP and SHP's decision was upheld or the appeal remains unresolved after thirty (30) days. If the appeal requires expedited review, it may be brought immediately to the DMHC's attention. The DMHC may waive the requirement that the member follow SHP's Grievance process in extraordinary and compelling cases.

IMR for denial of Experimental or Investigational Treatment for Life-Threatening or Seriously Debilitating Conditions

If a service is denied because it is deemed to be an investigational or experimental therapy, the member may be entitled to request an IMR of the denial. To qualify for review, all of the following conditions must be met:

1. The member must have a life-threatening or seriously debilitating condition. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity. "Life-threatening" means either or both of the following:
    a. disease or conditions where the likelihood of death is high unless the course of the disease is interrupted
    b. disease or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival
2. The physician must certify that the member has a condition, as described in paragraph 1 above, for which standard therapies have not been effective, or for which standard therapies would not be medically appropriate, or for which there is no more beneficial standard therapy covered by SHP than the proposed therapy.
3. Either (a) the provider has recommended a drug, device, procedure or other therapy that he/she certifies in writing is likely to be more beneficial to the member than any available standard therapies, or (b) the member or a specialist physician (board eligible or certified) has requested a therapy that, based on documentation from the medical and scientific evidence, is likely to be more beneficial than any available standard therapy.

4. The member has been denied coverage by SHP for a drug, device, procedure, or other therapy recommended or requested as described in paragraph 3 above.
5. The specific drug, device, procedure, or other therapy recommended would be a covered service, except for SHP's determination that the therapy is experimental or investigational.

If there is potential that a member would qualify for IMR under this section, SHP will send the member an application within five (5) days of the date services were denied. To request IMR, the member should return the application to the DMHC. The treating provider will be asked to submit the documentation described in paragraph 3 above. An expedited review will occur if the provider determines that the proposed therapy would be significantly less effective if not promptly initiated. In such cases the analyses and recommendations of the experts on the panel will be rendered within seven days of the request for IMR.

DMHC Help Center

The California **Department of Managed Health Care (DMHC)** is responsible for regulating health care service plans. If a member has a Grievance against the Health Plan, the member should first telephone SHP toll-free at **(844) 337-3700** or TTY/TDD at **(888) 515-4065** to access SHP's Grievance process before contacting the DMHC. Utilizing this Grievance procedure does not negate any potential legal rights or remedies that may be available to the member. If the member needs help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by SHP, or a Grievance that has remained unresolved for more than 30 days, the member may call the department for assistance. Members may also be eligible for an Independent Medical Review (IMR). If 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 **(888) 466-2219** and a TDD line **(877) 688-9891** for the hearing and speech impaired. The department's website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions.

After Services are Authorized

Providers will receive a written authorization that will specify the extent of the services authorized, Providers may not exceed those authorization limits without an additional authorization form, except in the case of a medical emergency. Providers should inform the patient's primary care physician of the need for further referral, treatment, or consultation. Please use the required authorization form or enter via the Scripps Care Link via In-Basket to request additional services. Scripps Care Link access requires a user name and password. For additional information or to request access to the Scripps Care Link, contact Provider Relations at (858) 927-5399 or via email, ProviderRelations@ScrippsHealth.org. If you have any questions about an authorization, contact Customer Service at (844) 337-3700 and request the Utilization Review Coordinator.

Concurrent Hospitalization Review

All inpatient stays are reviewed to determine the appropriate level of care in accordance with written guidelines. Telephonic and/or on-site chart reviews are conducted at all contracted Hospitals and Skilled Nursing Facilities by licensed UM staff. An initial review of all hospitalizations will occur within one business day of the notification to SHP. Subsequent reviews are conducted as

deemed necessary by the UM nurse to ensure that the length of stay and level of care meet clinical criteria. If the criteria have not been met or medical record documentation is inadequate to authorize continued stay, the nurse reviewer will consult with the patient's attending physician, physician advisors, or other appropriate hospital staff to obtain additional information.

- California licensed registered nurses or licensed physicians perform the concurrent review process utilizing approved criteria based on professionally recognized standards of practice. The process involves review of the member's medical records, contact with the attending physician, and if appropriate, speaking with the member and family.
- Concurrent review is initiated for all diagnoses within the first business day after SHP is notified of an admission (or service requiring continuing review).
- Concurrent reviews are performed respective to medical necessity and may be performed on-site or telephonically or a combination of both at the contracted hospital (or ancillary provider) for all continued stays/services.
- The UM Nurse refers all questionable cases or potential medical necessity denials to the SHP Chief Medical Officer or UM Physician Reviewers for review and action as appropriate.
- The UM Nurse, SHP's Chief Medical Officer or UM Physician Reviewer will contact the provider before making denial decisions regarding care that is already underway, (concurrent review), and that care shall not be discontinued until the provider has been notified, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that member.

Concurrent Review Decision Making Timeframes: SHP will make concurrent review decisions within twenty-four (24) hours of obtaining all necessary information.

- SHP will notify practitioners within twenty-four (24) hours of making concurrent review decisions.
- SHP will provide members and practitioners with written or electronic confirmation of review decisions within twenty-four (24) hours of making concurrent review decisions.

In the event that a Member is admitted to a facility outside the SHP's Service Area, the UM department will work with the Out-of-Area (OOA) facility to assess whether repatriating the member (transferring the Member to a SHP-contracted facility) is indicated, determine when it is medically appropriate for the member to be safely transferred back into the service area, and assist in coordination of the transfer. The UM staff reviews admissions to Out-of-Network (OON) facilities telephonically. The UM staff facilitates transfer of the patient to a SHP contracted hospital as soon as medically appropriate.

- Admissions to non-contracted facilities are reviewed via telephone by a registered nurse/physician.
- The UM Nurse, member's PCP or other treating physician will work with the non-contracted provider in order to bring the member back into the care of contracted providers and facilities as soon as the member's condition is medically stable and appropriate for transfer (or transition, in the case of ambulatory services).
- The UM Nurse will monitor services provided by the non-contracted provider for potential quality issues (PQIs), and intervene as needed to avoid duplications of, or gaps in care, or other events which could lead to poor patient outcomes. Quality issues will be referred to the Quality Management Department for investigation and resolution where appropriate.

Discharge Planning

Discharge Planning is an integral component of the UM process that is initiated at admission (or earlier, when possible) with an assessment of the member's potential discharge care needs. It includes preparation of the member and his/her family for continuing care needs and initiation of arrangements for placement or services needed after discharge. Discharge planning is a process that begins prior to an inpatient admission with an assessment of each patient's potential discharge needs. Discharge planning activities are carried out by SHP or a delegated entity's UM staff in coordination with hospital staff, which may include discharge planners, social workers, or nurse case managers in conjunction with the treatment team.

Retrospective Authorization Review

Medical record review to determine appropriate utilization of services may be conducted in cases where there is a question regarding medical management, or for cases in which SHP was not notified before or during the provided service. Cases for retrospective review are often identified upon receipt of an unauthorized claim. Cases may also be identified through requests for retrospective authorization from OON or OOA Providers. Retrospective reviews will be processed within thirty (30) days of receipt.

Emergency Services

"Emergency services" means a medical and/or psychiatric screening, examination, and evaluation by a physician, or by other appropriate licensed persons, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

"Emergency Services & Care" means services provided for an emergency medical condition, including a psychiatric emergency medical condition or active labor, manifesting 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:

1. Placing the Member's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part; or
4. A psychiatric disorder placing the member in immediate danger to himself/herself or to others, or is unable to provide or use food, shelter or clothing

"Active labor" means a labor at a time at which either there is inadequate time to effect safe transfer to another hospital prior to delivery or a transfer may pose a threat to the health and safety of the patient or the unborn child.

A patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating physician, or other appropriate licensed persons, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient. Emergency Services Providers may screen and stabilize a member without prior authorization in order to stabilize an emergency medical condition.

Second Medical Opinions

A second medical opinion by an appropriately qualified healthcare professional are available in accordance with AB12, and CA Health and Safety Code 1383.15. A second medical opinion may be covered by SHP, if requested by the member or a participating health professional, for any of the following reasons:

- If member questions the reasonableness or necessity of the recommended surgical procedures.
- If the member questions their diagnosis or plan of care for a condition that threatens loss of life, limb, loss of bodily functions, or substantial impairment, including a serious chronic condition.
- If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating provider is unable to diagnose the condition.
- If the treatment plan in progress is not improving the medical condition 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.
- If the member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

Members or Providers may request a second opinion through SHP's UM Department or the member's PMG. Requests will be reviewed and facilitated through the authorization process. A request for a second opinion about care provided by the member's PCP must be obtained by another qualified participating provider within the member's PMG and the PMG shall provide the second opinion. A second opinion consult about care from a specialist, the member or provider may request authorization to receive the second opinion from a specialist of the same or equivalent specialty within any PMG in the SHP network.

When there is no qualified provider within the network, the member may request authorization for a second opinion consultation from an out-of-network provider. If authorization is received for an out-of-network provider, the authorization will be for a consult only and that provider should not perform, or provide care beyond the consult, as SHP does not provide reimbursement for such care. For questions about second opinions or a copy of the SHP's policy, please visit www.scrippshealthplan.com.

Standing Referrals

Members who require specialized care over a prolonged period for a life-threatening, degenerative or disabling condition, including Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), may be granted a standing referral to a specialist who has expertise in treating the condition or disease, or for the purpose of having the specialist coordinate the member's healthcare. Specialists and specialty care centers are validated to assure the provider holds appropriate accreditation or designation as having special expertise in treating the condition or disease. A list of specialists, including HIV/AIDS specialists, are reviewed and updated annually, emailed to the UM/Case Management & Provider Relations staff and kept in shared files. A listing of specialists and specialty care centers, including HIV/AIDS specialists are available to providers via the plan website to assist in the referral process. The PCP can request authorization for an out-of-network specialist if one is not available within SHP' Network, who can provide appropriate

specialty care to the member as determined by the PCP in consultation with SHP's Chief Medical Officer and as documented in the treatment plan.

Requesting a Standing Referrals

Members and their treating/referring physicians may contact Customer Service to request a Standing Referral:

1. The PCP and specialist determine the need for continuing care from the specialist and request authorization based on an agreed upon treatment plan, if any. Treatment plans may limit the number of specialist visits or the length of time the visits are authorized, and may require the specialist to make regular reports to the PCP.
2. The determination shall be made within three (3) business days of the date the request from the member or the member's PCP and all appropriate medical records and other items of information necessary to make the determination are provided.
3. If authorized, the referral will be made within 24 hours of the decision, specifying the specific services approved. Services shall be authorized as medically necessary for proposed treatment, of a duration not to exceed one year at a time, utilizing established criteria and consistent with benefit coverage.
4. Once a determination has been made, the referral shall be made within four (4) business days of the date the proposed treatment plan, if any, is submitted to the UM team.
5. The PCP retains the responsibility for basic case management and coordination of the member's care, unless a specific arrangement is made to transfer care to the specialist for a specified period of time, in accordance with the PCP contract with SHP.
6. After receiving the standing referral approval, the specialist is authorized to provide healthcare services that are within the specialist's area of expertise and training to the member in the same manner as the PCP.
7. When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, SHP will refer the member to an HIV/AIDS specialist who meets California Health and Safety Code criteria.
8. Member Denial Letters for Standing Referrals will include:
    a. Clear and concise explanation of the reasons for the denial or modification of the originally requested service;
    b. Clinical reasons for the Plan's decision to deny, delay, or modify health care services.
9. Written communications to a member of a denial, delay or modification of a request include information as to how the member may:
    a. File a grievance to the Plan;
    b. Request an Independent Medical Review in cases where the member believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers
10. Written communications to a Physician or other health care provider of a denial, delay, or modification of a request shall include the following information:
    a. The name of the health care professional responsible for the denial, delay, or modification;

b. The direct telephone number or an extension of the healthcare professional responsible for the denial, delay, or modification to allow the requesting Physician or health care provider to easily contact them.

Complex Case Management Program

SHP's Complex Case Management Program uses a client/caregiver approach to promote availability of appropriate care and resources while maximizing the member's quality of life and health care benefits. Case Management is a collaborative process with the patient, family, physician, and other treating entities, designed to meet the individual's needs while promoting quality outcomes. Our Case Management nurses work closely with Plan Providers to develop and implement the most appropriate treatment plan for the member's needs. Providers interested in referring a member to the Complex Case Management Program, can call SHP Customer Service department at 844-337-3700. Any individual involved in the care of a member may make a referral to the Complex Case Management Program, including the Primary Care Provider (PCP), Specialist, Discharge planner, and Plan staff.

Each case is considered on an individual basis. Cases not accepted into the Complex Case Management Program are kept on file for future reference. Referrals to the Complex Case Management Program are screened for medical, psychosocial, financial, and related needs no later than thirty (30) calendar days from the date the member is eligible for Complex Case Management. The Case Manager assesses each referral through medical records and discussion with the PCP and other involved parties, as needed. Referrals for Case Management services include, but are not limited to, the following situations in which care coordination is needed to meet members' needs while promoting appropriate utilization of services and cost-effective outcomes:

- Transplants
- Chronic pain management
- Behavioral health issues
- Medication management
- Out-of-area/out-of-network services
- Care facilitation
- Second opinion coordination
- Social support issues

As appropriate, the Case Manager will facilitate care coordination for Members who have the following indicators:

- Three (3) or more acute hospital admissions per year
- Two (2) or more emergency department visits in a three (3)-month period
- Non-compliance with medical recommendations and care
- Complex medical needs that require close monitoring
- Home-health needs
- Life expectancy of six (6) months or less
- Inpatient hospital stay of greater than ten (10) days
- Complex psychosocial or functional requirements
- Quality issues related to clinical care

When a member is accepted into the Complex Case Management Program, the Case Manager performs the following functions:

- Serves as a liaison and resource for providers and members and their families
- Communicates information to caregivers to obtain consensus on a plan of care
- Develops and coordinates a plan of care with realistic and appropriate goals/outcomes

- Assists with the transfer of members from one facility to another
- Facilitates physician-to-physician communication and other communication when needed
- Manages all Authorizations for services for the assigned member
- Makes appropriate referrals to state and county waiver programs or other community resources

The Case Manager closes a case when one or more of the following endpoints have been established:

- Services are no longer needed due to resolution of the patient's illness or the patient's death
- Reasonable goals and objectives in the Plan of Care have been met and the member's condition is stabilized
- Family and other support systems are able to adequately provide needed services
- Care coordination is ongoing without the need for oversight by the Case Manager
- The member has moved out of the Service Area
- The member refuses Case Management services

Disease Management

The purpose of SHP's the Disease Management (DM) Program is to guarantee the delivery of the highest quality possible in the level of care and service provided to SHP members with chronic conditions. To ensure this level is achieved and/or surpassed, programs/activities having a direct or indirect influence on the quality and outcome of clinical care and service delivered to all members are consistently and systematically monitored and evaluated. The evaluation process is fully documented, issues are relevant to the enrolled member population, responsibility is assigned to appropriate individuals, and when opportunities for improvement are noted, recommendations are provided. The DM Program clearly defines the structure, goals, organization, objectives and processes, functional areas, reporting relationships and assignment of responsibilities to appropriate individuals.

Continuity of Care

Scripps Health plan (SHP) is in compliance with CA Health and Safety Code Sections 1300, 1367, 1373 and provides continuity of care for members currently receiving a course of treatment from a terminated provider and for new enrollees who are undergoing an Active Course of Treatment from a non-participating provider. Transitions of Care (TOC) include member notifications when an individual in a course of treatment enrolls in SHP and when a medical group or provider is terminated from the network. SHP also facilitates transitions of care when changes occur within the provider network as well as for new members and members with special needs and circumstances. The member should request a transition of care form from customer service to expedite the approval of the transition of care. When a member is actively receiving care and that care may be disrupted by the departure of a physician from the network, the member will be notified of the departure sixty (60) days prior to the provider termination date. When the provider fails to notify SHP timely of their termination with the plan, SHP will notify the member as soon as possible. .

Monitoring for Over- or Under-Utilization

SHP monitors UM performance indicators by each provider group and individual providers. Utilization statistics are reviewed and monitored for identification of high risk, high volume utilization. Statistics monitored include inpatient statistics for both acute hospitalizations, emergency encounters, and skilled nursing facility stays. Inpatient utilization management may focus on specific high volume or problem prone diagnoses and outpatient ambulatory statistics are also monitored. Readmissions to acute and skilled nursing facilities are monitored with a quarterly report submitted to the Medical Management Committee. If the Committee identifies adverse trends, a corrective action plan will be recommended.

Data related to appeals are tracked and trended to identify delays in care or service. A summary report is presented to the Medical Management Committee quarterly. Adverse trends are addressed through identification and implementation of an appropriate corrective action.

III. Enrollment & Eligibility

Member Enrollment Overview

SHP members select a Primary Care Physician (PCP) upon enrollment. Members who select a PCP affiliated with a clinic may be assigned to the clinic, not an individual physician within the clinic. In the event a PCP and PMG are not selected on the enrollment form, SHP will assist with selecting a PCP and PMG near the member's residence. SHP encourages selection of a PCP within thirty (30) minutes or thirty (30) miles of a member's residence or work place. In the event SHP cannot reach a member, the Plan will assign a PCP based on the following factors:

- The member's home address and/or work address
- The member's documented language preference
- The member's age (pediatric or adult medicine)

Members will receive an ID card by mail that lists the PCP that has been assigned to them. They can contact Customer Services at 844-337-3700 to change their PCP. In most cases, members are effective with their PCP on the first day of the next month. For example, if the member calls to select a PCP on March 16th, the assignment to that PCP becomes effective on April 1. Exceptions may be made on a case-by-case basis.

Eligibility Verification

Providers are responsible for verifying every member's eligibility prior to rendering services, unless the services are emergent. All members should present their health plan identification card each time services are requested. The SHP Identification Cards identify the following information:

- Member Name and ID Number
- Group name and number
- Card issue date
- Assigned Medical Group
- Primary Care Physician (PCP) name and office phone number
- Copayments and Deductibles
- Claims mailing address
- SHP Customer Service toll-free number
- MedImpact (pharmacy benefit) phone number
- Cigna Behavioral Health (mental health benefit) phone number
- American Specialty Health Plans (acupuncture and chiropractic benefit) phone number

It is the responsibility of each Provider to verify eligibility prior to providing services. Although the ID card is a primary method of identification, possession of the card does not guarantee eligibility, coverage, or benefits. Eligibility to receive services depends on verification from SHP. A new identification card is issued each time a member changes their PCP or PMG, but members may forget to present the most recent card when accessing services. Therefore, it is important to verify eligibility with each visit. Eligibility may be verified through the Epic web portal or by calling SHP Customer Service at 844-337-3700 Monday through Friday, 8:00 a.m. to 5:00 p.m.

Eligibility List

In order to ensure the proper management of care for members enrolled with SHP, our contracted PMGs have access to the SHP secured file transfer (FTP) site to obtain current eligibility files by

PMG. The electronic eligibility data files are updated regularly at mutually agreed-upon intervals. These lists contain information regarding the member's enrollment status for that particular month. It is the responsibility of the PMG to share this information with its PCPs and other contracted Providers. In the event of a reported discrepancy between the eligibility file and the member's current enrollment, please use the options listed above under Eligibility Verification to confirm the member's current status.

Provider Initiated Member Dismissal

Rarely, a Provider may provide care to a member who is disruptive or excessively difficult. In the event that the patient-physician relationship is irreparably damaged, the provider may submit a request to SHP to have the member assigned to a new PCP or to have care transferred to a new specialist. The provider is obligated to provide medically necessary care and access to services for as long as the member requires services, or until the relationship is terminated appropriately. A member may not be terminated or denied care due to diagnosis, health status/needs, or language barriers. Member dismissal will be considered under the following circumstances:

1. Member is non-compliant with recommended treatment plans to the extent that member's health is endangered.
2. Member demonstrates verbally abusive behavior toward the physician, ancillary or administrative office staff, or to other plan members.
3. Member physically assaults a provider, staff member, or plan member, or the member threatens any individual with any type of weapon on plan or provider premises, or verbalizes the intent to cause bodily harm. In such cases, appropriate charges should be brought against the member, and a copy of the police report submitted along with the request.
4. Member is disruptive to provider or plan operations with potential for limitations on access to care by other patients.
5. Member habitually uses non-contracted providers for non-emergency services without required authorization.
6. Member refuses to meet financial obligations such as copayments or coinsurance.
7. Member has a history of multiple missed appointments.
8. Member attempts to fraudulently obtain health care services, including allowing others to use the member's plan identification card to receive services.

The process for dismissal, if necessary, is as follows:

1. The Provider should discuss the conflict or problem with the member prior to requesting dismissal. Communication should include written documentation that conveys a clear set of instructions, the compliance requirements, and the consequences, if any, for not following the instructions, placing responsibility for compliance directly on the member.
2. The Provider requests authorization to dismiss the member from the panel by faxing a completed "Scripps Health Provider Member Dismissal Form" to the attention of Performance Improvement at (858) 260-5879.
3. The Dismissal Form should be completed in full and include supportive documentation detailing the situation. Supporting documentation may be in the form of copies of medical records, office notes, etc., and may include:
    a. Pertinent dates (missed appointments);
    b. Documentation of conversations (verbal abuse);

   c. Billing statements, including amount due, letters advising members to pay their bill (financial); and/or
   d. Documentation of previous attempts to educate member regarding noncompliance with recommended treatment plans or office practices.
4. SHP will request additional documentation from the Provider if necessary. Failure to provide documentation to support the dismissal request within five (5) working days of SHP's request will result in the request for dismissal being denied.
5. Requests for dismissal will be reviewed by the Chief Medical Officer.
6. If approved, the Provider will receive written authorization to dismiss the member within thirty (30) days of SHP's receipt of all supporting documentation.
7. After the Provider receives authorization from SHP to dismiss the member, the Provider has five (5) working days to provide the written notification to the member and to send a copy of such notice to SHP.
8. The notification must include the reason for the dismissal, and must not occur before authorization is received from SHP.

SHP will not contact the member for reassignment until SHP has received a copy of the dismissal letter sent to the member by the provider. If SHP does not receive a copy of the dismissal letter within ten (10) business days following SHP's approval to dismiss, the dismissal becomes invalid. The Provider is required to initiate the process again if they wish to pursue the dismissal. The provider is required to provide treatment and access to services until the member selects a new physician or a new physician is assigned. When a PCP dismisses a member, all referrals and authorizations for that member will be invalidated. The member must contact the new PCP to obtain new referrals and authorizations. If a PMG wishes to dismiss a SHP member from all of their office locations, the PMG should contact the SHP Compliance Director. The request will be reviewed on a case-by-case basis.

IV. Claims & Provider Reimbursement

As required by California Assembly Bill 1455, the Department of Managed Health Care (DMHC) has set forth regulations establishing "fair" and "reasonable" claims settlement practices, and the process for resolving claims disputes between providers and commercial managed care plans regulated by the DMHC.

The purpose of this notice is to inform you of your rights, responsibilities, and related procedures as they relate to claim settlement practices and claim disputes for **Commercial HMO** products where Scripps Health Plan Services (SHPS) is the primary payor, or has been delegated to perform claims payment and provider dispute resolution processes. AB 1455 does not apply to Medicare or Med-Cal managed care products. Specific obligations of AB 1455 – including a provider's right to fair claims reimbursement practices – have been included. Unless otherwise provided herein, *italicized* terms have the same meaning as set forth in Sections 1300.71 and 1300.71.38 of Title 28 of the California Code of Regulations.

Submitting Claims to SHP

Electronically: We currently accept claims submission via Change Healthcare (please contact your vendor to add payor ID 330099), Office Ally (please contact your vendor to add payor ID SHPM1), or the Scripps Care Link. Contact Customer Service if you need access to Scripps Care Link by calling (844) 337-3700.

Via Mail:

Scripps Health Plan
Attention: Claims
P.O. Box 2529
La Jolla, California 92038

Claims which are not the responsibility of SHP (e.g., carve-outs, non-delegated services, incorrect responsible payor, COB, etc.) are forwarded to the responsible payor within ten (10) calendar days. *Plans are required to forward misdirected claims to the appropriate medical group/IPA and medical groups must forward misdirected claims to the appropriate health plan.*

ICD-10

SHP conforms to ICD -10 clinical coding conversion and does not accept claims with ICD-9 codes. Professional and Institutional claims received electronically or on paper with ICD-9 codes will not be accepted with dates of services on or after October 1, 2015. These claims will be returned to the provider. The provider will be required to resubmit the claims with the appropriate ICD-10 codes. A claim cannot contain both ICD-9 and ICD-10 codes if the services span after October 1, 2015. These claims must be split on separate claims to reflect the dates of service September 30, 2015 and prior, with ICD-9 codes and dates of service October 1, 2015 and after, with ICD-10 codes.

Claims Submission Requirements

SHP accepts claims from contracted providers within ninety (90) calendar days of the date of service. SHP reserves the right to deny reimbursement of claims submitted beyond this timeframe and shall take into account extenuating circumstances or "good cause" for a delay in submission. The forms CMS 1500, UB-04 or equivalent form shall include, but not be limited to the following data elements:

- Enrollee's name, address, member ID, date of birth, sex, date(s) of service, place of service, diagnostic code(s) and description(s) and the authorization number.
- Procedures, services or supplies furnished. CPT codes for the current year shall be used for all professional services and HCPCs codes shall be used for supplies, equipment, injections, etc. Items not listed shall be billed utilizing CPT and HCPCs claims submission guidelines
- Skilled Nursing Facility Claims require Level of Care
- Inpatient forms UB04 require at least (1) DRG code
- For ESRD claims, Boxes 39 and 41 must be completed to determine reimbursement
- Box 32 – Service Facility/Location Information
- Taxonomy Codes on Institutional Claims
- Physician Group, Physician's name and Facility Name
- National Drug Code (NDC) qualifier, number quantity and unit/basis of measure. If any of these elements are missing, the line or claim will be denied
- National Provider Identifier ("NPI") Number
- Provider's address and telephone number
- Billed Charges
- Units (when applicable)
- Resubmission Code is required for all corrected claims. If a Resubmission Code is 6, 7, or 8. Field 22 on the CMS-1500 and Field 4 on the UB-04, the original claim number is required

Claims Submission Instructions. We currently accept claims submission via:

- Scripps Care Link: If you need access to Epic's provider web portal, call Customer Service at (844) 337-3700
- **Change Healthcare:** Please contact your vendor to add payor ID 330099
- **Office Ally:** Providers already registered with Office Ally should call (360) 975-7000, SHP's Client ID number is: SHPM1. New users can register online at cms.officeally/register/register.aspx

Calling SHP Regarding Claims: For claim filing requirements or status inquiries, Providers may contact Customer Service at (844) 337-3700. Providers who have access to Epic's web portal may view claims status online.

Plans may not impose a deadline for claims submission that is less than ninety (90) days for contracting physicians and less than one hundred and eighty (180) days for non-contracting physicians. Plans must accept a late claim if the physician files a formal physician dispute with the payor and demonstrates "good cause" for the claim filing delay.

Special or Unique Billing Codes

A Provider whose contract has the approval to use special billing or unique billing codes please follow there instructions:

- Special billing code(s) be sent at the line level (2400 loop) or the 837 claim file.
- Specifically the 2400 NTE segment with qualifier of ADD.
  For example: NTE*ADD*EP
- In cases where a description needs to be sent along with the code, the caret character (^) needs to be added to separate the code from the description.
- All other 5010 Requirements are to be followed.

Claim Receipt Verification

Providers will receive an automatic claim receipt notification in the same format the original claim was submitted. For verification of claim receipt by SHP, contact Customer Service at (844) 337-3700. Providers who have access to Epic's web portal may view claims status online.

Plans must acknowledge receipt of all physician claims, whether or not complete, electronically, by post, phone or website. Plans must provide physicians with a Notice to Provider of Dispute Mechanisms whenever a plan contests, adjusts or denies a claim.

Claims Adjudication

The Health Plan Matrices describes which payor (SHP, a delegated group, or a carved-out benefit) is responsible for reimbursement of Professional and Institutional services and assists Provider in determining where to submit claims. The Health Plan Matrices are updated regularly and provide general guidelines for the Claims Department to accurately and promptly process claims for which SHP is financially responsible. SHP utilizes a claim scrubbing software program which automatically applies CMS Correct Coding Initiative ("CCI") edits along with other coding guidelines to ensure appropriate billing-coding practices and reimbursement to Providers. This software provides auditing logic for all modifiers allowing payment modifications, if appropriate. SHP will process claims based on the industry standards, CPT guidelines, CCI edits, and in compliance with State and Federal regulations.

SHP proactively makes appropriate claims adjustments and applies interest to reimbursements. Payment errors that are identified prior to the check runs are adjusted by reprocessing and re-adjudicating it at the correct rate. All claims adjustments or modifications which affect reimbursement are reflected on the Provider's Explanation of Benefits (EOB).

Plans must provide an accurate and clear written explanation of the specific reasons that each claim has been denied, adjusted or contested.

Reimbursement Timeliness

SHP will adjudicate complete claims within sixty (60) calendar days (Forty-five [45] working days) of the Date of Receipt. A complete claim is defined as a claim that may be processed without obtaining additional information from the provider of service or from the patient.

SHP may contest or deny a claim, or portion thereof, by notifying the Provider in writing on the Explanation of Benefits (EOB) that the claim is contested or denied, within sixty (60) calendar days (Forty-five [45] working days) after the Date of Receipt of the claim by SHP. If an uncontested Provider claim is not processed within sixty (60) calendar days (Forty-five [45] working days), then the Provider is entitled to applicable late payment interest rate. If SHP fails to include the interest amount in a payment to a provider a $10.00 fee will also be imposed on SHP. Late payments on complete claims for emergency service shall include $15.00.Plans must reimburse claims with the correct payment including the automatic payment of all interest and penalties due. Plans must contest or deny claims within forty-five (45) days (HMO) of receipt.

Providers Dispute Resolution

A Provider Dispute is a provider's written notice to SHP challenging, appealing or requesting reconsideration of a claim or a bundled group of substantially similar multiple claims that are individually numbered. The disputed claim(s) must meet at least one of the following conditions:

- Denied, Adjusted or Contested, or
- An adjudication error or other contract interpretation dispute, or
- Disputing a request for reimbursement of an overpayment of a claim, or
- Disputing a request of a refund letter from Scripps Health Plan.

Additional Information: Resubmitted claims that have additional information attached such as records, authorization or itemized statements that have been previously processed and paid at zero should be marked "corrected claim" and are not considered Provider Disputes. Do not submit these types of claims as a Provider Dispute. Each Contracted Provider Dispute must be in writing and contain at a minimum the following information:

- Written notation on the cover sheet that it is a Provider Dispute Request
- Provider's Name
- Provider's Identification Number (Tax ID)
- Provider's Contact Information, and

If the Provider Dispute concerns a claim the following must be provided:

- Member/Patient Name and Date of Birth
- Corrected claim (if appropriate)
- Reports or other supporting attachments, i.e. progress notes, operative reports, etc.
- A clear written identification of the disputed item(s)
- SHP claim number(s)
- Copy of the SHP Explanation of Benefits (EOB) for the date of service
- A clear explanation in writing of the basis upon which the Provider believes the payment amount, request for additional information, contest, denial, adjustment or other action is incorrect

Bundled Claims: If the Provider Dispute involves a bundled group of substantially similar claims each claim must be individually numbered. If the Provider Dispute is not about a claim, a clear written explanation of the issue and the provider's position on such issue. If the Provider Dispute represents a member or group of members the following written information must be provided:

- The names and identification number(s) of the member or members
- The Date of Service
- A clear written explanation of the disputed item and the Provider's position on the dispute
- A member's written authorization for Provider to represent said member.
- SHP claim number(s)

SHP Provider Dispute Resolution Team shall process all provider disputes. If the Provider Dispute involves an issue of medical necessity or utilization review, the provider shall have an unconditional right of appeal. Providers shall appeal the claim dispute for a de novo review and resolution for a period of sixty (60) working days from SHP's Date of Determination. Included in this Provider Manual is the Provider Dispute Resolution Form (Exhibit B) which must be used to submit a Provider Dispute Resolution Request. This form is also available at www.scrippshealthplan.com.

All Provider Disputes must be sent to the attention of SHP Provider Disputes Department:

Scripps Health Plan
Attention: Provider Dispute Resolution
P.O. Box 1928
La Jolla, California 92038
Fax: 858-260-5878

Time Period for Submission of Provider Disputes

Provider Disputes must be received by SHP within three hundred and sixty-five (365) calendar days from SHP's last date of action on the issue, or in the case of inaction, Provider Disputes must be received by SHP within three hundred and sixty-five (365) calendar days after the time for contesting or denying a claim has expired. Provider Disputes that do not include all required information set forth above may be returned to the submitter for completion. An amended Provider Dispute, which includes the missing information, must be submitted to SHP within thirty (30) working days of the receipt of a returned Provider Dispute. SHP will acknowledge receipt of all Contracted Provider Disputes by sending an acknowledgment letter within two (2) working days when submitted electronically, and fifteen (15) working days from the Date of Receipt by SHP for all other claims.

Plans may not impose a provider dispute filing deadline of less than three hundred and sixty-five (365) days from the date the plan denied the claim. Plans must acknowledge the receipt of a provider dispute within two (2) working days of the receipt of an electronic provider dispute and within fifteen (15) days of the date of receipt of a paper provider dispute.

Acknowledgement of Contracted Provider Disputes: SHP will acknowledge receipt of all Contracted Provider Disputes by sending an acknowledgment letter within fifteen (15) working days from the Date of Receipt by SHP.

Contacting SHP Regarding Contracted Provider Disputes: Contact Customer Service at (844) 337-3700 for inquiries regarding the status of a Provider Dispute, or about filing a Provider Dispute.

SHP will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) working days after the Date of Receipt of the Provider Dispute. If the Provider Dispute is regarding an underpaid claim and it is determined in whole or in part in favor of the provider, SHP will pay any outstanding monies determined to be due, and applicable State interest and penalties required by law or regulation.

Plans must resolve physician disputes within forty-five (45) days of receipt of the physician dispute.

Claim Overpayments

If SHP determines a claim or claims have been overpaid, SHP will notify the Provider in writing through a separate notice. The notice will clearly identify the claim(s), the name of the member/patient, the Date of Service(s) and a clear explanation of the basis upon which SHP believes the amount paid on the claim(s) was in excess of the amount due, including applicable State or Federal interest and penalties on the claim(s). SHP must submit a written request for a refund of an overpayment to the Provider within three hundred and sixty-five (365) calendar days from the Date of Payment, or last action on the claim.

Plans must appropriately request refunds for claims that have been overpaid.

Contested Notice: If the Provider contests SHP's notice of overpayment of a claim, the Provider**,** within thirty (30) working days of the receipt of the notice of overpayment of a claim, must send written notice to SHP. The notice must state the basis upon which the Provider believes that the claim was not overpaid. SHP will process the contested notice in accordance with SHP's Provider Dispute Resolution Process described in this Provider Operations Manual.

No Contest: If the Provider does not contest SHP's notice of overpayment of a claim, the Provider must reimburse SHP within thirty (30) working days of the Provider's receipt of the notice of overpayment of a claim. If a provider reimbursement is not received and posted at SHP within forty-five (45) working days of the initial letter, the claim will be offset from future monies owed to the provider.

Offsets to Payments: SHP may only offset an uncontested notice of overpayment of a claim against a Provider's current claim submission when the Provider fails to reimburse SHP within the time frame set forth above. In the event that an overpayment of a claim or claims is offset against the Provider's current claim or claims pursuant to this section, SHP will provide the Provider with a detailed written description. The specific overpayment or payments that have been offset against the specific current claim or claims will be identified in the initial overpayment notification letter.

Additional Protections for Contract Providers

AB 1455 requires health plans and their delegates responsible for reimbursement to abide by certain other requirements promulgated by the DMHC, which are considered to generally prevent unfair and/or unreasonable claims settlement practices.

Contracting: Plans may not include a provision in a provider contract that requires a provider to submit medical records that are not reasonably relevant to the adjudication of a claim.

- Plans must contractually require its claims processing organizations and/or its capitated provider(s) to comply with the requirements of these regulations.
- Plans must provide Information for Contracting Providers, the Fee Schedule and Other Required Information disclosures to all contracted providers on or before January 1, 2004, initially upon contracting and upon the contracted provider's request.
- Plans must provide contracted providers with forty-five (45) days-notice of any modifications to the Information for Contracting Providers, to the Fee Schedule or Other Required Information.
- Plans may not require physicians to waive protections or assume any plan obligations pursuant to the Knox-Keene Act.

Requests for Additional Documentation (Medical Records): Plans must justify to DMHC that requests for medical records more frequently than in three-percent (3%) of the claims submitted over any 12-month period for non-emergency services and twenty percent (20%) of the claims submitted for emergency services were reasonably necessary.

Authorizations: Plans cannot rescind or modify an authorization for services after the provider renders the services pursuant to a prior authorization.

Coordination of Benefits (COB) & Order of Benefit Determination

Industry standard rules have been developed by the National Association of Insurance Commissioners (NAIC) in order to assist with this evaluation. Additionally, some states have also developed their own standards (which typically follow the general guidelines of the NAIC rules). These rules have been adopted by SHPS and are called "the Order of Benefit Determination" (OBD). These guidelines are detailed below and shall be utilized by SHPS staff when determining if primary and secondary payer responsibility.

At the time the Provider obtains patient billing information from the Member, the Provider should also determine if additional insurance resources exist. When they do exist, these resources must be identified on the claim form in order for SHP to adjudicate the claim properly.

In General, when a Member is the primary beneficiary (as an employee, individual subscriber, policyholder or retiree), that plan is billed first (the primary plan) and the plan that covers the Member as a dependent is the secondary plan. If the person is a Medicare beneficiary (including Medicare Advantage Members), in accordance with Title 18 of the Social Security Act, Medicare shall be secondary to the plan covering the person as a dependent.

Dependent Child Covered Under More Than One Plan

For a dependent child whose parents are married or are living together, whether or not they have ever been married the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

For a dependent child whose parents are divorced or separated or are not living together, if a court decree states that one of the parents is responsible for the dependent child's health care expenses or coverage, that plan is primary.

Contact SHP Customer Service if you have questions about benefit coordination or to request SHP's Coordination of Benefits & Order of Benefit Determination Policy.

Subrogation: (Third Party Liability)

Upon enrolling, SHP's Members agree to subrogation in the event of a claim resulting from an injury or loss attributed to the negligence or other action of another party and for SHP to seek a legal remedy on behalf of the member. Members are required to provide accurate information with regard to their health coverage, failure to do so is considered fraud.

SHP's Providers have direct contact with SHP Members, making them the best source of timely third-party liability (TPL) notification to SHP. Providers have an obligation to report the existence of other insurance or liability due to an accident or injury caused by a third party. Cooperation is essential to ensure prompt and accurate reimbursement. Providers should contact SHP's TPL Department by calling (844) 337-3700.

V. Quality of Care

SHP's Quality Management (QM) Department is responsible for overseeing the Quality & Safety of clinical care provided in the SHP Network and to SHP's Members. Program Goals are achieved through the development of a systematic, and on-going processes for the objective evaluation of member care. QM Program goals are prioritized to identify opportunities for improvement which have the greatest opportunity to improve care delivery and outcomes throughout the health care delivery network and population served.

SHP utilizes the Plan-Do-Study-Act process for evaluating performance improvement activities. Processes are in place to monitor key performance improvement indicators, such as member and provider satisfaction questionnaires, member and provider complaints and appeals & grievances, risk management reports, UM statistics, credentialing/re-credentialing results, clinical record audits and findings through peer review.

Quality Management (QM)

The purpose of the SHP Quality Management (QM) Program is to maintain a comprehensive, coordinated process that continually evaluates, monitors, and improves the quality of clinical care and service provided to members within the SHP health care delivery system. SHP's QM Program incorporates review and evaluation of all aspects of the health care delivery system. Following is an outline of several components of the QM Program.

Medical Record & Documentation Standards

Timely and complete documentation of all health care services ordered and provided is a critical element to patient safety, compliance, and accurate reimbursement. All care providers must accurately and legibly record the medical services provided in the medical record at the time the service is performed or the finding or event observed. In order to reflect the complexity of the patient's case, it is also important to document a complete history and physical, including all comorbidities present. Providers must diligently document physician authorizations, referrals, and orders for care when required.

Standards for Documentation: All Medical Records, regardless of form or format, must be maintained in their entirety, and no document or entry may be deleted from the record. Handwritten entries should be made with permanent black or blue ink, with medium point pens to ensure the quality of electronic scanning, photocopying and faxing. All entries in the medical record must be legible to individuals other than the author.
Content Requirements: The Medical Record contents should meet all State and federal legal, regulatory and accreditation requirements including but not limited to the standards found at Title 22 of the California Code of Regulations15 and the Medicare Conditions of Participation16.
Completion, Timeliness and Authentication: Inpatient Medical Records must be completed within fourteen (14) days from the date of discharge. Providers should be familiar with additional requirements within their medical practice or hospital Medical Staff Policies. Operative and procedure reports must be completed timely after the procedure. Medical Record entries must include the date, the time entered, and the Provider's signature (entries may be authenticated by a signature stamp or computer key, in lieu of a medical staff member's signature).

Late Entries: When a pertinent entry was missed or not written in a timely manner, the author must meet the following requirements:

- Identify the new entry as a "late entry"
- Enter the current date and time – do not attempt to give the appearance that the entry was made on a previous date or an earlier time
- The entry must be signed.
- Identify or refer to the date and circumstance for which the late entry or addendum is written.
- When making a late entry, document as soon as possible. There is no time limit for writing a late entry; however, the longer the time lapse, the less reliable the entry becomes.

Medications: Evidence of prescribed medications should be clearly noted in the record and should include dose, frequency and dates of initial or refill of prescription. A medications list should be updated each visit. Allergies and adverse reactions to medications should also be prominently noted in chart.
Problem List: A problem list recorded with progress must be present and include any significant illness or medical and/or psychological condition found in the history or in previous encounters. The problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-10 diagnosis code on the date of service. A problem list may be either a classical separate listing of problems or an updated summary of problems in the progress note section (usually a periodic health exam). The latter should be updated at least annually and should include health maintenance documentation.
Medical History: A past medical history which includes dates of serious accidents, operations and illnesses. For children and adolescents, the past medical history includes dates of prenatal care,

birth, operations and childhood illnesses. Family history should include a review of medical events, diseases and hereditary conditions that may place the member at risk. History and Physical (H&P) documentation should have subjective/objective information for each presenting complaint, past medical history including physical examinations, necessary treatments and possible risk factors for the member relevant to the particular treatment. For members 14 years and older a response to an inquiry concerning alcohol, smoking and/or substance abuse history as part of risk screening in support of preventative health.

Immunizations & Preventive Care: An immunization record (for children) which includes the name of the vaccine and date of administration or disease (e.g., chickenpox) is up to date or an appropriate history has been made in the medical record (for adults). There is evidence that preventive screenings and services are offered in accordance with SHPS' clinical guidelines. Preventive screenings specific to member age, gender, or illness (e.g., Pap/HPV tests, BMI value for adults mammography, immunizations, BMI percentiles for ages 15 and under, colorectal cancer screening, diabetic eye exams) are documented.

Treatment Plan and Care Notes: Documentation of clinical findings and evaluation for each visit (presenting complaints, diagnosis and treatment plan, prescriptions, referral authorization, studies, instructions). Encounter forms or notes include the reason for the visit and notes regarding follow-up care, calls or visits as appropriate.

Preventing Risk: Diagnostic and therapeutic procedures are appropriate for the member's diagnosis and risk factors. Examples: a) Member has complaint of right hip pain but no X-ray of the right hip is ordered. b) Abnormal lab and imaging study results do not have explicit note regarding follow-up plans.

Medical Record & Documentation Audits

Medical record documentation audits are performed to assess medical record keeping practices and assure that medical records are legible, contain accurate and comprehensive information, and are readily accessible to healthcare providers. Medical records should be maintained in a current, organized and detailed manner and in conformance with evidenced based medical practices & preventative health management, and include notation of the continuity and coordination of care.

Medical record reviews and documentation audits are performed for all PCPs at least every two years and results will be used in the re-credentialing process. More frequent medical record reviews may be performed to study a particular issue or to correct a problem situation. Medical record audits may also be performed on an as needed basis to collect data (e.g., HEDIS measures).

Using Appeals and Grievances for QM

SHP will maintain a process for resolving member appeals and grievances. The Appeals and Grievances Department will have overall responsibility for:

- Maintaining and updating appeal and grievance policies and procedures
- Review and evaluation of the operations and results of the appeal and grievance process
- Review and assessment of trended data for identification and implementation of care service, and/or process improvements

- Review utilization of any emergent patterns of appeals and grievances in the formulation of policy and procedure changes

Recommendations for appeal and grievance policy changes will be referred to the Policy and Procedure Committee for review and approval as applicable.

Organizational Provider Quality Assessments

Prior to contracting with a hospital, skilled nursing facility, free standing surgical center, or home health agency, SHP will confirm that the facility has obtained accreditation from a recognized accreditation body and has met all state and federal licensing requirements. Re-verification of this information is performed at least every three (3) years.

SHP will perform on-site facility assessments when any facility has three (3) related grievances in a twelve (12) month period, or to investigate quality concerns that directly impact the safety and well-being of SHP's Members. Facility re-assessments will be performed until corrective action is complete. Facility assessments may also be performed on an as needed basis to collect data (e.g. HEDIS measures).

Potential Quality Issues (PQIs)

SHP monitors various reports, including appeals and grievance data and audit result reports, to identify potential quality issues (PQIs) impacting the quality of care provided to SHP's Members. Examples of PQIs include: surgical misadventures, unanticipated clinical outcomes, allegations of abuse and/or neglect, allegations that a provider failed to diagnose, treat, or appropriately monitor a patient, prescribing errors, or any other unexpected adverse outcome or incident associated with the delivery of care. SHP has adopted the following professionally recognized definitions for identifying and classifying PQIs:

- Sentinel Events – *The Joint Commission*
- Never Events – *National Quality Forum & CA SB 1301 (2006)*

The MMC reviews the findings of all PQI investigations and the Quality Department maintains findings for tracking and trending purposes. PQIs may also be considered when considering delegation (or de-delegation), credentialing (and re-credentialing), and inclusion in SHP's Provider Network.

Corrective Action Process

When the MMC, a delegated entity or one of the related Review Panels determines that inappropriate care or sub-standard services have been provided or services which should have been furnished have not been provided, the Associate Chief Medical Officer of QI is responsible for communicating concerns identified by the MMC and working with the provider to develop a corrective action plan. The SHP MMC reserves the right to terminate a Provider contract. SHP retains the right to make final decisions pertaining to a provider's participation in the SHP network.

Sanction activities currently used by SHP are described in the Policy/Appeals Process and Reduction, Suspension or Termination of Provider Status.

Preventive Care Guidelines

SHP has adopted the US Preventive Services Task Force (USPSTF) Preventive Care Guidelines as the standard that will be used from a utilization and quality perspective. Your review and usage of these guidelines will ensure best practices for your patients. The link to review these standards is: http://www.ahrq.gov/clinic/prevenix.htm

Members are educated about Preventive Health Services and recommended screenings:

- In the Member Handbook (aka. Explanation of Care or EOC)
- In New Member "Welcome" letters and other periodic Member communications.
- Annual Member Outreach (Members who have not accessed services for over 1 year).
- Online at www.ScrippsHealthPlan.com

Providers are expected to promote member engagement and utilization of these Preventive Health Services. Primary Care Physicians are responsible for ensuring their assigned patients are offered Preventive care consistent with SHP's Preventive Health policy. SHP's also monitors provider utilization of preventive health services and offers provider education to promote preventive health and issues corrective action when care is not provided consistent with USPSTF recommendations.

Pharmacy & Therapeutics

SHP's Pharmacy & Therapeutics (P&T) Committee, co-chaired by the Pharmacy Manager and the SHP's CMO, is responsible for maintaining the drug formulary to promote safety, effectiveness, and affordability according to drug selection process. The P&T Committee is also responsible for the following clinical oversight duties:

- Review new drugs, drug classes, new clinical indications, therapeutic advantages, new chemical entities, and new safety information.
- Recommend formulary status and what position or tiered covered medications should occupy on the formulary.
- Review the drug formulary and therapeutic classes at least annually.
- Promote the appropriate use of high quality and cost-effective pharmaceuticals for Scripps Health Plan members.
- Ensure compliance with appropriate standards and state and federal regulations.
- Serve as the policy recommending body on matters related to the safe and therapeutic use of medications
- Enforce the appropriate AWP discounts and rebate(s) back to the health plan
- Ensure the P&T Committee of the delegated Pharmacy Benefit Manager (PBM) performs the following major functions, consistent with professionally accepted standards of clinical review:
    - Maintain the drug formularies to promote safety, effectiveness, and affordability according to drug selection process.
    - Review new drugs, drug classes, new clinical indications, therapeutic advantages, new chemical entities, and new safety information.

  - Recommend formulary status and what position or tiered covered medications should occupy on the formulary.
  - Review the drug formulary and therapeutic classes at least annually.
  - Review and approval of new medical technologies based on clinical scientific evidence and standards of practice, considering drug therapeutic advantages in terms of safety and efficacy
- Committee recommendations are subject to the administrative approval process and summaries are brought to the MMC.

Provider Credentialing

Credentialing and re-credentialing is required for all contracted providers, practitioners and allied health care professionals (e.g., Physician Assistants ("PA") and Nurse Practitioners ("NP")), and health delivery organizations providing services to SHP members. The Quality Management (QM) staff, as part of the credentialing and re-credentialing process, may perform Site Visits and Medical Record Review. Providers will be contacted in advance if a site visit or audit is needed.

Final credentialing approval is coordinated through SHP's Credentialing Review Panel, under the guidance of the Associate Chief Medical Officer of QM or designee. SHP retains the right to approve, suspend, and/or terminate individual practitioners, providers, and/or sites. The SHP process meets the California State and NCQA credentialing requirements.

Credentialing: SHP or a delegated entity credentials all contracted providers. Practitioners must meet the SHP criteria for acceptance as a provider and are required to maintain compliance with all standards as a condition for continued participation. To begin the credentialing process, practitioners are required to submit a completed signed Application with the following attachments:

- Licensure to practice
- DEA certificate
- Proof of professional liability insurance
- An explanation of malpractice suits filed against the Practitioner to include case number; court number; a brief narrative case summary of the charge, facts, status, and outcome
- A signed release granting the SHP access to records of any medical society, medical board, college of medicine, hospital, or other institution, organization, or entity that does or may maintain records concerning the applicant
- A signed statement by the practitioner at the time of application regarding any physical or mental health problems, any history of chemical dependency/substance abuse, history of loss of license and/or felony convictions, and/or history of loss or limitation of privileges or disciplinary actions
- Work history with explanation of any gaps in employment that exceeds six (6) months

SHP will initiate the credentialing process and will complete the Primary Source Verification, based on NCQA standards and other pertinent information supplied or collected during the application process.

After medical staff office review, credentialing information is presented to the Credentialing Review Panel for review and approval. The Credentialing Review Panel meets quarterly. Providers are

notified in writing of the Credentialing Review Panel's decision. Final credentialing approval is granted by the SHP Board of Directors, which also meets on a quarterly basis.

No applicant is automatically entitled to participate with the SHP via participation with a PMG or professional organization, via board certification or via staff membership or privileges for a particular health facility or practice setting.

Standards and Guidelines: At a minimum, the following requirements must be met for the SHP to consider acceptance of the applicant for participation in SHP's network:

- A participation agreement in the form prescribed by SHP and signed by the Provider.
- The physician applicant has not been rejected or terminated by SHP within the previous twelve (12) months.
- No felony, misdemeanor convictions nor evidence of committing other acts involving moral turpitude, dishonesty, fraud, deceit, or misrepresentation.
- Unrestricted license to practice in California.
- Use of SHP facilities for his/her regular practice and routinely makes rounds at participating facilities. If the physician does not have privileges at a SHP Hospital, he/she must have formal admitting arrangements with a Provider who does.
- Listing of office locations, names, and addresses of associates in the practice of medicine or osteopathy, and any physician or other practitioner who provides on-call services.

Additionally Primary Care Physicians (PCPs) and specialty physicians are required to meet the following standards to be considered for participation in SHP's network:

- Current unrestricted license to practice medicine or osteopathy in California.
- Current, valid federal Drug Enforcement Agency (DEA) certificate.
- Current staff membership, clinical privileges, and admitting privileges granted by a SHP Hospital within the service area or arrangements with a Provider who has such privileges.
- Graduation from medical school and completion of a residency for MDs and DOs. (An exception may be made for a Provider who has only completed a rotating internship, if the Provider agrees to be classified as a General Practitioner and practices in an underserved area of the county.)
- Documentation of board certification (if applicable). Practitioners will provide ongoing documentation of certification, at the time of application and at a minimum of every three (3) years thereafter, by the appropriate Board for physician specialty or of active and current involvement in the Board certification and examination process.
- Professional liability insurance policy of not less than $1,000,000 per incident and $3,000,000 per year.
- Twenty-four (24) hour-a-day coverage for all SHP members with another participating PCP or with another SHP physician who agrees to abide by the guidelines of SHP.
    - PCPs must be able to perform the following in the office setting:
    - EKG (pediatric offices as appropriate)
    - Office gynecology including routine pelvic and pap smears (pediatric office excepted)
    - Blood draws (not applicable if using national lab contract)
    - Minor surgery to include incision and drainage of abscess and suture of superficial lacerations
    - Availability and accessibility to include:

  - Minimum of twenty (20) hours each week of regularly scheduled office hours for treatment of patients for a one-physician practice and minimum of thirty (30) hours for a practice of two (2) or more physicians
  - During and after-hours response time to calls not greater than thirty (30) minutes after notification
  - Ability to accept a minimum of 250 new Members at time of application
  - No more than an average of five patients scheduled and seen each hour for routine office visits for adult medicine and six (6) patients per hour for pediatrics
- Compliance with Medical Board continuing education requirements.
- Absence of felony convictions, sound moral character, and in good professional standing in the community.
- Provision of quality, appropriate, and timely care.
- Supportive of the philosophy and concept of managed care and of SHP.
- Good standing with Centers for Medicare and Medicaid Services (CMS) in any state in where they have been licensed.

Delegated Credentialing/Re-Credentialing: Delegation status is granted only to entities that perform the credentialing/re-credentialing activities according to NCQA standards. Credentialing delegation oversight audits are conducted annually by SHP or by another NCQA-accredited health Plan in California via the Industry Collaborative Effort (ICE) shared delegation oversight credentialing audit process.

Credentialing appeals: To ensure Providers will be treated fairly and uniformly, Providers may appeal any adverse credentialing decision, including the right to discuss the decision and for any errors to be corrected.

Re-Credentialing: Re-review of Provider credentials for re-credentialing is performed no less than every three (3) years according to NCQA standards. Providers receive a re-credentialing application and release form approximately six (6) months before their current credentialing period is to expire. SHP utilizes a universal reapplication and only information that may have changed since the last credentialing will be requested.

Providers are responsible for producing adequate information for a complete evaluation of experience, background, training, and ability to perform as a clinician without limitations, including physical and mental health status as allowed by law. In order to keep the application on active status, Providers will be asked to supply the needed information within a specified time frame. Failure to provide the information within the required time frame will result in termination from the SHP network.

A copy of SHP's Provider credentialing policy may be requested by contacting SHP Customer Service.

VI. Compliance & Privacy

Regulatory Compliance

Scripps Health Plan (SHP) has a responsibility to our Members and the community, to provide health care ethically and with integrity. In building upon the Mission and Values of Scripps Health, every Provider, employee, and business affiliate of SHP is expected to strive for the highest standards of individual and organizational conduct. This includes performing our respective roles in an honest and ethical manner, in both personal and business activities, and being compliant with all laws and regulations that govern the delivery and coverage of health care. SHP Compliance Department is responsible for providing guidance and interpretation of legislation and regulations which impact the daily operations of Scripps Health Plan, its Members, and Providers in the delivery of care.

The **Anti-Kickback Statutes** prohibit knowingly and willfully soliciting, receiving, offering, or paying any inducement (e.g., a kickback, bribe, or rebate) for referrals for services that are paid for, in whole or in part, under a Federal health care program. This includes any referral from any type of Provider and for any item or service. Criminal penalties include fines (up to $25,000 per violation) and up to 5-years in prison per violation. Providers may also be civilly liable under the *False Claims Act*.

The **Stark Law** (or Physician Self-Referral) prohibits a physician from referring a Medicare patient for certain designated health services to an entity with which the physician (or a member of his or her family) has an ownership/investment interest or a compensation arrangement. Exceptions to this rule are called "Safe Harbors" and are highly prescriptive. Providers who have questions about the Stark Law should contact appropriate legal counsel. This law does not require the federal government to prove intent to defraud or misrepresent.

Fraud, Waste and Abuse

SHP is committed to fostering an atmosphere of integrity, honesty and ethical behavior. SHP's Compliance Program supports health plan employees and contracted Providers in the effective implementation of policies and procedures, oversight and monitoring processes, and establishing best practices. SHP's Anti-Fraud Plan is integrated into SHP's routine compliance monitoring activities and is used to organize and implement an effective strategy to identify and reduce costs to health plans, Providers, Members and others impacted by fraudulent activities; and to protect consumers in the delivery of healthcare services through timely detection, investigation and reporting (or prosecution) of suspected fraud.

Health care **Fraud** is knowingly or willfully executing, or attempting to execute, a scheme to defraud any health care benefit program, or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program through false representation. Fraud occurs when an individual knows, or should have known, that something is false or does not faithfully represent the truth, and takes deceptive actions, or actions inconsistent with the billing & coding standards of

federally administered health programs that results or could result in improper reimbursement to themselves or another person.

The **False Claims Act** (FCA) protects the Government from being overcharged or sold substandard goods or services. The civil provisions of the FCA make a person liable for treble (x 3) damages if he or she knowingly carries out any act to obtain property from the Government by misrepresentation; knowingly conceals or avoids an obligation to pay the Government; makes or uses a false record or statement supporting a false claim; or presents a false claim for payment or approval. The terms "knowing" and "knowingly" mean that a person, with respect to information–has actual knowledge of the information; acts in deliberate ignorance of the truth or falsity of the information, or; acts in reckless disregard of the truth or falsity of the information, and; require no proof of specific intent to defraud. There also are criminal penalties for submitting false claims, which may include fines, imprisonment, or both.

Abuse in health care includes actions that may directly or indirectly result in unnecessary costs to SHP, the Medicare program, or any health care benefit program. Abuse includes improper payment; payment for services that fail to meet professionally recognized standards of care; or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the Provider has not knowingly or intentionally misrepresented the facts to obtain payment.

Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the health care system. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

In 2012, Donald Berwick, M.D. (then head of the CMS) estimated that **Fraud** and **Abuse** cost the US health system $272 billion annually. The immediate effects of this glut includes higher premiums, higher costs of services, more regulatory burdens on Providers, and leaves the most vulnerable in our communities uninsured and with fewer dollars available for their immediate health care needs.

Health care *Fraud* and *Abuse* comes in many forms, including:

- Falsification of a claim or any part of a claim which may impact the rate of reimbursement, capitation or other remuneration
- Unbundling of claims for which payment guidelines establish those services should be billed as a "bundle" (one payment for multiple services).
- Up-coding or Down-coding of claims or otherwise making a false representation of the clinical severity, complication or other factor impacting the rate of reimbursement.
- Use of benefits by non-covered persons (with or without the knowledge or abetment of the beneficiary).
- Excessive charges for services or supplies above the Fair Market Value charges for those items or services or contrary to an agreed upon contracted rate.
- Charges for services which are included in the capitation rate.
- Soliciting, offering or receiving a kickback, bribe or other self-inducement, in violation of the Stark Law and/or Anti-Kickback regulations (i.e., paying for the referral of patients or the assignment of Members).

- *Fraud* or *Abuse* perpetrated by plan staff or contracted network staff for purposes of self-inducement or to improperly compensate or receive compensation from a Network Provider.
- *Fraud* and *Abuse* perpetrated by plan staff or contracted network staff in collusion with Providers, Members, and/or applicants.
- Provider collusion to unfairly raise the market price of a specific medical service.
- Use of health plan ID cards by persons who are not entitled to benefits
- Falsification of drug prescriptions

Reporting Compliance Issues and Concerns

SHP's policies and the *Standards of Conduct* require all contracted Providers and their employees to promptly report instances of non-compliance related to a managed care patient or impacting SHP operations or activities. Providers and employees are advised to report concerns to the Plan Compliance Officer. All communications are maintained in a confidential manner, to the extent permitted by applicable law, and will be used only for the purpose of investigating and correcting instances of non-compliance, as necessary

Linda Pantovic, Plan Compliance Officer
(858) 927-5360 *Confidential Phone & VM*
Pantovic.Linda@scrippshealth.org

Reporters may also make an anonymous report to the *Scripps Health Compliance Alertline* by calling (888) 424-2387. This service is managed by an unbiased third-party, and is available day & night.

Notice of Non-Retaliation – You Are Protected

It is SHP's policy that neither retribution nor retaliation for reporting a suspected or actual compliance violation or concern will be tolerated. Efforts will be made to protect the identity of the employee to the extent allowable by law. Anonymity cannot be protected if individuals identify themselves or provide information that may reveal their identity. No matter how you choose to report an issue or concern, so long as it is made in good faith, you are protected from retaliation by Scripps Health and SHP policy, as well as Federal and State law.

Fraud and Abuse Prevention and Detection

Potential fraud or abuse cases will be submitted to the Plan Compliance Officer for tracking, review, investigation, and reporting to the Regulatory Oversight Committee, the Management Advisory Committee (MAC) and any government agencies as required by law or as appropriate. Referrals are also made to the Credentialing & Peer Review Panel for issues concerning misconduct, the quality of care, documentation or other concerning practices of a credentialed Provider. Reports of potential fraud or abuse cases may come from a variety of sources including but not limited to

Members, UM staff, claims staff, Providers, government agencies, Customer Service staff, or Case Management staff.

SHP monitors internal data to identify potential *Fraud* or *Abuse* issues including but are not limited to claims data, PCP panel size assessment, medical record reviews, grievances and complaints, Member surveys, risk management reports, Provider surveys, UM statistics, staff surveys, sentinel event reports, financial data and laboratory reports. Complete details of SHP's Anti-Fraud Plan and training materials may be obtained by contacting the Plan Compliance Officer at (858) 927-5360 or SHPSCompliance@scrippshealth.org.

Delegation Oversight

SHP may delegate responsibility for performing organizational functions to contracted entities (e.g., hospitals, capitated providers, ancillary providers) that meet SHP's standards for delegation. SHP performs annual audits of delegated entities to assure compliance with standards, and that the care provided by the delegated entity is based on professionally recognized standards of practice. Delegation oversight is performed by the Compliance Department or designated area. Quarterly reports of delegation activity, including findings and corrective actions taken as a result of oversight activities, to the MMC.

Member Privacy & Confidentiality

It is the expectation of our members, a tenet of quality healthcare, and a requirement of State and Federal law that we protect the privacy of health information. SHP Providers and their employees must ensure the privacy of confidential medical records and related information for all patients. Each contracted Provider is a Business Associate and must comply with certain provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and regulations from the Department of Health and Human Services – Office of Civil Rights ("OCR") that relate to the privacy of protected health information ("PHI"). Protected information includes, but is not limited to:

- Patient Appointment and other non-clinical Records
- Patient Medical Records (Including Electronic Health Information)
- Files containing PHI or other protected information
- Faxes sent and received containing PHI
- Medical Claims documents and supporting materials
- Organizational, utilization, quality or medical staff committee minutes and documentation
- Information received from non-SHP physicians and external agencies containing PHI or privileged information

SHP has carefully developed policies that both establish best practices for the management of personal and confidential information as well as support and encourage patients to exercise their

rights regarding their protected information. Protecting your patient's privacy must be a conscious effort as you conduct patient care. As a SHP Provider, you are expected to:

1. Ask the patient to identify who is involved in their care so that you can share relevant health information.
2. Provide patients with the opportunity to agree to have individuals stay or be excused before you discuss their care.
3. Share sensitive information with others and conduct phone calls in a private location, especially when discussing potentially stigmatizing conditions.

Notice of Privacy Practices

Health plans informs Members and their representatives of the privacy oversight program annually and upon enrollment by sending a Notice of Privacy Practices, which includes requisite disclosures as stipulated in the Privacy Rule. You can download a copy of Scripps Health Plan's *Notice of Privacy Practices* by visiting https://www.scrippshealthplan.com/privacy-and-confidentiality.

Providers are responsible for complying with SHP's policies regarding proper handling of Protected Health Information (PHI), including maintaining their own Notice of Privacy Practices and making it available publicly.

Reporting Privacy Incidents

Providers must immediately notify SHP when they become aware of a suspected or confirmed breach of a patient's protected health information (PHI). Reporting privacy breaches immediately upon discovery is critical to minimizing your risk of penalties and fines. Report all suspected privacy breaches to SHP Compliance Department via email at SHPSCompliance@scrippshealth.org or telephonically (858) 927-5360.

Safeguarding Member Information

All contracted Providers are required to sign a *Business Associates Agreement* which describe Providers' specific obligations to protect and safeguard the privacy of patient information. This agreement requires Providers understand their responsibilities as they relate to:

1. **Minimum Necessary**. Be aware when accessing or disclosing patient information outside of Scripps verbally or electronically.
2. **Devices.** Do not store electronic protected health information on hard drives or removable devices (e.g., memory sticks, PDAs, laptops) or on non-Scripps owned or controlled devices unless they have been equipped with encryption software.
3. **Password Protection**. Do not share your password(s) as your logon represents your electronic signature. The integrity of your orders or documentation is at risk if passwords are shared and you may be legally responsible for actions in such circumstances.
4. **E-Mail**. Providers should not include any confidential patient information in the body of any email without such information being safeguarded in password protected documents, email encryption or other approved mechanism.
5. **Authorized Access**. Access only accounts of the patients who are under your care. Information systems activity and network access is monitored and reviewed on a regular basis as part of SHP Privacy Program.

Nondiscrimination in Health Care

SHP does not discriminate exclude, or treat individuals differently on the basis of sex, sexual orientation, gender identity, national origin, ethnicity, religion, race, color, creed, nationality, primary-language, education, disability, age, or any other individually definable factor. To assist Members in accessing services, SHP provides:

1. Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.
2. Free aids and services to people with disabilities such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, and other formats.

SHP complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act, which includes notification of nondiscrimination and information for accessing language services in all significant Member materials.

SHP Providers must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). SHP requires Providers to deliver services to SHP Members without regard to sex, sexual orientation, gender identity, national origin, ethnicity, religion, race, color, creed, nationality, primary-language, education, disability, age, or any other individually definable factor. This also includes expressions of gender identity, pregnancy and sex stereotyping. Participating Providers and medical groups may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost-care.

Section 1557 Investigations

SHP's Compliance Officer is responsible for overseeing civil rights complaints. If a Member believes that SHP has failed to provide access or language services or that SHP has discriminated against the Member in another way (such as on the basis of race, color, national origin, age, disability, or sex), the Member should be directed to contact the Plan Compliance Officer. Additionally, SHP Providers are expected to disclose all complaints subject to Section 1557 of the Affordable Care Act to SHP's Compliance Officer.

Facilities, Equipment, and Personnel

Provider offices, facilities, equipment, personnel and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements including the accessibility requirements of the Americans with Disabilities Act (ADA). .

VII. Providers' Role & Responsibilities

This Provider Manual is an extension of your contract, as a SHP provider you agree to abide by the following:

- Understand and abide by the Knox Keene Health Care Service Plan Act of 1975 that protects members from receiving bills or statements of any kind, except for non-authorized services if the member is made aware of financial responsibility in advance and in writing of non-covered services and/or co-payments
- Provide all covered Hospital, Professional or Ancillary services to members enrolled through SHP as authorized
- Freely communicate with patients regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations
- Obtain prior authorization from SHP when required. Failure to obtain prior authorization may result in non-payment of claims. In case of services already provided, it is the provider's responsibility to request retro-authorization
- Adhere to the SHP Formularies, clinical step-therapy protocols, and Mandatory Generic Prescription policies.
- Participate in the Quality Management and Utilization Management procedures defined by SHP.
- Comply with credentialing and re-credentialing requirements as stipulated.
- Ensure SHP has current Medical and DEA Licenses on file.
- Refer members and utilize SHP contracted providers for your Hospital, Professional and Ancillary service needs
- If an out-of-plan second opinion is authorized, co-payments should be consistent with in-plan co-payments to the same type of provider.
- Adhere to SHP Fraud, Waste, and Abuse & *Privacy Programs – reporting potential misconduct or breach of privacy immediately to the Plan Compliance Officer*
- Retain records to support all Compliance Activities for at least ten (10) years or longer as required by law.

Verifying Eligibility

SHP members should present for services with their insurance identification card issued by SHP. Member ID cards contain pertinent information about the member's Primary Medical Group (PMG) and co-payments. Providers are responsible for verifying eligibility with the SHP prior to rendering authorized services.

Access to Care

Timely access to the appropriate level of health care services for members is essential. Providers are required to offer a sufficient number of available appointments and telephone capabilities to serve the needs of the members. Providers are prohibited from the unlawful discrimination against any member based on factors including, but not limited to, race, religion, color, national origin, gender, age, disability, marital status, sexual orientation, or source of payment.

Access to Care Standards

Access standards have been established to ensure that all health care services are available and delivered in a timely manner for all members. The Access Standards are required by law under California Health and Safety Code Section 1367.03 and Title 28 of the California Code of Regulations rule 1300.67.2.2.

SHP utilizes the access to care standard criteria to ensure that health care services are available and accessible to members at reasonable times. SHP will monitor compliance to the standards in various ways. Monitoring methods may include access surveys, wait-time studies and annual mystery caller audits. Providers will be monitored at least annually for access to health care, and monitoring results will be shared with the provider. Should any deficiencies be identified, providers will be required to submit a Corrective Action Plan (CAP) to ensure future compliance with the access standards. Access studies are conducted by the Compliance department no less than annually, based on the following standards:

Appointment Wait Times

Non-Urgent Appointments	
Primary Care Physician	Within 10 business days
Specialty and Ancillary Care	Within 15 business days
Urgent Care Appointments	
Authorization NOT required	Within 48 hours
Authorization required	Within 96 hours
Emergency Services	Immediately
Mental Health Care Services	
Non Urgent	Within 10 business days
Urgent	Within 48 hours
Emergent	Immediately
Follow-up Care – *following an inpatient stay*	Within 7–30 days of discharge
Telephone Wait times	
During Normal Business Hours *Answer by a Non-Recorded Voice*	Within 10 minutes
Provider Response to After-Hours Calls	Within 30 minutes
Office Wait times	
PCP and Specialty Provider Offices	Within 30 minutes of check in

No Detrimental Impact Determination

The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member.

Preventive Follow-Up Care Services, and Standing Referrals

Preventive care services and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care Provider acting within the scope of his or her practice.

The Primary Care Physician (PCP) must, in consultation with the specialist, determine the need for a standing referral. This determination must be made within three (3) business days from the date all appropriate medical records and other items of information necessary to the determination are provided. A treatment plan will be developed in coordination with PCP, Specialist, and Chief Medical Officer. In order to request a standing referral please consult with the member's PCP.

After-Hours Telephone Access

SHP requires PCP or designee to be available so that assigned members have access to urgent and emergency care 24 hours per day, 7 days per week. Providers must maintain 24 hour, 7 day per week telephone access capability to provide immediate response to emergency inquiries by members. Providers must maintain a procedure for triaging or screening member telephone calls which, at a minimum, incudes the employment, after business hours, of a telephone answering service, and/or answering machine, and/or office staff that will inform the caller:

- Regarding the wait time for a return call from the Provider, and
- How the caller may obtain urgent or emergency care, including how to contact another Provider who has agreed to be on call to triage by phone or, if needed, deliver urgent or emergency care.
- Every after-hours caller is expected to receive emergency instructions, whether a line is answered live or by recording. Callers with an emergency are expected to be told to:
    - Hang up and dial 911, or
    - Go to the nearest emergency room, or
    - Hang up and dial 911 or go to the nearest emergency room.

After receiving emergency instructions, callers with non-emergency situations who cannot wait until the next business day should receive one of the following options when speaking

- With a live person:
    - Stay on the line to be connected to the doctor on call.
    - Leave a name and number and a physician or qualified health care professional will call back within 30 minutes.
    - Reach the doctor at another number.
- When reaching a recording:
    - Leave a message and the call is returned within 30 minutes.
    - Call an alternate phone or pager number to contact the physician on call.

The waiting time for a member to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care, may not exceed 30 minutes.

All patient telephone calls should be documented on a phone message form, with the response given documented on the same form. Documentation of phone calls must be affixed to the progress notes and become a permanent part of the medical record. At minimum, documentation of the phone call must include:

- Patient name
- Date and time of call
- Patient's question/concern
- Advice/response provided
- Signature of individual who triaged the call

Behavioral Health (BH) Telephone Access

Behavioral Health practitioners will maintain access to BH screening and triage to ensure that callers reach a non-recorded voice within thirty (30) seconds. Telephone abandonment rates shall not exceed five percent (5%) at any time. Calls must be returned a by psychiatrist or qualified health care professional within thirty (30) minutes.

Failed Appointments

Failed appointments are those where a patient does not arrive for a scheduled medical appointment, either with or without prior notice from the patient. Failed appointments must be documented in the medical record according to the PMG's or Provider's written policy and procedure, with provisions for a case-by-case review of members with repeated failed appointments. Some providers have established a missed-appointment fee for their patients. SHP shall reserve the right to review and approve such policies. Providers must demonstrate that members are notified in advance regarding any missed appointment fees. Policies must also include a provision for waiving the fee under extenuating circumstances. SHP does not reimburse providers for missed appointment fees.

Advanced Directives

The Omnibus Budget Reconciliation Act of 1990 provides individuals with information about their rights regarding advanced directives and encourages compliance by health care providers with any advance directives. An advanced directive is any written document, made in advance of an incapacitating illness or injury, in which an individual specifically makes choices about health care treatments or names someone to make these treatment decisions if he or she is incapable. Under this law, Providers are required to inform patients about their rights to institute an Advance Directive:

- The physician must communicate information to each patient regarding the right to institute an advance directive and,
- The physician is required to document the results of this discussion in the patient's medical record file. If the patient completes an advance directive, a copy of it should be included in this file.

Member Billing

Providers agree contractually to look solely to SHP as the source of final payments for SHP members. It is a violation of law to bill HMO members directly except for co-payments, co-insurance or for benefits not covered by HMO insurance. For benefits not covered by HMO insurance, providers must obtain a written waiver from the patient prior to delivering the service to prevent misunderstandings.

ICD-9 / ICD-10 Coding Accuracy

As a health care provider you are expected to report all diagnosis codes that impact the patient's care and ensure these diagnoses are accurately documented in a medical record. This includes the main reason for the episode of care; all co-existing, acute or chronic conditions; and pertinent past conditions that impact clinical evaluation and therapeutic treatment. Symptoms that are common to the main reportable diagnosis should not be coded. Report ICD-9-CM/ICD-10-CM codes to the highest level of specificity on all billing forms and/or encounter data forms.

VIII. Frequently Requested Forms

You can access many of the forms, notices or other documents reference in this Manual from our website, www.ScrippsHealthPlan.com. You can also request forms by calling Customer Service at (844) 337-3700.

A. Provider Dispute Resolution Request Form
B. Member Grievance Resolution Form
C. Medical Prior Authorization Request
D. Prescription Drug Prior Authorization Form
E. Scripps Care Link Access Request Form
F. SHP Notice of Privacy Practices