PROVIDER OPERATIONS MANUAL

For Use By
Primary Care and Specialty Providers

101 Callan Avenue, Suite 300
San Leandro, California 94577

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Provider Manual
Primary Care Provider
Table of Contents

10. Inter-Rater Reliability
11. Risk Management
12. Quality Classification System for the Peer Review Process
13. Experimental and Investigational Therapies
14. Utilization Management Timeliness Standards

BILLING

1. How to Bill for Services
2. Electronic Explanation of Benefit (EOB) Process
3. Locum Tenens Provider Claim Submission
4. PCP Cap Exceptions Code Designation
5. Commonly Required Claim Attachments
6. Immunization Matrix
7. Billing for Obstetric Care
8. Adult Sterilization and Consent Standards for Medi-Cal
9. Acupuncture Benefit Announcement (6/1/17)
10. Chiropractor Benefit Announcement (6/1/17)
11. Outpatient Diagnostic and Laboratory Services (6/7/17)
12. Provider Claim Dispute Resolution

MEMBERSHIP SERVICES

1. Verifying Membership
2. Complaint/Grievance/Appeal Procedures
3. Authorization Appeals
4. AAH Member Complaint Form & Appeal Process
5. BC Grievance & Appeal Process
6. Member Rights and Responsibilities
7. Member Access

PROVIDER CONNECTION

1. How to use Community Health Center Network's Web Portal
2. Web Portal Access Request Form
3. Provider Satisfaction Survey Administration
4. Provider Initiated Complaint

INTERPRETIVE SERVICES

1. Interpretive Services Guidelines

TRANSPORTATION SERVICES

1. Transportation Services Guidelines

PROVIDER RESPONSIBILITIES

1. Staying Healthy Assessments
2. Child Health and Disability Prevention

HIPAA

1. HIPAA Guidelines

GLOSSARY OF TERMS

1. Definition of Managed Care Terms

Introduction to Community Health Center Network

Community Health Center Network (CHCN) is a partnership between eight health service organizations to provide a comprehensive range of professional health care and social services in a manner respectful of the community's values and traditions. Incorporated in 1996, CHCN's purpose was to introduce the managed care business to its member clinics by serving as a network of management services. Current member clinics of CHCN are: Asian Health Services, Axis Community Health, La Clinica de la Raza, LifeLong Medical Care, Native American Health Center, Tiburcio Vasquez Health Center, Tri-City Health Center and West Oakland Health Council. These clinics provide services in over 35 locations in the Bay Area and contain approximately 250 primary care providers and mid-level practitioners. Language capacity exceeds 25 spoken and 8 written languages. Our clinics are located in Alameda, Pleasant Hill, Oakland, Livermore, Pleasanton, Pittsburg, Concord, Oakley, Berkeley, San Pablo, Richmond, Union City, Hayward and Fremont.

Membership criteria for participation in the network were developed with the goal of providing cost-effective services with the highest quality standards. CHCN serves the health centers by coordinating the managed care infrastructure activities as well as acting as the communicating body with the health plans and specialty providers.

A board of directors, which are the Chief Executive Officers of the eight member clinics, governs CHCN. The Chief Executive Officers for strategic reasons as well as for sheer survival formed CHCN. Due to cuts in funding in caring for the under-served and uninsured, the future existence of the eight corporations and the entire community of safety net providers were jeopardized. Therefore, diversification of revenue and participation in managed care was essential to continue as the safety net providers. The additional managed care markets offer CHCN health centers the ability to retain members regardless of the constant changes in the health insurance industry. The greater the success CHCN has with retaining managed care patients, the greater our ability will be to continue to hold steadfast our mission.

CHCN believes the care, choices, and satisfaction of our patients will be greatly enhanced as we enter new markets and develop new partnerships.

Community Health Center Network Responsibilities

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

2. Review HMO contracts and act as the communicating body to the health centers.

3. Coordinate all professional services of a managed care member including specialty, radiology, lab, and some minor ancillary services.

4. Process and pay claims for managed care members.

5. Coordinate authorizations.

6. Review utilization of specialty services.

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

8. Coordinate membership and eligibility services.

9. Review provider and member concerns.

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

COMMUNITY HEALTH CENTER NETWORK
101 Callan Avenue, Suite 300
San Leandro, CA 94577
Phone: 510-297-0200 Fax: 510-297-0209
Website: www.chcnetwork.org
Web Portal: portal.chcnetwork.org

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- *Authorization Intake and Status*

General Information

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Website address		www.chcnetwork.org
Secured Web Portal		https://portal.chcnetwork.org

ASIAN HEALTH SERVICES

Services/Hours-Days of Operation

CLINIC	SERVICES PROVIDED	HOURS AND DAYS OF OPERATION
Asian Health Services (main clinic) 818 Webster St Oakland, CA 94607 (510) 986-6800 Fax: (510) 986-6896 **Language(s)** Cantonese, Mandarin, Khmer, Korean, Laotian, Tagalog, Mien, Vietnamese	Pediatrics Medical Preventive Prenatal Immunization OB/GYN Mental Health Counseling Nutrition Radiology	M-F 9am-5pm Sat 8:45am-1pm Closed daily 12:30pm-1:30pm **Teen Clinic** W 5pm-7pm
Frank Kiang Medical Center 250 East 18th St 2nd Fl Oakland, CA 94606 (510) 735-3888 Fax: (510) 628-0568 **Language(s)** Burmese, Chinese, Cantonese, Mandarin, Khmer, Korean, Mongolian, Tagalog, Vietnamese	Medical Pediatrics Preventive Prenatal Mental Health Counseling Nutrition Immunization	M-F 9am-5pm Closed daily 12:30pm-1:30pm
Rolland & Kathryn Lowe Medical Center (RKLMC) 835 Webster St Oakland, CA 94607 (510) 318-5800 Fax: (510) 986-8681 **Language(s)** Cantonese, Mandarin, Vietnamese	Medical Preventive Immunization Geriatrics Nutrition Mental Health Counseling	M-F 9am-5pm Closed daily 12:30pm-1:30pm

AXIS COMMUNITY HEALTH

Services/Hours-Days of Operation

CLINIC	SERVICES PROVIDED	HOURS AND DAYS OF OPERATION
Axis Community Health-Hacienda 5925 W Las Positas Blvd Suite 100 Pleasanton, CA 94588 (925) 462-1755 Fax: (925) 462-1650 Español, Farsi, Hindi, Telugu, Urdu, Punjabi, Dari, Tamil, Kannada, Marathi,Nepali,Burmese	Adult Medicine Preventive Behavioral Health Prenatal Pediatric Immunizations Health Education STD Tuberculosis Laboratory HIV Testing Mental Health Services/IBH Case Management Family Planning Drug/Alcohol Diversion SBIRT Senior Support Services	M-W 8:30am-9pm Tu,TH - F 8:30am-5pm Sat (1,3 & 4th) 9am-1pm **Immunizations** Call (925) 462-1755 for Appointment M-F 8:30am-5pm
Axis Community Health-Livermore 3311 Pacific Ave Livermore, CA 94550 (925) 462-1755 Fax: (925) 449-7157 **Language(s)** English,Español, Italian,French,Telugu.	Adult Medicine Preventive Prenatal Pediatric Immunizations Health Education STD Tuberculosis Laboratory HIV Testing Mental Health Services/IBH Case Management Family Planning Drug/Alcohol Diversion SBIRT Senior Support Services	M-W 8:30am-9pm Tu,Th-F 8:30am-5pm Sat (1&3rd) 9am-1pm **Immunizations** Call (925) 462-1755 for Appointment M-F 8:30am-5pm
Axis Community Health-Pleasanton 4361 Railroad Ave Pleasanton, CA 94566 (925) 462-1755 Fax: (925) 462-1650 **Language(s)** English, Español, Farsi, Dari.	Prenatal Pediatric Immunizations Health Education STD Tuberculosis Laboratory HIV Testing Mental Health Services/IBH Case Management Family Planning SBIRT Senior Support Services Women's Health	M,TH-F 8:30am-5pm Sat (2nd) 9am-1pm Tu-W Closed **Immunizations** Call (925) 462-1755 for Appointment M-F 8:30am-5pm *hours as of May 1st.

LA CLINICA DE LA RAZA

Services/Hours-Days of Operation

CLINIC	SERVICES PROVIDED	HOURS AND DAYS OF OPERATION
La Clinica Transit Village 3451 E 12th St BART Transit Village Oakland, CA 94601 (510) 535-3500 Fax: (510) 535-4225 **Language(s)** Español **Dental** (510) 535-3302 **Family Medicine** (510) 535-3319 **Immunization Clinic** (510) 535-3600 **Laboratory** (510) 535-3331 Fax: (510) 535-4246 **Member Services & HSS Liaison** (510) 535-3650 **Pediatrics** (510) 535-3600 **Pharmacy** (510) 535-3375 **Preventive Medicine/Integrated Behavioral Health** (510) 535-3700 **Radiology** (510) 535-3345	Medical Dental Podiatry Preventive Prenatal Pediatric Immunizations Laboratory Services Health Education STD Tuberculosis OB/GYN Pharmacy Laboratory Radiology Mental Health	**Dental** M-Th 8am-7pm F 8am-5:30pm Sat 8am-4:30pm Closed 12pm - 12:30pm **Family Practice** M-Th 8:15am-7:30pm F 8:15am-5:30pm Closed daily 12:30 - 1:15pm, except Wednesdays closed 11:30am - 1:15pm Sat 8:45am-4:30pm **Laboratory** M-F 8am-5pm Closed 3rd Wednesday of each month from 11:30am-1:30pm **Mental Health** M-Th 8:30am-7pm F 9am-6pm **Pediatrics** M-F 8:30am-5:30pm Closed daily 12:30pm-1:30pm, except 1st, 3rd, 4th, and 5th Wednesdays closed 11:30am - 1:15pm Sat 8:45am - 12:30pm (Urgent care/Same day appointment) **Pharmacy** M-F 9am-5:30pm Closed daily 12:45pm-1:30pm **Radiology** M-F 9am-4:30pm Closed daily 12pm-1:30pm **Women's** M-F 8:45pm-5:30pm Closed daily 12:30-1:15pm, except 1st, 4th & 5th Wednesdays closed 11:30am-1:15pm

LA CLINICA DE LA RAZA

Services/Hours-Days of Operation

CLINIC	SERVICES PROVIDED	HOURS AND DAYS OF OPERATION
Registration (510) 535-3650 **Triage** (510) 535-3500 **Women's** (510) 535-3317		
La Clinica San Antonio Neighborhood Health Center 1030 International Blvd Oakland, CA 94606 (510) 238-5400 Fax: (510) 238-5437 **Language(s)** Español, Vietnamese, Cantonese, Madarin, Toisanese, French, Mam , Tagalog and Arabic	Medical Dental Optometry Podiatry Preventive Prenatal Pediatric Immunizations Health Education STD Tuberculosis OB/GYN Pharmacy Laboratory Radiology Mental Health	M-Sat 8:30am-5:30pm N/A N/A Every Friday 1pm-5pm M-Sat 8:30am-5:30pm M-Sat 8:30am-5:30pm M-Sat 8:30am-5:30pm M-Sat 8:30am-5:30pm M-Fri 8:30am-5:30pm M-Fri 8:30am-5:30pm M-Fri 8:30am-5:30pm M-Fri 8:30am-5:30pm M-Fri 8:30am-5:30pm M-Fri 8:30am-5:30pm N/A M-Fri 8:30am-5:30pm
La Clinica Alta Vista 1515 Fruitvale Ave Oakland, CA 94601 (510) 535-6300 Fax: (510) 535-4019 **Language(s)** Español **Age Limitations:** Services limited to patients under the age of 21	Medical Dental Optometry Podiatry Preventive Prenatal Pediatric Immunizations Health Education STD Tuberculosis	M-F 8:30am-5:30am (3rd Wednesday of the month: 9:30am - 5:30pm) **Teen Clinic** M-F 8:15am-5:30pm Closed the 3rd Wednesday of the month from 11:30am-1:15pm

LA CLINICA DE LA RAZA

Services/Hours-Days of Operation

CLINIC	SERVICES PROVIDED	HOURS AND DAYS OF OPERATION
	OB/GYN Pharmacy Laboratory Radiology Mental Health	
La Clinica Pittsburg Medical 2240 Gladstone Dr Ste 4 Pittsburg, CA 94565 (925) 431-2100 Fax: (925) 431-1234 **Language(s)** Español	Medical Dental Preventive Prenatal Pediatric Immunizations Health Education STD Tuberculosis Laboratory Mental Health	**Medical** M-F 8:30am-7:30pm Sat 8am-4:30pm **Community Health Ed** M-F 9am-5:30pm **Dental** M-F 8:30am-5:30pm Sat 8am-4:30pm
La Clinica Monument 2000 Sierra Rd Concord, CA 94518 (925) 363-2000 FAX: (925) 363-2006	Medical Dental Optometry Preventive Prenatal Pediatric Immunizations Health Education STD Tuberculosis OB/GYN Laboratory Mental Health	**Medical** M Tu 8:30am–8:30pm W 8:30am-6:30pm Th F 8:30am-5:30pm Sat 8:30am-5pm **Community Health Ed** M-F 9am-5:30pm **Dental** M-F 8am–5:30pm Sat 8:30am-5:30pm
La Clinica Oakley 2021 Main St Oakley, CA, 94561 (925) 776-8200 Fax: (925) 776-8260	Medical Preventive Pediatric Immunizations STD Tuberculosis Laboratory Mental Health	M-F 8:30am -5:30pm

LA CLINICA DE LA RAZA

Services/Hours-Days of Operation

CLINIC	SERVICES PROVIDED	HOURS AND DAYS OF OPERATION
La Clinica Julian R. Davis Pediatrics 5461 Foothill Blvd Oakland, CA 94601-5515 (510) 532-0918 Fax: (510) 532-0956 **Age Limitations:** Services limited to patients under the age of 18 **Language(s)** Español, Cantonese, Vietnamese	Pediatric	M-F 9am - 5pm

LIFELONG MEDICAL CARE

Services/Hours-Days of Operation

CLINIC	SERVICES PROVIDED	HOURS AND DAYS OF OPERATION
LifeLong Corporate Office P.O. Box 11247 Berkeley, CA 94712-2247 Member Srvcs: (510) 704-6010 Admin/Billing (510) 981-4100 Fax: (510) 981-4191 **Language(s)** Espanol, Cantonese, Tagalog, Thai	MedicalPreventive Prenatal Pediatrics HIV Geriatrics Social Services Health Education STD Tuberculosis Podiatry Dentistry Acupuncture Detox	M-F 9am-5pm
LifeLong Ashby Health Center 3075 Adeline St Ste 280 Berkeley, CA 94703 (510) 981-4100 Fax: (510) 553-2171 **Language(s)** Español, Tagalog, French, Hindi	Dentistry Acupuncture Detox Pediatrics HIV Geriatrics Health Education STD Tuberculosis	M, W-F 8:15am-5pm Tu 8:15am-8pm
LifeLong West Berkeley Family Practice 837 Addison St Berkeley, CA 94710 (510) 981-4100 Fax: Pod 1- 510-845-2196 Pod 2 - 510-981-4293 Pod 3- 510-981-4295 **Language(s)** Español, Mandarin, Thai, Tagalog		M W 8am-8:30pm Tu Th Fri 8am-5pm Sat 8:30am-4:30pm
LifeLong Over 60 Health Center 3260 Sacramento St Berkeley, CA 94702 (510) 981-4100 Fax: (510) 549-5458		M-F 8am-5pm Sat 8am-12pm

LIFELONG MEDICAL CARE

Services/Hours-Days of Operation

CLINIC	SERVICES PROVIDED	HOURS AND DAYS OF OPERATION
Language(s) Español **Age Limitations** Adult Care Only – age 55 and older		
LifeLong Downtown Oakland 616 16th St Oakland, CA 94612 (510) 981-4100 Fax: (510) 549-5458 **Age Limitations** Adult Care Only – 19 years and older		M-F 8:15am-5pm Closed 12pm-1pm 1st and 3rd Saturday of the month: 8am-12pm
LifeLong Trust Health Center 386 14th St Oakland, CA 94612 (510) 210-5050 Fax: (510) 549-5458 **Language(s)** Español, French	Medical/Preventive	M-F 8am-4:30pm
LifeLong East Oakland 10700 MacArthur Blvd Ste 14B Oakland, CA 94605 (510) 981-4100 Fax: (510) 549-5458 **Language(s)** Español **Age Limitations** Adult Care Only – 19 years and older	Medical Preventive Prenatal Pediatrics HIV Geriatrics Social Services Health Education STD Tuberculosis Podiatry Dentistry Acupuncture Detox	M-F 8am-5pm Sat 8am-12pm
LifeLong Howard Daniel Clinic 9933 MacArthur Blvd Oakland, CA 94605	Medical Preventive Prenatal	M-F 8am-5pm Sat 8am-12pm

LIFELONG MEDICAL CARE

Services/Hours-Days of Operation

CLINIC	SERVICES PROVIDED	HOURS AND DAYS OF OPERATION
(510) 981-4100 Fax: (510) 549-5458 **Language(s)** Español	Pediatrics	
LifeLong Brookside San Pablo Health Center 2023 Vale Rd San Pablo, CA 94806 (925) 215-9092 Fax: (510) 549-5458 **Language(s)** Español	Medical Preventive Prenatal/Postnatal Care Pediatrics Health Education	M-Th 8:30am-8:30pm F 8:30am-5pm Sat 8:30am-2:30pm
LifeLong Brookside Richmond 1030 Nevin Ave Richmond, CA 94801 (510) 215-5001 Fax: (510) 549-5458 **Language(s)** Español	Medical Preventive Prenatal/Postnatal Care Pediatrics Health Education	M-Th 7:30am-5pm F 8:30am-5pm Closed 12pm-1pm 1st Saturday of the month: 9am-12:30pm
LifeLong Pinole Health Center 1690 San Pablo Ave Ste F Pinole, CA 94564 (510) 981-3255 Fax: (510) 724-4021		M T W 8:30am-5:30pm TH 1:30-5:00pm
LifeLong Richmond Health Center 2600 Macdonald Ave Ste B Richmond, CA 94804 (510) 981-4100 Fax: (510) 549-5458		Clinic Hours: M W Th 8:45am-3:45pm Office Hours: M - F 8:00am- 5:00pm
LifeLong William Jenkins Health Center 150 Harbour Way Richmond, CA 94801 (510 237-9537 Fax: (510) 549-5458	Medical Preventive Pediatrics	Clinic Hours: M-Th 9am-3pm

LIFELONG MEDICAL CARE

Services/Hours-Days of Operation

CLINIC	SERVICES PROVIDED	HOURS AND DAYS OF OPERATION
Language(s) Español **Age Limitations** Services limited to patients under the age of 19		Office Hours: M-Th 9am-5pm

NATIVE AMERICAN HEALTH CENTER

Services/Hours-Days of Operation

CLINIC	SERVICES PROVIDED	HOURS AND DAYS OF OPERATION
Native American Health Center (NAHC) 2950 International Blvd Oakland CA 94601 (510) 535-4400 Fax: (510) 533-8474 **Language(s)** Mam Spanish Tongan Vietnamese Cantonese Cambodian Mien	Medical Dental (adult and children) Preventive Prenatal Pediatric & Teens Immunizations Health Education STD Tuberculosis Nutrition Integrated Behavior Health	M-F 8:00am-5:30pm

TRI-CITY HEALTH CENTER

Services/Hours-Days of Operation

CLINIC	SERVICES PROVIDED	HOURS AND DAYS OF OPERATION
TCHC Liberty 39500 Liberty St Fremont, CA 94538 (510) 770-8040 Fax: (510) 770-8145 **Language(s)** English, Spanish, French, Gujrati, Hindi, Punjabi, Farsi, Tagalog, Pashto, Urdu, Polish, Amharic, Malayalam, Telugu, Vietnamese, Ilocano, Cantonese, Mandarin,, Sindhi, Tamil	Adult Primary Care Behavioral Health Family Practice Health Insurance Enrollment/Member Services Nutrition Medication Assistance Onsite Triage Nurse Transgender Care Optometry - Pediatric and Adult Vision Services	M-Th 8am-7pm F Sat 8am-5pm
TCHC Mowry I 2299 Mowry Ave Suite 3B Fremont CA 94538 (510) 770-8040 Fax: (510) 456-4390 **Language(s)** English, Spanish, Hindi, Punjabi, Urdu, Gujrati, Kannada, Mandarin, Cantonese **Age Limitations:** Services limited to patients under the age of 18	Pediatrics and Immunization Enrollment/ Member Services Behavioral Health	M-Th 8am-7pm F 8am-5pm
TCHC Mowry II 1999 Mowry Ave Suite F/N/D/A Fremont, CA 94538 (510) 770-8040 Fax: (510) 456-4390	HIV/HEP C Prevention, Testing, Treatment, and Case Management Primary Care Health Insurance Enrollment/Member Services Needle Exchange Wound care Teen Services Prenatal Care Women's Health Services Family Practice	**Suite F** M W Th F 8am-5pm Tu 8am-6pm **Suite N** M-F 8am-5pm **Suite D**

TRI-CITY HEALTH CENTER

Services/Hours-Days of Operation

CLINIC	SERVICES PROVIDED	HOURS AND DAYS OF OPERATION
Language(s) English, Tagalog, Spanish, Mandarin, Gujrati, Cantonese, Vietnamese, Portuguese, Tongan ,Hindi, Urdu, Chinese, Dari, Farsi, Pashto, Taiwanese	Family Planning Behavioral Health Convenient Care: rapid attention for minor illnesses and injuries	M-F 8am-5pm **Suite A** M-F 8am-5pm **Teen Services** M -Th 9:30am-6pm F 8:30am-5pm **Convenient Care** M-F 5pm-8pm
TCHC Main St Village 3607 Main St, Ste B Fremont, CA 94538 (510) 770-8040 FAX: (510) 933-0598 **Language(s)** English, Spanish, Hindi, Punjabi, Urdu,	Primary Care Family Practice Behavioral Health	M-F 8am-5pm
TCHC Irvington 40910 Fremont Blvd Fremont, CA 94538 (510) 770-8040 Fax: (510) 623-8926 **Language(s)** English, Spanish, Farsi, Punjabi, Tagalog, Hindi, Nepali, Mandarin, Chinese, Gujrati, Marathi, Cantonese, Vietnamese, Telugu, French, Dari, Persian, Kapampangan, Sign Language, Burmese, Assyrian	Primary Care Dental Behavioral Health/Mental Health Family Practice	M-F 8am-8pm Sat 8am-5pm

TIBURCIO VASQUEZ HEALTH CENTER

Services/Hours-Days of Operation

CLINIC	SERVICE PROVIDER	HOURS AND DAYS OF OPERATION
Tiburcio Union City 33255 Ninth St Union City CA 94587 (510) 471-5880 Fax: (510) 471-9051 **Language(s)** English, Español, Tagalog, Korean	Medical Preventive Prenatal Pediatric Immunizations Health Education STD Tuberculosis Obstetrics/Gyn Laboratory Dental	M-Sat 8am-5pm Lab hours: M-F 8am-5pm
Tiburcio Hayward 22331 Mission Blvd Hayward, CA 94541 (510) 471-5880 Fax: (510) 690-0703 **Language(s)** English, Español, Hindi, Pujabi, Russian, Tagalog	Medical Preventive Prenatal Pediatric Immunizations Health Education STD Tuberculosis Obstetrics/Gyn Laboratory Dental	M-Sat 8am-5pm Lab hours: M-F 8am-5pm
Tiburcio San Leandro Clinic 16110 E 14th St San Leandro, CA 94578 (510) 398-7500 Fax: (510) 476-0404 **Language(s)** English, Espanol, Hindi, Urdu, Farsi, Russian	Medical Preventive Prenatal Pediatric Obstetrics/Gyn Laboratory	M-Sat 8am-5pm Lab hours: M-F 8am-5pm
Tiburcio Silva Pediatric Clinic 680 W Tennyson Rd Rm 12 Hayward, CA 94544 (510) 782-4470 Fax: (510) 782-4756 English	Medical Preventive Pediatric	M-Sat 8am-5pm
Tiburcio Firehouse Clinic 28300 Huntwood Ave Hayward, CA 94544 (510) 398-7474 Fax: (510) 293-1288 **Language(s)** Español, Tagalog, English	Medical Preventive Pediatric Prenatal GYN	M-F 8am-5pm

WEST OAKLAND HEALTH COUNCIL

Services/Hours-Days of Operation

CLINIC	SERVICES PROVIDED	HOURS AND DAYS OF OPERATION
West Oakland Health Center 700 Adeline St Oakland, CA 94607 (510) 835-9610 Fax: (510) 225-2318 **Language(s)** Español, Punjabi (On site) WOHC uses the Language line at all sites. Access to ALL languages.	Adult Medical Pediatrics Preventive Prenatal Immunizations Health Education Nutrition Counseling STD HIV Dental Family Planning Behavioral Health WIC	M-F 8:30am - 5:00pm Thursdays: 8:30am - 8:00 pm Saturdays 9:00am - 1:00 pm
East Oakland Health Center 7450 International Blvd Oakland, CA 94621 (510) 835-9610 Fax: (510) 225-2322 **Language(s)** Español	Adult Medical Pediatrics Prenatal Health Education Family Planning WIC Dental	M-F 8:30am-5pm
William Byron Rumford Medical Clinic 2960 Sacramento St Berkeley, CA 94702 (510) 835-9610 Fax: (510) 225-2314 **Language(s)** Español, Farsi, Punjabi, Mandarin, Cantonese	Adult Medical	M-F 8:30am-5pm
Albert J Thomas Medical Center 10615 International Blvd Oakland, CA 94603 (510) 835-9610 Fax: (510) 225-2315 **Language(s)** Español	Adult Medical	M-F 8:30am-5pm

Community Health Center Network Extended Clinic Hours

ASIAN HEALTH SERVICES:

818 Webster	Teen Clinic: Wednesday: 5pm - 7:00pm Saturday: 8:45am – 1:00pm

AXIS COMMUNITY HEALTH:

Hacienda	Tuesday – Thursday: until 9:00pm Saturday: 9am – 1:00pm
Pleasanton	Tuesday – Thursday: until 9:00pm Saturday: 9am – 1:00pm
Livermore	Tuesday – Thursday: until 9:00pm Saturday: 9am – 1:00pm

LA CLINICA DE LA RAZA:

Transit Village	Monday – Thursday: until 7:30pm Saturday: Medical Dept. 8:45am – 12:30pm Dental Dept. until 4:30pm
San Antonio	Saturday: 8:30am - 5:30pm (closed 12:30-1:30pm)
Pittsburg	Monday – Thursday: until 7:30pm; Friday: 8:30am - 5:30pm Saturday: 8:00am – 4:30pm
Monument	Monday & Tuesday: until 8:30pm Wednesday: until 6:30pm Saturday: 8:30am – 5:00pm

LIFELONG MEDICAL CARE:

Ashby Health Center	Tuesday: until 8:15pm
Berkeley Immediate Care	Saturday: 10:00am – 6:00pm
Brookside/Richmond	1st Saturday: 9:00am – 12:30pm
Brookside/San Pablo	Monday – Thursday: until 8:30pm Saturday: 8:30am – 2:30pm
Downtown	1st & 3rd Saturday: 8:00am – 12:00pm
East Oakland Clinic	Saturday: 8:00am – 12:00pm
Howard Daniel Clinic	Saturday: 8:00am – 12:00pm
Over 60 Health Center	Saturday: 8:00am – 12:00pm
Urgent Care San Pablo	Monday – Friday: until 8:00pm Saturday & Sunday: 9:00am – 5:00pm
West Berkeley Family Practice	Monday & Wednesday: until 8:30pm Saturday: 8:30am – 4:30pm

TIBURCIO VASQUEZ HEALTH CENTER:

Union City	Saturday: 8:00am – 5:00pm
Hayward	Saturday: 8:00am – 5:00pm
San Leandro	Saturday: 8:00am – 5:00pm
Silva	Saturday: 8:00am – 5:00pm

TRI-CITY HEALTH CENTER:

Liberty	Monday – Thursday: until 7:00pm Saturday: 8:00am - 5:00pm
Mowry I	Monday - Thursday: until 7:00pm
Mowry II	Convenient Care: Monday – Friday 5:00 – 8:00pm Primary Care: Tuesday and Wednesday until 7:00pm
Irvington	Monday – Friday: until 8:00pm Saturday: 8:00am - 5:00pm

Please be aware the health centers listed may change the extended hours of operation and services. For the most up-to-date information, contact the health center directly

Community Health Center Network
Description of Insurance Programs

Alameda Alliance for Health (www.alamedalliance.com)

Medi-Cal

Alameda Alliance for Health is the local initiative of the two-plan model of Medi-Cal Managed Care in Alameda County. In 2000, CHCN began managing the care of Alameda Alliance for Health Medi-Cal population. Coverage includes complete primary and preventive care including inpatient and outpatient services as well as dental, pharmacy and vision.

Medi-Cal Expansion

Effective January 1, 2014 adults without children, ages 19-64, will be eligible for Medi-Cal. Eligibility is based upon income as required by the Affordable Care Act. Alameda Alliance for Health will take part in the managed care delivery system. Coverage includes a core set of services, including doctor visits, hospital care, and pregnancy-related services, as well as nursing home care for individuals age 21 or older.

Group Care

Group Care is health coverage developed by Alameda Alliance for Health to meet the needs of In-Home Supportive Services (IHSS) home care workers in Alameda County. Coverage includes inpatient and outpatient care as well as dental, and vision services. There is a monthly premium obligation, plus applicable co-pays and eligibility requirements.

Anthem Blue Cross (http://www.anthem.com/ca/home-providers.html)

Medi-Cal

Early February 1997, California was mandated to offer a managed care model to the State's low-income population. As the Commercial plan, Anthem Blue Cross became one of the two health plans available to members who were in the mandatory aid codes. Coverage includes complete primary and preventive care including inpatient and outpatient services as well as dental, pharmacy, vision, and mental health services.

Medi-Cal Expansion

Effective January 1, 2014 adults without children, ages 19-64, will be eligible for Medi-Cal. Eligibility is based upon income as required by the Affordable Care Act. Anthem Blue Cross will take part in the managed care delivery system. Coverage includes a core set of services, including doctor visits, hospital care, and pregnancy-related services, as well as nursing home care for individuals age 21 or older.

HEALTH INSURANCE PROGRAMS AVAILABLE THROUGH COMMUNITY HEALTH CENTER NETWORK (CHCN) CLINICS

ELIGIBILITY CRITERIA	MEDI-CAL ↓	GROUP CARE (IN-HOME SUPPORTIVE SERVICES (IHSS) ↓
Eligibility:	• Children birth up to 21 • Some parents/adults • Pregnant women • Blind or Disabled people • People 65 and over • Minors under 21 may be eligible for some confidential services on their own	• An IHSS worker is eligible to enroll after working two consecutive months in which he or she is authorized to work an average of 35 hours per month. In addition the IHSS worker must: Reside in the service area on a full-time basis (full time means a resident and physically present at the location for residential purposes), work in the service area, not have previously been terminated by the Alliance, has submitted the required enrollment information and have met the Public Authority eligibility requirements. • No Dependent Coverage.
Scope of Benefits:		• Inpatient and outpatient care; routine medical care; preventive services; x-rays and laboratory services; prescription drugs; DME; orthotics; cataract spectacles and lenses for cataracts; perinatal care; PKU; family planning services; abortion services; emergency services; inpatient and outpatient mental health services; inpatient and outpatient alcohol/drug abuse services; home health care services; skilled nursing care; chiropractic services; hearing aids and services; blood and blood products; health education; hospice, organ transplants, dental and vision care.
Immigration Issues:	• U.S. Citizens, Legal Permanent Residents and certain other immigrants may receive full-scope Medi-Cal. • Undocumented and certain other immigrants can still receive Restricted Medi-Cal for emergency conditions and pregnancy-related services.	
Income Limits:	• Children Birth up to 1: up to 200%FPL • Children 1through 5: up to 133%FPL • Children 6 through 18 up to 100%FPL • 19 up to 21: varies, around 100%FPL • Pregnant Women: up to 200%FPL NOTE 1: Effective 3/1/2000 Families up to 100% of FPL even if they do not receive cash assistance. NOTE 2: Assets are not considered when determining eligibility for the categories listed above.	
Premiums and Co-Payments:	• No co-payments or premiums are required.	• Member monthly premium cost share is $8.00. • There are co-payments for some services; OV $10, ER $35, Rx $10G/$15/B, INPT $100, ACI $5, CHIRO $10

Community Health Center Network

Group Care/In Home Supportive Services (IHSS)
Eligibility Requirements

To be eligible for Group Care (IHSS) the following rules shall apply:

An IHSS worker is eligible to enroll for coverage after working two consecutive months in which he or she is authorized to work at least eighty (80) hours each month on-going. In addition, the IHSS worker must:

- Reside in the Service Area on a full-time basis (full-time means that person used the location as a residence and is physically present at the location for residential purposes), or
- Work in the Service Area;
- Not have previously been terminated by Alliance for fraud or deception of failing to provide complete information;
- Have submitted the required enrollment information to the Public Authority; and
- Have met the Public Authority eligibility requirements.

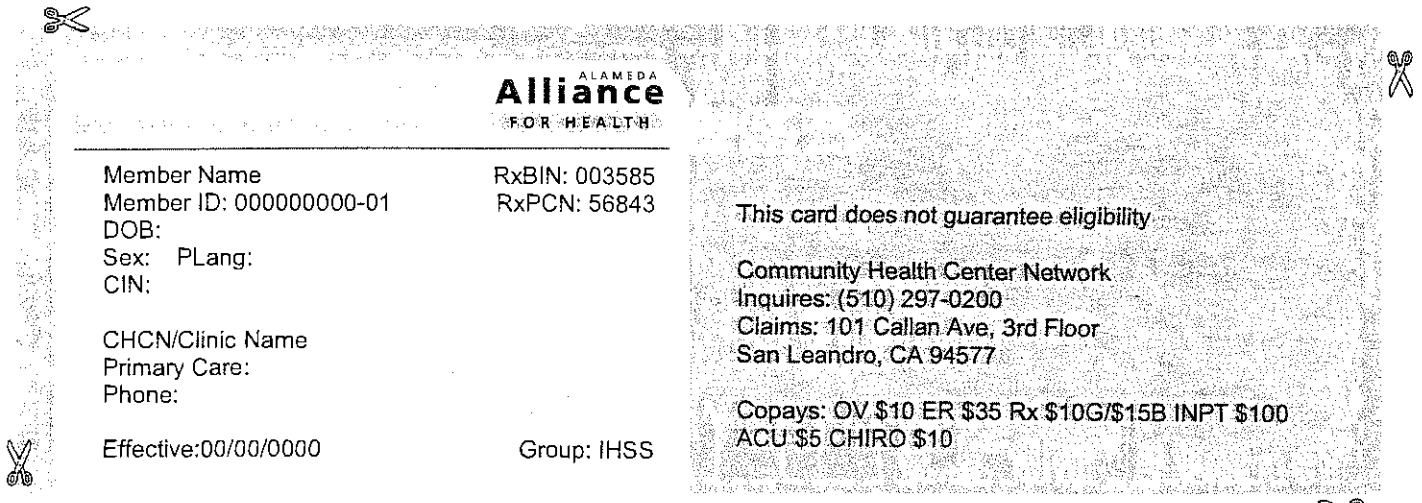
Member Monthly Premium

Once covered, IHSS workers will have a$20.00 or $45.00 monthly premium depending on their choice of dental plans.

Dependents are not eligible for Benefits under this Agreement.

Community Health Center Network

Group Care (IHSS) Identification Card



ALAMEDA Alliance FOR HEALTH

Member Name
Member ID: 000000000-01
DOB:
Sex: PLang:
CIN:

CHCN/Clinic Name
Primary Care:
Phone:

Effective:00/00/0000

RxBIN: 003585
RxPCN: 56843

Group: IHSS

This card does not guarantee eligibility

Community Health Center Network
Inquires: (510) 297-0200
Claims: 101 Callan Ave, 3rd Floor
San Leandro, CA 94577

Copays: OV $10 ER $35 Rx $10G/$15B INPT $100
ACU $5 CHIRO $10

↑THIS IS YOUR MEMBER ID CARD. REMOVE ALONG THE DOTTED LINE.↑

MEMBER NUMBER:	Patient ID
MEMBER NAME:	Member's name
EFFECTIVE DATE:	Effective date of eligibility
DATE OF BIRTH:	Birth date of member
LANGUAGE:	Primary language of member
PRIMARY CARE PROVIDER:	Primary care provider clinic selected by member
C0-PAYMENT:	Co-payment for service

Community Health Center Network
Group Care (IHSS)
Scope of Benefits

BENEFIT	SERVICES	BILL TO	REFERAL/AUTH	CO-PAYMENT
Abortion Services	Provided by CHCN provider	CHCN		$10 per visit
Acupuncture	20 visits per year	AAH	Referral	$5 per visit
Alcohol and Drug Abuse	Inpatient: As medically appropriate to remove toxic substances from the system-3 days	PacifiCare Behavioral Health	Authorization	No
	Outpatient: 10 visits per benefit year	Medi-Cal-DHS Non-Medi-Cal-PacifiCare Behavioral Health	Authorization	$10 per visit
Biofeedback		Not Covered		
Cataract Spectacles and Lenses	Glasses and lenses are covered post surgery with insertion of intraocular lens	VSP	None required	No
Chemotherapy	Professional	CHCN	Authorization	No
	Drug	AAH	Authorization	No
Chiropractic Services	20 visits per year	AAH	Authorization	$10 per visit
Dental	Dental Services – Provided through Delta Dental	Delta Dental		
Diagnostic x-ray Inpatient/Outpatient	Including Electrocardiography, electroencephalography, and mammography for screening or diagnostic purposes	CHCN	Refer to Auth grid for radiology services that require authorization	No
Durable Medical Equipment	Medical equipment for use in the home which is used repeatedly and is not useful to a person who is not sick or hurt	AAH	Authorization	No
Emergency	Twenty four hour emergency care	CHCN-In area (within Alameda County and contiguous Counties AAH for out of area)	None required\notification to AAH within 24 hours	$35 per visit
		AAH-Out of Area		

Community Health Center Network
Group Care (IHSS)
Scope of Benefits

BENEFIT	SERVICES	BILL TO	REFERAL/AUTH	CO-PAYMENT
Eye Exams/Supplies	Refractions to determine the need for corrective lenses; and dilated retinal eye exams	VSP	None required	No
Family Planning	Counseling, surgical procedures for sterilization, FDA-approved contraceptives and devices	CHCN	None Required	No
Health Education	Health education services	CHCN	None required	No
Hearing aids and Services	Audiological evaluations, hearing aids, supplies, visits for fittings, counseling, adjustments	AAH	Authorization	No
Hemodialysis	Professional	CHCN	Authorization	No
	Technical	AAH	Authorization	No
Home Health Care	Prescribed by PCP	AAH	Authorization	No Co-payment *Except: $10 for home visits for PT/OT/ST*
Hospice	Care and services provided in a home by a licensed or certified provider are: a) designated to provide palliative and supportive care to individuals who are diagnosed with a terminal illness b) directed and coordinated by medical professionals	AAH	Authorization	No
Hospital	• General hospital services, in a room of two or more, with customary furnishings and equipment, meals, and general nursing care • All medically necessary ancillary services	AAH	Authorization Authorization	$100 Co-payment per visit
Laboratory Services	Inpatient and Outpatient	CHCN	None required	No
Medical Transportation	Emergency	AAH	ER-none required	No
Mental Health	Inpatient-10 days Outpatient-10 days	PacifiCare Behavior Health		Inpatient-$100 Co-payment per inpatient admission Outpaient-$10 per visit

Community Health Center Network
Group Care (IHSS)
Scope of Benefits

BENEFIT	SERVICES	BILL TO	REFERAL/AUTH	CO-PAYMENT
Orthotics and Prosthetics	Prescribed by PCP	AAH	Authorization	No
Perinatal Care	Medically necessary professional and hospital services relating to maternity care: • Pre-natal and post-natal care and complications of pregnancy • Newborn examinations and nursery care for the month of birth and the following month of life • Diagnostic and genetic testing • Counseling for nutrition, health education and social support needs • Labor and delivery care, including midwifery services	CHCN		No
Physical, occupational, speech therapy	Short-term therapy not exceeding 60 consecutive calendar days per condition following the date of the first therapy session. Additional therapy beyond the 60 days provided if medically necessary.	CHCN	Authorization	$10 per visit
Physician	Home visits	CHCN	None required	$10
	Specialist	CHCN	Referral	$10
	PCP office visit	CHCN	None required	$10
	Surgery/Assistant surgery/Anesthesia	CHCN	Authorization	No
	Outpatient procedures	CHCN	None required	$10
	Inpatient hospital and skilled nursing facility visits	CHCN	Authorization	No
	Well baby care for month of birth and the following month of life, including newborn hospital visits, health examinations, and other office visits.	CHCN	None required	No

Community Health Center Network
Group Care (IHSS)
Scope of Benefits

BENEFIT	SERVICES	BILL TO	REFERAL/AUTH	CO-PAYMENT
Prescription Drug	Outpatient: • 30 day supply generic medications • One cycle of tobacco cessation drugs per benefit year. (It is recommended that members attend tobacco use cessation classes or program)	Pharmaceutical Care Network	None required	$10(G) $15(B) per prescription
	Inpatient-coverage for any and all prescription drugs	Pharmaceutical Care Network	None required	No
Preventive Care	Periodic health exams	CHCN	None required	No
	Family Planning	CHCN	None required	No
	Immunization-Administration	CHCN	None required	No
	Immunizations-Serum	CHCN	None required	No
	Cytology examination (including annual Pap smear exam)	CHCN	None required	No
	Hearing Test	CHCN	None required	No
	Venereal disease tests, including Confidential HIV/AIDS counseling and testing	CHCN	None required	No
	Prenatal Care	CHCN	None required	No
	Health education services	CHCN	None required	No
Radiation Therapy	Professional	CHCN	Authorization required for hospital based services	No
Radiation Therapy	Technical	AAH		
Skilled Nursing Care	100 days per benefit year	AAH	Authorization	No
Transplants		AAH	Authorization	No

Community Health Center Network

Medi-Cal
Eligibility Requirements

To receive the benefits (CHCN) Medi-Cal, members may have the following Aid Codes.

AID GROUPS	ALAMEDA COUNTY
AFDC/PA	30,32,33,35,38,39,3A,3C,3G,3H,40,42,54,59,3N,3P,3R
AFDC/MN	34
AGED/PA	10,16,18
BD/PA	14,20,60,66,68,6C,6H,6J,6N,6V,6E
BD/MN	24,64
MI Child	03,04,5K,8P,47,72,82,4F,4M,40,42
Refugees/Entrants	01,02,08,7A,8R
MIA/Medi-Cal only	86

Call Health Care Options at 1-800-430-4263.

Community Health Center Network
Medi-Cal Medical Identification Card

ALAMEDA
Alliance
FOR HEALTH

Member Name
Member ID: 000000000-01
DOB:
Sex: PLang:
CIN:

CHCN\ Clinic Name
Primary Care:
Phone:

Effective:

RxBIN: 003585
RxPCN: 56843

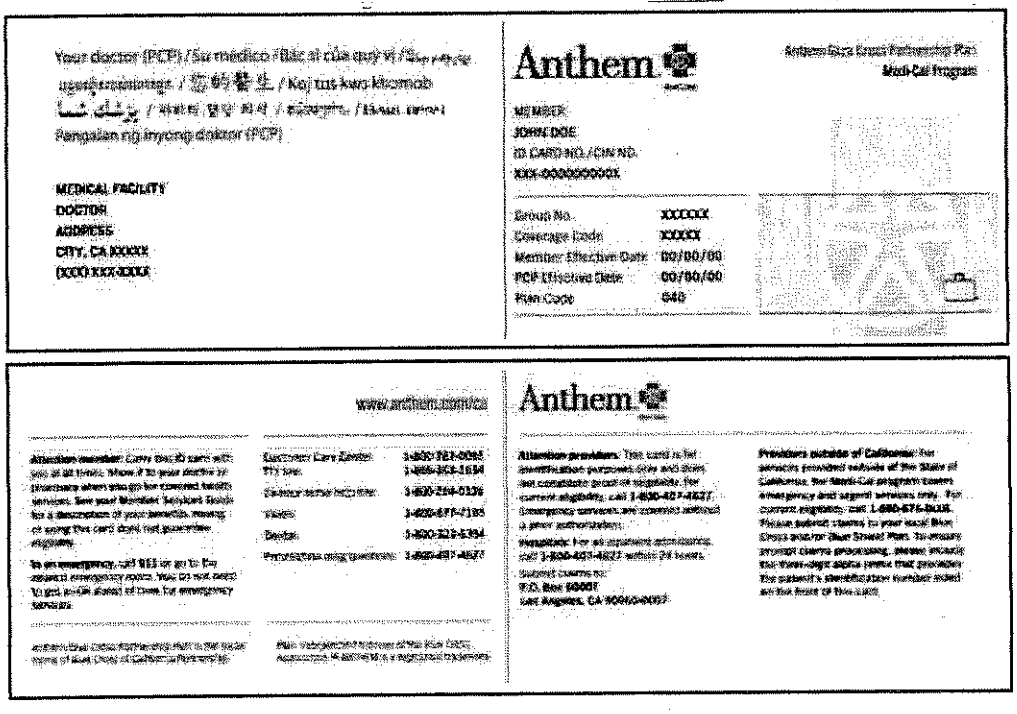
Group: MCAL

This card does not guarantee eligibility

Community Health Center Network
Inquires: (510) 297-0200
Claims: 101 Callan Ave, 3rd Floor
San Leandro, CA 94577

Copays: OV $0 ER $0 RX $0

↑THIS IS YOUR MEMBER ID CARD. REMOVE ALONG THE DOTTED LINE.↑



Community Health Center Network
Medi-Cal
Scope of Benefits

BENEFIT	SERVICES	BILL TO	REFERRAL/AUTH	CO-PAYMENT
Abortion Services	Provided by CHCN Provider	CHCN		No
Acupuncture	Member Benefit	EDS-FFS		No
AIDS	Facility Component	Health Plan (AAH or BC)	Authorization	No
	Professional Component	CHCN	Referral	No
Alcohol and Drug Abuse	Member Benefit Carve Out	EDS-FFS		No
Allergy Testing	Testing	CHCN	Referral	No
	Serum	Health Plan (AAH or BC)	N/A	No
Biofeedback	Not Covered			No
Blood and Blood Products	From Blood Bank	Health Plan (AAH or BC)	Authorization	No
Cataract Spectacles and Lenses		VSP		No
Chemotherapy	Professional Component	CHCN	Authorization	No
	Drugs (Intravenously administered)	Health Plan (AAH or BC)	Authorization	No
Chiropractic Services	Member Benefit	EDS-FFS		No
Dental	Dental services due to accidental injury to sound natural teeth	CHCN	Authorization	No
	Other dental services	Medi-Cal		No
Detoxification	Not Covered	County Mental Health		No
Diagnostic x-ray Outpatient		CHCN	None required	No
Durable Medical Equipment		Health Plan (AAH or BC)	Authorization	No
Emergency	Professional Component	CHCN	None required	No
	Facility Component (in area and out-of area)	Health Plan (AAH or BC)	None required	No
Eye Exams/Supplies		VSP		No
Family Planning	Self-Referral	CHCN	None required	No
Genetic Testing		CHCN	Authorization	No

Community Health Center Network
Medi-Cal
Scope of Benefits

BENEFIT	SERVICES	BILL TO	REFERRAL/AUTH	CO-PAYMENT
Health Education		CHCN	None required	No
Hearing Services	Evaluations	CHCN	Authorization	No
Hearing Aids and Services	Aids, Supplies, Adjustments	CHCN	Authorization	No
Hemodialysis	Professional Component	CHCN	Authorization	No
	Facility Component	Health Plan (AAH or BC)	Authorization	No
Home Health Care	Including meds	Health Plan (AAH or BC)	Authorization	No
Hospice	Medially necessary nursing care, medical social services, home health aid services, physician services, drugs, medial supplies and appliances, counseling and bereavement services, homemaker, volunteer, physical therapy and speech therapy	Facility – Health Plan (AAH or BC) Professional - CHCN	Authorization	No
	Inpatient Facility Component	Health Plan (AAH or BC)	Authorization	No
Hospital	Professional Component	CHCN	Authorization	No
Immunizations	Administration (VFC Vaccine)	CHCN	None required	No
	Administration and Serum (non-VFC)	CHCN	None required	No
	Administration and Serum (Adults)	CHCN	None required	No
Laboratory Services	Professional Component or non-hospital facility component	CHCN	None required	No
Mammography	Technical	Health Plan (AAH or BC)	Referral	No
	Professional	CHCN	Referral	No
Medical Transportation	Emergency Non-emergency	Health Plan (AAH or BC)	ER-none required Coordinate w/Plan	No No
Mental Health		County Mental Health		No
Orthotics and Prosthetics		Health Plan (AAH or BC)	Authorization	No
Perinatal Care	Inpatient facility	Health Plan (AAH or BC)	Authorization	No
	Professional Component; CPSP	CHCN	None required	No

Community Health Center Network
Medi-Cal
Scope of Benefits

BENEFIT	SERVICES	BILL TO	REFERRAL/AUTH	CO-PAYMENT
	Fetal Monitoring	CHCN	Referral	No
	Amniocentesis	CHCN	Referral	No
Physical, occupational, speech therapy	Professional Component (inpatient and outpatient) or non-hospital facility component	CHCN	Authorization	No
Physician	Specialist	CHCN	Referral	No
	PCP office visit	CHCN	None required	No
	Outpatient procedures	CHCN	None required	No
	Inpatient hospital visits	CHCN	Authorization	No
Podiatry		CHCN	Authorization	No
Prescription Drug	Prescribed in writing by a doctor for the care and treatment of an injury or an illness; 30-day supply	Participating Drug Store		No
Preventive Care	Health exams (including well baby care)	CHCN	None required	No
	Family Planning	CHCN	None required	No
	Cytology examination (including annual Pap smear exam)	CHCN	None required	No
	Mammography-professional component	CHCN	None required	No
	Hearing Test	CHCN	None required	No
	Sexually Transmitted Infections	CHCN	None required	No
	Prenatal Care	CHCN	None required	No
	Health Education Services	CHCN	None required	No
Radiation Therapy	Professional Component	CHCN	Authorization	No
	Inpatient and outpatient facility	Health Plan (AAH or BC)	Authorization	No
Skilled Nursing Care		Health Plan (AAH or BC)	Authorization	No
Transplants	Kidney and Corneal transplants only-professional component	CHCN	Authorization	No

How to Submit an Authorization

1. Determine if the service needs authorization by checking the CHCN Referral and Authorization Grid located in this section

2. Use the CHCN authorization form. You may copy the authorization form in this section or download the form from the CHCN website at:
http://www.chcnetwork.org/ManagedCareServices/InformationforProviders/Authorizations

3. Before filling out the authorization, check the member's eligibility by using the CHCN web portal or by checking with the health plan

4. Check to make sure that the services you are requesting authorization for are done by a contracted CHCN provider. A list of contracted providers can be found on our website at: http://www.chcnetwork.org/ManagedCareServices/WheretoRefer.

5. Be sure to check if the service is a covered benefit. Things that are not covered usually include over the counter devices, cosmetic interventions (removal of skin tags to make the member look better), fertility work ups including reversals of sterilizations. Services that are not covered will not be authorized

6. Fill out the form and fax it to CHCN at 510-297-0222

7. CHCN has 5 business days to process routine authorizations. If you have not heard from CHCN in 4 days you may call the utilization management office at 510-297-0220 or log into the web portal at https://portal.chcnetwork.org to see if the authorization has been approved

Authorization Procedures

The primary purpose of the authorization process is to ensure that the primary care provider is advised of the findings, treatment, and diagnosis provided. In order to ensure this communication, CHCN must have the authorization **before any specialty claim is paid**. CHCN will also be responsible for tracking outstanding claims; this enables CHCN to monitor unsubmitted claims.

CHCN has designed a single Referral and Authorization Form to be used for all specialty services. Send a single copy of the form to CHCN by fax to 510-297-0222. Expiration dates for authorizations is three (3) months from date of request unless otherwise noted. Turn around time for routine authorization requests five (5) business days.

IF A SERVICE IS NOT A "COVERED BENEFIT" IN THE MEMBER'S PLAN OR THE MEMBER IS INELIGIBLE, THE SERVICE WILL NOT BE PAID FOR BY THE PLAN OR BY CHCN EVEN IF THE PCP COMPLETES A REFERRAL REQUEST FORM.

CALL CHCN AT 510-297-0220 TO VERIFY ELIGIBLITY.

	Click Here for CHCN's Provider Portal			
COMMUNITY HEALTH CENTER NETWORK	**Community Health Center Network (CHCN) PRIOR AUTHORIZATION GRID** **Before services are provided PLEASE CHECK Provider Portal for:** ***Member Eligibility *Benefit Coverage *Contracted Provider** **Questions --Call CHCN at 510-297-0220** **7/1/2017**	**Non-Covered Benefit**	**Authorization Required**	**No Authorization Required**
Acupuncture	Prior authorization required for 25 or more visits in an elapsed year (one year from first date of acupuncture service for that member).			√
All Services from non-contracted providers	Excluding sensitive services		√	
All Out-of-Area Services	Outpatient and office		√	
Bariatric psychiatric evaluations			√	
Biofeedback	Refer to plan Evidence Of Coverage (EOC) for exceptions	√		
Cataract spectacles and lenses			√	
Cataract Surgery	AAH		√	
	ABC		√	
Chiropractor	Chiropractor only allowed if provided in FQHC. Prior authorization required for 5 or more visits in a month or 11 or more visits in an elapsed year (one year from first date of chiropractic service for that member).			√
Laser Surgery				√
Cardiac Rehab			√	
Children's Developmental Evaluations				√
Clinical Trials			√	
Cosmetic Services	Excluding reconstructive or certain transgender surgeries. Refer to plan EOC	√		
Custodial Care Services		√		
Coumadin Clinic Services				√
Dental Care	**Medi-Cal:** IV Sedation and general anesthesia		√	
	Refer to plan EOC for coverage criteria and exceptions			
	Group Care: Covered through Public Authority	√		
Dermatology	Keloid Scar Treatments such as 5-FU, cryotherapy, surgery, radiation, laser therapy (effective 5/1/17)		√	
	Keloid Scar Treatments such Topical pressure/silicone gel, intralesional steroid injection (effective 5/1/17)			√
Diabetes Self-Management			√	
Diagnostic and Laboratory Services	Lab tests performed by Quest Diagnostics			√
	Lab tests performed by providers other than Quest Diagnostics		√	
	All genetic testing performed by Quest Diagnostics		√	
Dialysis	**AAH**: Refer to plan.			√
	ABC: Extended authorizations for 6 months		√	

COMMUNITY HEALTH CENTER NETWORK	**Community Health Center Network (CHCN) PRIOR AUTHORIZATION GRID** **Before services are provided PLEASE CHECK Provider Portal for:** ***Member Eligibility *Benefit Coverage *Contracted Provider** **Questions --Call CHCN at 510-297-0220** **7/1/2017**	**Non-Covered Benefit**	**Authorization Required**	**No Authorization Required**
Durable Medical Equipment/Repair	**AAH:** Submit CHME DME Prior Authorization (PA) form to CHME: Phone: 1-800-906-0626; fax: 650-357-8551; email: aaquestions@chme.org; aaquestions@chme.org		√	
	ABC: Submit CHCN Prior Authorization form to CHCN, ONLY for the following DME: *Air Fluidized Beds, *Bone Growth Stimulators, *Cervical Collars, *Cold Therapy Units, *Compression Hosiery & Support Stockings, *Continuous Glucose Pump, *CPM device, *Cranial Helmets, *Diabetic Shoes, *Dynamic Splint, *Electric Patient Lifts, *Electric Seat Lift Chairs, *Home Infusion Therapy, *Insulin Pump, *Mastectomy Related Accessories, *Ocular Prosthetics, *Respiratory Therapy Medication, *Lymphedema Pumps, *Speech Generating Devices, *Tractions, *Vest Airway Clearance System		√	
Enteral and nutrition formulas	**AAH:** refer to plan.			
	ABC: submit PA to CHCN		√	
Emergency Care/Treatment				√
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) supplemental services				√
Experimental/Investigational treatments		√		
Facility admissions	Inpatient, SNF, LTAC, Hospice, Acute Rehab, Respite, Burn Centers		√	
Gender Identity/Transgender Services	Surgical Treatments		√	
Hearing Aids	**AAH:** refer to plan.			
	ABC: Submit PA to CHCN		√	
Home Health:	Evaluation			√
Skilled Nursing, OT,PT, ST	Visits beyond evaluation		√	
Hospice Services	Home or Inpatient		√	
Incontinence creams and washes		√		
Infertility treatment		√		
Injectable, Chemotherapy, Infusion, Transfusions--Outpatient	Refer to plan website for Drug Formulary		√	
Mental Health Services	**Mild to Moderate:** Refer to plan			
	AAH: Submit PA to BEACON for **Pre-Bariatric** surgery Psych Eval			
	ABC: Submit PA to CHCN for **Pre-Bariatric** surgery Psych Eval		√	
Nutrition and dietician assess/counseling	Pre-Bariatric surgery		√	
OB/GYN Services	Including ultrasounds			√
Ophthalmology	Annual services and care related to DM, glaucoma, ocular degeneration			√
Orthodontics, orthognathic and appliance therapy for TMJ		√		
Orthotics and Prosthetics (e.g. breast prostheses,	**AAH:** Refer to plan			
footwear to treat/prevent diabetes complications,	**ABC:** submit PA to CHCN		√	
Outpatient surgery and specialty procedures			√	
Outpatient Therapy (OT, PT, ST)	OT, PT, ST Initial Evaluations			√
	OT, PT, ST follow-up visits		√	

COMMUNITY HEALTH CENTER NETWORK	**Community Health Center Network (CHCN) PRIOR AUTHORIZATION GRID** **Before services are provided PLEASE CHECK Provider Portal for:** ***Member Eligibility *Benefit Coverage *Contracted Provider** **Questions --Call CHCN at 510-297-0220** **7/1/2017**	**Non-Covered Benefit**	**Authorization Required**	**No Authorization Required**
Podiatry	**Medi-Cal:** performed in FQHC all ages			√
	Medi-Cal: performed outside of FQHC under 21 y.o. or with diabetes			√
	Medi-Cal: performed outside of FQHC and over 21 y.o. for members with chronic disese or, acute condition impairing ability to walk.		√	
	Group Care: All ages, clinic settings, and continuous		√	
Preventive Care				√
Pulmonary Rehab			√	
Interventional Radiology				√
Radiology	**Advanced Radiology provided within the Hospital:** CT with or without contrast, MRI, MRA, Nuclear Med, PET Scans, DEXA Scans.		√	
	Advanced Radiology provided within Non-Hospital/Freestanding facilities: CT with contrast, MRI, MRA, PET Scans, and DEXA Scans for members 64 years of age and younger.		√	
	Advanced Radiology provided within Non-Hospital/Freestanding facilities: CT without contrast, Nuclear Med, and DEXA Scans for members 65 years of age and older.			√
	Routine: X-ray, Ultrasound including OB, Mammography, VCUG, IVP, BE, Upper GI			√
Second Opinions			√	
Sensitive Services (including therapeutic abortion & HIV testing & counseling	**Medi-Cal:** (contracted and non-contracted providers)			√
	Group Care: (contracted providers only)			√
	Group Care: (non-contracted providers)		√	
Sleep Studies				√
Specialist and Hospitalist Referrals (In-network)	PA required **only** for Dr. Scott Taylor			√
Standard diagnostic procedures	EKG, PFT, EGD, KUB, Nuchal Translucency Scan, Transthoracic Echocardiograms			√
Specialty diagnostic procedures	Stress/Pharmacologic or Trans-esophageal Echocardiograms,		√	
	Colonoscopy/Sigmoidoscopy			√
Surgery Services - Outpatient			√	
Transplant Services	All pre-transplant service evaluations, Kidney and Corneal			
	Medi-Cal: Refer to plans for major organ transplants (heart, lung, liver, bone marrow, etc.)			
	Group Care: All major organ and bone marrow transplants		√	
Vaccines	Administered by primary and specialty care providers			√
Wound Care services			√	

Community Health Center Network

Setting the standard for Community Health Care

MEMORANDUM

TO: ALL PROVIDERS

FROM: COMMUNITY HEALTH CENTER NETWORK

SUBJECT: RETROSPECTIVE REVIEW PRIOR AUTHORIZATION POLICY

DATE: JUNE 1, 2016

Please read this important notice regarding prior authorization requests. Effective immediately, CHCN accepts authorizations submitted after the date(s) of service(s) on a case by case basis. Generally, retrospective reviews will be considered when:

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

To initiate the retrospective review process, please submit a CHCN Authorization Request form and mark the request as “Retro.” CHCN will review the request within the 30 calendar day allowable timeframe and issue a formal Notice of Action following the review. Should you not agree with our decision, you may request a formal appeal with the health plan Grievance and Appeals department.

Please contact CHCN Utilization Management department at 510-297-0481 if you have any questions.

Community Health Center Network
Setting the standard for Community Health Care

Please Don't Handwrite!
Download this PDF file and type in the data fields before printing. You can save your data in the PDF file.

CHCN Prior Authorization Request

Fax: (510) 297-0222 **Telephone:** (510) 297-0220
Note: All fields that are **BOLDED** are required.

Authorizations are based on medical necessity and covered services. Authorizations are contingent upon member's eligibility and are not a guarantee of payment. The provider is responsible for verifying member's eligibility on the date of service.

Member must be eligible on date of service and procedure must be a covered benefit. REMAINING BALANCE MAY NOT BE BILLED TO THE PATIENT. If interested in becoming a CHCN contracted provider, contact Provider Services at 510-297-0200. Please verify eligibility using one of the following methods:

1. Web: https://connect.chcnetwork.org
2. CHCN Customer Services: (510) 297-0220

TYPE OF REQUEST (please select only one):

- ☐ **Routine** Approval based on CHCN clinical review. CHCN has up to 5 business days to process routine requests.
- ☐ **Urgent** Inappropriate use will be monitored. CHCN has up to 72 hours to process urgent requests for all lines of business.
- ☐ **Retro** Authorization requests submitted after services are rendered will NOT be reviewed. 30 day limitation, approved on exception basis only. CHCN has up to 30 calendar days to process retro requests from the date of receipt of request.
- ☐ **Modification** Request for existing authorized services. Please enter the CHCN Auth Number and the Member information below. Use a separate sheet to specify your changes or to attach additional supporting documentation.

If Mod, CHCN AUTH #:

REQUESTING PROVIDER

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

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

First Name:
Last Name:
Date of Birth:
Address:
City: State: Zip:

Health Plan ID#:
☐ Newborn? DOB:
Phone:
Other Insurance (i.e. Commercial, Medicare A, B):

PLACE OF SERVICE:
☐ **Inpatient** ☐ **Outpatient** ☐ **Doctor's Office** ☐ **Ambulatory Surgical Center** ☐ **DME** ☐ **HHA**

AUTHORIZE TO

Name/Facility:
Specialty/Dept:
NPI #:
Anticipated Date of Service:

Phone:
Fax:
Address:
City: State: Zip:

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

DIAGNOSES / SERVICE CODES **ICD-10 codes required beginning 10/01/2015. Only enter the code, modifier, and quantity.**

ICD Code(s):											
CPT/HCPCS	Mod	**Qty**	CPT/HCPCS	Mod	Qty	CPT/HCPCS	Mod	Qty	CPT/HCPCS	Mod	Qty

NOTE: The information being transmitted contains information that is confidential, privileged and exempt from disclosure under applicable law. It is intended solely for the use of the individual or the entity to which it is addressed. If you have received this communication in error, please immediately notify us. Revised: V11.1 9/2015

CHCN Prior Authorization Request form is now a fillable PDF form that you can use to type in your information and then print. All fields that are marked in **"Bold"** are mandatory. Please submit an electronically completed form with all the required information to help us service your request faster. The following table provides information regarding expected information in some of the key fields.	
Request Type	Please check only one of the four boxes provided. CHCN follows the turnaround times for authorization processing as establish by regulations and the health plans. **NOTE:** 'Modification' requests are considered as 'Routine' requests.
Requesting Provider	Please enter information for your practice. For convenience you can type in your information once and then save the file for future use.
Name	Please enter provider name (First name Last name).
NPI#	Please enter the NPI number of the provider.
Office Contact	Please enter name of the office contact (First Name Last Name). CHCN staff will communicate with this person if needed.
If Mod, CHCN Auth #	If you are requesting modification for an existing authorization please enter the authorization number provided to you so that we can uniquely identify your record. Please specify member information in the form as well. Include your modification request on a separate sheet of paper.
Member	Please enter CHCN member information. **NOTE:** If the requested service is for a newborn please enter mother's member information below. Newborn care is covered under mothers' benefit plan during the birth month and one month after that.
First Name	Please enter CHCN member's first name.
Last Name	Please enter CHCN member's last name.
Date of Birth	Please enter member's date of birth in MM/DD/YYYY format.
Health Plan ID #	Please enter member's Health Plan ID #.
Newborn	Please check this if the authorization request is for a newborn child.
DOB	Please enter new born child's date of birth in MM/DD/YYYY format.
Other Insurance	If the member has other insurance coverage please mention insurance id.
Place of Service	For all future elective procedures please check 'Inpatient'. For other services check appropriately. For home health services please check 'HHA'.
Authorize To	Please enter information about the provider (or facility) that you are requesting authorization for.
Name / Facility	Please enter name (First Name Last Name) of the provider you are authorizing in the request. If you do not know the name please enter the facility information (e.g. UCSF).
Specialty / Dept	Please enter Specialty of the provider or the department if you have entered a facility name above.
NPI #	Please enter the NPI number of the requested provider if available.
Anticipated Date of Service	Please enter the date of service if known. This will help CHCN to verify if the patient is eligible for that service on this date.
Non-contracted	Please check if the provider is not within CHCN contracted provider network
Reason	If you have selected non-contracted provider please enter the reason for requesting an out of network provider. (The reason could be unavailability of the particular specialty within CHCN network).
Diagnoses / Service Code	Please enter ICD-9 codes for diagnoses and CPT/HCPCS codes for request service / equipment / supplies
Diagnoses	Please enter ICD-9 codes to describe diagnoses. At least one code is required for us to process your request. You can enter up to nine diagnoses codes on the form. If you need to enter more than nine please enter your first nine codes and then attach a separate sheet with the rest of the codes.
CPT / HCPCS code	Please enter CPT (or HCPCS) codes for procedures (or equipment/supplies) that you are requesting authorization for. At least one code is required. You can enter up to twelve codes on this form. If you need to enter more than 12 codes please enter your first twelve codes on this form and then attach a separate sheet with the rest of the codes.
Mod	Please enter modifier for the CPT code if applicable. If you have multiple modifiers for one CPT / HCPCS code please enter each modifier in a separate line.
Qty	Please enter number of units of service (or equipment / supplies) requested. For every CPT /HCPCS code you enter you are required to provide associated quantity.

California Children's Services
Referrals and Medical Eligibility

POLICY

CHCN will coordinate the referral of all children with potential California Children's Services (CCS) eligible diagnoses to CCS for review. CCS provides case management services for Medi-Cal and Healthy Families eligible children with CCS-eligible conditions; eligibility for children covered under insurance programs other than Medi-Cal or Healthy Families will be determined on a case by case basis.

SCOPE

All children with potential CCS- eligible conditions from birth to 21 years of age who meet the following requirements:

- has a CCS eligible medical condition (see list at end of the policy)
- parents/legal guardians are residents of Alameda County
- child has full scope Medi-Cal or Health Families Insurance
- family's adjusted gross income is less than $40,000 per year or out of pocket medical expense for the child is more than 20% of adjusted gross income.

CCS services may include diagnostic evaluation, treatment services, physical and occupational therapy and lastly, medical case management.

PROCEDURE

CHCN UM staff is responsible for coordinating the referral to CCS with the network clinics or specialists as described in the following procedure:

- CHCN UM staff and claims receives on-going education on CCS through UM supervisor and QI/UM Director;

- Provider staff is made aware of CCS Program through the CHCN Provider Operation Manual. The Provider Manual explains how to refer and defines eligible conditions;

- Members are also made aware of CCS through CHCN's new Member Handbook;

- CHCN UM staff provides office orientations for all 7 clinics that include information on the CCS program;

- During the prospective review and concurrent review processes members with potential CCS eligible conditions are identified. **OF NOTE:** PCP will authorize a referral for specialty care using the CHCN authorization process. The PCP does not need to determine if this specialty care is CCS eligible; the CHCN UM Department will make this determination;

- CCS Eligibility Criteria (see attached) is reviewed to determine if a referral to CCS is needed *within 24 hours*;

- The CCS Managed Care Liaison is contacted *within 24 hours* to determine if the member is already open to CCS. In cases where an open CCS case exists, the case number is noted and the referring provider is notified for future coordination with the CCS authorized provider. In instances where there is not an open CCS case, the PCP or

specialist will be contacted to provide the necessary documents for a CCS review. The outcome of the CCS review will be shared with the primary care provider;

- CHCN staff will review with the CCS Case Managers for all CCS inpatient admissions. CHCN will maintain a monthly log of all CCS inpatient admissions. (See attached CCS Log);

- On a quarterly basis, the UM Manager sends to the health plan a list of the CCS identified referrals.

- When CCS approval is received back to CHCN, UM staff enters the CCS code into the patient database.

- CHCN UM staff will notify health plan of inpatient CCS members;

- A physician, public health nurse, teacher, parent, community agency or interested individual may refer a child to the CCS office;

- At no time will the child's care be interrupted during the evaluation and transition time to CCS providers once a case is opened.

- To ensure continuity of care, on a monthly basis UM staff will identify new CCS cases from the monthly health plan reports and send a form letter to all providers that one (or more) of their patients have been identified as CCS. CHCN will request in the letter that this notification be filed in the medical record or that the provider enter 'CCS referral' in the member's medical record (see attached form letter).

CALIFORNIA CHILDREN SERVICES MEDICAL ELIGIBILITY
(Effective 8/1/00)

Infectious Diseases
Bone infections
Eye infections that may cause blindness
Central Nervous System infections requiring surgery or rehab
In-utero infections (herpes, CMV, rubella, syphilis) requiring treatment
HIV/AIDS

Cancer
All malignant neoplasm's (includes leukemia)
Benign neoplasm which is either disrupting a vital organ, causing a physical disability or is severely disfiguring

Endocrine
All diabetes (no qualifying criteria)
Growth Hormone Deficiency (no qualifying criteria)
Delayed onset (after age 15) or precocious puberty (prior to age 8 for females, 9 for males)
Diseases of pancreas pituitary, thyroid, parathyroid, thymus and adrenal glands
Acquired or congenital immunologic deficiencies (PKU, galactosemia, glycogen storage disease, maple syrup disease)

Blood
Anemia d/t abnormal RBC production (not r/t malnutrition)
Hemolytic Anemias
Pancytopenia
Nutropenia and chronic granulomatous disease
Hemophilia, Von Willebrands
Polycythemia, hypersplenism, hypercoagulable states

Nervous System
Noninfectious diseases of the nervous system producing neuro impairment that is life threatening or disabling
CP if rigidity, spasticity, hypotonia, dystonic/choreoid/atheoid involuntary movements, ataxia are present
Seizure disorder if r/t a CCS elig dx
Seizure disorder of unknown origin which requires 2 or more seizure meds, monthly med visits or an episode of Status Epilepticus

MTU
Polio, osteogenesis imperfecta, amputations
Under the age of 3 w/2 or more of the following: deep tendon reflexes (DTR) 3+ or greater, exaggerations of or persistence of primitive reflexes, abnormal posturing, asymmetry of motor findings.
Under age 1 if hypotonic w/normal or increased DTRs

Skin
Pemphigus, epidermolysis bullosa
Scars requiring surgery if there is loss of mobility of a major joint OR disabling or disfiguring

Musculoskeletal
Acute and chronic suppurative infections of the joint
Rheumatoid arthritis, inflammatory polyarthropathy, lupus erythematosus, dermatomyositis, scleroderma, myasthenias, myotonias dystrophies that lead to atrophy, weakness, contracture or deformity
Intervertebral disc herniation
Scoliosis w/20 degree curvature or greater
Diseases of the bones and joints (except fractures) that limit normal function and require sx, complex custom bracing **OR**>2 castings *(Tibial torsion femoral anteversion, knock knee, pigeon toes and flat feet are not covered)*
Orthopedic conditions due to infection, injury, or congenital malformations

Congenital anomalies
Limits or compromises a body function
Severely disfiguring such as cleft lip, oro-facial anomalies, and burns
(inguinal and umbilical hernias, hydroceles and unilateral undescended testicle are not covered)
Conditions requiring orthodontic reconstruction, such as cleft palate, severe malocclusion, oro-facial anomalies

Fractures
Spine, pelvis and femur fractures
Skull factures that could result in neuro complications or disfigurement
Any fracture requiring ORIF or that involves a joint or growth plate

Burns
2nd or 3rd degree burns>10% of BSA in child< 10
2nd or 3rd degree burns>20% of BSA in child> 10
3rd degree burns>5% BSA for any age
Burns involving inhalation injury or causing resp distress
2nd or 3rd burns of the face, ear, mouth, throat, genitalia, perineum, major joints, hands or feet
Electrical injuries or burns, including lightning

Accidents/injuries
Foreign body resulting in life threatening condition or compromise of body function requiring sx
Ingestion of drugs/poisons requiring inpt hospital tx
Lead poisoning > 20 mcg
Poisonous snake or spider bites
Severe reaction to immunization

Eyes
Strabismus requiring surgery
Keratitus, choroiditis
Infections requiring sx
Cataracts, glaucoma, retinal detachment, optic atrophy, hypoplasia, optic neuritis, lens dislocation, retinopathy of prematurity, hyperplastic primary vitreous, ptosis, congenital anomalies

Ears
Failed hearing tests (or auditory brain stem evoked response)
Craniofacial anomalies, congenital anomalies
SEE CRITERIA FOR WHEN CCS WILL COVER HEARING TESTS
Tympanic membrane perforation requiring tympanoplasty
Mastoiditis, Cholesteatoma

Heart
Endocarditis, myocarditis or pericarditis
Dysrhythmias requiring med or sx intervention
Embolisms, thrombosis, aneurysms
Cerebral and subarachnoid hemorrhages
Primary hypertension requiring medication
Rheumatic fever

Respiratory
Pulmonary abscess or bronchiectasis
Cystic Fibrosis
BPD if vent>6 days AND O2@60% for >4 days on vent AND needs supplemental O2 for >30 days OR radiographic changes of CLD(hyperinflation, radiolucency, radiodensity d/t peribronchial thickening or patchy atelectasis OR Impaired pulmonary function (increase airway resistance, inc residual capacity, PaCO2>45 or PaO2<80 OR Pulmonary or systemic hypertension OR R or L ventricular hypertrophy
Asthma if it has produced chronic lung disease
Respiratory failure requiring vent assistance
Hyaline membrane disease

Digestive
Acute of Chronic liver failure
Pancreatitis, peptic ulcer, ulcerative colitis, regional enteritis, diverticultitis or cholecystitis requiring complex med management or sx
GE Reflux if it is r/t or complicates a CCS elig dx or it is an isolated condition w/ complications Such as esophageal stricture of chronic aspiration pneumonia.

Genitourinary
Acute glomerulonephritis w/acute renal failure, malignant hypertension or CHF
Chronic glomerulonephritis, nephrosis or nephritic syndrome
Chronic Renal Insufficiency
Obstructive Uropathy
Grade 2 or greater Vesicoureteral reflux
Renal Calculus

Community Health Center Network

Setting the standard for Community Health Care

MEMORANDUM

DATE:

TO:

FROM: **CHCN's UM Staff**

RE: **CCS Referral**

* *

CHCN Utilization Management staff would like to notify you that your patient:

NAME: ____

DOB: ______________________

HEALTH PLAN: ______________________________

DIAGNOSIS: ____________________________________

has been accepted by California Children's Services (CCS) for services. Please make note in this child's medical record, that he/she has been identified as a CCS case.

Thank you.

Sensitive Service Information by Line of Business

CHCN/Alameda Alliance for Health Medi-Cal Members

Adult and adolescent Medi-Cal members have the right to timely access to confidential and sensitive services without the need for preauthorization from their medical group (CHCN) or their health plan, and have the option to choose any willing physician or provider, whether in network or out-of-network. If the member chooses a provider within network all claims are made automatically. However, should the member choose a non-contracted provider the primary diagnosis must qualify as a sensitive service (see Sensitive Services DX list).

CHCN/Alameda Alliance for Health Group Care, Healthy Families and Healthy Kids members

Adult and adolescent members for all other AAH products may self-refer for sensitive services within CHCN's Network. If members choose to seek services out of network, an authorization will be required in order to issue payment to the provider.

CHCN/Blue Cross Medi-Cal Sensitive Service Payment

CHCN/BC Medi-Cal members can choose any providers within the CHCN Network *(providers contracted with CHCN)* for sensitive services; CHCN will remit payment to these providers without referral or authorization required.

CHCN/Blue Cross Healthy Families Sensitive Service Payment

CHCN/BC Healthy Families members may self refer for sensitive services within the CHCN Network. If members choose to seek services out of network, an authorization will be required in order to issue payment to the provider.

Important: CHCN and Health Plans (AAH and BC) will not pay for OB care provided by any out-of-network providers. If the member chooses to be seen by an out-of-network provider for her prenatal care, she may be billed by the provider since neither the health plans or CHCN are not financially responsible for the visits. As the member's primary medical group, CHCN will reimburse the provider for only the pregnancy test.

Information and records related to sensitive services is strictly confidential and shall not be released to any third party without the consent of the member involved, including adolescents.

Types of Sensitive Services:

Adolescent Sensitive Services

In California, an adolescent is considered between the ages of 12 and 18. Adolescents can see a physician for the following reasons without preauthorization, and without the permission of their parent or guardian:

- Outpatient mental health service for:
    a. Sexual abuse
    b. Physical abuse
    c. Harmful behavior to themselves or others
- Sexual assault
- Drug or alcohol abuse
- Pregnancy
- Family planning
- STI / STD testing and care
- HIV testing

Adult Sensitive Services

Adult Sensitive Service includes the following:

- Family planning
- STI / STD testing and care
- HIV testing

Sensitive Service Diagnosis Codes

The following table is a list of possible sensitive services diagnosis codes. The list of sensitive service diagnosis codes will be reviewed quarterly by CHCN's Medical Director for updates and change recommendations.

Note: Quest is the contracted lab for CHCN

DX	Description
042	Human immunodeficiency virus (HIV)
053	Herpes zoster
054.1	Genital herpes
078	Molluscum contagiosum
078.1	Viral warts
078.19	Other specified viral warts
079	Viral and Chlamydia infection in conditions classified elsewhere and of unspecified site
091-092	Syphilis
098	Gonococcal infections
099.0	Chancroid
112	Candidiasis
131	Trichomoniasis
611.72	Breast Cancer
616.1	Vaginitis and vulvovaginitis
V25	Family Planning/contraception

Non-Sensitive Service Diagnosis Codes

The following table is a list of possible sensitive services diagnosis codes. The list of sensitive service diagnosis codes will be reviewed quarterly by CHCN's Medical Director for updates and change recommendations.

DX	Description
599.0	Urinary tract infection
603	Hydrocele
604	Orchitis and epididymitis
607	Disorders of penis
614	Inflammatory disease of ovary, fallopian tube, pelvic cellular tissue and peritoneum
614.9	Pelvic inflammatory disease
615	Inflammatory diseases of uterus
616	Inflammatory disease of cervix, vagina, and vulva
620.2	Other and unspecified ovarian cyst
625.9	Unspecified symptoms associated with female genital organs
626	Disorders of menstruation and other abnormal bleeding from female genital tract

Primary Care & Specialty Guidelines

To deliver efficient and cost-effective medical care, CHCN uses specific criteria to authorize the following:

- **CTs**
- **Colonoscopies for patients under 50 years of age**
- **DEXA Scans**
- **MRIs**
- **OB Ultrasound if more than 2 are needed**
- **Physical Therapy – selected treatments**
- **Wheelchairs**

The criteria used for the most requested authorizations are included in this section. If the supporting clinical does not adhere to the guideline, the authorization will go to the Medical Director for review. The guidelines used by CHCN are from many sources including other health plans (Aetna), Milliman Care Guidelines and the government web site: www.guideline.gov

Patient Requested: Note that there is a box on the CHCN authorization for checking "*Patient Requested*." Please check this box when the patient is requesting the service but the provider does not believe there is a clinical reason to support the request. Additionally this box may be checked when the patient is insisting on seeing a non-contracted provider.

Brain (CT Scans)

MILLIMAN CareGuidelines
Ambulatory Care
8th Edition

CPT™ or HCPCS : 70450, 70460, 70470

For a complete list of ICD-9 codes, See Appendix D: ICD-9 Appendix.

Arteriovenous Malformation (AVM)

Return to top of *Brain - AC*

- Indicated for sudden, severe headache with or without focal neurologic or prodromal symptoms(1)(2)

Altered Mental Status

Return to top of *Brain - AC*

- See Delirium and Dementia sections in this guideline.

Central Nervous System Infection

Return to top of *Brain - AC*

- Indicated for **ANY ONE** of the following(2)(3):
  - Suspected brain abscess due to presence of **ANY ONE** of the following: (probably as second-line test after MRI)
    - Headache
    - Fever
    - Focal neurologic deficit
    - Nausea and vomiting
    - Photophobia
  - Immunosuppressed, ie, receiving chemotherapy or HIV patient, with focal neurologic findings (probably as second-line test after MRI)
  - Follow-up of brain abscess

Delirium

Return to top of *Brain - AC*

See *Delirium* Guideline

- Indicated for **ANY ONE** of the following[A](5)(6): (probably as second-line test after MRI)
  - History of falls or suspected subdural hematoma
  - Patient who is at risk for falls or trauma, ie, elderly or disabled
  - Focal neurologic findings
  - Suspected brain abscess due to presence of **ANY ONE** of the following:
    - Headache
    - Fever
    - Focal neurologic deficit
    - Nausea and vomiting
  - Suspected metastatic cancer
  - Unexplained mental status change and **ALL** of the following[B]:
    - No other signs or symptoms
    - No medical explanation exists

Dementia

Return to top of *Brain - AC*

See *Dementia* Guideline

- Indicated when **ANY ONE** of the following applies(7)(8)[C]: (usually without contrast)
  - Dementia is of abrupt or of relatively recent onset, ie, months to a year, or has acutely worsened.
  - Neurologic signs and symptoms point to focal defects
  - Early onset of dementia, ie, <65 years of age(10)
  - Etiology of the dementia is unclear by clinical assessment and the provider suspects ANY ONE of the following potentially treatable abnormalities:
    - Subdural hematoma
    - Frontal lobe tumor
    - Hydrocephalus
    - Stroke or hemorrhage
    - Brain abscess
    - Vascular dementia[D]

Headaches

Return to top of *Brain - AC*

See *Headaches* Guideline

- Indicated for **ANY ONE** of the following(11)(12)(13)(14)[E]:
  - Symptoms suggesting an ominous headache with a possibly more serious, underlying cause, as indicated by **ANY ONE** of the following[F]:
    - First or worst headache of the patient's life, particularly if the onset was rapid
    - Suspected subarachnoid hemorrhage when **ANY ONE** of the following is present(1)(2): (without contrast)
      - Abrupt onset of severe headache
      - Headaches during exertion or sexual intercourse
      - Warning headache, ie, a recent unusually severe headache with abrupt onset
    - A change in the frequency, severity, or clinical features of the headache attack from what the patient has commonly experienced
    - Onset of headache after 50 years of age
    - A new or progressive headache that persists for days
    - Precipitation of head pain with coughing, sneezing, or bending down

- Systemic symptoms such as myalgia, fever, malaise, weight loss, scalp tenderness, or jaw claudication
- Neurologic abnormalities
  - Focal neurologic symptoms
  - Abnormalities on neurologic examination
  - Confusion
  - Any impairment in the level of consciousness

- Seizure disorder
- History of cancer

Hydrocephalus

Return to top of *Brain - AC*

- Indicated for **ANY ONE** of the following(15)(16)(17):
  - Infant or child with **ANY ONE** of the following:
    - **ANY ONE** of the following signs on physical exam:
      - Increasing head size beyond normal rate[G]
      - Widening or bulging anterior fontanelle or persistence of anterior fontanelle beyond 18 months
      - Abnormal neurologic exam, ie, increased deep tendon reflexes, spasticity, clonus, or Babinski's sign
      - Gait disturbance
      - Papilledema
      - Posterior fontanelle persists beyond 6 to 8 weeks.
    - **ANY ONE** of the following symptoms:
      - Irritability
      - Lethargy
      - Decrease mentation
      - Vomiting
      - Headache
  - Adult and **ANY ONE** of the following symptoms suggestive of normal pressure hydrocephalus:
    - Mild dementia
    - Gait disturbance[H]
    - Urinary incontinence
  - Monitoring of ventriculoperitoneal shunt and **ANY ONE** of the following:
    - Postoperative follow-up
    - Occurrence of any symptoms listed above

Progressive Neurologic Deficit

Return to top of *Brain - AC*

- Indicated as second choice after MRI for **ANY ONE** of the following[I](18): (noncontrast)
  - Focal sensory deficit of face, limb, or whole side of body
  - Focal weakness of face, limb, or whole side of body
  - Change in speech pattern, ie, dysarthria or aphasia
  - Ataxia or gait disturbance
  - Visual disturbance, ie, diplopia, visual field effect, or central nystagmus
  - Change in speech, ie, aphasia or dysarthria

Epilepsies, Generalized

Return to top of *Brain - AC*

See *Epilepsies, Generalized* Guideline

- Indicated for **ANY ONE** the following(19):

- Unable to perform MRI. See Imaging, MRI, Brain, Epilepsies, Generalized.
- In an emergency situation to rule out major intracranial problems (noncontrast CT)
- Posttraumatic seizure that occurs within a week of injury(19)

Epilepsies, Localized

Return to top of *Brain - AC*

See *Epilepsies, Localized* Guideline

- Indicated for **ANY ONE** the following(19):
  - Unable to perform MRI. See Imaging, MRI, Brain, Epilepsies, Localized.
  - In an emergency situation to rule out major intracranial problems (noncontrast CT)
  - Posttraumatic seizure that occurs within a week of injury(19)

Subarachnoid Hemorrhage

Return to top of *Brain - AC*

- Indicated for **ANY ONE** of the following(1)(2): (without contrast)
  - Abrupt onset of severe headache, ie, "worst headache of my life"
  - Headaches during exertion or sexual intercourse
  - Warning headache, ie, a recent unusually severe headache with abrupt onset
  - Headaches associated with meningismus

Transient Ischemic Attack and Ischemic Stroke

Return to top of *Brain - AC*

See *Transient Ischemic Attack and Ischemic Stroke* Guideline

- Indicated for **ALL** of the following(1): (unenhanced)
  - **ANY ONE** of the following neurologic findings:
    - Focal sensory deficit of face, limb, and whole side of body
    - Focal weakness of face, limb, and whole side of body
    - Change in speech pattern, ie, dysarthria or aphasia
    - Ataxia or gait disturbance
    - Visual disturbance
  - **ANY ONE** of the following:
    - First-choice test for rapid assessment to rule out major bleed within the first 3 to 6 hours, if considering thrombolysis
    - MRI not feasible

Syncope

Return to top of *Brain - AC*

See *Syncope* Guideline

- Indicated when **ALL** of the following are present[J](20):
  - History or physical examination suggestive of focal CNS problem
  - Cardiac source has been excluded.

Trauma/Concussion

Return to top of *Brain - AC*

- Indicated for **ANY ONE** of the following(21)(22)(23):
  - Child <2 years of age and **ANY ONE** of the following:
    - Depressed mental status[K]

- Evidence of skull fracture[L]
- Focal neurologic findings
- Irritability
- Bulging fontanelle
- Loss of consciousness[M]
- Vomiting, particularly >5 times or persisting for >6 hours
- Scalp hematomas, particularly when large or located in the temporoparietal area
- Worrisome injury due to presence of **ANY ONE** of the following[N]:
  - High-force mechanism of injury, such as a high-speed vehicular accident or child falling >3 to 4 feet
  - Unobserved trauma or suspicion of significant trauma

- Child of any age and **ANY ONE** of the following(22):
  - Altered mental status, even mild
  - Focal neurologic deficits
  - Basilar or depressed skull fracture
  - Depending on intensity or duration for **ANY ONE** of the following[O]:
    - Loss of consciousness
    - Amnesia
    - Seizure
    - Headache
    - Persistent vomiting
    - Irritability or behavioral change
- Adult with concussion and **ANY ONE** of the following:
  - Altered mental status
  - Focal neurologic deficits
  - Basilar or depressed skull fracture
  - Depending on intensity or duration for **ANY ONE** of the following[P]:
    - Loss of consciousness
    - Amnesia
    - Seizure
    - Headache
    - Persistent vomiting
    - Irritability or behavioral change

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Return to top of *Brain - AC*

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Footnotes

Return to top of *Brain - AC*

[A] Very few studies of brain imaging in delirium have been published.(4) [A in Context Link 1]

[B] Possible causes of delirium include: metabolic disorders such as hepatic encephalopathies, hypoxia, and hypoglycemia; drug intoxication with opiates, barbiturates, sedatives, or antidepressants; alcohol withdrawal; thyrotoxicosis; and sepsis. [B in Context Link 1]

[C] An MRI or CT scan read as "consistent with Alzheimer's disease" is not diagnostic and should not prevent the provider from further investigation if appropriate.(9) [C in Context Link 1]

[D] MRI may be especially helpful in detecting ischemic brain injury causing vascular dementia.(10) [D in Context Link 1]

[E] The prevalence of significant intracranial abnormalities for patients with atypical migraine history is approximately 0.2%. Although MRI provides greater resolution, this is usually not necessary for nonacute headaches.(13) [E in Context Link 1]

[F] Only rarely does serious underlying disease cause a headache without atypical features or warning signs.(12) [F in Context Link 1]

[G] Normal growth for premature infant is 0.5 cm/week in first 2 weeks; 0.75 cm in 3rd week; 1.0 cm/week in 4th

week and after, until 40th week of development. Normal head circumferences for term infant are: 34 cm to 35 cm at birth, 44 cm by 6 months, and 47 cm by 1 year of age. [G in Context Link 1]

[H] Gait disturbance with normal pressure hydrocephalus may be mild with uncertain short steps that may progress to unsteady balance. [H in Context Link 1]

[I] Contrast usually is not essential with progressive neurological deficit, as most lesions that cause symptoms will show up without contrast.(18) [I in Context Link 1]

[J] Syncope is an episodic, transient loss of consciousness and postural tone due to cerebral hypoperfusion. There is spontaneous recovery without resuscitation, usually within 5 minutes. It may be abrupt in onset or occur with some warning. [J in Context Link 1]

[K] Depressed mental status is defined as either the difficulty in getting the child to an awake state or in maintaining an awake state or an ability to normally arouse the child. Those with milder behavioral or mental status changes may either receive a CT scan or be observed for 6 hours.(21) [K in Context Link 1]

[L] In proposed consensus guidelines after reviewing literature, evidence of the basilar skull fracture or a skull fracture of <24 hours duration is considered high risk and clear indication for CT scan after head trauma. A nonacute skull fracture, defined as >24 hours old, is considered an indication for either CT scan or continued observation for 4 to 6 hours.(21) [L in Context Link 1]

[M] Loss of consciousness for >1 minute is considered a clear indication for imaging after head trauma. Loss of consciousness for <1 minute, particularly when >3 months of age, is considered indication for either CT scan or continued observation for 4 to 6 hours.(21) [M in Context Link 1]

[N] These children may receive a CT scan or be observed for 4 to 6 hours.(21) [N in Context Link 1]

[O] No clear line can be drawn for these symptoms regarding whether CT scan or close observation at home is indicated for head trauma. However, high intensity and longer duration of symptoms should make the consideration for CT scan stronger.(22) [O in Context Link 1]

[P] No clear line can be drawn for these symptoms regarding whether CT scan or close observation at home is indicated. However, high intensity and longer duration of symptoms should make the consideration for CT scan in stronger. [P in Context Link 1]

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Sinuses (CT Scans)

MILLIMAN CareGuidelines
Ambulatory Care
8th Edition

Sinusitis and Polyposis

Return to top of *Sinuses - AC*

See *Sinusitis and Polyposis* Guideline

- Indicated for **ANY ONE** of following(1)(2)(3): (Perform limited CT for the diagnosis of sinusitis and a **full** CT preoperatively.)
  - Medically refractory sinusitis, as indicated by presence of **ALL** of the following:
    - **ANY ONE** of the following symptoms present for >8 weeks after initiation of appropriate medical therapy:
      - Frequent throat clearing
      - Nasal congestion and postnasal drip
      - Persistent bad breath and headache
      - Chronic cough, particularly in child
      - Persistent sinus pain or pressure
    - Failure of appropriate medical therapy, including **ALL** of the following:
      - At least 2 courses of antibiotics, 1 of them utilizing a second-generation cephalosporin, a fluoroquinolone, amoxicillin/clavulanate, or clindamycin
      - Nasal corticosteroids
      - Management of all allergic conditions
  - Nasal polyps and **ALL** of the following[A]:
    - No response to nasal or oral corticosteroids
    - **ANY ONE** of the following symptoms:
      - Nasal blockage
      - Hyposmia
      - Rhinorrhea and postnasal drainage
      - Sneezing
  - Evidence of **ANY ONE** of following serious complications of sinusitis:
    - Meningitis
    - Central nervous system empyema
    - Brain abscess
    - Cavernous sinus thrombosis
    - Osteomyelitis
    - Periorbital infections
    - Cellulitis
    - Suspected malignancy due to the presence of **ANY ONE** of the following:
      - Epistaxis without obvious source
      - Persistent pain, particularly unilateral, without source
      - Bone changes on x-ray
      - Soft tissue density on x-ray

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Return to top of *Sinuses - AC*

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Footnotes

Return to top of *Sinuses - AC*

[A] Polyps are outgrowths of the mucosa arising from sinuses and are found along the lateral wall of nose, usually at the middle meatus. They rarely appear before 40 years of age. While they are an uncommon cause of true sinusitis, symptoms associated with polyps may mimic chronic sinusitis. Some of these patients will have aspirin sensitivity or asthma.(3) [A in Context Link 1]

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National Guideline Clearinghouse
www.guideline.gov

COLONOSCOPY

Brief Summary

GUIDELINE TITLE

Colorectal cancer screening and surveillance: clinical guidelines and rationale-update based on new evidence.

BIBLIOGRAPHIC SOURCE(S)

Winawer S, Fletcher R, Rex D, Bond J, Burt R, Ferrucci J, Ganiats T, Levin T, Woolf S, Johnson D, Kirk L, Litin S, Simmang C. Colorectal cancer screening and surveillance: clinical guidelines and rationale-Update based on new evidence. Gastroenterology 2003 Feb;124(2):544-60. [102 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline. It updates a previous version: Winawer SJ, Fletcher RH, Miller L, Godlee F, Stolar MH, Mulrow CD, Woolf SH, Glick SN, Ganiats TG, Bond JH, Rosen L, Zapka JG, Olsen SJ, Giardiello FM, Sisk JE, Van Antwerp R, Brown-Davis C, Marciniak DA, Mayer RJ. Colorectal cancer screening: clinical guidelines and rationale [published errata appear in Gastroenterology 1997 Mar;112(3):1060 and 1998 Mar;114(3):625]. Gastroenterology 1997 Feb;112(2):594-642.

According to the guideline developer, the Clinical Practice Committee meets 3 times a year to review all American Gastroenterological Association guidelines. This review includes new literature searches of electronic databases followed by expert committee review of new evidence that has emerged since the original publication date.

BRIEF SUMMARY CONTENT

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Excerpted by the National Guideline Clearinghouse (NGC)

Note from the guideline developers: *These guidelines differ from those published in 1997 in several ways:*

- *They recommend against rehydrating fecal occult blood tests*
- *The screening interval for double-contrast barium enema has been shortened to 5 years*
- ***Colonoscopy*** *is the preferred test for the diagnostic investigation of patients with findings on screening and for screening patients with a family history of hereditary nonpolyposis colorectal cancer*
- *Recommendations for people with a family history of colorectal cancer make greater use of risk stratification*
- *Guidelines for genetic testing are included*
- *Guidelines for surveillance are also included*
- *Follow-up of postpolypectomy patients relies now on* ***colonoscopy****, and the first follow-up examination has been lengthened from 3 to 5 years for low-risk patients*

General Recommendations

Screening programs should begin by classifying the individual patient's level of risk based on personal, family, and medical history, which will determine the appropriate approach to screening in that person.

Men and women at average risk should be offered screening for colorectal cancer and adenomatous polyps

beginning at age 50 years.

They should be offered options for screening, with information about the advantages and disadvantages associated with each approach, and should be given an opportunity to apply their own preferences in selecting how they should be screened.

If the result of a screening test is abnormal, physicians should recommend a complete structural examination of the colon and rectum by colonoscopy (or flexible sigmoidoscopy and double contrast barium enema if colonoscopy is not available).

Surveillance with colonoscopy should be considered for patients who are at increased risk because they have been treated for colorectal cancer, have an adenomatous polyp diagnosed, or have a disease that predisposes them to colorectal cancer, such as inflammatory bowel disease.

Health care providers who perform the tests should have appropriate proficiency, and the tests should be performed correctly. To achieve these aims, care systems should establish standards and operating procedures.

Screening should be accompanied by efforts to optimize the participation of patients and health care providers--both with screening tests and appropriate diagnostic evaluation of abnormal screening test results--and to remind patients and providers about the need for rescreening at recommended intervals.

Risk Stratification

Clinicians should determine an individual patient's risk status well before the earliest potential initiation of screening (typically around age 20 years, but earlier if there is a family history of familial adenomatous polyposis) (see figure 1 in the original guideline document). The individual's risk status determines when screening should be initiated and what tests and frequency are appropriate. Risk stratification can be accomplished by asking several questions aimed at uncovering the risk factors for colorectal cancer:

1. Has the patient had colorectal cancer or an adenomatous polyp?
2. Does the patient have an illness (e.g., inflammatory bowel disease) that predisposes him or her to colorectal cancer?
3. Has a family member had colorectal cancer or an adenomatous polyp? If so, how many, was it a first-degree relative (parent, sibling, or child), and at what age was the cancer or polyp first diagnosed?

A positive response to any of these questions should prompt further efforts to identify and define the specific condition associated with increased risk.

Recommendations for Screening People at Average Risk

Men and women at average risk should be offered screening with one of the following options beginning at age 50 years. The rationale for presenting multiple options is that no single test is of unequivocal superiority and that giving patients a choice allows them to apply personal preferences and may increase the likelihood that screening will occur. The strategies are not equal with regard to evidence of effectiveness, magnitude of effectiveness, risk, or up-front costs. Reviewing the rationale section for each screening test (presented in the original guideline document) will provide clinicians with information that they can use in presenting the relative effectiveness of each test to patients.

Fecal Occult Blood Testing

Offer yearly screening with fecal occult blood test (FOBT) using a guaiac-based test with dietary restriction or an immunochemical test without dietary restriction. Two samples from each of 3 consecutive stools should be examined without rehydration. Patients with a positive test on any specimen should be followed up with colonoscopy.

Sigmoidoscopy

Offer flexible sigmoidoscopy every 5 years.

Combined FOBT and Flexible Sigmoidoscopy

Offer screening with FOBT every year combined with flexible sigmoidoscopy every 5 years. When both tests are performed, the FOBT should be done first.

Colonoscopy

Offer **colonoscopy** every 10 years.

Double-Contrast Barium Enema

Offer double-contrast barium enema (DCBE) every 5 years.

Recommendations for Screening People at Increased Risk

People With a Family History of Colorectal Cancer or Adenomatous Polyps

People with a first-degree relative (parent, sibling, or child) with colon cancer or adenomatous polyps diagnosed at age <60 years or 2 first-degree relatives diagnosed with colorectal cancer at any age should be advised to have screening **colonoscopy** starting at age 40 years or 10 years younger than the earliest diagnosis in their family, whichever comes first, and repeated every 5 years (see Table 3 in the original guideline document).

People with a first-degree relative with colon cancer or adenomatous polyp diagnosed at age ≥60 years or 2 second-degree relatives with colorectal cancer should be advised to be screened as average risk persons, but beginning at age 40 years.

People with 1 second-degree relative (grandparent, aunt, or uncle) or third-degree relative (great-grandparent or cousin) with colorectal cancer should be advised to be screened as average risk persons.

Familial Adenomatous Polyposis

People who have a genetic diagnosis of familial adenomatous polyposis (FAP), or are at risk of having FAP but genetic testing has not been performed or is not feasible, should have annual sigmoidoscopy, beginning at age 10-12 years, to determine if they are expressing the genetic abnormality. Genetic testing should be considered in patients with FAP who have relatives at risk. Genetic counseling should guide genetic testing and considerations of colectomy.

Hereditary Nonpolyposis Colorectal Cancer

People with a genetic or clinical diagnosis of hereditary nonpolyposis colorectal cancer (HNPCC) or who are at increased risk for HNPCC should have **colonoscopy** every 1-2 years beginning at age 20-25 years, or 10 years earlier than the youngest age of colon cancer diagnosis in the family--whichever comes first. Genetic testing for HNPCC should be offered to first-degree relatives of persons with a known inherited mismatch repair (MMR) gene mutation. It should also be offered when the family mutation is not already known, but 1 of the first 3 of the modified Bethesda Criteria is met (see Table 5 in the original guideline document).

Surveillance of People at Increased Risk

People with a History of Adenomatous Polyps

Patients who have had 1 or more adenomatous polyps removed at **colonoscopy** should be managed according to the findings on that **colonoscopy**. Patients who have had numerous adenomas, a malignant adenoma (with invasive cancer), a large sessile adenoma, or an incomplete **colonoscopy** should have a short interval follow-up **colonoscopy** based on clinical judgment. Patients who have advanced or multiple adenomas (≥3) should have their first follow-up **colonoscopy** in 3 years. Patients who have 1 or 2 small (<1 cm) tubular adenomas should have their first follow-up **colonoscopy** at 5 years. It is not unreasonable, given available evidence, to choose even longer intervals. However, the evidence is still evolving. Future evidence may clarify the intervals more precisely.

The timing of the subsequent **colonoscopy** should depend on the pathology and number of adenomas detected at follow-up **colonoscopy**. For example, if the first follow-up **colonoscopy** is normal or only 1 or 2 small (<1 cm) tubular adenomas are found, the next **colonoscopy** can be in 5 years.

People With a History of Colorectal Cancer

Patients with a colon cancer that has been resected with curative intent should have a **colonoscopy** around the time of initial diagnosis to rule out synchronous neoplasms. If the colon is obstructed preoperatively, **colonoscopy** can be performed approximately 6 months after surgery. If this or a complete preoperative examination is normal, subsequent **colonoscopy** should be offered after 3 years, and then, if normal, every 5 years.

People With Inflammatory Bowel Disease

In patients with long-standing, extensive inflammatory bowel disease, surveillance **colonoscopy** with systematic biopsies should be considered. This applies to both ulcerative colitis and Crohn's colitis because the cancer risk is similar in both diseases.

CLINICAL ALGORITHM(S)

A clinical algorithm is provided for colorectal cancer screening.

Top^

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Specific guideline recommendations are accompanied by a discussion of the rationale and new evidence supporting their use.

Top^

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Winawer S, Fletcher R, Rex D, Bond J, Burt R, Ferrucci J, Ganiats T, Levin T, Woolf S, Johnson D, Kirk L, Litin S, Simmang C. Colorectal cancer screening and surveillance: clinical guidelines and rationale-Update based on new evidence. Gastroenterology 2003 Feb;124(2):544-60. [102 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1997 Feb (revised 2003 Feb)

GUIDELINE DEVELOPER(S)

American College of Gastroenterology - Medical Specialty Society
American College of Physicians - Medical Specialty Society
American Gastroenterological Association - Medical Specialty Society
American Society for Gastrointestinal Endoscopy - Medical Specialty Society

GUIDELINE DEVELOPER COMMENT

The original guidelines were prepared by a panel convened by the U.S. Agency for Health Care Policy and Research and published in 1997 under the sponsorship of a consortium of gastroenterology societies. The original GI Consortium Panel was comprised of experts in primary care, gastroenterology, surgery, oncology, epidemiology, behavioral science, clinical economics, and nursing, as well as a patient advocate. The panel responsible for the current guidelines was comprised of representatives from the original panel and of the U.S. Multisociety Task Force on Colorectal Cancer, a combined effort of the American College of Gastroenterology, the American Society of Gastrointestinal Endoscopy, the American Gastroenterological Association, and the American College of Physicians/Society of Internal Medicine. This group was asked to review the original guidelines, prepare appropriate revisions with rationale, highlight new evidence since 1997, and suggest research questions--the answers to which seem critical to progress in colorectal cancer screening and surveillance. Societies with representatives on the panel included the American Academy of Family Practice, American College of Gastroenterology, American College of Physicians-American Society of Internal Medicine, American College of Radiology, American Gastroenterological Association, American Society of Colorectal Surgeons, and American Society for Gastrointestinal Endoscopy.

SOURCE(S) OF FUNDING

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Gastrointestinal Endoscopy.

GUIDELINE COMMITTEE

U.S. Multisociety Task Force on Colorectal Cancer

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

ENDORSER(S)

American Cancer Society - Disease Specific Society
American College of Gastroenterology - Medical Specialty Society
American Society for Gastrointestinal Endoscopy - Medical Specialty Society
American Society of Colon and Rectal Surgeons - Medical Specialty Society
Crohn's and Colitis Foundation of America - Disease Specific Society
Oncology Nursing Society - Professional Association
Society of American Gastrointestinal Endoscopic Surgeons - Medical Specialty Society

GUIDELINE STATUS

This is the current release of the guideline. It updates a previous version: Winawer SJ, Fletcher RH, Miller L, Godlee F, Stolar MH, Mulrow CD, Woolf SH, Glick SN, Ganiats TG, Bond JH, Rosen L, Zapka JG, Olsen SJ, Giardiello FM, Sisk JE, Van Antwerp R, Brown-Davis C, Marciniak DA, Mayer RJ. Colorectal cancer screening: clinical guidelines and rationale [published errata appear in Gastroenterology 1997 Mar;112(3):1060 and 1998 Mar;114(3):625]. Gastroenterology 1997 Feb;112(2):594-642.

According to the guideline developer, the Clinical Practice Committee meets 3 times a year to review all American Gastroenterological Association guidelines. This review includes new literature searches of electronic databases followed by expert committee review of new evidence that has emerged since the original publication date.

GUIDELINE AVAILABILITY

Electronic copies: Available from the American Gastroenterological Association (AGA) Web site.

Print copies: Available from American Gastroenterological Association, 4930 Del Ray Avenue, Bethesda, MD 20814.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on June 30, 1998. It was verified by the guideline developer on December 1, 1998. This summary was updated by ECRI on May 20, 2003. The updated information was verified by the guideline developer on June 24, 2003.

National Guideline Clearinghouse
www.guideline.gov

COLONOSCOPY

Brief Summary

GUIDELINE TITLE

Polyp guideline: diagnosis, treatment, and surveillance for patients with colorectal polyps.

BIBLIOGRAPHIC SOURCE(S)

Bond JH. Polyp guideline: diagnosis, treatment, and surveillance for patients with colorectal polyps. Am J Gastroenterol 2000 Nov;95(11):3053-63. [108 references]

GUIDELINE STATUS

This is the current release of the guideline.

It is a revision of a previously issued version (Bond JH. Polyp guideline: diagnosis, treatment, and surveillance for patients with nonfamilial colorectal polyps. Ann Intern Med 1993 Oct 15;119[8]:836-43).

BRIEF SUMMARY CONTENT

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Excerpted by the National Guideline Clearinghouse (NGC)

Diagnosis and Treatment

Colorectal polyps can be diagnosed by endoscopy or barium radiography. When there is an indication to examine the entire large bowel, **colonoscopy** is the diagnostic procedure of choice. It is the most accurate method of detecting polyps of all sizes and it allows immediate biopsy or polypectomy. Most polyps found during **colonoscopy** can be completely and safely resected, usually using electrocautery techniques. Scientific studies now conclusively show that resecting adenomatous polyps prevents colorectal cancer.

- Single-contrast barium enema is an inaccurate method for detecting polyps in most patients. Double-contrast techniques greatly improve the accuracy of radiological methods for detecting polyps. However, even when double-contrast methods are employed, barium enema examinations as they are currently performed in most community hospitals are insufficiently sensitive for the reliable detection of colorectal polyps. The other main limitations of barium enema is that it does not allow biopsy or polypectomy, and it has relatively low specificity (many false-positives) for polyps.
- The most common use of flexible sigmoidoscopy is for screening asymptomatic average-risk persons for colonic neoplasms. Sensitivity and specificity are very high because few polyps within reach of the instrument are missed, and the false-positive rate is negligible. The combination of a double-contrast barium enema and flexible sigmoidoscopy has been promoted as an acceptable alternative to **colonoscopy** for patients requiring a complete examination of the large bowel in whom **colonoscopy** is incomplete or unacceptable. When a barium enema is used for diagnosis or surveillance, flexible proctosigmoidoscopy usually should be done to ensure an adequate examination of the rectum. Flexible sigmoidoscopy also provides a more accurate examination of the sigmoid colon, which is often a difficult area for the radiologist to examine. Double-contrast barium enema seems to be more accurate in the proximal colon than in the distal colon. Although flexible sigmoidoscopy allows biopsy of lesions, it should not be used for

electrosurgical polypectomy unless the entire colon is prepared, to eliminate the risk for electrocautery-induced explosion. Furthermore, detection of a neoplastic polyp by screening flexible sigmoidoscopy is usually an indication for **colonoscopy**, at which time the polyp can be resected and a search made for synchronous neoplasia.

Management

Initial Management of Polyps

Most patients with polyps detected by barium enema or flexible sigmoidoscopy, especially if the polyps are multiple or large, should undergo **colonoscopy** to excise the polyp and search for additional neoplasms. The decision whether to perform **colonoscopy** for patients with polyps <1 cm in diameter must be individualized depending on the patient's age, comorbidity, and past or family history of colorectal neoplasia. Complete clearing **colonoscopy** should be done at the time of every initial polypectomy to detect and resect all synchronous adenomas. Additional clearing examinations may be required after resection of large sessile adenomas or if, because of multiple adenomas or other technical reasons, the colonoscopist is not reasonably confident that all adenomas have been found and resected.

- Most polyps diagnosed during **colonoscopy** can be completely removed by electrocautery techniques. Surgical resection of a polyp is indicated only when an experienced endoscopist is unable to resect an advanced adenoma safely or when a malignant polyp requires colonic resection.
- Most pedunculated polyps are resected by snare-polypectomy and the entire specimen is submitted for pathological evaluation. A total excisional biopsy is desirable so that the polyp can be properly classified and the presence or absence of malignancy determined; and so that, for malignant polyps, the grade, vascular and lymphatic involvement, and proximity to the margin of resection of the cancer can be assessed.
- Large sessile polyps usually require piecemeal snare resection; but, again, every effort is made to retrieve all resected tissue for pathological analysis. Injection of saline into the submucosa under a large or flat sessile polyp (saline-assisted polypectomy) may increase the ease and safety of snare-resection, especially in the right colon.

Management of Small Polyps

Small polyps (<1 cm) encountered during **colonoscopy** are usually resected using one of a number of different techniques, with and without electrocautery. The monopolar hot biopsy forceps has limitations and risks that need to be carefully considered. Representative biopsies should be obtained when small polyps are numerous. When a small polyp is encountered during screening flexible sigmoidoscopy, it should be biopsied to determine whether it is an adenoma and, thus, may be an indication for **colonoscopy**. Current evidence supports the recommendation that a hyperplastic polyp found during flexible sigmoidoscopy is not, by itself, an indication for **colonoscopy**. Data are conflicting as to whether small distal adenomas predict the presence of proximal clinically significant adenomas; therefore, the decision to do **colonoscopy** must be individualized.

- Small sessile polyps are resected using several different techniques including hot and cold biopsy (with and without cautery), hot or cold minisnare, or cold biopsy followed by fulgeration with a monopolar or bipolar electrode. The monopolar hot biopsy forceps should be used with great caution in the thin-walled right colon. There have been reported perforations and a relatively high rate of delayed bleeding using this device. When using any type of cautery probe in the right colon, it is important to apply low-power cautery cautiously without pressing the tip of the probe into the bowel wall. Even modest pressure can thin out the wall and increase the chance of perforation.

A Small Polyp Found During Screening Flexible Sigmoidoscopy

- When a polyp less than about 8 mm in size is detected during screening flexible sigmoidoscopy, a biopsy usually should be done to determine whether it is an adenoma. If the only abnormality found during screening sigmoidoscopy is a hyperplastic polyp, no further evaluation or follow-up is indicated. Most larger polyps (>0.7 cm) are adenomas; therefore, there is usually no need to do a biopsy during screening sigmoidoscopy.
- The management of a patient found to have small tubular adenomas at flexible sigmoidoscopy must be individualized. **Colonoscopy** to look for synchronous adenomas, or for follow-up to search for metachronous neoplasia, may be of little benefit to most patients with only one or two small (<1 cm)

tubular adenomas. Younger, healthy individuals may wish to have colonoscopy to reduce their risk of cancer even below that of the average-risk population. Older patients, especially those with significant comorbidity, may not benefit from an intensive evaluation or follow-up.

The Small Flat Adenoma

- Many recent papers describe small flat colorectal adenomas with a purportedly high malignant potential. These reports suggest that such lesions are common, may be missed during conventional colonoscopy, and frequently and rapidly degenerate into small flat cancers. Most, but not all, of the papers reporting these lesions have come from Japan and other Eastern countries. They stress the need for special techniques employing dye-staining chromoendoscopy, with or without magnification, to accurately detect these lesions. Small flat adenomas with a high malignant potential seem to be rare in Western countries, and there is little evidence that early colonic cancer is a frequently overlooked entity in Western countries, provided that patients undergo colonoscopy by well-trained, experienced endoscopists. Modern high-resolution video endoscopy seems to detect most clinically significant lesions without the need for special techniques.

Management of Large Sessile Polyps

A patient who has had successful colonoscopic excision of a large sessile polyp (>2 cm) usually should undergo follow-up colonoscopy in 3 to 6 months to determine whether resection was complete. If residual polyp is present, it should be resected and the completeness of resection documented within another 3 to 6-month interval. If complete resection is not possible after two or three examinations, the good-risk patient should usually be referred for surgical therapy.

Malignant Polyps

No further treatment is indicated after colonoscopic resection of a malignant polyp (an adenomatous polyp with cancer invading the submucosa) if the endoscopic and pathological criteria listed below are fulfilled.

Recommendations for a Patient With a Malignant Polyp

Because the risk for local recurrence or for lymph node metastasis from invasive carcinoma in a colonoscopically resected polyp is less than the risk for death from colonic surgery, the American College of Gastroenterology recommends no further treatment if the following criteria are fulfilled:

1. The polyp is considered to be completely excised by the endoscopist and is submitted in toto for pathological examination.
2. In the pathology laboratory, the polyp is fixed and sectioned so that it is possible to accurately determine the depth of invasion, grade of differentiation, and completeness of excision of the carcinoma.
3. The cancer is not poorly differentiated.
4. There is no vascular or lymphatic involvement
5. The margin of excision is not involved. Invasion of the stalk of a pedunculated polyp, by itself, is not an unfavorable prognostic finding, as long as the cancer does not extend to the margin of stalk resection.

Patients with malignant sessile polyps with favorable prognostic criteria should have follow-up in about 3 months to check for residual abnormal tissue at the polypectomy site. After one negative result examination, the clinician can revert to standard surveillance as performed for patients with benign adenomas.

When a patient's malignant polyp has poor prognostic features, the relative risks of surgical resection should be weighed against the risk of death from metastatic cancer. The patient at high risk for morbidity and mortality from surgery probably should not have surgical resection. If a malignant polyp is located in that part of the lower rectum that would require an abdominal-perineal resection, local excision rather than a standard cancer resection usually is justified. Rectal ultrasound studies may assist in determining correct treatment. During colonoscopic excision of a large sessile polyp that may require subsequent surgical resection, it may be useful to mark the polypectomy site with India ink.

Primary Prevention of Colorectal Adenomas

To prevent initial or recurrent colorectal adenomas, a diet that is low in fat and high in fruits, vegetables, and fiber is recommended. Normal body weight should be maintained, and smoking and excessive alcohol use should be

GUIDELINE TITLE

Osteoporosis: prevention and treatment.

DEXA SCANS

BIBLIOGRAPHIC SOURCE(S)

University of Michigan Health System. Osteoporosis: prevention and treatment. Ann Arbor (MI): University of Michigan Health System; 2002 Mar. 12 p. [3 references]

GUIDELINE STATUS

This is the current release of the guideline.

BRIEF SUMMARY CONTENT

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note from the National Guideline Clearinghouse (NGC): The following key points summarize the content of the guideline. Refer to the full text for additional information on drug dosing, Dexa-T scoring, patient screening criteria, etc. The levels of evidence (A, B, C, D) are repeated at the end of the Major Recommendations field.

Definitions

- *Bone mineral density* (BMD) correlates with skeletal strength and fracture risk.
- *Dual emission X-ray absorptiometry* (DEXA) measures BMD.
- A DEXA *T-score* is the number of standard deviations from mean BMD in young adult women.
- *Osteoporosis* is defined as a DEXA T-score ≤-2.5, *osteopenia* as >-2.5 but <-1.0 (refer to Table 1 in the original guideline document for details).

General Clinical Relevance

Fractures related to osteoporosis are common and have high morbidity *[C]*.

Glucocorticoids can cause significant bone loss, particularly during the first 6 to 12 months of use *[C]*.

Prevention

Recommend weight bearing exercise and adequate calcium and vitamin D across the life span (refer to Table 6 in the original guideline document for details) *[D]*.

Risk Assessment and Diagnosis

- Assess all adults for clinical risk factors for osteoporotic fracture (refer to Table 2 in the original guideline document for details) *[C]*
  - Postmenopausal woman with one or more of the following:
    - Age ≥65 years
    - Current smoking
    - Low body weight
    - Frailty
    - Personal history of fracture without substantial trauma age ≥40
    - Hip, wrist, or spine fracture without substantial trauma in 1st degree relative ≥50
  - Chronic glucocorticoid use (prednisone ≥7.5 mg daily, or equivalent, for ≥6 months)
  - Organ transplant or pending transplant

Brain (MRI)

MILLIMAN CareGuidelines
Ambulatory Care
8th Edition

CPT™ or HCPCS : 70551, 70552, 70553

For a complete list of ICD-9 codes, See Appendix D: ICD-9 Appendix.

Ataxia

Return to top of *Brain - AC*

- Indicated for patient with new diagnosis of ataxia, ie, inability to coordinate muscles with voluntary movements (1)[A]

Autoimmune Illness

Return to top of *Brain - AC*

- Indicated for **ALL** of the following(2):
  - Known or suspected autoimmune illness, ie, systemic lupus erythematosus, vasculitis, temporal arteritis, Wegener's granulomatosis, generalized polyarteritis nodosa, or giant cell arteritis
  - **ANY ONE** of the following neurologic symptoms:
    - Headache
    - Focal neurologic symptoms
    - Change in mental status

Bell's Palsy and Facial Paralysis

Return to top of *Brain - AC*

See *Bell's Palsy and Facial Paralysis* Guideline

- Indicated only if an acoustic neuroma or intracranial mass is suspected.[B] See Acoustic Neuroma or Neoplasm of the Brain, Suspected or Actual section in this guideline.

Central Nervous System Infection, Suspected

Return to top of *Brain - AC*

- Indicated for **ANY ONE** of the following(3)(4):
  - Suspected brain abscess due to presence of **ANY ONE** of the following(4):
    - Headache
    - Fever
    - Focal neurologic deficit
    - Nausea and vomiting
    - Photophobia
  - Immunosuppressed, ie, receiving chemotherapy or HIV patient, with focal neurologic findings
  - Follow-up of brain abscess

Mental Status Change

Return to top of *Brain - AC*

- See Imaging, MRI, Brain, Delirium or Imaging, MRI, Brain, Dementia.

Delirium

Return to top of *Brain - AC*

See *Delirium* Guideline

- Indicated for **ANY ONE** of the following[C](6)(7):
  - History of falls or suspected subdural hematoma
  - Patient at risk for falls or trauma, ie, elderly or disabled
  - Focal neurologic findings
  - Suspected brain abscess due to presence of **ANY ONE** of the following:
    - Headache
    - Fever
    - Focal neurologic deficit
    - Nausea and vomiting
  - Suspected metastatic cancer
  - Unexplained mental status change with no other signs or symptoms present and no other medical explanation exist[D]

Dementia

Return to top of *Brain - AC*

See *Dementia* Guideline

- Indicated when **ANY ONE** of the following applies(8)(9)[E]: (nonenhanced)
  - Dementia is of abrupt or of relatively recent onset, ie, months to a year or so, or has acutely worsened.
  - Etiology of the dementia is unclear by clinical assessment and the provider suspects a potentially treatable abnormality, such as **ANY ONE** of the following:
    - Subdural hematoma
    - Frontal lobe tumor
    - Hydrocephalus
    - Stroke or hemorrhage

- Brain abscess
- Vascular dementia

- Neurologic signs and symptoms point to focal defects that suggest other diseases that may be causing or exacerbating dementia.
- Early onset of dementia, ie, <65 years of age(10)

Headaches

Return to top of *Brain - AC*

See *Headaches* Guideline

- Indicated for **ANY ONE** of the following(12)(13)[F]:
  - Symptoms suggesting an ominous headache with a possibly more serious, underlying cause, as indicated by **ANY ONE** of the following[G]:
    - First or worst headache of the patient's life, particularly if the onset was rapid
    - A change in the frequency, severity, or clinical features of the headache attack from what the patient has commonly experienced
    - Onset of headache after 50 years of age
    - A new or progressive headache that persists for days
    - Precipitation of head pain with coughing, sneezing, or bending down
    - Systemic symptoms such as myalgia, fever, malaise, weight loss, scalp tenderness, or jaw claudication
    - **ANY ONE** of the following neurologic abnormalities:
      - Focal neurologic symptoms
      - Abnormalities on neurologic examination
      - Confusion
      - Any impairment in the level of consciousness
  - Seizure disorder
  - Constitutional symptoms: fever, weight loss, or cough
  - History of cancer
  - HIV-positive patient, generally as preferred test

Hydrocephalus

Return to top of *Brain - AC*

- Indicated for **ANY ONE** of the following(15)(16):
  - Infant or child with **ANY ONE** of the following:
    - **ANY ONE** of the following signs on physical exam:
      - Increasing head size beyond normal rate[H]
      - Widening anterior fontanelle or persistence of anterior fontanelle beyond 18 months
      - Abnormal neurologic exam, ie, increased deep tendon reflexes, spasticity, clonus, or Babinski's sign
      - Gait disturbance
      - Papilledema
      - Posterior fontanelle persists beyond 6 to 8 weeks.
    - **ANY ONE** of the following symptoms persist and remain unexplained:
      - Irritability
      - Lethargy
      - Decrease mentation
      - Vomiting
      - Headache
  - Adult and **ANY ONE** of the following symptoms suggestive of normal pressure hydrocephalus:
    - Mild dementia
    - Gait disturbance[I]
    - Urinary incontinence
  - Monitoring of ventriculoperitoneal shunt and **ANY ONE** of the following:

- Postoperative follow-up
- Occurrence of any symptoms listed above

Acoustic Neuroma

Return to top of *Brain - AC*

See *Acoustic Neuroma* Guideline

- Indicated for **ANY ONE** of the following(17)[J]:
  - Alterations in hearing, generally unilateral, and **ALL** of the following[K]:
    - Cannot be explained by other findings[L]
    - Documented by audiometry
  - Hearing changes associated with any neurologic symptoms or findings
  - Periodic monitoring of acoustic neuroma being followed without surgery, as follows(19): (contrast often required for monitoring)
    - 6 and 12 months after initial diagnosis
    - Then yearly for 3 years
    - Then every 1 to 2 years afterwards
  - Approximately 3 years after radiosurgery

Multiple Sclerosis

Return to top of *Brain - AC*

See *Multiple Sclerosis* Guideline

- Indicated for **ANY ONE** of the following:
  - Patient presenting with **ANY ONE** of the following symptoms that cannot be otherwise explained(20):
    - Episodic clumsiness or dysarthria
    - Tonic limb posturing
    - **ANY ONE** of the following sensory disturbances:
      - Eye symptoms: optic neuritis and diplopia
      - Lhermitte's sign, ie, posterior neck paresthesias evoked by neck flexion
      - Paroxysmal pain and paresthesias
      - Trigeminal neuralgia
    - Episodic limb weakness, clumsiness, and gait ataxia
    - Gait abnormalities or ataxia
    - Neurogenic bladder and bowel symptoms
    - Symptomatic worsening with increases in body temperature
    - Pseudoexacerbations with fever
    - Tremor
  - Repeat study after several months when diagnosis is unclear after initial study
  - During treatment periodically to evaluate treatment efficacy

Neoplasm of the Brain, Suspected or Actual

Return to top of *Brain - AC*

- Indicated for **ANY ONE** of the following(17)(21)(22): (generally starting with unenhanced)
  - Headache. See Headaches section in this guideline.
  - Mental status changes
  - Papilledema on the physical exam
  - **ANY ONE** of the following focal neurologic findings:
    - Weakness
    - Cranial nerve palsy
    - Ataxia
    - Nystagmus
    - Sensory deficit

- Visual loss or visual changes

- Repeat as enhanced study for **ANY ONE** of the following(23)(24):
  - Negative unenhanced MRI but metastatic disease is suspected clinically
  - Only 1 to a few lesions, considered amenable to treatment with surgery or gamma knife, seen on unenhanced study
- Follow-up after chemotherapy or radiation treatment
- Initial staging for cancer located elsewhere[M]

Parkinson's Disease

Return to top of *Brain - AC*

See *Parkinson's Disease* Guideline

- Indicated for **ANY ONE** of the following:
  - Parkinson's disease with atypical features unresponsive to levodopa (unenhanced)(25)
  - Preoperatively before Parkinson's surgery (unenhanced)

Pituitary Tumor

Return to top of *Brain - AC*

- Indicated for **ANY ONE** of the following:
  - Suspected pituitary tumor due to presence of **ANY ONE** of the following(23)(24)(26): (unenhanced)
    - **ANY ONE** of the following neurologic findings:
      - Visual field deficit[N]
      - Oculomotor palsies
      - Headaches
      - Hyperphagia
      - Abnormal temperature regulation
    - Hyperprolactinemia, ie, elevated serum prolactin levels, and NONE of the following explanations are present:
      - Hyperthyroidism
      - Recent seizure
      - Postpartum
      - Breast-feeding
      - Hormone replacement therapy
    - Diabetes insipidus due to the presence of **ALL** of the following(27):
      - 24-hour urine output >50 mL/kg/day, ie, >3500 mL in average-sized man
      - Urine osmolality <300 mOsm/kg
      - Failure to concentrate urine with a fluid deprivation test, followed by an increase in urine osmolality after administration of desmopressin
    - Hypogonadotropic hypogonadism, due to the presence of **ALL** of the following:
      - Symptoms of hypogonadism[O]
      - Low levels of testosterone, luteinizing hormone (LH) or follicle-stimulating hormone (FSH), the last 2 to be measured on 3 pooled samples taken 20 minutes apart
      - Absent response to intravenous gonadotropin-releasing hormone (GnRH)
    - Central hyperthyroidism, as indicated by presence of **ALL** of the following: (unenhanced)
      - Normal or increased free T4
      - Elevated TSH
    - Central hypothyroidism, as indicated by presence of **ALL** of the following:
      - Free T4 below normal
      - TSH below normal
    - Cushing's syndrome[P] (unenhanced)
    - Acromegaly due to presence of **ALL** of the following(26):
      - Failure of growth hormone suppression to <1 mcg within 1 to 2 hours after an oral glucose load of 75 g
      - Symptoms of acromegaly, ie, frontal bossing, increased hand size, mandibular

enlargement, widening space between lower incisor teeth
- Panhypopituitarism, ie, deficiency in most or all of pituitary hormones (unenhanced)

- Abnormal sella turcica on x-ray or CT scan
- Follow-up of pituitary tumor after treatment

Progressive Neurologic Deficit

Return to top of *Brain - AC*

- Indicated as test of first choice for **ANY ONE** of the following neurologic findings(21): (generally starting with unenhanced)
  - Focal sensory deficit of face, limb, or whole side of body
  - Focal weakness of face, limb, or whole side of body
  - New onset or a change in speech pattern
  - Ataxia or gait disturbance
  - Visual disturbance, ie, diplopia, visual field effect, or central nystagmus
  - Change in speech, ie, aphasia, dysarthria

Epilepsies, Generalized

Return to top of *Brain - AC*

See *Epilepsies, Generalized* Guideline

- Indicated for **ANY ONE** of the following(28):
  - Immediately for **ANY ONE** of the following:
    - Persistently altered mental state, with or without intoxication
    - Fever
    - History of significant head trauma
    - Persistent headache
    - Suspected primary or secondary malignancy of the brain
    - Patient on anticoagulants
    - AIDS
    - Prolonged altered mental state
    - Focal or progressive neurologic deficit
  - Within several days for **ANY ONE** of the following:
    - First focal seizure
    - First generalized seizure not associated with an acute metabolic or toxic disturbance
    - Elderly patient, ie, >60 years of age
    - Change in a seizure pattern
    - Chronic epilepsy with a poor therapeutic response

Epilepsies, Localized

Return to top of *Brain - AC*

See *Epilepsies, Localized* Guideline

- Indicated for **ANY ONE** of the following(28):
  - Immediately for **ANY ONE** of the following:
    - Persistently altered mental state, with or without intoxication
    - Fever
    - History of significant head trauma
    - Persistent headache
    - Suspected primary or secondary malignancy of the brain
    - Patient on anticoagulants
    - AIDS
    - Prolonged altered mental state
    - Focal or progressive neurologic deficit

- Within several days for **ANY ONE** of the following:
  - First focal seizure
  - First generalized seizure not associated with an acute metabolic or toxic disturbance
  - Elderly patient, ie, >60 years of age
  - Change in a seizure pattern
  - Chronic epilepsy with a poor therapeutic response
- For preoperative evaluation for all patients when surgery is being considered (high resolution)[Q]

Transient Ischemic Attack and Ischemic Stroke

Return to top of *Brain - AC*

See *Transient Ischemic Attack and Ischemic Stroke* Guideline

- Indicated for **ANY ONE** of the following(29)[R]:
  - **ANY ONE** of the following symptoms suggestive of stroke[S]:
    - Symptoms of carotid disease including **ANY ONE** of the following:
      - Monocular blindness, ie, amaurosis fugax
      - Weakness and sensory loss on one side of body
      - Aphasia
    - Vertebrobasilar system disease, including **ANY ONE** of the following:
      - Binocular blindness
      - Paresthesias
      - Dysarthria
      - Ataxia
      - Vertigo
      - Lightheadedness
      - Loss of consciousness[T]
      - Transient global amnesia
  - Follow-up of CT scan findings atypical for infarction

Syncope

Return to top of *Brain - AC*

See *Syncope* Guideline

- Indicated for syncope and **ANY ONE** of the following findings suggestive of focal CNS problem(30)[U]:
  - Focal sensory deficit of face, limb, or whole side of body
  - Focal weakness of face, limb, or whole side of body
  - New onset or a change in speech pattern
  - Ataxia or gait disturbance
  - Visual disturbance, ie, diplopia, visual field effect, or central nystagmus
  - Change in speech, ie, aphasia, or dysarthria

Tremor

Return to top of *Brain - AC*

See *Essential Tremor* Guideline

- Indicated preoperatively before surgery or nerve simulator implant

Vertigo And Dizziness

Return to top of *Brain - AC*

See *Vertigo and Dizziness* Guideline

- Indicated for presence of vertigo or dizziness and **ANY ONE** of the following(17)(31):
  - Persistent dizziness or vertigo that is unresponsive to treatment, including but not limited to **ANY ONE**

of the following:
- Meclizine
- Dimenhydrinate
- Promethazine
- Prochlorperazine
- Metoclopramide
- Antibiotic therapy for any sinus or ear infection present

- Dizziness associated with **ANY ONE** of the following:
  - Focal neurologic findings, eg, weakness, numbness, or paresthesias on 1 side of the body
  - Cerebellar findings, eg, incoordination of voluntary movements, intention tremor, disorder of equilibrium or gait, or diminished muscle tone
- Suspected acoustic neuroma and **ANY ONE** of the following:
  - Alterations in hearing, generally unilateral, and **ALL** of the following[V]:
    - Cannot be explained by other findings[W]
    - Documented by audiometry
  - Hearing changes associated with any neurologic symptoms or findings
- Seizures. See Epilepsies, Generalized and Epilepsies, Localized guidelines.
- Suspected multiple sclerosis
- Suspected stroke

Visual Loss

Return to top of *Brain - AC*

- Indicated with painful or painless visual loss(31)[X] (contrast equal in efficacy to no contrast)

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Return to top of *Brain - AC*

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Footnotes

Return to top of *Brain - AC*

[A] Differential diagnosis of ataxia includes infection, postinfectious changes, neoplasm, vascular insult, degenerative process, demyelinating process, posttraumatic changes, or hereditary process. [A in Context Link 1]

[B] Magnetic resonance imaging for Bell's palsy can show abnormalities in the facial nerve, but treatment of Bell's palsy will not change based on the imaging findings. [B in Context Link 1]

[C] Very few studies of brain imaging in delirium have been published.(5) [C in Context Link 1]

[D] Possible explanations of mental status changes include: metabolic disorders such as hepatic encephalopathies; hypoxia; hypoglycemia; drug intoxication with opiates, barbiturates, sedatives, or antidepressants ; alcohol withdrawal; thyrotoxicosis; and sepsis. [D in Context Link 1]

[E] MRI for dementia may be especially helpful in detecting ischemic brain injury causing vascular dementia.(10) An MRI or CT scan read as "consistent with Alzheimer's disease" is not diagnostic and should not prevent the provider from further investigation if appropriate.(11) [E in Context Link 1]

[F] The prevalence of significant intracranial abnormalities for patients with atypical migraine history is approximately 0.2%. Although MRI provides greater resolution, this is usually not necessary for nonacute headaches.(12) [F in Context Link 1]

[G] Only rarely does serious underlying disease cause a headache without atypical features or warning signals. (14) [G in Context Link 1]

[H] Normal growth for premature infant is 0.5 cm/week in first 2 weeks; 0.75 cm in 3rd week; 1.0 cm/week in 4th week and after, until 40th week of development. Normal head circumferences for term infant are: 34 cm to 35 cm at birth, 44 cm by 6 months, and 47 cm by 1 year of age. [H in Context Link 1]

[I] Gait disturbance in normal pressure hydrocephalus may be mild with uncertain short steps that may progress to unsteady balance. [I in Context Link 1]

[J] Contrast is frequently required, especially when monitoring after surgery. [J in Context Link 1]

[K] Although Brainstem Auditory Evoked Response is commonly positive with larger acoustic neuromas, this test becomes progressively less sensitive with smaller tumor size. Therefore, symptoms of acoustic neuromas cannot be used as a criterion to determine whether patients should have magnetic resonance imaging for a clinically suspicious presentation.(18) [K in Context Link 1]

[L] While unilateral hearing symptoms are most common, bilateral symptoms may occur and should be taken very seriously. Hearing loss is present in 1/2 to 3/4 of patients. The vertigo associated with acoustic neuromas is more likely to be present on a regular basis as opposed to the discrete attacks associated with Meniere's disease.(17) [L in Context Link 1]

[M] Tumors that commonly metastasize to the brain include, but are not limited to, melanoma, colon cancer, breast cancer, and lung cancer. [M in Context Link 1]

[N] Visual field defects associated with pituitary tumors may include bitemporal hemianopsia, complete loss of vision in 1 eye, bitemporal scotomas. [N in Context Link 1]

[O] Women with hypogonadism may experience oligomenorrhea or amenorrhea, infertility, reduced vaginal secretions, decreased libido, and breast atrophy. Men may experience decreased libido, decreased potency, infertility, decreased muscle mass, reduced body hair, soft testicles, and fine facial wrinkles. Both sexes may experience osteoporosis.(26) [O in Context Link 1]

[P] Appropriate laboratory tests to evaluate Cushing's syndrome include: serum ACTH levels, dexamethasone suppression test, and serum cortisone. Symptoms in adults include: cortical obesity, easy bruising, hypertension, glucose intolerance, weakness, depression, and others. [P in Context Link 1]

[Q] A high-resolution study may be necessary if prior MRI scan was not capable of identifying small lesions causing seizure disorder. High-resolution scans frequently identify hippocampal sclerosis, malformations of cortical development, vascular malformations, tumors, and acquired cortical damage. Between 15% and 30% of patients with temporal lobe epilepsy will have a normal high-resolution MRI. [Q in Context Link 1]

[R] MRI is a more sensitive test, especially for identifying small infarcts in the first 24 hours or for lesions in the posterior fossa. The need for MRI to supplement preceding tests is present in probably about 25% to 30% of stroke cases, though no good literature exists. [R in Context Link 1]

[S] A TIA is a focal neurologic deficit present <24 hours and usually <1 hour. An ischemic stroke requires presence of a focal neurologic deficit for >24 hours. Patients who have a TIA of longer duration may actually have had an infarct, proven only by performing a CT or MRI. These patients are labelled as having had a cerebral

infarct with transient symptoms (CITS). [S in Context Link 1]

[T] Any loss or significant change of consciousness should raise concern about possible intracranial hemorrhage or posterior fossa mass effect. [T in Context Link 1]

[U] Syncope is an episodic, transient loss of consciousness and postural tone due to cerebral hypoperfusion. There is spontaneous recovery without resuscitation, usually within 5 minutes. It may be abrupt in onset or occur with some warning. [U in Context Link 1]

[V] Although Brainstem Auditory Evoked Response is commonly positive with larger acoustic neuromas, this test becomes progressively less sensitive with smaller tumor size. Therefore, it cannot be used as a criterion to determine whether patients should have magnetic resonance imaging for a clinically suspicious presentation.(18) [V in Context Link 1]

[W] While unilateral hearing symptoms are most common for acoustic neuromas, bilateral symptoms may occur and should be taken very seriously. Hearing loss is present in 1/2 to 3/4 of patients. The vertigo associated with acoustic neuromas is more likely to be present on a regular basis as opposed to the discrete attacks associated with Meniere's disease. [W in Context Link 1]

[X] Differential diagnosis of visual loss includes gliomas, astrocytomas, meningiomas, optic neuritis, optic neuropathy, orbital pseudotumor, and trauma. [X in Context Link 1]

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Cervical Spine (MRI)

MILLIMAN CareGuidelines
Ambulatory Care
8th Edition

CPT™ or HCPCS : 72141, 72142, 72156

For a complete list of ICD-9 codes, See Appendix D: ICD-9 Appendix.

Thoracic Outlet

Return to top of *Cervical Spine - AC*

See *Thoracic Outlet Syndrome* Guideline

- Indicated only when cervical spine disease is considered likely.[A] See Neck Pain, Arthritis, and Disk Disease section in this guideline.

Neck Pain, Arthritis, and Disk Disease

Return to top of *Cervical Spine - AC*

See *Neck Pain, Cervical Arthritis and, Disk Disease* Guideline

- Indicated for **ANY ONE** of the following(1)(2)(3): (Generally starting with unenhanced using enhanced to differentiate scar formation or for persistent radicular symptoms in presence of negative unenhanced study)
  - Urgently when **ANY ONE** of the following is suspected:
    - Evidence of cord compression due to presence of **ANY ONE** of the following:
      - Urinary incontinence or retention
      - Spasticity
      - Incontinence of stool
      - Significant or progressive sensory or motor deficits
    - Neoplasm in cervical spine due to presence of **ANY ONE** of the following:
      - New-onset back pain associated with history of neoplasm
      - Persistent or progressive back pain that fails conservative therapy
    - Epidural abscess, when **ALL** of the following are present(3):
      - Pain
      - Fever
      - Rapidly progressive weakness
    - Disk space infection
    - Osteomyelitis of the vertebrae when **ANY ONE** of the following is present(1):
      - Positive bone scan
      - Persistent neck pain and **ANY ONE** of the following[B]:
        - Elevated sedimentation rate
        - Pain exacerbated by motion and relieved by rest
        - Localized tenderness over spine segment
    - Neck pain and **ALL** of the following:
      - Severe, disabling pain
      - Unresponsive to any comfort measures and conservative therapy
  - Less urgently for **ANY ONE** of the following:
    - Neurologic deficits of any type that either persist or slowly progress
    - Subacute or chronic neck or radicular pain and **ALL** of the following are present:

- Fails to improve after at least 6 to 8 weeks or more of conservative treatment[C]
- After consultation with a musculoskeletal specialist
- Surgical or invasive treatment is being considered.

• Previous spine surgery, to differentiate between scar and bulging disk **if ALL** of the following are present:
- Significant new symptoms
- Surgical management is being considered.

References

Return to top of *Cervical Spine - AC*

1. Engstrom J. Back and neck pain. In: Braunwald E, et al., editors. Harrison's Online: McGraw-Hill; 2001. Available at: http://www.harrisonsonline.com.[Context Link 1, 2, 3]
2. Maguire J. Osteomyelitis. In: Braunwald E, et al., editors. Harrison's Online: McGraw-Hill; 2001. Available at: http://www.harrisonsonline.com.[Context Link 1]
3. Hauser SL. Diseases of the spinal cord. In: Braunwald E, et al., editors. Harrison's Online: McGraw-Hill; 2001. Available at: http://www.harrisonsonline.com.[Context Link 1, 2]

Footnotes

Return to top of *Cervical Spine - AC*

[A] MRI of brachial plexus is occasionally done, looking for fibrous bands or vascular anomalies. No good literature exists to assess sensitivity or specificity. [A in Context Link 1]

[B] Patients considered at particular risk for osteomyelitis include those with another source of infection in the body and intravenous drug users.(1) [B in Context Link 1]

[C] Conservative therapy for nonurgent back pain includes: nonsteroidal medication, pain medication, modification of activity that exacerbate or produce symptoms, exercises when possible, and physical therapy or spinal manipulation. [C in Context Link 1]

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Lumbar Spine (MRI)

MILLIMAN CareGuidelines
Ambulatory Care
8th Edition

CPT™ or HCPCS : 72148, 72149, 72158

For a complete list of ICD-9 codes, See Appendix D: ICD-9 Appendix.

Low Back Pain, Sciatica, and Arthritis

Return to top of *Lumbar Spine - AC*

See *Low Back Pain, Sciatica, and Arthritis* Guideline

- Indicated for **ANY ONE** of the following(1)(2)(3)(4)(5)(6): (generally starting with unenhanced, using enhanced either to differentiate scar formation from prior surgery or with radicular symptoms below the knee in negative unenhanced study)
  - Urgently when **ANY ONE** of the following is suspected:
    - Evidence of cord compression or cauda equina syndrome due to presence of **ANY ONE** of the following:
      - Urinary incontinence or retention
      - Spasticity
      - Incontinence of stool
      - Significant sensory or motor deficits
      - Saddle anesthesia
    - Significant or progressive focal neuromotor deficits
    - Neoplasm in cervical spine due to presence of **ANY ONE** of the following:
      - New-onset back pain associated with history of neoplasm
      - Persistent or progressive back pain which fails conservative therapy
    - Epidural abscess when **ALL** of the following are present(2):
      - Pain
      - Fever
      - Rapidly progressive weakness
    - Disk space infection
    - Osteomyelitis of the vertebrae when **ANY ONE** of the following is present(1):
      - Positive bone scan
      - Persistent back pain and **ANY ONE** of the following[A]:
        - Elevated sedimentation rate
        - Pain exacerbated by motion and relieved by rest
        - Localized tenderness over spine segment
    - Back pain and **ALL** of the following:
      - Severe, disabling pain
      - Unresponsive to any comfort measures and conservative therapy
    - Suspected postoperative infection, ie, spondylodiskitis
  - On less urgent basis for **ANY ONE** of the following:
    - Severe, disabling back pain unresponsive to comfort measures
    - Pseudoclaudication
  - When low back pain fails to improve after 6 to 8 weeks of conservative treatment and **ANY ONE** of the following[B](4)(5)(6):
    - Persistent neurologic deficit persists for >6 to 8 weeks.
    - Persistent subacute or chronic radicular pain beyond 6 to 8 weeks and **ALL** of the following:

- Fails to improve after at least 6 to 8 weeks or more of conservative treatment[C]
- Interferes with daily function
- Surgical management is being considered.

- Suspected spondylolisthesis causing **ANY ONE** of the following:
  - Radicular symptoms
  - Spinal claudication
- Recurrent lumbar pain after previous lumbar surgery, to differentiate between scar and bulging disk if **ALL** of the following are present: (generally requires enhanced)
  - Significant new symptoms
  - Surgical management is being considered.
- Spinal claudication, as indicated by presence of **ALL** of the following:
  - Pain is worse with prolonged standing and activities requiring lumbar extension.
  - Pain is relieved by either sitting or forward flexion.

- Radicular symptoms below knee and equivocal findings on nonenhanced studies
- Suspected inflammatory process in the nerve root not secondary to compression

References

Return to top of *Lumbar Spine - AC*

1. Engstrom J. Back and neck pain. In: Braunwald E, et al., editors. Harrison's Online: McGraw-Hill; 2001. Available at: http://www.harrisonsonline.com.[Context Link 1, 2, 3]
2. Hauser SL. Diseases of the spinal cord. In: Braunwald E, et al., editors. Harrison's Online: McGraw-Hill; 2001. Available at: http://www.harrisonsonline.com.[Context Link 1, 2]
3. Maguire J. Osteomyelitis. In: Braunwald E, et al., editors. Harrison's Online: McGraw-Hill; 2001. Available at: http://www.harrisonsonline.com.[Context Link 1]
4. Deyo RA, Weinstein JN. Review Articles: Primary Care: Low back pain. New England Journal of Medicine 2001;344(5):363-70.[Context Link 1, 2, 3]
5. McCall IW. Lumbar herniated disks. Radiologic Clinics of North America 2000;38(6):1293-309.[Context Link 1, 2, 3]
6. Jinkins JR, Van Goethem JW. The postsurgical lumbosacral spine. Magnetic resonance imaging evaluation following intervertebral disk surgery, surgical decompression, intervertebral bony fusion, and spinal instrumentation. Radiologic Clinics of North America 2001;39(1):1-29.[Context Link 1, 2]

Footnotes

Return to top of *Lumbar Spine - AC*

[A] Patients considered at particular risk for osteomyelitis include those with another source of infection in the body and intravenous drug users.(1) [A in Context Link 1]

[B] Multiple studies of asymptomatic patients commonly found bulging lumbar disks. Herniated discs are even found in up to 22% of patients <60 years of age and in up to 36% of patients >60 years of age. Even simple herniation has a poor correlation with symptoms. Impingement of the nerve root is most associated with symptoms.(4)(5) [B in Context Link 1]

[C] Conservative therapy for nonurgent back pain includes the following: nonsteroidal medications, pain medications, modification of activity which exacerbates or produced symptoms, exercises when possible, and physical therapy or spinal manipulation. [C in Context Link 1]

Table 3. Screening and Management Based on Risk Factors for Osteoporosis and Osteoporotic Fractures

Clinical Risk (from Table 2)	First DEXA [a]	Management Based on T-score from First DEXA [b]		
		< -2	-2 to -1	> -1
Extremely High	DEXA not required for diagnosis. Order only if it will help follow response to treatment or guide treatment changes.	Treat: Yes. 2nd DEXA: Only if results will change treatment.	Treat: Yes. 2nd DEXA: Only if results will change treatment.	Treat: Yes, but first carefully consider other cause of fracture, e.g., malignancy. 2nd DEXA: Only if results will change treatment.
Very High	Order DEXA.	Treat: Yes. If on estrogen, change or add therapy. 2nd DEXA: 6–12 mo.	Treat: Yes. If on estrogen, consider changing or adding therapy. 2nd DEXA: 6–12 mo.	Treat: Consider preventive therapy. 2nd DEXA: 6–12 mo.
High	Order DEXA.	Treat: Yes. If on estrogen, consider changing or adding therapy. 2nd DEXA: ≥ 2 yrs.	Treat: Consider treating. If on estrogen, consider changing or adding therapy. 2nd DEXA: ≥ 2 yrs.	Treat: No. Reassess clinical risk in 1 year. 2nd DEXA: 3–5 yrs unless change in risk status.
Moderate	Consider DEXA, especially if risk for falling (Table 2). If not ordered, reassess clinical risk in 1 year.	Treat: Yes. If on estrogen, consider changing or adding therapy. 2nd DEXA: ≥ 2 yrs.	Treat: Consider treating. If on estrogen, consider changing or adding therapy. 2nd DEXA: ≥ 2 yrs.	Treat: No. Reassess clinical risk in 1 yr. 2nd DEXA: 3-5 yrs unless change in risk status.
Some (all others)	Reassess clinical risk in 1 yr.	(No first DEXA.)	(No first DEXA.)	(No first DEXA.)

Note: DEXA $100-406. Lower price is reimbursement accepted from Medicare. Higher price is that charged by UMHS. Payment accepted from most commercial insurance is ~50% of UMHS charge.

[a] Order DEXA only if results will affect management, e.g., not already receiving full therapy, or starting or stopping estrogen.

[b] Lowest T-score from femoral neck, greater trochanter, total hip, or any lumbar vertebra. Wards triangle is less predictive of fracture risk *[D]*.

Table 4. Evaluation for Secondary Causes of Osteoporosis and Osteopenia *[D]*

All patients: consider calcium, alkaline phosphatase, renal function, liver function tests [Comprehensive metabolic panel $15-50], TSH [$23-71]

Men: consider testosterone [Free: $35-120, Total: $36-125] (1/3 of older men with osteoporosis have hypogonadism *[C]*)

Premenopausal with amenorrhea not due to polycystic ovary syndrome: estradiol & FSH [$65-209] (hypogonadal)

Based on clinical situation:

- Intact-PTH [$57-187] with calcium [$7-21] (hyperparathyroidism, primary or secondary)
- 24h urine free cortisol [$23-99] or 1 mg dexamethasone suppression [$23-70] (hypercortisolism)
- 25-hydroxy-vitamin D (osteomalacia) [$41-66]
- Evaluation for occult malignancy, e.g., multiple myeloma, bony metastases

Note: Lower price is reimbursement accepted from Medicare. Higher price is that charged by UMHS. Payment accepted from most commercial insurance is ~50% of UMHS charge.

Table 5. Considerations for Subsequent DEXA

Assess:

- Number and types of risk factors, Table 2.
- Results from prior DEXAs.
- If transplant patient, time since transplant. (Highest risk for fracture is within first 2-3 years following transplant *[C]*.)
- Overall context, e.g., patient life expectancy.

Repeat DEXA:

- Only if results will change management.
- If BMD not ↑ing, stable, or ↓ing slowly.
- After starting, stopping, or changing antiresorptive therapy *

Use intervals suggested for 2nd DEXA in Table 3.

* Antiresorptive therapies include, alendronate, risedronate, raloxifene, estrogen, and calcitonin.

Table 1. World Health Organization [WHO] Definitions

Classification	DEXA T-score (SD from young normal)
Normal	≥ -1.0
Osteopenia	> -2.5 but < -1.0
Osteoporosis	≤ -2.5

Table 2. Clinical Risk Categories for Osteoporosis and Osteoporotic Fractures (for use with Table 3)

Extremely High Risk

Prior osteoporotic fracture [a]
(fracture in absence of significant trauma)

Very High Risk

Glucocorticosteroid use [b]
(prednisone ≥ 7.5 mg/d, or equivalent, for ≥ 6 months)

Solid organ transplant [c]
(awaiting or following, especially within 2-3 yrs after)

High Risk

Postmenopausal with ≥1 of[d]:
- Age 65 years or greater
- Personal history of fracture without substantial trauma ≥ age 40
- Family history of fracture (hip, wrist, or spine in first-degree relative ≥ age 50)
- Current smoking
- Weight in lowest quartile (< 57.8 kg or 127 pounds)
- Frailty (inability to rise from chair unassisted)

Moderate Risk

Postmenopausal not taking estrogen and no higher level risk factors

Family history of osteoporosis

Medications:
- Cyclosporine A
- GnRH therapy (e.g., leuprolide (Lupron®), goserelin (Zoladex®), and others)
- Anticonvulsants (phenytoin, phenobarbital > carbamazepine, valproic acid; gabapentin probably no risk)
- Heparin (unfractionated > LMWH)
- Tacrolimus (FK506, Prograf®)
- Tamoxifen before menopause
- Inhaled glucocorticoids, high dose and/or prolonged duration

Conditions with significant association:
- Alcoholism
- Cushing's syndrome
- Gastrectomy
- Hypogonadism, including due to medication, surgery, or chemotherapy
- Hemochromatosis
- Hyperparathyroidism, primary or secondary
- Inflammatory bowel disease (Crohn's > ulcerative colitis)
- Severe liver disease (especially primary biliary cirrhosis)
- Multiple myeloma
- Malabsorption, including due to medical disorder or surgery
- Rheumatoid arthritis
- Premenopausal amenorrhea except PCOS (e.g., anorexia nervosa, exercise, hyperprolactinemia)

Some Risk

Postmenopausal taking estrogen and no higher level risk factors

Conditions with possible association:
- Addison's disease
- Amyloidosis
- Diabetes mellitus, type 1
- Thalassemia (major > minor)
- Multiple sclerosis
- Nephrolithiasis
- Thyrotoxicosis
- Sarcoidosis

Risk Factors for Falling
- Use of any benzodiazepine or sedative/hypnotic agent
- Frailty
- Environmental hazards for falls
- History of falls
- Impaired vision
- Impaired cognition
- Impaired gait, balance or transfer skills
- Impaired leg or arm muscle strength or range of motion
- Low physical function
- Postural hypotension

[a] Prior fracture is more predictive of future fracture than is bone mineral density [BMD].
[b] Glucocorticoids produce the greatest bone loss in the initial 6-12 months of use, average of 4-5%.
[c] Bone loss can be as much as 10% in the first year after transplant.
[d] Early in menopause, including after bilateral oophorectomy, bone loss is more rapid in the spine than the hip.

    - Other associated medical conditions and medications
- Order DEXA based on clinical risk factors and potential impact of results on management (refer to Table 3 in the original guideline document for details).
- Evaluate appropriately and refer, when indicated, for secondary causes of osteoporosis (refer to Table 4 in the original guideline document for details) *[D]*.

WHEELCHAIRS

Clinical Policy Bulletins

Number: 0271
Subject: Wheelchairs

Important Note

This Clinical Policy Bulletin expresses Aetna's determination of whether certain services or supplies are medically necessary. Aetna has reached these conclusions based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). Aetna expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. ***Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply.*** The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e., will be paid for by Aetna) for a particular member. The member's benefit plan determines coverage. Some plans exclude coverage for services or supplies that Aetna considers medically necessary. If there is a discrepancy between this policy and a member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid members. CMS's Coverage Issues Manual can be found on the following website: http://cms.hhs.gov/manuals/pub06pdf/pub06pdf.asp.

Policy

Aetna considers wheelchairs to be durable medical equipment. Coverage may therefore be available to members enrolled in plans that provide this benefit. Please check benefit plan descriptions for details.

Aetna considers the rental or, if less costly, purchase of one wheelchair at a time medically necessary when selection criteria are met. Whatever type of wheelchair is necessitated by the member's physical condition should be able to be used inside or outside the home. Rental or purchase of two or more wheelchairs is *not* considered medically

necessary, but rather a matter of convenience for the member and his/her family.

One-month rental of a wheelchair is considered medically necessary if a member-owned wheelchair is being repaired. Charges for repairing a wheelchair are considered medically necessary when needed to make the wheelchair serviceable. The charge for repairing the wheelchair must not exceed the estimated cost of rental or purchase of a replacement wheelchair. Replacement of a wheelchair is considered medically necessary only when the replacement is needed due to a change in the member's physical condition or when the wheelchair is inoperative and cannot be repaired at a cost less than rental or replacement.

An upgrade that is beneficial primarily in allowing the member to perform leisure or recreational activities is *not* considered medically necessary.

Note: Reimbursement for wheelchairs includes all labor charges involved in the assembly of the wheelchair and all covered additions, accessories and modifications. Reimbursement for a wheelchair also includes support services such as emergency services, delivery, setup, education and ongoing assistance with use of the wheelchair.

Manual wheelchairs:

A wheelchair is a mobile chair mounted on four wheels for persons who are unable to walk. Aetna considers the rental or purchase of one manual wheelchair (including any medically necessary accessories and attachments) medically necessary when the member's condition is such that, without the use of a wheelchair, the member would otherwise be unable to ambulate about the home (e.g., from bedroom to bathroom, bedroom to kitchen, etc.).

Electric, power or motorized wheelchairs:

An electric or power wheelchair is a motorized wheelchair. Electric wheelchairs are for persons who are unable to walk and have upper extremity impairment. Aetna considers the rental or purchase of one electric, motorized or power wheelchair either initially or to replace a manual wheelchair medically necessary, when the medical necessity criteria noted under manual wheelchairs above are met and *all* of the following criteria are met:

1. The member is bed or chair-bound without the use of a wheelchair; *and*
2. The member is unable to operate a wheelchair manually; *and*
3. The member is physically able to safely operate the electric or motorized wheelchair on their own; *and*
4. The member's condition is such that the requirement for a power wheelchair is long term (at least six months).

Aetna considers a manual-assist electric wheelchair (iGlide, Independence Technology, LLC, Warren, NJ) an acceptable alternative to a power wheelchair for neuromuscularly stable persons who meet the medical necessity criteria for an electric wheelchair and who weigh

250 lbs or less and who are able to use their arms to propel themselves for short distances of 10 feet.

An electric, power, or motorized wheelchair is considered *not* medically necessary when it is only for use outside the home. An electric, power, or motorized wheelchair that is beneficial primarily in allowing the member to perform leisure or recreational activities is *not* considered medically necessary.

A member who requires an electric, motorized, or power wheelchair usually is totally non-ambulatory and has severe weakness of the upper extremities due to a neurological or muscular disease/condition. If a member can only bear weight to transfer from a bed to a chair or wheelchair, the member is considered nonambulatory. However, if the member is able to walk either without any assistance or with the assistance of an ambulatory aid, such as a walker, the power wheelchair is considered not medically necessary. A power wheelchair is considered medically necessary only if the member does not have sufficient trunk stability but otherwise meets selection criteria for a power operated vehicle/scooter, or the member is nonambulatory and is unable to self-propel a manual wheelchair within their home.

A lightweight power wheelchair is characterized by a weight of < 80 lbs. without battery and a folding back or collapsible frame. Requests for a lightweight power wheelchair will be reviewed on an individual basis to determine medical necessity.

A custom power wheelchair base is one in which the frame has been uniquely constructed or substantially modified for a specific member. A custom power wheelchair base is considered medically necessary only if the feature needed is not available as an option in an already manufactured base.

Aetna considers a stair-climbing wheelchair (iBOT Mobility System, Independence Technology, LLC, Warren, NJ) as *not* medically necessary. Aetna has chosen to adopt Medicare rules with respect to power or motorized wheelchairs. A motorized or powered wheelchair is considered medically necessary for individuals who lack the capacity to ambulate a sufficient distance to accomplish essential activities of daily living within the home; this is generally defined by Medicare as inability to ambulate at least 100 feet. Medicare does not consider inability to climb stairs a medically necessary indication for an electric, motorized, or powered wheelchair. An electric wheelchair is not considered medically necessary to elevate a person to eye level or to extend a wheelchair-bound person's reach. In addition, inability to navigate rough or uneven terrain outside the home is not considered a medically necessary indication for an electric wheelchair.

Electric, motorized or power operated vehicle/scooter:

Power operated vehicles, commonly known as "scooters", are three or four wheel non-highway motorized transportation systems for persons with impaired ambulation. CMS states that the criteria for a power operated vehicle are slightly different than a power wheelchair. Aetna considers a motorized, electric or power operated vehicle/scooter medically necessary when the criteria noted under manual wheelchairs

above are met and *all* of the following criteria are met:

1. The member's condition is such that a wheelchair is required for the member to get around in the home; *and*
2. The member is unable to operate a manual wheelchair; *and*
3. The member is capable of safely operating the controls for the power operated vehicle/scooter; *and*
4. The member can transfer safely in and out of the power-operated vehicle/scooter, and has adequate trunk stability to be able to safely ride in the power-operated vehicle; *and*
5. The member's condition is such that the requirement for a power-operated vehicle/scooter is long term (at least six months).

A power-operated vehicle/scooter is *not* considered medically necessary when it is only for use outside the home. A power-operated vehicle that is beneficial primarily in allowing the member to perform leisure or recreational activities is *not* considered medically necessary.

Power operated vehicles/scooters may be considered medically necessary when they represent an alternative to a motorized wheelchair in a member who would otherwise qualify for such equipment. If it is determined that this specialized power vehicle/scooter is medically necessary, then it will be paid in lieu of a wheelchair, not in addition to a wheelchair.

Power add-ons and power-assist wheelchairs:

Aetna considers a power add-on to a manual wheelchair, or a push-rim activated power assist wheelchair medically necessary as alternatives to an electric, motorized, or power operated vehicle/scooter for persons who meet medical necessity criteria for a power-operated vehicle/scooter. A power add-on is used to convert a manual wheelchair to a motorized wheelchair. A push-rim activated power assist is an option for a manual wheelchair in which sensors in specially designed wheels determine the force that is exerted by the person on the wheel. Additional propulsive and/or braking force is then provided by motors in each wheel.

Hemi-type wheelchair:

A hemi-type wheelchair has a lower seat height (17"-18") than a standard wheelchair (19"-21"). A standard hemi-type wheelchair is considered medically necessary for members who meet the medical necessity criteria for a manual wheelchair and who require a lower seat height because of short stature or to enable the member to place his feet on the ground for propulsion (e.g., due to amputation, stroke, paralysis, or weight imbalance, etc.).

Lightweight wheelchair:

A lightweight wheelchair is one that weighs between 30 to 36 lbs. The member must meet the medical necessity criteria for a manual wheelchair and provide information to indicate they cannot propel themselves in a standard wheelchair, but can propel themselves in a lightweight wheelchair.

High-strength lightweight wheelchair:

A high-strength lightweight wheelchair is one that weighs less than 34 lbs. and has high-strength side frames and crossbraces. A high-strength lightweight wheelchair is considered medically necessary if the member meets the medical necessity criteria for a manual wheelchair and *either* of the following criteria:

1. The member self-propels the wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair; *or*
2. The member requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the chair.

A high-strength lightweight wheelchair is rarely considered medically necessary if the expected duration of need is less than three months (e.g., post-operative recovery).

Ultralight wheelchair:

An ultralight wheelchair is one that weighs less than 30 lbs. An ultralight wheelchair would rarely be considered medically necessary to perform the usual activities of daily living. Any requests for an ultralight wheelchair require documentation from the prescribing healthcare provider as to why the member cannot function with a light weight wheelchair.

Heavy duty and extra heavy duty wheelchairs:

A heavy-duty wheelchair is one that can support a member weighing > 250 lbs. and an extra heavy-duty wheelchair can support a member weighing > 300 lbs. Reinforced back and seat upholstery are standard features of these wheelchairs. The member must meet the medical necessity criteria for a manual wheelchair and must have severe spasticity or weigh over 250 lbs for the heavy-duty wheelchair and over 300 lbs for the extra heavy-duty wheelchair.

Custom manual wheelchair base:

A custom manual wheelchair base is one that has been uniquely constructed or substantially modified for a specific member. There must be customization of the frame for the wheelchair base to be considered customized. A custom wheelchair base is considered medically necessary only if the feature needed is not available as an option to an already manufactured base.

Specially adapted wheelchairs for children:

Aetna considers wheelchairs that are specially adapted for children medically necessary when the child is non-ambulatory and *either* requires more support than a regular wheelchair provides or the child is too small for a standard children's wheelchair. Aetna does not cover standard strollers that are not specially adapted because they do not meet the contractual definition of durable medical equipment in that

they are not primarily for medical use, and they are of use in the absence of illness and injury.

Rollabout Chairs and hand driven tricycles in lieu of wheelchairs:

Aetna considers a Rollabout Chair or a hand driven tricycle medically necessary when they are used in lieu of a wheelchair and coverage is limited to those Rollabout chairs having casters of at least 5 inches in diameter and specifically designed to meet the needs of ill, injured, or otherwise impaired individuals. Rollabout chairs may be called by other names such as "transport" or mobile geriatric chairs ("geri-chairs").

Note: The wide range of chairs with smaller casters, which are found in general use in homes, offices, and institutions for many purposes do not meet the definition of durable medical equipment, in that they are not related to the care or treatment of ill or injured persons and they are not primarily medical in nature.

General use seat and back cushions:

A *general use seat cushion* and/or *a general use wheelchair back cushion* is considered medically necessary for members who have a medically necessary wheelchair or rollabout chair.

A *general use seat cushion* is a static, prefabricated cushion that has the following characteristics:

1. It is composed of foam, flexible cellular material, air, fluid or solid gel/elastomer or a combination of these materials; *and*
2. It has the following minimum performance characteristics:

    a. Simulation tests demonstrate a loaded contour depth of at least 25 mm with an overload deflection of at least 5 mm, *or*
    b. Human subject tests demonstrate peak interface pressures that are less than 125% of those of a standard reference cushion at each of the three following anatomic locations: right and left ischial tuberosities and sacrum/coccyx; *and*

3. Following fatigue testing simulating 12 months of use, overload testing does not demonstrate bottoming out; *and*
4. It has a removable vapor permeable or waterproof cover or it has a waterproof surface; *and*
5. The cushion and cover meet the minimum standards of the California Bulletin 117 for flame resistance; *and*
6. It has a permanent label indicating the model and manufacturer; *and*
7. It has a warranty that provides full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 12 months.

A *general use back cushion* is a static, prefabricated cushion, which has the following characteristics:

1. It is composed of foam, flexible cellular material, or solid

gel/elastomer; *and*
2. It is planar or contoured; *and*
3. It has a removable vapor permeable or waterproof cover or it has a waterproof surface; *and*
4. The cushion and cover meet the minimum standards of the California Bulletin 117 for flame resistance; *and*
5. It has a permanent label indicating the model and the manufacturer; *and*
6. It has a warranty that provides full replacement if the manufacturing defects are identified or the surface does not remain intact due to normal wear within 12 months.

Specialized seat and back cushions:

A *skin protection seat cushion*, *positioning seat cushion*, or *combination skin protection and positioning seat cushion*, a *positioning and/or skin protection back cushion*, and *positioning accessories* are considered medically necessary for members who meet *both* of the following criteria:

1. The member has a wheelchair or rollabout chair and the member meets Aetna's medical necessity criteria for it; *and*
2. The member has *any* of the following:

    a. Past history of or current pressure ulcer on the area of contact with the seating surface; *or*
    b. Absent or impaired sensation in the area of contact with the seating surface due to one of the following diagnoses: spinal cord injury, other etiology of quadriplegia or paraplegia, multiple sclerosis; *or*
    c. The member has significant postural asymmetries that are due to one of the following diagnoses: spinal cord injury, other etiology of quadriplegia or paraplegia, hemiplegia or monoplegia of the lower limb due to stroke or other etiology, cerebral palsy, multiple sclerosis, anterior horn cell diseases including amyotrophic lateral sclerosis, post polio paralysis, muscular dystrophy, traumatic brain injury, childhood cerebral degeneration, torsion dystonias.

A *skin protection seat cushion* is a static, prefabricated cushion that has the following characteristics:

1. The cushion must be:

    a. Composed of two or more of the following materials: foam, flexible cellular material, air, fluid or solid gel/elastomer; *or*
    b. A multi-compartment air cushion; *or*
    c. A cushion composed of two or more types of foam with different stiffness of foam; *and*

2. It has the following minimum performance characteristics:

    a. Simulation tests demonstrate a loaded contour depth of at least 40 mm with an overload deflection of at least 5 mm; *or*
    b. Human subject tests demonstrate peak interface pressures

that are less than 90% of those of a standard reference cushion at each of the three following anatomic locations: right and left ischial tuberosities and sacrum/coccyx; *and*

3. Following fatigue testing simulating 18 months of use, overload testing does not demonstrate bottoming out; *and*
4. It has a removable vapor permeable or waterproof cover or it has a waterproof surface; *and*
5. The cushion and cover meet the minimum standards of the California Bulletin 117 for flame resistance; *and*
6. It has a permanent label indicating the model and manufacturer; *and*
7. It has a warranty that provides full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 18 months.

A *positioning seat cushion* is a static, prefabricated cushion that has the following characteristics:

1. It is composed of foam, flexible cellular material, air, fluid or solid gel/elastomer, or any combination of these materials; *and*
2. It has two or more of the following structural features:

    a. A pre-ischial bar or ridge which is placed anterior to the ischial tuberosities and prevents forward migration of the pelvis,
    b. Two lateral pelvic supports which are placed posterior to the trochanters and provide lateral stability to the pelvis,
    c. A medial thigh support which is placed anterior to the trochanters and provides medial stability to the lower extremities,
    d. Two lateral thigh supports which are placed anterior to the trochanters and provide lateral stability to the lower extremities.

    The feature must be at least 25 mm in height in the pre-loaded state, from the lowest point of contact of the targeted body part to the highest point of contact; *and*

3. It has the following minimum performance characteristics:

    a. Simulation tests demonstrate a loaded contour depth of at least 25 mm with an overload deflection of at least 5 mm, *or*
    b. Human subject tests demonstrate peak interface pressures that are less than 125% of those of the standard reference cushion at each of the three following anatomical locations: right and left ischial tuberosities and sacrum/coccyx, *and*

4. Following fatigue testing simulating 18 months of use, overload testing does not demonstrate bottoming out; *and*
5. It has a removable vapor permeable or waterproof cover or it has a waterproof surface; *and*
6. The cushion and cover meet the minimum standards of the California Bulletin 117 for flame resistance; *and*
7. It has a permanent label indicating the model and the

manufacturer; *and*

8. It has a warranty that provides full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 18 months.

A positioning cushion may have materials or components that may be added or removed to help address orthopedic deformities or postural asymmetries.

A *skin protection and positioning seat cushion* is a static, prefabricated cushion which has the following characteristics:

1. The cushion must be:

   a. Composed of two or more of the following materials: foam, flexible cellular material, air, fluid or solid gel/elastomer; *or*
   b. A multi-compartment air cushion; *or*
   c. A cushion composed of two or more types of foam with different stiffness of foam; *and*

2. It has two or more of the following structural features:

   a. A pre-ischial bar or ridge which is placed anterior to the ischial tuberosities and prevents forward migration of the pelvis,
   b. Two lateral pelvic supports which are placed posterior to the trochanters and provide lateral stability to the pelvis,
   c. A medial thigh support which is placed anterior to the trochanters and provides medial stability to the lower extremities,
   d. Two lateral thigh supports which are placed anterior to the trochanters and provide lateral stability to the lower extremities.

   The feature must be at least 25 mm in height in the pre-loaded state, from the lowest point of contact of the targeted body part to the highest point of contact; *and*

3. It has materials and components which may be added or removed to help address orthopedic deformities or postural asymmetries; *and*
4. It has the following minimum performance characteristics:

   a. Simulation tests demonstrate a loaded contour depth of at least 40 mm with an overload deflection of at least 5 mm, *or*
   b. Human subject tests demonstrate peak interface pressures that are less than 90% of those of the standard reference cushion at each of the three following anatomical locations: right and left ischial tuberosities and sacrum/coccyx, *and*

5. Following fatigue testing simulating 18 months of use, overload testing does not demonstrate bottoming out; *and*
6. It has a removable vapor permeable or waterproof cover or it has a waterproof surface; *and*

7. The cushion and cover meet the minimum standards of the California Bulletin 117 for flame resistance; *and*
8. It has a permanent label indicating the model and the manufacturer; *and*
9. It has a warranty that provides full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 18 months.

A skin protection and positioning cushion may have materials or components that may be added or removed to help address orthopedic deformities or postural asymmetries.

A *positioning and/or skin protection back cushion* is a static, prefabricated cushion which (a) meets criterion 1 or 2, and (b) meets criteria 3-6:

1. The cushion provides *all* of the following features:

    a. Full back support, which starts in the sacral spine or pelvis and reaches the spine of the scapula; *and*
    b. Both posterior and lateral support; *and*
    c. One inch or more of posterior contour, either through pre-contouring or load-contouring; *and*
    d. Three inches or more of lateral support, either through pre-contouring or load-contouring.

2. The cushion is:

    a. Composed of two or more of the following materials: foam, flexible cellular material, air, fluid or solid gel/elastomer; *or*
    b. A multi-compartment air cushion; *or*
    c. A cushion composed of two or more types of foam with different stiffness of foam; *and*

3. It has a removable vapor permeable or waterproof cover or it has a waterproof surface; *and*
4. The cushion and cover meet the minimum standards of the California Bulletin 117 for flame resistance; *and*
5. It has a permanent label indicating the model and the manufacturer; *and*
6. It has a warranty that provides full replacement if manufacturing defects are identified or the surface does not remain intact due to normal wear within 18 months.

A positioning and skin protection cushion may have materials or components that may be added or removed to help address orthopedic deformities or postural asymmetries.

Custom fabricated seat and back cushions:

A *custom fabricated seat cushion* and/or a *custom fabricated back cushion* is considered medically necessary for members who meet *all* of the following criteria:

1. The member has a wheelchair or rollabout chair and the member

meet's Aetna's medical necessity criteria for it; *and*
2. The member has significant postural asymmetries that are due to one of the following diagnoses: spinal cord injury, other etiology of quadriplegia or paraplegia, hemiplegia or monoplegia of the lower limb due to stroke or other etiology, cerebral palsy, multiple sclerosis, anterior horn cell diseases including amyotrophic lateral sclerosis, post polio paralysis, muscular dystrophy, traumatic brain injury, childhood cerebral degeneration, torsion dystonias; *and*
3. A written evaluation by a healthcare professional clearly explains why a prefabricated seating system is not sufficient to meet the member's seating and positioning needs.

A custom fabricated seat cushion or custom fabricated back cushion is a static cushion that is individually made for a specific member starting with basic materials including: a) liquid foam or a block of foam and b) sheets of fabric or liquid coating material. The complete cushion must be fabricated using molded-to-member-model technique, direct molded-to-member technique, CAD-CAM technology, or detailed measurements of the person used to create a carved foam cushion. The cushion must have a removable vapor permeable or waterproof cover or it must have a waterproof surface.

Powered wheelchair seat cushion:

A powered seat cushion is considered *not* medically necessary because its effectiveness has not been established.

A powered wheelchair seat cushion is a battery-powered, prefabricated cushion in which an air pump provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the cushion. One type of powered seat cushion is an alternating pressure cushion.

Miscellaneous seat and back cushions:

A static, prefabricated wheelchair seat or back cushion not meeting the definition of general use, skin protection, or positioning cushion is considered not medically necessary.

Replacement cushions:

Replacement of wheelchair seat cushions, wheelchair back cushions, and wheelchair positioning accessories is considered medically necessary every 5 or more years unless one of the following conditions is met:

1. The item has been accidentally, irreparably damaged (other than usual wear and tear), *or*
2. The item has been lost or stolen, *or*
3. There is a change in the member's medical condition that requires a different type of seating or positioning item.

Note:

A seat or back cushion includes any rigid or semi-rigid base or posterior panel, respectively, that is an integral part of the cushion. It also includes any mounting hardware that is directly attached to the cushion.

Wheelchair accessories:

Aetna considers certain wheelchair accessories medically necessary if the wheelchair is considered medically necessary and the options or accessories are necessary for the member to function in the home and perform the activities of daily living.

The following wheelchair accessories/attachments are considered medically necessary when criteria are met:

Adjustable arm-height option is considered medically necessary if the member requires an arm height that is different than that available using non-adjustable arms and the member spends at least 2 hours per day in the wheelchair.

Reinforced back upholstery or reinforced seat upholstery is considered necessary if used with a power wheelchair base and the member weighs more than 200 pounds. When used in conjunction with a heavy duty or extra heavy duty wheelchair bases, the allowance for reinforced upholstery is included in the allowance for the wheelchair base. Reinforced back and seat upholstery are *not* medically necessary if used in conjunction with other manual wheelchair bases.

Hook-on headrest extension (sling support for the head) is considered medically necessary if the member has weak neck muscles and needs a headrest for support, or if the member meets the criteria for and has a reclining back on the wheelchair.

Chin control is considered medically necessary if the member has weak neck muscles and needs a chin control for support.

A fully reclining back option is considered medically necessary if the member spends at least 2 hours per day in the wheelchair and has one or more of the following conditions:

1. Quadriplegia, *or*
2. Fixed hip angle, *or*
3. Trunk or lower extremity casts or braces that require the reclining back feature for positioning, *or*
4. Excess extensor tone of the trunk muscles, *or*
5. The need to rest in a recumbent position two or more times per day and transfer between wheelchair and bed is very difficult.

A solid seat insert is considered medically necessary when the member spends at least 2 hours per day in the wheelchair. A solid seat insert is a rigid piece of wood or plastic which is added to a seat cushion to provide a firm base for the seat cushion. A solid seat insert is considered an integral part of a seat cushion.

A safety belt/pelvic strap is considered medically necessary if the member has weak upper body muscles, upper body instability or muscle spasticity, which requires use of this item for proper positioning.

Elevating leg rests are considered medically necessary if:

1. The member has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion of the knee, *or*
2. The member has significant edema of the lower extremities that requires having an elevating leg rest, *or*
3. The member meets criteria for and has a reclining back on a wheelchair.

Articulating (telescoping) elevating leg rests are *not* considered medically necessary because they do not have significant benefits compared to standard (non-telescoping) elevating leg rests.

Swingaway, detachable footrests are considered part of the wheelchair base. They should be billed separately only when they are replacements.

A non-standard seat width, depth, or height is considered medically necessary only if:

1. The ordered item is at least 2 inches greater than or less than a standard option, *and*
2. The member's dimensions justify the need.

Anti-rollback device and anti-tip device are considered medically necessary if the member propels himself/herself and needs the device because of ramps.

A U-1 battery, 22 NF deep-cycle lead acid battery, or gel battery provides adequate power for a power wheelchair. Up to two batteries at one time are considered medically necessary if required for the power wheelchair. Group 24 batteries are usually *not* considered medically necessary.

A one arm drive attachment is considered medically necessary if the member propels the chair himself/herself with only one hand and the need is expected to last at least 6 months.

An arm trough is considered medically necessary if the member has quadriplegia, hemiplegia, or uncontrolled arm movements.

Powered tilt recline, motorized tilt, and tilt-in space wheelchair backs are considered medically necessary for members that are unable to shift their own weight without assistance.

Power stander attachment is considered medically necessary only when a member needs assistance to assume standing position *and* has some residual muscular strength in the legs, such that standing will improve lower body strength. A power stander is *not*

considered medically necessary for members who are completely paralyzed in the legs and hips, such that standing will not improve lower body strength; for these latter members, there is no evidence that a power stander offers clinically significant benefits.

Nonpowered seat elevator or standing device is considered medically necessary for members who cannot bend or sit.

Lap tray wheelchair attachment is considered medically necessary when used to provide trunk support in wheelchairs. Wheelchair trays not used to provide trunk support, work trays, and cutout tables are not considered medically necessary.

Electronic interface to allow a speech generating device (SGD) to be operated by the power wheelchair control interface is considered medically necessary if the member has a medically necessary SGD.

Swingaway, retractable, or removable hardware is considered *not* medically necessary if the primary indication for its use is to allow the member to move close to desks or other surfaces. One example (not all-inclusive) of a medically necessary indication is to move the component out of the way so that the member could perform a slide transfer to a chair or bed.

Miscellaneous medically necessary accessories

The following miscellaneous wheelchair accessories may be considered medically necessary:

1. Amputee adapter
2. Heel loops
3. IV rod
4. Narrowing device
5. Oxygen carrier
6. Ventilator shelf
7. Speech generating device (SGD) table
8. Step tube
9. Suspension fork
10. Wide stance arm bracket.

Note: This list is not all-inclusive.

Wheelchair items that are considered *not* medically necessary

The following wheelchair items are *not* considered medically necessary:

Back support systems have a plastic frame which is padded and covered with cloth or other material; they are designed to be attached to a wheelchair base, but do not completely replace the wheelchair back. These back support systems are considered *not* medically necessary, because they are not generally necessary to provide trunk support in members in wheelchairs. An adequate seating system would allow the member to function appropriately

in the wheelchair.

A battery charger for a power wheelchair is included in the allowance for a power wheelchair base. A dual mode charger for a power wheelchair is *not* considered medically necessary.

Home modifications: Modifications to the structure of the home to accommodate wheelchairs are *not* considered medically necessary. Examples of home modifications and installations that are *not* considered medically necessary include wheelchair ramps, wheelchair accessible showers, elevators, and lowered bath or kitchen counters and sinks.

Attendant controls: An attendant control is considered not medically necessary. An attendant control is one which allows the caregiver to drive the wheelchair instead of the member. The attendant control is usually mounted on one of the rear canes of the wheelchair.

Miscellaneous non-covered wheelchair accessories: Generally a wheelchair accessory/attachment is not considered medically necessary when needed to adapt to the outside environment, for convenience, for work, or to perform leisure or recreational activities. Examples of wheelchair accessories/attachments that are *not* considered medically necessary include the following:

1. Wheelchair rack for automobile (auto carrier) - car attachment to carry wheelchair
2. Wheelchair baskets, bags, or pouches - used to hold personal belongings
3. Crutch and cane holder
4. Gloves
5. Wheelchair ramp - provides access to stairways or vans
6. Snow tires for wheelchair
7. Flat-free inserts (zero pressure tubes)
8. Shock absorbers
9. Tie-down restraints
10. Wheelchair lifts (e.g., Wheel-O-Vator, trunk loader) - devices to assist in lifting wheelchair up stairways, into car trunks, or in vans (see CPB 459 - Seat Lifts and Patient Lifts)
11. Powered seat elevator attachments for electric, powered, or motorized wheelchairs.
12. Canopies
13. Clothing guards to protect clothing from dirt, mud, or water thrown up by the wheels (similar to mud flaps for cars);
14. Identification devices (such as labels, license plates, name plates);
15. Lighting systems;
16. Speed conversion kits;
17. Warning devices, such as horns and backup signals.

Note: This list is not all inclusive.

The above policy is based on the following references:

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Community Health Center Network
Setting the standard for Community Health Care

CHCN Physical Therapy Guidelines

Adapted from Partnership Health Plan of California (PHC) Guidelines
And Milliman Care Guidelines

Procedure: A CHCN-contracted Primary Care Provider or Specialty Provider refers patient to the ancillary provider for an evaluation. The ancillary provider completes the initial assessment, develops a treatment plan and submits an authorization request to CHCN. The authorization request must indicate the services requested, an explanation of medical need and a copy of the treatment plan. The treatment plan must include the following information:

- Medical diagnosis necessitating the service with a summary of medical condition and date of recent injury and/or related surgery
- Related medical/surgical conditions
- Functional limitations
- Dates and length of treatment, therapeutic goals of treatment
- Specific services to be rendered (e.g. evaluation, treatment, modalities)
- Plan for teaching a home exercise program

The CHCN Utilization Management staff reviews each authorization request for **medical necessity** and consults with the referring physician or ancillary provider as indicated.

> **Definition of Medical Necessity** – *Medically necessary means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.*

Once therapeutic benefit has been achieved, or a home exercise program could be used for further gains, continuing supervised physical therapy is not considered medically necessary. Physical therapy in asymptomatic persons or in persons without an identifiable clinical condition is considered not medically necessary.
Provided that medical necessity has been demonstrated, CHCN generally authorizes initial services for a limited number of physical/occupational therapy visits with a maximum of 8 visits based on the diagnosis.

Initial Authorization Guidelines (after PT evaluation)		
Acute Conditions*	**Number of visits on initial Auth Request**	
Ankle Sprain	Grade I/II - 2 visits	Grade III – 7 visits
Elbow Pain/Epicondylitis	7 visits	
Plantar Fasciitis	4 visit	
Hip Pain/Soft Tissue Injury	Pt <age 60 - 2 visits	Pt >age 60 – 6 visits
Hip Osteoarthritis	Pt <age 60 - 3 visits	Pt >age 60 – 6 visits
Patellofemoral Syndrome	Initial - 6 visits	Recurrent – 2 visits
Partial Tear Cruciate/Collateral Ligament	6 visits	
Knee Osteoarthritis	8 visits	
Shoulder -Acute	Impingement/Tendonitis - 6 visits	Rotator Cuff Tears - 8 visits
Low Back Pain/Sciatica	6 visits	
Neck Pain/Arthritis/Disc Disease	6 visits	
Fibromyalgia	8 visits	
Wrist – Carpal Tunnel	6 visits (First refer to Workers Comp, as indicated)	
S/P Surgical Repair/Joint Replacement	13 visits	

*For conditions not listed above, the maximum number of initial visits is 8.

Additional Visits for Acute Conditions: Requests for further visits must include evidence of communication with the treating physician (i.e. MD order for more PT based on re-evaluation OR signed agreement with the PT treatment plan). The request must also include *current* clinical documentation demonstrating the **medical necessity of continued treatment**, including a member's ability to achieve rehabilitation goals and ability to perform a home exercise program: these are reviewed by the CHCN UM staff to determine approval of additional visits.

Chronic Conditions: For chronic conditions previously treated with PT/OT which require further treatment, CHCN generally authorizes up to 4 visits per year, with extensions based on documentation.

Utilization Review Process

Policy:
Utilization review is conducted to establish that appropriate level of care and appropriate providers of care are being utilized to provide medically necessary services. Utilization review is conducted as prospective review, concurrent review, or retrospective review as appropriate. The UM Supervisor, a licensed professional, or other appropriately licensed designees, conducts the reviews. Complex cases or cases not meeting criteria are forwarded to the Medical Director. The utilization review process does not interfere with or cause delays in service or preclude authorized services.

Scope:
Utilization review is conducted on all pre-service requests provided by non-contracted provider, services provided by contracted provider outside of the office, or retrospectively on medical records. Utilization review is also conducted on a more broad scale approach for data analysis as it relates to potential quality issues.

Procedure
Guideline criteria:
Milliman and Robertson Healthcare Management Guidelines are used to determine medical necessity and length of stay (LOS). The UMC reviews guidelines for the appropriateness of application within the medical community's definition of "appropriate standard of care". Revisions to the guidelines are made when necessary and review of the guidelines occurs on an annual basis. Guidelines are made available to CHCN providers upon request. To ensure that criteria are being applied consistently, CHCN conducts annual review of criteria application for both UM staff and for physician reviewer(s). Any necessary follow-up, based on the outcome of this review, is conducted by the UMC.

Medical expertise is utilized in the UM process. Board certified specialists are available and may be consulted for complicated reviews involving a particular specialty. The Medical Director will be responsible for coordinating telephone contacts between requesting provider and physician reviewer to discuss any determinations based on medical necessity. An initial telephone request for case discussion will be followed by a letter within 24 hours if there is no response to the initial telephone request.

Denials:
Only the Medical Director or designee is able to issue a denial during any of the review processes. When appropriate, the Medical Director shall consult with a board certified physician from an appropriate specialty to make the denial decision. Only California licensed physicians who are competent to evaluate specific clinical issues may deny or modify requests for services based on medical necessity. When a denial is made the requesting provider, rendering provider (if different) and member are notified in writing within 24 hours. The denial includes the reason for the denial, specific criteria used in the review process, any suggested alternative service when applicable, appeals rights with instructions for submitting an appeal and contact information for the Department of Managed Care. Provider notification will include the name and phone number of the physician reviewer.

Any denial decisions related to emergency services must take into consideration presenting symptoms and not be based solely on discharge diagnosis.

Some procedures of denials of service will be handled per specific Health Plan requirements. These special requirements include:

- CHCN will forward a copy of all letters denying or modifying requested services with the authorization request to the Health Plan at the time of notification to the member.
- CHCN will contact the Health Plan prior to issuing denial for transplants, investigational therapies (experimental procedures), new technologies or new use for existing technologies, or oncology services. (Note: AAH handles transplants & new technologies)
- Any appeals made by either a provider or a Blue Cross member that are received by CHCN will be faxed directly to Blue Cross of California Grievance and Appeal Department within 24 hours from date of receipt at CHCN. Expedited appeals will be faxed to Blue Cross immediately upon receipt.

ALL members may request an independent, external review for any referral that is denied, modified, or delayed because of a lack of medical necessity.

PROSPECTIVE REVIEW
The primary purpose of prospective review is to ensure that requested services are covered health plan benefits, medically necessary, and provided at the most appropriate level of care. Prospective reviews are conducted on requests for in-patient services and outpatient services including diagnostic procedures, outpatient surgeries and referrals to all non-contracted providers.

Referral to non-contracted providers:
In the event that a contracted specialty provider is unavailable to provide care, or a patient is established with a specialty provider for treatment of a chronic illness, CHCN providers may refer patients to non-contracted specialists. All referrals to non-contracted specialists must be submitted to CHCN. In these instances, CHCN will work with the specialist to establish a Memorandum of Understanding (MOU) for the patient's care.

As required by law, any CHCN member may request a second opinion from a specialist or PCP. Any member requesting a second opinion should make such request through their primary care provider.

Reasons for a second medical must include one of the following:

- The member questions the reasonableness of necessity of recommended surgical procedures.

- The member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily functions or substantial impairment.

- Clinical indications are not clear or are complex, a diagnosis is in doubt due to conflicting tests, the treating provider is unable to diagnose the condition, or the member requests an additional diagnosis.

- 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.

- 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.

If the original opinion is from a PCP, the second medical opinion may be obtained within CHCN's network. The primary provider will complete a new referral to another network provider within the requested specialty. As with any referral, if a specialist is not available within the CHCN network, a non-network provider will be authorized to provide services. The second opinion must be rendered by a PCP or specialist acting within the scope of practice and who possesses clinical background including training and expertise related to the particular illness or condition. The referral takes into account the member's ability to travel to the provider rendering the second medical opinion. The provider rendering the second opinion must provide the member and requesting provider with a consultation report including any recommended procedures or tests. The primary provider should indicate on the referral form that this is a request for a second opinion to avoid confusion at the MSO level. No authorization of service is required by CHCN. ***Please see "Second Opinion" policy and procedure.***

Standing Referrals

A "standing referral" means a referral by a primary care provider to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care provider having to provide a specific referral for each visit. *PLEASE SEE Standing Referral P & P for details.*

Continuing Coverage of Services by a Terminated Provider

"Acute condition" means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

"Serious chronic condition" means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that does either of the following:

- Persists without full cure or worsens over and extended period of time.
- Requires ongoing treatment to maintain remission or prevent deterioration.

At the request of the member, CHCN will arrange for continuation of covered services rendered by a terminated provider to a member who is undergoing a course of treatment from a terminated provider for an acute condition or serious chronic condition, a high-risk pregnancy, or a pregnancy that has reached the second or third trimester.

CHCN shall not provide for continuity of care by a provider whose contract with the plan or group has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason.

In cases involving an acute condition or a serious chronic condition, CHCN shall furnish the member with health care services on a timely and appropriate basis from the terminated provider

for up to 90 days or a longer period if necessary for a safe transfer to another provider as determined by CHCN in consultation with the terminated provider, consistent with good professional practice. In the case of a pregnancy, CHCN shall furnish the member with health care services from the terminated provider until postpartum services related to the delivery are completed or for a longer period if necessary for a safe transfer to another provider as determined by CHCN in consultation with the terminated provider, consistent with good professional practice.

CHCN may require the terminated provider whose services are continued beyond the contract termination date to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, there shall be no obligation on the part of CHCN to continue the provider's services beyond the contract termination date. If the provider voluntarily leaves CHCN, there shall be no obligation on the part of the provider or CHCN to continue the provider's services beyond the contract termination date.

OB-GYN SERVICES
All members have the option to obtain OB/GYN physician services directly from a participating OB/GYN without having to obtain prior approval from another physician.

CONCURRENT REVIEW
The purpose of concurrent review is to determine that the severity of illness matches the intensity of services at the appropriate levels of care. Concurrent review is conducted for all acute hospital and skilled nursing facility patients.

Review activities that take place during a patient's hospital stay include:

1. Review of evidence that discharge planning began at admission for an emergency admission or prior to admission for a non-emergency admission.
2. Review of evidence that care is being delivered at the appropriate resource level.
3. Review of continued need for inpatient hospitalization with adjustment of discharge date if appropriate, based on complications and/or revised diagnosis.
4. Review of cost and/or stay data to determine stop-loss attachment level status.
5. Issue a lower level of care letter if medical necessity for an inpatient stay is not supported in the patient's medical record and attending physician is in agreement.
6. Identification/coordination of continued case management needs beyond the hospitalization. (see Case Management P&P for further details)

In instances that the UM reviewer feels that rendered services n o longer meet criteria for continued services, the case will immediately be forwarded to the Medical Director or designee for review. The Medical Director or designee will contact the treating provider by telephone to discuss the criteria and services provided. Decision to deny or continue authorization of services shall be made by Medical Director or designee within 24 hours of receiving the case. Notification or the decision will be issued to the treating provider via telephone, fax, or email within 24 hours of making decision. Denials and authorization notifications will follow established policy regarding content and timeliness. *See TAT section below.*

In cases of denial of continued services, care cannot be discontinued until the member's treating provider has been notified of decision and a care plan has been agreed to by the treating provider.

RETROSPECTIVE REVIEW

Retrospective review is conducted on two levels. All requests for authorization or payment of services to a provider, without prior necessary authorization, are reviewed for appropriateness of services. These reviews could include inpatient stays, outpatient services, and emergency services.

Retrospective review is also conducted as a method of evaluating utilization data for the purposes of problem solving, education and quality improvement. Specific or focused review would include (but not limited to) the following:

1. Review of reasons for discharges that were beyond authorized stay.
2. Review of cases involving transfer of patient to and from other institutions.
3. Review of all cases involving re-admission within thirty (30) calendar days.
4. Review of patterns of ambulatory care utilization to assure appropriateness of services and identify potential utilization problems.
5. Review of documentation for follow-up problem areas to determine that corrective actions have been taken and have been effective.
6. Review of appropriateness in utilization of emergency room service (note: all ER visits are approved but retrospectively reported to CHCN physicians for follow up & appropriateness).
7. Review of all cost outlier and reinsurance cases.

Turn Around Time (TAT):

The TAT for routine requests is 5 days from the receipt of the information. The TAT for emergent requests occurs immediately, and urgent within 24 hours. For pre-service authorizations that are urgent, CHCN makes the decision within 1 calendar day. If the pre-service is a denial, CHCN will also notify the member within 1 calendar day. Concurrent review decisions are sent within 1 working day of original notification to provider and include expedited appeals rights. If the concurrent review decision results in a denial, CHCN gives members and practitioners written or electronic confirmation within 1 working day of the original notification. Ongoing ambulatory care decisions that are routine, will be made within 10 working days of obtaining all the necessary information. Retrospective review decisions are made within 30 days of receiving request for review. An attempt is made to gather all pertinent information prior to making the decision. Providers receive faxed confirmation of the authorization within 24 hours of the decision being made. Urgent requests will include expedited appeals rights. Written notice is sent to members within 2 business days of the decision. Correspondence regarding service approvals identifies the specific healthcare services authorized. Quarterly studies are conducted to assure that the TAT standards are being met. Appropriate corrective actions are initiated as necessary.

Independent Medical Review

Members may request an independent, external review for any referral that is denied, modified or delayed because of lack of medical necessity. Information on eligibility and how to obtain an independent medical review is in the body of the denial/modification letter. Members are also

educated about the independent medical review in the New Member Handbook. See Denial Letter section of the UM P & P.

Pended Requests:
Any service request lacking information necessary to make an informed decision regarding the request will be pended. The decision to pend a request is made immediately upon expiration of the pertinent time frame standard or as soon as CHCN becomes aware that the decision will not meet the timeframe (see TAT section for timeframes). Requesting provider will be notified by telephone and in writing within 24 hours of the decision to pend request and to request additional information. Both member and requesting provider will be sent written notification within 2 business days of the decision to pend. This notification includes the following:

- Reasons for the delay in decision
- Request for information needed to make decision
- Anticipated ate on which decision may be rendered.
- Physician reviewer's name and direct phone number.
- Grievance and appeals rights.

If CHCN is not able to obtain the information pertinent to the diagnosis or procedure under review within 30 calendar days of the request, CHCN may deny precertification request for non-urgent care and retrospective reviews on the basis of lack of information.

Determination on pended urgent requests will be made within 24 hours using all available information. Determination on pended routine requests will be made within seven business days. Notification to providers of authorization or denial will follow the appropriate policies already established.

Tracking Authorizations and Referrals
CHCN uses proprietary software that allows authorizations and referrals to be tracked based on status, particular conditions, create date, receipt date, decision date and numerous other fields. Custom reports are written to track particular measurements including denial rates, turn-around time and pended requests.

ER Access & Utilization Policy

POLICY:
The Community Health Centers are best suited to the provision of primary medical care for non-urgent, non-emergent conditions. Emergency services provided to screen and stabilize members will be covered without pre-authorization in cases where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed. CHCN will honor any emergency services referred to by providers or authorized provider staff. The Community Health Center Network promotes the reduction of emergency room services for the treatment of non-emergent conditions by its members.

PURPOSE:
To reduce the utilization of non-emergent services provided in the emergency room setting, particularly during clinic's business hours.

PROCEDURE:

An identified contact at each clinic is responsible for the receipt and routing of the ER reports.

Each ER report is forwarded to a provider for a decision on follow-up for medical reasons. The provider conducting the review, with follow-up instructions for staff, signs each ER report. ER report review is completed within one week of receipt of report.

Simultaneously, the ER contact at the clinic determines whether or not the patient is known to the clinic.

> For those patients who have not been seen before at the clinic, an attempt to schedule a new patient visit is made and a welcome packet, including instructions for after hours care, sent to the patient if this has not already been done. Unsuccessful attempts to schedule a new patient visit are documented and filed with the ER report. CHCN is notified when clinics are unable to reach new patients.
>
> ER reports are filed in the patient's medical record after review, if patient has previously been seen at clinic. For patients who have no medical record at clinic, the ER reports will be kept in a separate file,

CHCN produces monthly ER reports for the health centers which identifies patients who have been seen in the ER two or more times in a six month period, without corresponding visits to their PCP. These members are potential case management candidates. Case management services are optional, left to the clinics' discretion.

CHCN produces monthly ER utilization reports for the Medical Directors to track and trend ER utilization.

CASE MANAGEMENT POLICY AND PROCEDURE

The Community Health Center Network (CHCN) will coordinate with case managers at its member clinics to provide case management services to members who require it due to complex medical needs or high volume utilization patterns.

PURPOSE:

To ensure that members receive appropriate coordinated services to optimize their medical care. Case management services at CHCN may include: identification of patients potentially warranting case management, support of increased communication between primary care provider and specialist, maintenance of a forum for providers to present particularly complicated or challenging patients to their peers, and identification of resources available to patients specific to their medical needs and included within their insurance benefit coverage.

PROCEDURE:
Patient Identification

CHCN identifies patients who could potentially benefit from case management when meeting the following conditions:

1. Two or more visits to emergency department within one month
2. Three or more referrals to specialists of different specialty type
3. Multiple hospitalizations within the last year
4. Lengthy hospitalization (> three days)
5. Request by clinic for assistance in managing

In order to facilitate case management with contracted health plans, CHCN Utilization Department notifies the health plan of:

1. Members that are hospitalized for longer than 3 days
2. Out of area admissions within 24 hours of notification of admission (if CHCN was notified of admission).

The Utilization Director of CHCN will conduct further research on each individual patient once identification has been made. Based on outcome of this research the determination will be made whether or not a case should be opened for a particular patient. All opened cases will document start date, all activities regarding the case, final outcome, and a close date.

CHCN will notify health plans of patients open to case management according to contractual agreements.

Transplants
CHCN is delegated to handle both kidney and corneal transplants. For all other transplants, the case manager will:

- All transplants cases will be called to the health plan's utilization management department.
- Those transplants not handled by CHCN, will be transferred to the health plan for follow up through their Transplant case manager.
- It is the responsibility of the health plan to initiate the dis-enrollment process when appropriate.

Increased Communication

CHCN increases communication between primary and specialty care using the following methods:

1. CHCN requires all specialists to submit updated treatment plans with any claim. Treatment plans are faxed to the primary care provider for their review and addition to the patient's medical records at the clinic.
2. When specialty providers request authorization for services beyond the original referral, the PCP is consulted for concurrence with the specialist's request.
3. Clinic case managers are contacted during the discharge planning stage when a patient is hospitalized and will require follow-up care after discharge.
4. The Medical Directors of each clinic receive copies of all emergency department reports for appropriate follow-up with their patient.

Case Presentation

Providers are invited to present a CHCN patient with complex medical or management issues at the monthly Utilization Management Committee meeting. Providers present a verbal, patient de-identified synopsis of the particular case to their peers for review and recommendations. The Utilization Management Director may request that a provider present a particular patient to the Committee based on utilization patterns.

Resource Identification

The Utilization staff at CHCN familiarizes itself with benefit coverage of the insurance lines that it administers. In addition, community resources outside of the benefit package are identified (i.e., CCS, County Mental Health, etc.). CHCN shares this information with clinic case managers and primary care providers to better coordinate the patient's overall medical care.

Transition of Care
Policy and Procedure

PURPOSE

To ensure continued care when Community Health Center Network (CHCN) members benefits have been or are about to become exhausted (e.g., acute, skilled, rehab facilities).

SCOPE

All CHCN active and eligible members.

POLICY

To ensure that a member is given the appropriate resources so that care can continue once their benefit has been exhausted or close to completion (as defined by the members plan).

PROCEDURE

1. Community Health Center Network receives an authorization request for continued care for a member

2. The referral request is entered into the system and referred to the appropriate staff (i.e. UR Coordinator or Medical Director).

3. The request is reviewed and determined that the member has reached their benefit maximum, as defined by the members plan.

4. Once it has been determined that the member has reached their benefit maximum (i.e. Physical Therapy, Mental Health), Community Health Center Network will assist the member with the transition to other care, if necessary. Transition of care may include:

    a. Authorization with a final number of visits to transition the member to alternate care that is appropriate (i.e. home physical therapy program).

    Or

    b. The member will be educated about other alternatives for continuing care as appropriate and Community Health Center Network informs the member of the ways to obtain continued care through other sources such as community, local and state funded agencies/resources.

    Or

    c. The CHCN UM staff will notify the health plan (e.g., members SNF days are coming close to completion) for determination. Determinations made by the Health Plans are communicated back to the UM department for follow up.

5. The member will be informed of the transition of care in a written letter from Community Health Center Network's Medical Director, UM Coordinator and/or case manager.

Continuity & Coordination of Medical Care

POLICY:

It is the policy of the Community Health Center Network to monitor the continuity and coordination of care that members receive and takes actions, as necessary, to ensure and improve continuity and coordination of care across the Network.

PURPOSE:

To use information at CHCN's disposal to coordinate transitions in medical care across the delivery system and assure continuity of care upon termination of practitioner contracts.

PROCEDURE:

1. **UM Surveillance**

   The CHCN UM department collects data to improve continuity and coordination of care by tracking authorizations for inpatient, SNFs and specialty care. The CHCN case manager coordinates care for high risk inpatients by notifying clinics that the patient will be discharged soon and will need immediate follow up. The UM manager sends weekly hospitalized patient reports to the primary care providers to assist PCPs with coordinating the patients care. CHCN also promotes the case management programs offered by the health plans and the individual clinics for patients with high risk conditions such as diabetes and asthma.

2. **UM Committee**

   The CHCN UM Committee comprised of Medical Directors from all 7 clinics in the Network, reviews on a monthly basis UM reports to assure continuity of care for CHCN members. The following steps may occur when reviewing UM reports:

   - Decisions are made as to which opportunities will be pursued.
   - Interventions are implemented to improve continuity of care for the members
   - Effectiveness of interventions is measured through continual review of data.

   For example, reports reviewed include ER utilization with efforts made to target patients that are high utilizers without regular primary care visits. Interventions would include case management for these patients. Other UM reports that are reviewed include inpatient admissions and referral patterns. Medical Directors are expected to provide this information to their individual clinics' practitioner meetings and to discuss possible intervention strategies.

3. **Provider Relations – Termination of Contracts**

   CHCN's provider relations staff notifies the network members via email notification and Provider Bulletins when a specialist and/or primary care provider leaves the network. The health plan is also immediately notified when a provider has terminated their services with the network. Updates on specialty panel additions and terminations are given to the UM Committee and Governing Board. CHCN also keeps an up-to-date specialty directory on the CHCN website. When a specialist leaves the network, the provider is deleted from the directory on the website. Since CHCN has an open authorization policy to many specialists, it is impossible for CHCN to notify the member that the specialist has left, however, it is expected that the primary care provider, directs the member to another in plan specialist.

Contents of Medical Records: Documentation Requirements for Provider Credentialing/Recredentialing

Policy:
Managed care contracts require a credentialing process for all providers seeing managed care members. The credentialing (or recredentialing) process includes a review of the providers medical records by a health plan representative. The components listed below are reviewed and should serve as documentation guidelines for all patients receiving care at **<CLINIC's NAME>**.

Documentation Guidelines:

1. **Allergies:** relevant allergies, adverse reactions and medical conditions documented.

2. **Problem list:** presenting problems and relevant psychological and social conditions affecting medical and psychiatric status documented.

3. **History:** medical and psychiatric history documented.

4. **Diagnoses consistent with findings:** diagnosis documented consistent with the presenting problems, history, mental status exam, and/or other assessment data.

5. **Treatment plans/Appropriate treatment:** treatment plans consistent with diagnoses and have objective measurable goals and estimated time frames for goal attainment.

6. **Medication(s) noted:** medications prescribed with dosages and dates of initial prescription or refills documented.

Items 1 – 6 listed above are National Committee for Quality Assurance (NCQA) Medical Record standards.

7. **Member identification:** noted on each page of the medical record.

8. **Biographical & Emergency information:** is documented in the chart along with an emergency 'contact'.

9. **Contents fastened:** charts should be securely fastened

10. **PCP Assigned:** patient's PCP should be identified in the medical record.

11. **Language needs:** primary language & linguistic service needs of non-or limited-English proficient or hearing impaired persons are prominently noted. In addition, refusal of translation services should be noted.

12. **Informed consent:** signed informed consents are present when appropriate.

13. **Advance Health Care Directive:** information is offered to adults, 18 years of age and older and emancipated minors. Note: clinics are not required to provide the advanced health care directive forms or assist the patient with filling them out. This requirement is only to inform the patient that they exist.

14. **Error Correction:** all errors are corrected according to legal medical documentation standards using a single line through the error, with 'error' written above or near the lined-through incorrect entry along with date, initials (or signature) and title of the author correcting the error.

15. **Follow up care:** instruction for follow up care (return to clinic) is documented.

16. **Unresolved problems:** are addressed in subsequent visit(s).

17. **Consultation/labs/diagnostic reports:** are reviewed by the provider and initialed

18. **Missed Appointments:** follow-up contacts/outreach efforts are noted

PEDIATRIC CHARTS *(items 19 through 28 pediatric patients only*)

19. **Initial Health Assessment**: must be completed on all new members within 120 days of the effective date of enrollment into the plan or documented within the past 12 months prior to member's enrollment.

20. **Individual Health Education Behavioral Assessment (Staying Healthy Tool or other DHS approved tool):** New members – age appropriate IHEBA is conducted within 120 days of effective enrollment date as part of the initial health assessment. Existing members – age appropriate IHEBA is conducted at member's next non acute care visit, but no later than the next scheduled health screening exam. Age intervals are 0-3 years, 4-8 years, 9-11 years, 12-17 years and 18 years and older.

21. **Age appropriate physical exams according to AAP schedule** – must include anthropometric measurements of weight/length/height and head circumference of infants up to age 24 months, PE/body inspection including screen for sexually transmitted infections on sexually active adolescents, and urine test at each health assessment visit starting at age 4-5 years

22. **Vision screening:** age appropriate visual screening occurs at each health assessment visit with referral to optometrist/ophthalmologist as appropriate.

23. **Hearing screening:** non audiometric screening for infants/children (2 months to 3 years), audiometric screening for children and young adults (3-21 years) is done at each health assessment visit. Failed audiometric screenings are followed up at repeated screening.

24. **Nutrition assessment:** screening includes anthropometric measurements, lab tests for anemia, breast feeding/infant feeding status, food/nutrient intake and eating habits. Referrals to be made to WIC for nutritionally at risk children less than 5 years of age.

25. **Dental assessment:** inspection of the mouth, teeth, gums at every visit. Beginning at age 3, all children are referred annually to a dentist.

26. **Lead Screening:** to be done at 12 months and 24 months of age, results indicating an elevated BLL of 10 micrograms of lead per deciliter of blood (or greater) requires additional follow up.

27. **TB screening:** all children are screened for risk of exposure to TB at each health assessment visit. Mantoux skin test is administered during health assessment visits at ages 4-5 years and ages 11-16 years.

28 **Childhood Immunizations**: assessed at each health assessment visit. VIS must be given and the publication date of the VIS is documented.

ADULT CHARTS (*items 29 through 38 adult patients only*)

29. **Initial Health Assessment:** must be completed on all new members within 120 days of the effective date of enrollment into the plan or documented within the past 12 months prior to member's enrollment.

30. **Individual Health Education Behavioral Assessment (Staying Healthy):** Staying Healthy assessment tool or other DHS-approved assessment tool is completed initially on all adults within 120 days of enrollment into the health plan or as part of the initial health assessment. For adults age 18 and older, the Staying Healthy tool is re-administered every 3-5 years.

31. **Periodic Health Evaluation:** periodic health evaluations in accordance with the frequency that is appropriate for individual risk factors.

32. **Tuberculosis screening:** adults should be screened upon enrollment. The Mantoux skin test is administered to all asymptomatic persons at increased risk of developing TB irrespective of age or periodicity if they have not had a test in the previous year.

33. **Blood Pressure:** BP measurements done annually.

34. **Cholesterol:** men aged 35 and older and women aged 45 years and older are screened for lipid disorders, which includes measurement of total cholesterol and high density lipoprotein cholesterol.

35. **Chlamydia Screening:** sexually active women are screened from the time they become sexually active until they are 25 years of age. Women aged 25 and older to be screened based on clinician's judgment.

36. **Mammogram:** routine screening for breast cancer every 1 – 2 years on all women starting at age 40 concluding at age 75.

37. **Pap Smear:** routine screening for cervical cancer with the Pap test is done on all women who are or have been sexually active and who have a cervix. Pap smears should begin with the onset of sexual activity and repeated at least every 1 – 3 years depending on individual risk factors.

38. **Adult Immunizations:** immunization status and immunizations administered, date Vaccine Information Sheet was given, and publication date of the VIS are documented in the medical record**.**

PRENATAL CHARTS (*items 39 through 48 prenatal patients only*)

39. **Initial Comprehensive Prenatal Assessment:** the ICA is completed within 4 weeks of entry to prenatal care & includes OB/medical history, PE, lab tests, nutrition, psychosocial & health education.

40. **Subsequent Comprehensive Prenatal Trimester re-assessments:** are to be completed during the 2nd and 3rd trimester.

41. **Prenatal care visits according to most recent ACOG standards:** for uncomplicated pregnancies, first visit by 6-8th week, approximately every 4 weeks for the first 28 weeks of pregnancy, every 2-3 weeks until 36 weeks gestation, weekly thereafter until delivery, postpartum visits within 4-8 weeks after delivery.

42. **Individualized Care Plan:** documents specific OB, nutrition, psychosocial and health education risk problems/conditions, interventions and referrals.

43 **Referral to WIC and Assessment of Infant Feeding status:** all potential eligible members must be referred to WIC and the referral is to be documented in the medical record. Infant feeding plans are to be documented during the prenatal period.

44. **HIV-related services offered:** prenatal HIV information, counseling & antibody testing must be offered. Patient participation is voluntary.

45. **AFP/Genetic Screening offered:** blood screening tests prior to 20 weeks gestation must be offered. Patient participation is voluntary.

46. **Domestic Violence/Abuse screening:** assessment of domestic violence is to be documented in the medical record.

47. **Family planning evaluation:** counseling, referral or provision of services is documented.

48. **Postpartum assessments:** comprehensive postpartum reassessment includes the 4 components of medical exam, nutrition (infant & mom), psychosocial and health education to be completed within 4 to 8 weeks postpartum.

Items 7 through 48 listed above are from the Department of Health Services (DHS) Medi-Cal Managed Care Division, "Medical Record Review Survey" used by the health plans when conducting credentialing and recredentialing audits for participating plan providers**.**

Maternity Benefits and Hospital Stays

Policy:
Ensure CHCN members receive full maternity benefits as prescribed by benefit package scope and state regulations.

Scope:
All CHCN members receiving perinatal care.

Procedure:

Perinatal Ambulatory Care

The Comprehensive Perinatal Services Program (CPSP) is a voluntary participation program for MediCal recipients, designed to provide comprehensive perinatal services during pregnancy and 60 days following delivery, by or under the personal supervision of a physician certified by DHS to provide CPSP services. CPSP services are extended to all pregnant CHCN members, regardless of insurance package. CHCN clinics are certified to provide a wide range of CPSP services and make them available to all prenatal patients as soon after pregnancy is determined as possible.

CPSP Services available to prenatal clinic patients include:

Case Coordination	Health Education Services
Obstetrical Services	Psychosocial Services
Nutrition Services	Genetic Screening
Perinatal care education.	

→ See CHCN Policy and Procedure on the CPSP program.

In addition all referrals mandated by CPSP (i.e. WIC, Dental Care, Genetic Screening) are made.

Hospital Delivery Benefits

The length of a post-delivery hospital stay should be based on the unique characteristics of each mother and her newborn child, taking into consideration the health of the mother, the health and stability of the newborn, the adequacy of support systems at home, and the access of the mother and her newborn to appropriate follow-up health care. Inpatient hospital care following delivery shall be no less that 48 hours following a normal vaginal delivery and 96 hours following a delivery by caesarean section, unless specific conditions are met. Authorizations for the inpatient hospital stay related to delivery are not required.

Scope: All managed care patients receiving inpatient hospital delivery care.

Procedure:

All contracted CHCN prenatal providers shall include the information on post-delivery hospital benefits within their prenatal registration or orientation process.

Services for home health visits after delivery are coordinated with the CHCN UM staff.

Exceptions: Coverage for inpatient hospital care may be for a time period less than 48 or 96 hours if both of the following conditions are met:

a.) The decision to discharge the mother and newborn before the 48- or 96-hour time period is made by the treating physicians in consultation with the mother.

b.) A post-discharge follow-up visit for the mother and newborn within 48 hours of discharge, when prescribed by the treating physician can be arranged. The visit shall be provided by a

licensed health care provider whose scope of practice includes postpartum care and newborn care. The visit shall include, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The treating physician shall disclose to the mother the availability of a post-discharge visit, including an in-home visit, physician office visit, or facility visit. The treating physician, in consultation with the mother, shall determine whether the post-discharge visit shall occur at home, the facility, or the treating physician's office after assessment of certain factors. These factors shall include, but not be limit to the transportation needs of the family, and environmental and social risks.

Physical Therapy

Policy: To ensure that eligible CHCN members receive physical therapy care for the examination and treatment of musculoskeletal and neuromuscular problems that affects the members' abilities to move and function.

Scope: All CHCN members with conditions requiring physical therapy treatment including but not limited to:

- Pain (back, neck, shoulder, arm, wrist, hand)
- Knee, ankle or foot problems
- Carpal tunnel
- Sprains (muscle)
- Arthritis
- Rehabilitation (cardiac, stroke, following serious injury)
- Chronic Respiratory Problems
- Hip fractures
- Balance problems

Procedure:

1. Requesting providers submit a referral to CHCN for a physical therapy evaluation.

2. Member receives an **initial evaluation** from physical therapy.

3. Following the initial evaluation, physical therapy or the requesting provider's office submits an **authorization** and **treatment plan** for further visits.

4. UM Nurse reviews the authorization according to Milliman Care Guidelines for visits and treatment plan. Any requests falling outside of the Milliman criteria for PT visits and type of treatment modalities are modified by the UM Nurse to be in compliance with Milliman criteria and returned to the sender with the modifications noted. If the requesting provider counters that the member must have visits and modalities beyond the modification, these authorizations will be brought to the CHCN Medical Director for review.

5. Authorization is approved or denied (see P & P on authorizations for further information on approvals & denials) and sent back to the requesting provider.

6. For additional visits **beyond the initial authorized visits**, the CHCN Medical Director must review and approve based on medical necessity.

UM Program Information Disclosure

Policy:

CHCN discloses, upon request, information on the UM program including criteria used to authorize, modify, or deny health care services and specific policies and procedures.

Scope:

All CHCN members and practitioners may request information on the UM (and QI) program.

Procedure:

Information on the UM and QI Programs are listed on the CHCN website at www.chcnetwork.org

Members and practitioners may call and request UM criteria/policies and procedures.

Callers must specify which policy and procedure they are requesting and/or which UM guideline they would like to receive.

Ten cents per page is to be charged to cover copying and postage costs.

Information is to be mailed out within 2 weeks from the date of the request.

Copy of the letter is to be kept electronically in the UM section of the R drive.

SAMPLE LETTER
For
People Requesting Info on UM Program

DATE

ADDRESS

Dear :

Thank you for requesting: _____*(Specify)*_____

The materials provided to you are guidelines used by the Community Health Center Network (CHCN) to authorize, modify or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.

Sincerely,

Director, QI/UM

Inter-Rater Reliability: UM Staff and Physician Reviewers

POLICY:
Community Health Center Network monitors the referral/authorization process for consistency and compliance with its standards as outlined in the policy and procedure for the referral/authorization process for both UM staff and physician reviewers.

SCOPE:
Annually, referral and authorization requests will be reviewed for each non-physician and physician reviewer based on the procedure below. Reviews of authorizations and denials only, involving physician decision-making will be conducted on all physician reviewers, based on the procedure outlined below.

PROCEDURE for NONPHYSICIAN REVIEWERS:
On an annual basis, the processing of authorizations and referrals is monitored for compliance with the CHCN's established standards. Authorizations and referrals processed will be randomly selected to check for consistency of standards, application of medical management criteria, turn around times, and appropriate physician involvement in denials for medical necessity.

A total of 30 requests will be reviewed; 10 referrals, 10 approved authorization requests, and 10 denied authorization requests.

All documents will be checked for completion of form including member name, date of birth, health plan identification number, referring provider, requested service, diagnosis, prior treatment (where applicable), eligibility confirmation, and benefit confirmation.

Authorization requests only will be checked for appropriate application of review criteria, turn around time, and physician involvement in cases of denials for medical necessity.

Scoring of the reviews will be as follows:

Review component	**Points possible**
Form completion	1
Eligibility confirmation	1
Benefit confirmation	1
Application of review criteria	1
Turn around time	1
Physician involvement in denial	1

A less than 80% score on the first three components will require follow-up and additional training with the CHCN staff.

Scores for the final three components will be reported to the Utilization Management Committee quarterly. Scores of less the 80% in any component will require corrective action to be determined by the Committee.

PROCEDURE for PHYSICIAN REVIEWERS:

The CHCN medical director reviews claims for urgent care that are provided during business hours. Unless the problem seems truly urgent, the claim is denied, with an explanation that it should have been seen by the PCP unless a referral was made. The provider of the urgent care may elect to contact the PCP for a retrospective referral, and if the PCP provides this, CHCN will pay.

To ensure inter-rater reliability for physician review, the Medical Director will bring to the UM Committee, on an annual basis, a number of actual cases for evaluation of decision-making criteria. UM Committee members will be asked to review the cases for appropriateness of denial or approval for the indicated urgent care visit. Cases for review will have occurred on a Monday through Friday, between 9 a.m. and 5 p.m., not on a holiday. There will be no evidence that the PCP referred the patient for the service.

Cases are to be reviewed and evaluated for whether or not the visit falls within the standard of care for primary care physicians. Additional criteria includes:

- How sick is the patient?
- How acute is the problem?
- Are services such as x-rays required, that would not be available at the clinic?
- What would be the medical consequences of telling the patient they needed to go elsewhere?

Results will be compared across UM physician members at the committee meeting and compared to the Medical Director's decision. Passing score must be 80% of the cases must be rated in the same manner as rated by the Medical Director. Scores of less the 80% in any component will require corrective action to be determined by the Committee and may include, but are not limited to, revisions to the policy, expansion of criteria, or a repeat of the test using additional cases.

Risk Management – Medical Office Policies & Procedures

Policy:

CHCN has adopted medical office & records policies and procedures developed by the Department of Health Services for Facility and Medical Record credentialing of providers. Each member clinic within CHCN must adopt internal policies and procedures that meet those adopted by CHCN with language specific to each clinic.

Scope:

All CHCN member clinics.

Procedure:

The CHCN QIC has adopted the risk management medical office policies and procedures (see attached DHS form: Full Scope Site Review Survey and Medical Record Review Survey) as minimum standards for all clinics within the network. Clinics must adopt internal policies and procedures and be able to pass the facility and medical record credentialing and recredentialing audits.

Clinics are to use the DHS Review Surveys as the policies and procedure template in the following areas:

- Medical Record Standards
- Confidentiality
- Missed Appointments
- After Hours Calls
- Treatment Consent
- Notification of Test Results
- Medical Office Policy and Procedures
- Medical office is clearly identified
- Wheel chair accessible
- Evacuation plans
- Posted Office hours
- Two exam rooms per provider
- Sterilization – including a policy for monthly bacteriological tests, maintenance records, calibration of equipment (see survey for specifics on Cold Disinfectant)
- Infection Control – Complete Exposure Plan
- OSHA/Blood-borne Pathogens
- Fire/Safety/Disaster – fire extinguisher(s) visible & inspected, exits/hallways free of obstruction
- Patient Emergency
- Storage of Medications and Narcotics – controlled substances to be stored in a lock area with restricted access to keys. Sign out log must be maintained for all controlled substances.

- Imaging Equipment
- Reporting Abuse including Employee acknowledgement form
  For Child Abuse, providers must report suspected or known abuse & neglect to Child Protective Agency immediately by telephone. Written documentation to be sent to CPS within 36 hours.
- Medical waste removal
- Laboratories – have certificate of waiver or CLIA certificate

Again, specifics for the above topics may be found within the DHS Survey tool. Monitoring of the above policies is done through the Department of Health Services (for licensing) and through the Health Plans using the DHS Audit tool for credentialing.

Confidentiality of Member Information and Records:

All clinic staff are expected to abide by internal policies on patient confidentiality. As of April 14, 2003, clinic staff will be trained on HIPAA and on the Patients Notice of Privacy Practices. In addition to adherence to individual clinic policies on medical records, CHCN endorses that the following are in place:

- Written authorization must be received from the patient before any medical information is disclosed except those disclosures allowed under HIPAA for treatment, payment and/or operations. Under no circumstances shall medical information be used for any purpose (e.g., sales, marketing, etc.,) not necessary to provide health care services to the patient, unless authorized by the patient. Under no circumstances shall practitioners require patients to sign an authorization or a release as a condition for receiving health care from the clinic.
- Medical record policies must address areas of retention and destruction of members' medical information. At a minimum, clinics should retain a medical record, 7 years after the patient have disenrolled from the clinic. In addition records must be stored in a confidential manner with authorized staff only having access to the medical records. Records send to be destroyed must be de-identified to protect the patient's protected health information. A destruction receipt should be requested (when available) and be kept on file by clinic's administration as proof that the record was completely destroyed.

Distribution of Medical Office Policies & Procedures

This policy and procedure and a copy of the DHS audit survey is provided to the Medical Directors at the QI Committee meeting for distribution at their clinics. Implementation of these policies is often delegated to the clinic manager. The CHCN QI/UM Director also distributes the DHS Survey Tool for Medical Office & Medical Record Survey and discusses the criteria at the monthly Clinic Managers Meeting. See meeting minutes for specifics.

Quality Classification System for the Peer Review Process

I. QUALITY CATEGORIES

A. Service

Staff courtesy, responsiveness, wait time in office, comfort and cosmetic issues.

Example

In general, service problems are rarely considered major. However, egregious rudeness or abuse on the part of the physician or their staff, and failure to respond to repeated (> than 3) requests for laboratory results, are examples of major service problems.

B. Access

Wait time for appointment, availability after hours and in emergencies.

Example

Provider unavailable to respond to emergency calls or when on call, tardy response to major, urgent health problem.

C. Care

Medical diagnosis and treatment, education, prescriptions, hygiene, over and under utilization.

Example

Unnecessary or inappropriate surgery; failure to diagnose typical major illness in a timely fashion; failure to administer standard or equivalent basic therapy for major illness; unexpected major complication to procedure indicative of operator error; failure to administer standard or equivalent basic treatment for common major complications to procedure; prescription of drug with major known allergy or known common contraindication; gross failure to obtain informed consent; gross abandonment.

D. Bedside Manner

Provider courtesy, appropriate consideration of patient's emotional needs.

Example

Yelling, swearing, inappropriate physical contact (violent or sexual), failure to provide information critical for preventing major care problem.

E. Medical Records

Legibility, completeness, falsification.

Example

Falsification or post-dating; legibility/completeness problems resulting in, or contributing to, major care problem.

II. Events in each quality category shall be characterized into three classifications:

1. Within standard of care (0).

2. Minor problem (1). All problems not categorized as major.
3. Major problem (2)

Major Illness: This is defined as an illness with the capacity to cause death, disability, loss of function, or shortened life expectancy without timely and proper diagnosis and treatment. Examples of such major illness would include cancer, CAD, TB, DM, fracture of bone, dislocation of a joint, Guillain-Barre Syndrome. Specifically, major illnesses do not include upper respiratory tract infections, viral gastroenteritis, vaginitis, tendinitis, joint sprains, migraine, etc.

Common Illness: This is defined as illness that all practitioners should be familiar with in their area of specialization and can expect to see in practice at least once every five years, or a serious illness which has a well recognized presentation. Example of an uncommon illness would be Degos' Disease.

III. QUALITY OF EVIDENCE:

To the extent possible, events should be categorized as to the quality of the evidence.
An **A** rating shall be given to events where the quality problem is felt to have been possible, but cannot be conclusively proven.
A **B** rating shall be given to events where the quality problem is felt to be highly probable or proven. Service problems, about which patients are more knowledgeable, require less substantiation to grade as a **B** than care problems, about which providers are more expert.

IV. PROCESS

A. QI Director and Medical Director review complaints/issue, collect information and make a preliminary determination as to classification. Medical records and a response from the physician will be solicited in all Care and Bedside manner issues, and as appropriate for other issues.
B. The QI Committee reviews major problems and minor Care problems in detail.
C. All cases not meeting the above criteria will be reviewed by the QI Committee, which will ratify, or modify, the Medical Director's classification.
D. The QI Committee will track the quality problems per 1,000 patient per year. The Medical Director will counsel physicians with 3 or more quality problems per calendar year.

V. INTERVENTIONS

A. Events categorized as 0 (within standard of care).
1. Track in database.
2. Keep records of process for documentation.
3. No report to credentialing of peer review file.
4. Letter to M.D. regarding disposition.

5. Letter to Health plan in the event that health plan grievance process was initiated.
6. Letter to patient at conclusion, with appropriate appeals language, if initiated by patient.

B. Events categorized as 1A (Possible, minor problems).

1. Track in database.
2. Keep records of process for documentation.
3. Report to credentialing/peer review file.
4. Letter to MD regarding disposition with suggested voluntary interventions.
5. For second episode of same or similar problem, one-on-one counseling with Medical Director or designee.
6. Third episode must be categorized and handled as a **"1B" = probable problem.**
7. Letter to health plan regarding disposition if health plan grievance process initiated.
8. Letter to patient at conclusion with appropriate appeals language, if review triggered by patient complaint/grievance.

C. Events categorized as 1B. (Definite, minor problems).

1. Track in database.
2. Keep records of process for documentation.
3. Report to credentialing/peer review file.
4. Letter to provider regarding disposition, with recommended interventions.
5. Counseling with Medical Director.
6. Second episode, similar problem: Collaborative corrective action plan (with approval by the QI Committee), and warning regarding disciplinary review in the event of repeat episodes.
7. Third episode, similar problem: disciplinary action by QI Committee
8. Letter to health plan regarding disposition if health plan grievance process initiated.
9. Letter to patient at conclusion, with appropriate appeals language, if review triggered by patient grievance/complaint.
10. Evaluate need for "805" report.

D. Events categorized as 2A. (Possible, major problems).

1. Track in database.
2. Keep records of process for documentation.
3. Report to credentialing/peer review file.
4. Letter to provider regarding disposition.
5. Counseling with Medical Director.
6. A second episode of same or similar problem must be classified as **"B"** problem and handled as first episode **2B**.
7. Letter to health plan regarding disposition of health plan if grievance process initiated.
8. Letter to patient at conclusion, with appropriate appeals language, if review triggered by patient complaint/grievance.

E. Events categorized as 2B. (Definite, major problems).

1. Track in database.
2. Keep records of process for documentation.
3. Report to credentialing/peer review file.
4. Letter to provider regarding disposition.
5. Collaborative corrective action plan developed by physician and Medical Director or Clinical Medical Director as appropriate, with approval of QI Committee.
6. First episode: Disciplinary action optional.
7. Second Episode, similar problem: Mandatory disciplinary action.
8. Letter to health plan regarding disposition if health plan grievance process initiated.
9. Letter to patient at conclusion, with appropriate appeals language, if review triggered by patient complaint/grievance.
10. Evaluate need for "805" report.

Experimental & Investigational Therapies – UM

Policy:
All CHCN members may request experimental and/or investigational treatment for a medical problem. CHCN has not been delegated by our contracting health plans to make UM decision on experimental and investigational therapies. These types of authorizations will be re-directed to the Medical Director of the health plans.

Scope: This policy applies to all CHCN members and providers.

Procedure:

Utilization Management Timeliness Standards
(Medi-Cal Managed Care - California)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Routine (Non-urgent) Pre-Service • All necessary information received at time of initial request	Within 5 working days of receipt of all information reasonably necessary to render a decision	Practitioner: Within 24 hours of the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service
Routine (Non-urgent) Pre-Service – Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer • Additional examination or tests to be performed (AKA: Deferral)	Within 5 working days from receipt of the information reasonably necessary to render a decision but no longer than 14 calendar days from the receipt of the request • The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Health Plan/ Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest • Notify member and practitioner of decision to defer, in writing, within 5 working days of receipt of request & provide 14 calendar days from the date of receipt of the original request for submission of requested information. Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered		
	Additional information received • If requested information is received, decision must be made within 5 working days of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of

Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s).

Utilization Management Timeliness Standards
(Medi-Cal Managed Care - California)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
			the request for service
	Additional information incomplete or not received • If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service
Expedited Authorization (Pre-Service) • Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. • All necessary information received at time of initial request	Within 72 hours of receipt of the request	Practitioner: Within 24 hours of making the decision Member: None specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 3 working days from the receipt of the request for service
Expedited Authorization (Pre-Service) - Extension Needed • Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or	**Additional clinical information required:** Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify practitioner and member using the "delay" form, and insert specifics about what has not been received, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered		

Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s).

Utilization Management Timeliness Standards
(Medi-Cal Managed Care - California)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
regain maximum function. • Additional clinical information required	• Note: The time limit may be extended by up to 14 calendar days if the Member requests an extension, or if the Provider Group / Health Plan can provide justification upon request by the State for the need for additional information and how it is in the Member's interest **Additional information received** • If requested information is received, decision must be made within 1 working day of receipt of information. **Additional information incomplete or not received** • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.	Practitioner: Within 24 hours of making the decision Member: None specified Practitioner: Within 24 hours of making the decision Member: None specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision
Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulatory services) In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. **CA H&SC 1367.01 (h)(3)**	Within 5 working days or less, consistent with urgency of Member's medical condition **NOTE:** When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process… would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision

Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s).

Utilization Management Timeliness Standards
(Medi-Cal Managed Care - California)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
	the information reasonably necessary and requested by the plan to make the determination **CA H&SC 1367.01 (h)(2)**		
Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulatory services) **OPTIONAL:** Health Plans that are NCQA accredited for Medi-Cal may chose to adhere to the more stringent NCQA standard for concurrent review as outlined.	Within 24 hours of receipt of the request	Practitioner: Within 24 hours of receipt of the request (for approvals and denials) Member: Within 24 hours of receipt of the request (for approval decisions)	Member & Practitioner: Within 24 hours of receipt of the request **Note:** If oral notification is given within 24 hour of request, then written/electronic notification must be given no later than 3 calendar days after the oral notification
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days from receipt or request	Member & Practitioner: None specified	Member & Practitioner: Within 30 calendar days of receipt of the request

Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s).

Utilization Management Timeliness Standards
(Medi-Cal Managed Care - California)

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Post-Service - Extension Needed • Additional clinical information required	**Additional clinical information required (AKA: deferral)** • Decision to defer must be made as soon as the Plan is aware that additional information is required to render a decision but no more than 30 days from the receipt of the request		
	Additional information received • If requested information is received, decision must be made within 30 calendar days of receipt of information Example: Total of X + 30 where X = number of days it takes to receive requested information	Member & Practitioner: None specified	Member & Practitioner: Within 30 calendar days from receipt of the information necessary to make the determination
	Additional information incomplete or not received • If information requested is incomplete or not received, decision must be made with the information that is available by the end of the 30th calendar day given to provide the information	Member & Practitioner: None Required	Member & Practitioner: Within 30 calendar days from receipt of the information necessary to make the determination
Hospice - Inpatient Care	Within 24 hours of receipt of request	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision

Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s).

How to Bill for Services

To Submit a Claim

Once services have been rendered, the claims form (electronic 837 file, CMS1500, or UB92) can be submitted to:

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

- Direct claims questions to CHCN's Claims Department at (510) 297-0210
- Direct electronic 837 filing questions to Candido Anicete or CHCN at (510) 297-0200

To Trace a Claim

If sending a hard copy claim, stamp 'Tracer' on the face of the claim and mail it to:

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

Obtain claims status information via CHCN's secured web portal. Request for access form available for download at https://portal.chcnetwork.org

Immunization Billing

Community Health Center Network has nine separate lines of business. Each line of business has its own set of protocols which should be followed for correct immunization billing and reimbursement.

CHCN/Alameda Alliance Medi-Cal
CHCN/Blue Cross Medi-Cal

- CHCN's Medi-Cal products are currently using the 'Vaccines for Children' program. This program supplies the serum free of charge from the state.
- Administration is capitated, and must be billed on the VFC program using CPT codes (effective 9/22/03). Adult immunizations are paid FFS and must be billed using CPT codes which includes both the vaccine and the administration.
- If the immunization is incorrectly billed with a HCPC code, CHCN will request resubmission of the claim with the appropriate CPT code.

How to Access your Electronic Explanation of Benefits (EOB)

To access your electronic **explanation of benefits** you must be a CHCN Web Portal registered and authorized user. To become a registered user, complete the enclosed "Web Portal Access Request" form and fax it to 510-297-0209. You should receive an email notification within 24-48 hours with your log-in and password information.

1. Using your browser go to **https://portal.chcnetwork.org**. The home page provides clinic news, calendar of upcoming events, links to CHCN clinic websites, and a place to login and register for login access to Managed Care Services.

2. Once logged in, go to Managed Care > Downloads > Finance > EOB Files page to retrieve files based on search criteria. User can search and download EOB by Paid Date and Check Number from a dropdown list of the past three (3) months payments.

3. Select the date paid and check number for the EOB you want to download and click the GO button.

4. If this is the correct EOB, choose a download file CSV or PDF. If this is not the correct EOB, click on the CLEAR button and enter a different check number.

Locum Tenens Provider Claim Submission and Processing

Billing for services rendered by locum tenens providers is usually made under arrangement with the regular physician who submits the claim for these services. Under this arrangement, the claim is submitted under the regular physician's Tax ID number.

Locum tenens providers are not listed as part of the (contracted) physician group billing for the services; nor are they separately credentialed with CHCN. The regular provider or provider group will be responsible for ensuring proper eligibility and qualifications of the locum tenens provider to render healthcare services. If the provider has not been registered in the system, CHCN will enter the locum tenens provider information so that claims can be processed in the usual manner.

A claim with a rendering provider identifier that is not registered in the system, as part of the regular provider group, and without the locum tenens modifier appended to the procedure code will be returned to the submitter for appropriate locum tenens modifier – **Q6**.

List of Commonly Required Claim Attachments

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

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

Type of Claim/Service	**CPT Codes**	**Attachment**
Multiple Procedures	Surgery/Medicine	Op/Procedure Report
Unusual Procedure or Multiple Modifiers	All	Op/Procedure Report
Unlisted Procedures	"By report" codes	Op/Procedure Report
Unusual Services	All	Op/Procedure Report
Adult Sterilization	55250, 58150, 58152, 58180, 58200, 58210, 58260, 58275, 58285, 58550, 58600, 58605, 58611, 58615, 58670, 58671, 58951, 59100, 59525	Sterilization Form
Vaginal Deliveries	01967	Anesthesia Report or Time in Attendance

101 Callan Avenue, Suite 300, San Leandro, CA 94577
Phone: 510-297-0200 * Fax: 510-297-0209
Website: www.chcnetwork.org

Last Revision: 4.14.2015

PCP Cap Exceptions, Service Code Designations

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

- **Level 1**: Services that should be provided by all clinics and covered by monthly capitation when billed by clinics' primary care providers
- **Level 2**: Services not required, but strongly encouraged to be provided by clinics and payable FFS when billed by clinics' primary care providers
- **Level 3**: Services requiring requisite experience when provided by clinics' PCPs and payable FFS when billed by clinics' primary care providers
- **Level 4: S**ervices that should be provided by a provider with specialty training

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

CPT CODE	SERVICE DESCRIPTION	EFFECTIVE DATE	COMMENTS	CROSS WALK FROM
D1206	TOPICAL APPLICATION OF FLORIDE	07/01/2014		D1203
J0171	ADRENALIN EPINEPHRINE INJ	01/01/2014		
J0456	AZITHROMYCIN	04/01/2014		
J0690	CEFAZOLIN SOCIUM INJECTION	01/01/2014		
J0696	CEFTRIAXONE SODIUM INJECTION	10/01/2008		X5864
J0696	SODIUM CEFTRIAXONE 250MGM	10/01/2008		
J1020	METHYLPREDNISOLONE 20MG INJECTION	01/01/2014		
J1030	METHYLPREDNISOLONE 40MG INJECTION	11/01/2001		
J1040	METHYLPREDNISOLONE 80MG INJECTION	11/01/2001		
J1050	MEDROXYPROGESTERONE ACETATE	01/01/2016		
J1100	DEXAMETHASONE SODIUM PHOS	01/01/2013		
J1200	DIPHENHYDRAMINE HCL INJECTION	11/01/2001		
J1725	HYDROXYPROGESTERONE CAPROATE	09/01/2013		
J1815	INSULIN INJECTION	09/01/2013		
J1885	KETOROLAC TROMETHAMINE INJECTION	11/01/2001		
J1940	FUROSEMIDE INJECTION	07/14/2015		
J1950	INJECTION LEUPROLIDE ACETATE PER 3	01/01/2010		
J1950	LUPRON INJECTION 3.75MG	06/01/2009		X7422
J2001	LIDOCAINE INJECTION	01/01/2013		
J2060	LORAZEPAM INJECTION	01/01/2013		
J2405	ODANSETRON HYDROCHLORIDE INJECTION	07152015		
J2540	PENICILLIN G POTASSIUM INJ	07/01/2013		
J2675	PROGESTERONE PER 50MG	10/01/2008		X6812
J2792	RHO (D) IMMUNE GLOBULIN H, SD	01/01/2014		
J2930	METHYLPREDNISOLONE INJECTION	11/01/2001		
J3301	TRIAMCINOLONE ACETONIDE INJECTION	11/01/2001		
J3303	TRIAMCINOLONE HEXACETONL INJ	10/01/2016		
J3420	VITAMIN B12 INJECTION	11/01/2001		
J3430	INJECTION, VITAMIN K, PHY	01/01/2014		
J3490	MEDROXYPROGESTERONE INJ	12/01/2014		
J7297	LEVONORGESTREL IU 52MG 3 YR	10/01/2016	Medi-Cal approved the code, but has not priced it yet	

LEVEL 2: Services not required, but strongly encouraged to be provided by clinics and payable FFS when billed by clinics' primary care providers				
CPT CODE	**SERVICE DESCRIPTION**	**EFFECTIVE DATE**	**COMMENTS**	**CROSS WALK FROM**
J7298	LEVONORGESTREL IU 52MG 5 YR	10/01/2016	Medi-Cal approved the code, but has not priced it yet	
J7300	PARAGARD IUD DEVICE	11/01/2001		X1522
J7301	SKYLA 13.5MG	07/01/2014		
J7307	ETONOGESTREL IMPLANT SYSTEM	01/01/2008		
J9260	METHOTREXATE SODIUM, 50MG	01/01/2011		
99XXX	ALL PREGNANCY RELATED E&M CODES	11/01/2001		
10021	FINE NEEDLE ASPIRATION; W/O IMAGING GUIDANCE	08/01/2008		
10080	DRAINAGE OF PILONIDAL CYST	01/01/2014		
10140	DRAINAGE OF HEMATOMA/FLUID	06/01/2013		
11300	SHAVE SKIN LESION 0.5 CM/<	01/01/2014		
11301	SHAVE SKIN LESION 0.6-1.0 CM	10/15/2015		
11305	SHAVE SKIN LESION 0.5 CM/<	07/01/2014		
11306	SHAVE SKIN LESION 3.6-1.0 CM	10/01/2015		
11307	SHAVE SKIN LESION 1.1-2.0 CM	10/01/2015		
11308	SHAVE SKIN LESION >2.0 CM	07/01/2014		
11311	SHAVE SKIN LESION 0.6-1.0 CM	07/01/2014		
11400	EXC TR-EXT B9+MARG < 0.5 CM	11/01/2001		
11401	EXC TR-EXT B9+MARG 0.6-1 CM	11/01/2001		
11402	EXC TR-EXT B9+MARG 1.1-2 CM	11/01/2001		
11403	EXC TR-EXT B9+MARG 2.1-3 CM	11/01/2001		
11404	EXC TR-EXT B9+MARG 3.1-4 CM	11/01/2001		
11406	EXC TR-EXT B9+MARG > 4.0 CM	11/01/2001		
11420	EXC H-F-NK-SP B9+MARG 0.5<	11/01/2001		
11421	EXC H-F-NK-SP B9+MARG 0.6-1	11/01/2001		
11422	EXC H-F-NK-SP B9+MARG 1.1-2	11/01/2001		
11423	EXC H-F-NK-SP B9+MARG 2.1-3	07/01/2014		
11426	EXC H-F—NK-SP B9+MARG> 4CM	11/01/2001		
11440	EXC FACE-MM B9+MARG 0.5 < CM	11/01/2001		
11441	EXC FACE-MM B9+MARG 0.6-1 CM	11/01/2001		
11442	EXC FACE-MM B9+MARG 1.1-2 CM	11/01/2001		
11443	EXC FACE-MM B9+MARG 2.1-3 CM	11/01/2001		
11444	EXC FACE-MM B9+MARG 3.1-4 CM	11/01/2001		
11446	EXC FACE-MM B9+MARG >4 CM	11/01/2001		
11730	REMOVAL OF NAIL PLATE, SINGLE	11/01/2001		
11732	REMOVE NAIL PLATE, ADD-ON	11/01/2001		
11740	DRAIN BLOOD FROM UNDER NAIL	11/01/2001		
11750	REMOVAL OF NAIL BED	11/01/2001		
11900	INTRALESIONAL INJECTION(NOT LOCAL ANE OR CHEMO)	01/01/2007		
11901	ADDED SKIN LESION IN	11/01/2011		
11981	INSERT DRUG IMPLANT DEVISE	01/01/2012		
11982	REMOVE DRUG IMPLANT DEVICE	07/01/2012		
11983	REMOVE/INSERT DRUG IMPLANT	01/01/2012		

LEVEL 2: Services not required, but strongly encouraged to be provided by clinics and payable FFS when billed by clinics' primary care providers				
CPT CODE	**SERVICE DESCRIPTION**	**EFFECTIVE DATE**	**COMMENTS**	**CROSS WALK FROM**
12004	REPAIR SUPERFICIAL WOUND(S)	11/01/2001		
12020	CLOSURE OF SPLIT WOUND	11/01/2001		
12021	CLOSURE OF SPLIT WOUND W/ PACKING	11/01/2001		
12031	INTMD RPR S/A/T/EXT 2.5 CM/<	07/01/2014		
12034	INTMD RPR S/TR/EXT 7.6-12.5	01/01/2014		
12041	INTMD RPR N-HF/GENIT 2.5C	09/01/2013		
12042	INTMD RPR N-HF/GENIT2.6-7.5	01/01/2014		
16030	DRESS/DEBRID P-THINK BURN L	11/01/2001		
17000	DESTROY BENIGN/PREMLG LESION	11/01/2001		
17003	DESTROY LESIONS, 2-14	11/01/2001		
17004	DESTROY LESIONS, 15 OR MORE	11/01/2001		
17110	DESTRUCT LESION, 1-14	11/01/2001		
17111	DESTRUCT LESION, 15 OR MORE	11/01/2001		
17250	CHEMICAL CAUTERY OF WOUND	09/01/2010		
17340	CRYOTHERAPY OF SKIN	11/01/2001		
19100	BX BREAST PERCUT W/O IMAGE	11/01/2001		
19101	BIOPSY OF BREAST, OPEN	11/01/2001		
20520	REMOVEAL OF FOREIGN BODY	11/01/2001		
20525	REMOVE MUSCLE FOREIGN BODY	11/01/2001		
20526	THER INJECTION CARP TUNNEL	10/01/2016		
20550	INJ TENDON SHEATH/LIGAMENT, APONEUROSIS	11/01/2001		
20551	INJ TENDON ORIGIN/INSERTION	12/02/2002		
20552	INJ TRIGGER POINT 1/2 MUSCL	12/02/2002		
20600	DRAIN/INJECT, JOINT/BURSA, SML JOINT/ BURSA	11/01/2001		
20605	DRAIN/INJECT, JOINT/BURSA	11/01/2001		
20610	DRAIN/INJECT, JOINT/BURSA, MAJOR JOINT/BURSA	11/01/2001		
20612	ASPIRATE/INJ GANGLION CYST	01/01/2014		
24201	REMOVAL OF ARM FOREIGN BODY	11/01/2001		
25111	REMOVE WRIST TENDON LESION	11/01/2001		
27086	REMOVE HIP FOREIGN BODY	11/01/2001		
27087	REMOVE HIP FOREIGN BODY	11/01/2001		
28190	REMOVAL OF FOOT FOREIGN BODY	11/01/2001		
28192	REMOVAL OF FOOT FOREIGN BODY	11/01/2001		
28193	REMOVAL OF FOOT FOREIGN BODY	11/01/2001		
29085	APPLY HAND/WRIST CAST	07/01/2008		
29405	APPLY SHORT LEG CAST	11/01/2001		
29515	APPLICATION LOWER LEG SPLINT	06/01/2015		
29580	APPLICATION OF PASTE BOOT	11/01/2001		
30300	REMOVE NASAL FOREIGN BODY	01/01/2012		
30903	CONTROL NASAL HEMORRAGE COMPL	11/01/2001		
31000	IRRIGATION, MAXILLARY SINUS	11/01/2001		
36400	BL DRAW < 3 YRS REM/JUGULALR	11/01/2001		
36405	BL DRAW < 3 YRS SCALP VEIN	11/01/2001		

LEVEL 2: Services not required, but strongly encouraged to be provided by clinics and payable FFS when billed by clinics' primary care providers				
CPT CODE	**SERVICE DESCRIPTION**	**EFFECTIVE DATE**	**COMMENTS**	**CROSS WALK FROM**
36406	BL DRAW <3 OTHER VEIN	11/01/2001		
40808	BIOPSY OF MOUTH LESION	11/01/2001		
45300	PROCTOSIGMOIDOSCOPY DX	11/01/2001		
45305	PROCTOSIGMOIDOSCOPY W/ BX	11/01/2001		
45330	DIAGNOSTIC SIGMOIDOSCOPY	11/01/2001		
45331	SIGMOIDOSCOPY AND BIOPSY	11/01/2001		
46600	DIAGNOSTIC ANOSCOPY	11/01/2001		
46606	ANOSCOPY AND BIOPSY	11/01/2001		
46608	ANOSCOPY REMOVE THE BODY	11/01/2001		
46611	ANOSCOPY	09/01/2013		
46900	DESTRUCTION ANAL LESION(S)	11/01/2001		
46916	CRYOSURGERY, ANAL LESION	01/01/2011		
51701	INSERT BLADDER CATHETER	09/22/2003		
51702	INSERT TEMP BLADDER CATHETER	01/01/2011		
56405	I & D OF VULVA/PER	11/01/2001		
56420	INCIS DRAIN OF BARTH	01/01/2007		
56501	DESTROY, VULVA LESION	01/01/2008		
56740	REMOVE VAGINA GLAND	11/01/2001		
57160	INSERT PESSARY OTHER DEVICE	04/01/2011		
58100	ENDOMET SAMPL,W/WO ENDOCERVICA	11/01/2001		
58300	INSERT INTRAUTERINE DEVICE	11/01/2001		
58301	REMOVE INTRAUTERINE DEVICE	11/01/2001		
76805	OB US >/= 14 WKS SNGL FETUS	06/01/2001		
76810	OB US >/= 14 WKS ADDL FETUS	06/01/2001		
76815	OB US, LIMITED	06/01/2001		
76816	OB US FOLLOW-UP PER FETUS	06/01/2001		
76817	TRANSVAGINAL US OBSTETRIC	01/01/2007		
76856	US EXAM, PELVIC, COM	06/01/2001		
76857	US EXAM PELVIC LIMITED	06/01/2001		
81005	URINALYSIS; QUAL OR SEMI-QUAN	11/01/2001		
81007	URINE SCREEN FOR BACTERIA	11/01/2001		
81015	MICROSCOPIC EXAM OF URINE	11/01/2001		
82270	TEST FOR BLOOD, FECES	11/01/2001		
82274	ASSAY TEST FOR BLOOD, FEC	09/01/2011		
82947	ASSAY, GLUCOSE, BLOOD QUANT	11/01/2001		
82950	GLUCOSE TEST	11/01/2001		
82951	GLUCOSE TOLERANCE TEST (GTT)	11/01/2001		
82962	GLUCOSE BLOOD TEST	11/01/2001		
83655	ASSAY OF LEAD	01/01/2012		
85013	SPUN, MICROHEMATOCRIT	11/01/2001		
85014	HEMATOCRIT	11/01/2001		
85610	PROTHROMBIN TIME	11/01/2001		
86480	TB TEST CELL IMMUN MEASURE	07/01/2015		
87210	SMEAR, WET MOUNT, SALINE/INK	11/01/2001		
87430	INFECT AGT ANT DET BY ENZYME I	11/01/2001		

LEVEL 2: Services not required, but strongly encouraged to be provided by clinics and payable FFS when billed by clinics' primary care providers				
CPT CODE	**SERVICE DESCRIPTION**	**EFFECTIVE DATE**	**COMMENTS**	**CROSS WALK FROM**
88720	BILIRUBIN TOTAL TRANSCUT	09/01/2010		
90384	99RH IG, FULL-DOSE	01/01/2012		J2790
90385	RH IG, MINIDOSE, IM	01/01/2012		J2790
90389	TETANUS IG IM	09/23/2003		
90586	BCG VACCINE, INTRAVE	01/01/2008		
90620	MENB RP W/OMV VACINE IM	10/01/2015		
90630	NON-VFC FLU VACC IIV4 NO PRESERV ID	10/01/2015		
90649	NON-VFC GARDASIL	12/01/2006		
90660	FLU VACCINE NASAL	01/01/2007		
90662	FLUXONE HIGH-DOSE (Adults 65 yrs or older)	11/01/2010		
90675	RABIES VACCINE, IM	01/01/2008		
90680	NON-VFC ROTOVIRUS VACC 3 DOSE, ORAL	11/01/2006		
90690	TYPHOID VACCINE, ORAL	09/22/2003		
90691	TYPHOID VACCINE, IM	09/22/2003		
90693	TYPHOID VACCINE AKD SC	09/22/2003		
90698	NON-VFC DTAP-HIB-IP	08/15/2008		
90715	NON-VFC DTAP VACCINE 7 YRS/>IM (POS 12)	01/01/2016		
90717	YELLOW FEVER VACCINE, SC	09/22/2003		
90725	CHOLERA VACCINE, INJECTAB	09/22/2003		
90736	ZOSTERSHINGLES VACCINE (Adults 60 yrs or older "once in a lifetime"	01/01/2008		
90746	HEPATITS B VACCINE, ADULT DOSAGE, FOR INTRAMUSCULAR USE (AGE 19 AND OLDER)	11/01/2001		
92557	COMPREHENSIVE HEARING TEST	11/01/2001		
95004	PERCUT ALLERGY SKIN TESTS	11/01/2001		
95052	PHOTO PATCH TEST(S)	11/01/2001		
95070	BRONCHIAL ALLERGY TESTS	11/01/2001		
95071	BRONCHIAL ALLERGY TESTS	11/01/2001		
97597	RMVL DEVITAL TIS 20 CM/<	07/01/2012		
99204	NURSING FACILITY CARE, INITIAL	01/05/2004		
99221	HOSPITAL CARE, INITIAL LEVEL I	11/01/2001		
99222	HOSPITAL CARE, INITIAL LEVEL II	11/01/2001		
99223	HOSPITAL CARE, INITIAL LEVEL III	11/01/2001		
99231	HOSPITAL CARE, SUBSEQUENT, LEVEL I	11/01/2001		
99232	HOSPITAL CARE, SUBSEQUENT, LEVEL II	11/01/2001		
99233	HOSPITAL CARE, SUBSEQUENT, LEVEL III	11/01/2001		
99238	HOSPITAL DISCHARGE DAY MGMT; 30 MIN	11/01/2001		
99239	HOSPITAL DISCHARGE DAY MGMT; > 30 MIN	11/01/2001		
99251	INPATIENT CONSULTATION, INITIAL, LEVEL I	11/01/2001		
99252	INPATIENT CONSULTATION, INITIAL, LEVEL II	11/01/2001		
99253	INPATIENT CONSULTATION, INITIAL, LEVEL IIII	11/01/2001		
99254	INPATIENT CONSULTATION, INITIAL, LEVEL IV	11/01/2001		
99255	INPATIENT CONSULTATION, INITIAL	11/01/2001		

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

CPT CODE	SERVICE DESCRIPTION	EFFECTIVE DATE	COMMENTS	CROSS WALK FROM
99283	EMERGENCY DEPT VISIT	09/01/2014		
99284	EMERGENCY DEPT VISIT	07/01/2015		
99285	EMERGENCY DEPT VISIT	01/01/2012		
99304	NURSING FACILITY CARE INIT	09/01/2013		
99305	NURSING FACILITY CARE, INITIAL	09/01/2011		
99306	NURSING FACILITY CARE, INITIAL	01/01/2011		
99307	NURSING FAC CARE SUBSEQ	10/01/2012		
99308	NURSING FAC CARE, SUBSEQ	01/01/2006		
99309	NURSING FAC CARE, SUBSEQ	01/01/2011		
99310	NURSING FAC CARE, SUBSEQ	01/01/2011		
99315	NURSING FAC DISCHARGE DAY	11/01/2001		
99316	NURSING FAC DISCHARGE DAY	11/01/2001		
99341	HOME VISIT NEW PATIENT	09/01/2013		
99342	HOME VISIT NEW PATIENT	09/01/2013		
99343	HOME VISIT NEW PATIENT	09/01/2013		
99344	HOME VISIT NEW PATIENT	09/01/2013		
99347	HOME VISIT-E&M OF ESTABLISHED PATIENT	07/01/2008		
99348	HOME VISIT-E&M OF ESTABLISHED PATIENT	01/01/2009		
99349	HOME VISIT-E&M OF ESTABLISHED PATIENT	01/01/2009		
99350	HOME VISIT-E&M OF ESTABLISHED PATIENT	09/01/2009		
99356	PROLONGED PHYSICIAN SERVICE, INPATIENT	01/01/2009		
99357	PROLONGED PHYSICIAN SERVICE; EACH ADDL 30 MINS	01/01/2009		
99460	INIT NB EM PER DAY HOSP	01/01/2009		
99461	INIT NB EM PER DAY, NON-F	09/01/2009		
99462	SBSQ NB EM PER DAY, HOSP	09/01/2009		

LEVEL 3: Services requiring requisite experience when provided by clinics' PCPs and payable FFS when billed by clinics' primary care providers

CPT CODE	SERVICE DESCRIPTION	EFFECTIVE DATE	COMMENTS	CROSS WALK FROM
10180	COMPLEX DRAINAGE WOUND	01/01/2012		
11424	EXC H-F-NK-SP-B9+MARG 3.1-4	07/01/2014		
11765	EXCISION OF NAIL FOLD TOE	01/01/2014		
12002	RPR S/N/AX/GEN/TRUNK2.6-7.5CM	11/01/2001		
12011	REPAIR SUPERFICIAL 2.5CM OR LESS	11/01/2001		
12013	REPAIR SUPERFICIAL WOUND(S)	11/01/2001		
12014	REPAIR SUPERFICIAL WOUND(S)	11/01/2001		
12015	REPAIR SUPERFICIAL WOUND(S)	11/01/2001		
12016	REPAIR SUPERFICIAL WOUND(S)	11/01/2001		
12017	REPAIR SUPERFICIAL WOUND(S)	11/01/2001		
12018	REPAIR SUPERFICIAL WOUND(S)	11/01/2001		
12051	INTMD RPR FACE/MM 2.5 CM/<	07/01/2014		
12052	INTMD RPR FACE/MM 2.6-5.0 CM	10/01/2015		

LEVEL 3: Services requiring requisite experience when provided by clinics' PCPs and payable FFS when billed by clinics' primary care providers				
CPT CODE	**SERVICE DESCRIPTION**	**EFFECTIVE DATE**	**COMMENTS**	**CROSS WALK FROM**
20612	ASPIRATE/INJ GANGLIN CYST	01/01/2014		
24640	TREAT ELBOW DISLOCATION	07/01/2014		
29075	APPLICATION OF FOREARM CAST	09/01/2013		
29240	STRAPPING OF SHOULDER	01/01/2015		
46083	INCISE EXTERNAL HEMORRHOID	07/01/2015		
54056	CRYOSURGERY PENIS LESION(S)	01/01/2011		
54115	TREATMENT OF PENIS LESION	11/01/2001		
56515	DESTROY VULVA LESION/S COMPL	07/01/2014		
56605	BX OF VULVA	11/01/2001		
57061	DESTROY VAGINAL LESION	11/01/2001		
57100	BIOPSY OF VAGINA	04/01/2011		
57410	PELVIC EXAMINATION UNDER ANESTHESIA	10/01/2015		
57452	EXAM OF CERVIX W/SCOPE	11/01/2001		
57454	BX/CURETT OF CERVIX W/SCOPE W/ENDOCERV CURRET	11/01/2001		
57455	BX/CURETT OF CERVIX W/SCOPE	11/01/2001		
57456	COLOPOSCOPY W ENDOCERVICAL CURRETTAGE	05/01/2007		
57460	BX OF CERVIX W/SCOPE, LEEP	11/01/2001		
57500	BIOPSY OF CERVIX	11/01/2001		
57510	CAUTERIZATION OF CERVIX	11/01/2001		
57511	CRYOCAUTERY OF CERVIX	11/01/2001		
58605	DIVISION OF FALLOPIAN TUBE	11/01/2001		
58611	LIGATE OVIDUCT(S0 ADD-ON	11/01/2001		
58661	LAPAROSCOPY, REMOVE ADNEXA	11/01/2001		
58662	LAPAROSCOPY EXISE LESIONS	01/01/2016		
58671	LAPAROSCOPY, TUBAL BLOCK	11/01/2001		
58925	REMOVAL OF OVARIAN CYSTS(S)	11/01/2001		
59025	FETAL NON-STRESS TEST	11/01/2001		
59300	EPISIOTOMY OR VAGINAL REPAIR	11/01/2001		
59320	REVISION CERVIX	11/01/2001		
59400	OBSTETRICAL CARE	01/01/2016		
59409	VAG DELIVERY ONLY (WITH OR W/O)	11/01/2001		
59414	DELIVER PLACENTA	07/14/2015		
59514	CAESAREAN DELIVERY ONLY	01/01/2002		
59612	VAG DEL ONLY AFTER PREV C-SEC	11/01/2001		
59620	C-SECT ONLY FOLL. ATTEMP. VAG	01/01/2002		
59820	CARE OF MISCARRIAGE	11/01/2001		
59870	EVACUATE MOLE OF UTERUS	01/01/2016		
60100	BIOPSY THYROID,PERCUTANEOUS CO	11/01/2001		
65205	REMOVE FOREIGN BODY FROM EYE	11/01/2001		
65210	REMOVE FOREIGN BODY FROM EYE	11/01/2001		
65220	REMOVE FOREIGN BODY FROM EYE	11/01/2001		
65222	REMOVE FOREIGN BODY FROM EYE	11/01/2001		
65235	REMOVE FOREIGN BODY FROM EYE	11/01/2001		
65260	REMOVE FOREIGN BODY FROM EYE	11/01/2001		

LEVEL 3: Services requiring requisite experience when provided by clinics' PCPs and payable FFS when billed by clinics' primary care providers				
CPT CODE	**SERVICE DESCRIPTION**	**EFFECTIVE DATE**	**COMMENTS**	**CROSS WALK FROM**
65265	REMOVE FOREIGN BODY FROM EYE	11/01/2001		
67413	EXPLORE/TREAT EE SOCKET	11/01/2001		
68840	EXPLORE/IRRIGATE TEAR DUCTS	11/01/2001		
76801	OB US <14 WKS, SINGLE FETUS	11/01/2001		
92551	PURE TONE HEARING TEST, AIR	11/01/2001		
92552	PURE TONE AUDIOMETRY, AIR	11/01/2001		
92553	AUDIOMETRY, AIR & BONE	11/01/2001		
92561	BEKESY AUDIOMETRY, DIAGNOSTIC	11/01/2001		
94010	BREATHING CAPACITY TEST	11/01/2001		
94150	VITAL CAPACITY TEST	11/01/2001		
96360	HYDRATION IV INFUSION, INIT	01/01/2010		

LEVEL 4: Services that should be provided by a provider with specialty training				
CPT CODE	**SERVICE DESCRIPTION**	**EFFECTIVE DATE**	**COMMENTS**	**CROSS WALK FROM**
19000	BARINAGE OF BREAST LESION	11/01/2001		
24500	TREAT HUMERUS FRACTURE	01/01/2015		
36420	VEIN ACCESS CUTDOWN <1YR	11/01/2001		
36425	VEIN ACCESS CUTDOWN >1YR	11/01/2001		
38500	BIOPSY/REMOVAL LYMPH NODES	11/01/2001		
38505	NEEDLE BIOPSY LYMPH NODES	01/01/2015		
42809	REMOVE PHARYNX FOREIGN BODY	11/01/2001		
49000	EXPLORATION OF ABDOMEN	01/01/2013		
49320	DIAG LAPARO SEPARATE PROC	11/01/2001		
49322	LAPAROSCOPY ASPIRATION	01/01/2008		
51729	CYSTOMETROGRAM W/VP&UP	09/01/2011		
51741	ELECTRO-UROFLOWMETRY	12/31/2011		
51784	ELECTROMYOGRAPHY STUDY	12/31/2011		
51797	INTRAABDOMINAL PRESS	12/31/2011		
51798	US URINE CAPACITY MEASURE	01/01/2012		
52000	CYSTOSCOPY	01/012007		
56700	PARTIAL REMOVAL OF HYMEN	07/01/2014		
57230	REPAIR OF URETHRAL LESION	09/01/2013		
57240	REPAIR BLADDER & VAGINA	01/01/2007		
57250	REPAIR RECTUM & VAGINA	01/01/2007		
57268	REPAIR OF BOWEL BULGE	01/01/2013		
57283	COLPOPEXY INTRAPERITONEAL	07/01/2014		
57288	REPAIR BLADDER DEFECT	07/01/2007		
57505	ENDOCERVICAL CURETTAGE	01/01/2007		
57520	CONIZATION OF CERVIX	01/01/2007		
57522	CONIZATION OF CERVIX W/O FULGURATION	01/01/2014		
57720	REVISION OF CERVIX	11/01/2011		
57800	DILATION OF CERVICAL CANAL	07/01/2015		
58120	DILATION AND CURETTAGE	01/01/2011		

LEVEL 4: Services that should be provided by a provider with specialty training				
CPT CODE	**SERVICE DESCRIPTION**	**EFFECTIVE DATE**	**COMMENTS**	**CROSS WALK FROM**
58140	MYOMECTOMY ABDOM MET	01/01/2011		
58150	TOTAL HYSTERECTOMY	01/01/2008		
58180	PARTIAL HYSTERECTOMY	01/01/2016		
58260	VAGINAL HYSTERECTOMY	01/01/2008		
58270	VAG HYST W/ENTEROCELE REPAIR	07/01/2014		
58350	REOPEN FALLOPIAN TUBE	09/01/2014		
58541	LSH, UTERUS 250 G OR LESS	01/01/2011		
58550	LAPARO-ASST VAG HYSTERECTOMY	01/01/2015		
58553	LAPARO-VAG HYST COMPLEX	10/01/2015		
58554	LAPARO-VAG HYST W/T/O COMPL	06/01/2014		
58555	HYSTEROSCOPY, DX, SEP PROC	11/01/2001		
58558	HYSTREOSCOPY, BIOPSY	01/01/2010		
58561	HYSTEROSCOPY REMOVE MYOMA	01/01/2012		
58562	HYSTEROSCOPY REMOVE FB (POS 21)	10/01/2015		
58563	HYSTOROSCOPY, ABLATION	01/01/2011		
58565	HYSTEROSCOPY STERILIZATION	01/01/2011		
58700	REMOVAL OF FALOPIAN TUBE	01/01/2013		
58720	REMOVAL OF OVARY/TUBE(S)	01/01/2016		
58740	ABHESIOLYSIS TUBE OVARY	01/01/2013		
58940	REMOVAL OF OVARY(S)	01/01/2013		
59150	TREAT ECTPIC PREGNANCY	01/01/2011		
59151	TREAT ECTOPIC PREGNANCY	01/01/2008		
59812	TREATMENT OF MISCARRIAGE	01/01/2009		
59160	D & C AFTER DELIVERY	07/01/2013		
64435	N BLOCK INJ PARACERVICAL	01/01/2015		

HISTORY – DELETED CODES

DELETED PCP Cap Exceptions, Service Code Designations

LEVEL 2: Services not required, but strongly encouraged to be provided by clinics and payable FFS when billed by clinics' primary care providers			
CPT CODE	**SERVICE DESCRIPTION**	**DELETE DATE**	**CROSS WALK TO**
11975	INSERT CONTACEPTIVE CAP – MOVED TO CAP	07/01/2014	
11976	REMOVAL OF CONTRACEPTIVE CAP – MOVED TO CAP	06/01/2015	
11977	REMOVAL/REINSERT CONTRA CAP – MOVED TO CAP	07/01/2014	
16010	TREATMENT OF BURN(S)	07/01/2014	
16015	TREATMENT OF BURN(S)	07/01/2014	
17100	12DESTRUCTION OF SKIN LESION	09/30/2008	
41115	EXCISION OF TONGUE FOLD	07/01/2014	
30905	CONTROL OF NOSEBLEED – MOVED TO CAP	06/01/2015	
30906	REPEAT CONTROL OF NOSEBLEED – MOVED TO CAP	06/01/2015	
81002	URINALYSIS, NONAUTO W/O SCOPE	06/01/2013	
81003	URINALYSIS, AUTO, W/O SCOPE	06/01/2013	
83036	GLYCATED HEMOGLOBIN	04/01/2013	
85018	HEMOGLOBIN, COLORIMETRIC	06/01/2013	
90656	FLU VACCINE NO PRESERV 3 & > - MOVED TO CAP	06/01/2015	
90665	LYME DISEASE VACCINE, IM	07/01/2014	
90692	TYPHOID VACCINE H-P SC/ID	12/31/2016	
90727	PLAGUE VACCINE IM	12/31/2016	
90742	SPECIAL PASSIVE IMMUNIZATION	07/01/2014	
97802	MEDICAL NUTRITION, INDIV	01/31/2014	
97803	MED NUTRITION, INDIV, SUBSEQUENT	01/31/2014	
99217	OBSERV CARE DISCHARGE DAY	07/01/2014	
99234	OBSERV/HOSP SAME DATE	07/01/2014	
99235	OBSERV/HOSP SAME DATE	07/01/2014	
99236	OBSERV/HOSP SAME DATE	07/01/2014	
99261	INPT. CONSULT, FOLLOW-UP	09/30/2008	
99262	INPATIENT CONSULTATION, FOLLOW	09/30/2008	
99263	INPT. CONSULT, FOLLOW-UP	09/30/2008	
99301	NURSING FACILITY ASMT., ANNUAL	09/30/2008	
99302	NURSING FACILITY ASSMT.	09/30/2008	
99303	NURSING FACILITY ASSMT., INITIAL	09/30/2008	
99313	NURSING FAC CARE, SUBSEQ	07/01/2014	
99431	NEWBORN, HISTORY AND EXAM	06/30/2014	
99433	NORMAL NEWBORN CARE/HOSPITAL	07/01/2014	
99436	ATTENDANCE, BIRTH	07/01/2014	
D1203	TOPICAL APPLICATION OF FLORIDE – TERMED CODE	06/30/2014	D1206
J0540	PENICILLIN G BENZATHINE INJECTION – MOVED TO CAP	11/01/2010	
J0550	PENICILLIN G BENZATHINE INJECTION – MOVED TO CAP	11/01/2010	
J0560	PENICILLIN G BENZATHINE INJECTION – MOVED TO CAP	11/01/2010	
J0570	PENICILLIN G BENZATHINE INJECTION – MOVED TO CAP	11/01/2010	
J0580	PENICILLIN G BENZATHINE INJECTION – MOVED TO CAP	11/01/2010	
J0715	CEFTIZOXIME SODIUM 500MG	07/01/2014	
J0780	PROCHLORPERAZINE, UP TO 10MG, INJECTION	01/01/2015	

LEVEL 2: Services not required, but strongly encouraged to be provided by clinics and payable FFS when billed by clinics' primary care providers			
CPT CODE	**SERVICE DESCRIPTION**	**DELETE DATE**	**CROSS WALK TO**
J1055	MEDRXYPROGESTER ACETATE INJECTION	08/31/2013	
J1080	INJECTION, TESTOSTERONE CYPIONATE MOVED TO CAP	10/31/2015	
J2790	RHO D IMMUNE GLOBULIN INJECTION – TERMED CODE	12/31/2011	90384 90385
J7040	NORMAL SALINE SOLUTION INFUSION	07/01/2014	
J7302	LEVONORGESTREL IU CONTRACEPT	12/31/2016	J7297 J7298
J7611	ALBUTEROL, 1MG, CONCENTRATE	09/30/2008	
J7612	LEVALBUTEROL, 0.5MG, CONCENTRATE	09/30/2008	
J7613	ALBUTEROL, 1MG UNIT DOSE – MOVED TO CAP	07/01/2014	
J7614	LEVALBUTEROL, 0.5MG, UNIT DOSE	09/30/2008	
J7616	ALBUTEROL, UP TO 5MG	09/30/2008	
J7619	ALBUTEROL INH SOL UNIT DOSE	09/30/2008	
J7621	(LEVO) ALBUTEROL/IPRA-BROMIDE	09/30/2008	
J7626	BUDESONIDE INHALATION SOL	07/01/2014	
J7644	IPRATROPIUM BROM INH SOL UNIT DOSE – TERMED CODE	07/01/2014	
J7645	07IPRATROPIUM BROMIDE CO	07/01/2014	
Q0090	LEVONORGESTREL INTRAUTERI – TERMED CODE	06/30/2014	J7301
X1522	PARAGARD IUD DEVICE	07/01/2014	J7300
X1532	MIRENA INTRAUTERINE SYSTEM	07/01/2014	J7302
X5280	PHYSICAL THERAPY VISIT	07/01/2014	
X5862	SODIUM CEFTRIAXONE 500MGM – TERMED CODE	09/30/2008	J0715
X5864	SODIUM CERFTRAIAXONE 250MGM – TERMED CODE	09/30/2008	J0696
X5974	HYDROXYPROGESTERONE 250MG/CC	09/30/2008	
X6046	MEDROXYPROGES 400MG/ML	09/30/2008	
X6051	DEPO-PROVERA 150MGM – TERMED CODED	10/31/2010	J1055
X6052	TESTOSTERONE CYPIONATE-50	07/01/2014	
X6812	PROGESTERONE PER 50MG – TERMED CODE	09/30/2008	J2675
X7422	LUPRON INJECTION 3.75MG – TERMED CODE	05/31/2009	J1950
X7430	LUPRON DEPOT-PED 11.	08/31/2009	
X7490	LUNELLE 5-25MG/0.5ML	10/01/2002	
LEVEL 3: Services requiring requisite experience when provided by clinics' PCPs and payable FFS when billed by clinics' primary care providers			
CPT CODE	**SERVICE DESCRIPTION**	**DELETE DATE**	**CROSS WALK TO**
Q3014	TELEHEALTH FACILITY FEE	07/01/2014	
59430	CARE AFER DELIVERY	12/31/2016	
J1070	INJECTION, TESTOSTERONE CYPIONATE,	12/31/2016	
LEVEL 4: Services that should be provided by a provider with specialty training			
CPT CODE	**SERVICE DESCRIPTION**	**DELETE DATE**	**CROSS WALK TO**
Z1210	TRANS/FALL TU UNI/BIL W/M	07/01/2014	

Immunization Matrix

Effective September 22, 2003
(For DOS prior to 9/22/03 refer to earlier version of this document)

Line of Business	Codes	Who to Bill
Blue Cross Medi-Cal	CPT w/SL, SK modifier for VFC	CHCN
AA Medi-Cal	CPT w/SL, SK modifier for VFC	CHCN

- Use CPT Code w/out modifier for Non-VFC
- Medi-Cal lines must follow DHS Immunization coding guidelines – See attached matrix of HCPCS Codes with Cross-walk CPT Codes.
- All VFC serums are not reimbursed FFS, admin fee is capitated
- All other lines of business using CPT are reimbursed FFS.
- Submission of IZ by CMC 04 format, use modifier 99 for combined SLSK coding

Note: If immunization is incorrectly billed, CHCN will request resubmission of the claim with the appropriate code.

Billing for OB Care

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

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

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

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

Billing for Total OB Care

CHCN reimburses providers for "Total OB Care" on a Fee-For-Service (FFS) basis, with a limit of 12 ante-partum visits per member/per pregnancy. Provider should submit a HCFA-1500 claim form for each ante-partum visit using the appropriate E & M codes. Refer to **Attachment A for OB FFS Payment Schedule.**

- CHCN reimbursement is higher for members identified as high risk during their pregnancy period. High risk reimbursement is determined by the billing of primary diagnosis codes on the HCFA-1500 claim form. Refer to **Attachment B for High Risk Diagnosis Codes** for Ante-partum services.

- CHCN will reimburse provider for one postpartum visit per member/per pregnancy period. Additional postpartum visits billed will be denied as "unit exceeds authorized number per pregnancy period".
    - Exception: If a member is determined to have complications during labor and delivery, provider is entitled to provide and bill for a second postpartum visit. Refer to **Attachment C for** list of diagnosis codes for **Complications of Labor & Delivery**.

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

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

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

Billing for OB Care

Delivery

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

Separate Payment for OB Related Services

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

COMMUNITY HEALTH CENTER NETWORK
Exhibit B-1

FEE-FOR-SERVICE SCHEDULE

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

CHCN Obstetrical (OB) Fee-For Service Payment Schedule		
Service Provided	CPT-4 Code	Payment Rate as of 4-1-14*
Initial Visit		
Initial Visit	99205	$99.24
Initial Visit if patient is transferred in	99204	$82.68
Antepartum Care		
Established Patient, minimal (5 minutes)	99211	$14.40
Established Patient, moderate (10minutes)	99212	$21.72
Established Patient, low-moderate (15 minutes)	99213	$28.80
Established Patient, moderate-severe (25 minutes)	99214	$45.00
Established Patient, moderate-high (40 minutes)	99215	$68.64
Delivery Only (Does not include Antepartum or Postpartum Care)		
Vaginal Delivery	59409	$653.14
Cesarean Delivery	59514	$653.66
VBAC Delivery	59612	$653.14
Cesarean Delivery after VBAC Attempt	59620	$653.66
Postpartum Office Visit		
Postpartum Office Visit between 21-56 days (One visit may be billed/paid)	59430	$95.00

** Payment will be adjusted in the future to reflect 120% of prevailing Medi-Cal Payment Schedule*

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

Laboratory Reimbursement Schedule						
Description	CPT Codes	Rate		Description	CPT Codes	Rate
UA dips w/ or w/out micro	81000	$4.37		Glucose Blood Test	82962	$3.74
Urinalysis, non-auto w/o scope	81002	$3.53		Assay of Lead	83655	$4.50
Urinalysis, auto, w/o scope	81003	$2.83		Natriuretic Peptide	83880	$37.94
Urinalysis; qual or semi-quan	81005	$2.99		Spun, Microhematocrit	85013	$2.64
Urine Screen for Bacteria	81007	$3.00		Hematocrit	85014	$2.64
UA micro only	81015	$3.80		Hemoglobin, Colorimetric	85018	$2.64
Urine Pregnancy Test	81025	$3.00		INR, finger stick	85610	$1.98
Test for Blood, Feces	82270	$2.58		Wet mount (provider only)	87210	$3.26
Glucose, finger stick	82947	$1.25		Strep screen	87430	$11.53
Glucose Test	82950	$5.06		Automated Hemogram	85025	$1.50
Glucose Tolerance Test (GTT)	82951	$15.38		TB Test	86580	$7.13

Adult Sterilization and Consent Standards for CHCN Medi-Cal

Sterilization services for Medi-Cal members are subject to federal requirements, including a minimum age, informed consent process and a waiting period before services can be rendered. Consent must be voluntary and individuals must not be coerced to employ or not employ any particular method of sterilization.

Human Reproductive Sterilization is defined as "Any medical treatment, procedure or operation for the purpose of rendering an individual permanently incapable of reproducing".

Sterilization Consent Procedures

The provider will determine the member meets the following criteria:

- 21 years of age or older.
- Mentally competent to give written consent.
- Not currently institutionalized.
- Able to understand the content and nature of the informed consent process.
- Voluntarily giving informed consent.

The informed consent process will be conducted either by the physician or the physician designee and will include:

- Ensuring the member time to ask questions regarding the procedure.
- Providing the member with a copy of the consent form.
- A thorough explanation of the procedure, length of hospitalization, and any risks or side effects associated with the procedure.
- Advice that the procedure is considered to be irreversible.
- Advice that the procedure will not be performed for at least thirty (30) days.
- The name of the physician performing the procedure.
- Advice to the individual that consent for the procedure can be withdrawn at any time before the sterilization without affecting the right to future care or treatment.

The physician will use the State of California Health and Welfare consent form (PM330) and ensure the form is properly completed and signed.

The physician will ensure the consent is signed at least thirty (30) days, but no more than one hundred eighty (180) days before the sterilization procedure.

The physician will document the informed consent process on the medical record and include the signed consent form in the medical record.

A copy of the PM330 must be attached to the claim in order to process the for payment. Claims for sterilization services must be submitted on a HCFA 1500 using appropriate CPT, HCPCS or Medi-Cal codes. The PM330 will be filed with the claim and with CHCN Health Services Department in order to maintain a record of the consent form at CHCN.

CHCN ACUPUNCTURE SERVICES

Effective 7/1/16, CHCN provides medically necessary acupuncture services to CHCN Anthem Medi-Cal managed care members. Beginning 7/1/17, CHCN provides acupuncture services to CHCN Alameda Alliance for Health Medi-Cal managed care members as well. CHCN follows the Medi-Cal medical necessity criteria for acupuncture benefits; however, CHCN does not follow the Medi-Cal limit of two visits per month. Although CHCN does not limit the number of acupuncture visits a member may receive in a month, more than 24 visits in an elapsed year requires prior authorization.

Medical Criteria

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

Procedure Codes

Acupuncture service may include one of the following:

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

Procedure Code Descriptions

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

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

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

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

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

Provider Network

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

CHCN ACUPUNCTURE SERVICES

Prior Authorization

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

Billing

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

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

CHCN CHIROPRACTIC SERVICES

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

Medical Criteria

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

Procedure Codes

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

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

Provider Network

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

Prior Authorization

Prior authorization is not required if service is provided at CHCN health center. Non-CHCN providers must submit prior authorization through CHCN as a non-contracted provider.

Billing

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

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

COMMUNITY HEALTH CENTER NETWORK

MEMORANDUM

TO: CHCN Contracted Providers

FROM: Karen Matsuoka, Provider Services and Contracts Manager

SUBJECT: Outpatient Diagnostic and Laboratory Services

DATE: June 7, 2017

Please read this important notice regarding diagnostic and laboratory access and reimbursement.

Community Health Center Network (CHCN) contracts with Quest Diagnostics in order to provide outpatient diagnostic and laboratory services to CHCN Anthem Blue Cross Medi-Cal managed care members. CHCN informed all providers of this change in July 2015, see original notice attached. A claims review has indicated that some outpatient laboratory services by non-Quest labs have been paid since this time. CHCN is now updating its claims adjudication system and effective June 7, 2017 outpatient laboratory services by labs other than Quest will not be paid without an authorization. CHCN would like to remind providers about how to access and bill for medically necessary outpatient diagnostic and laboratory services.

CHCN may reimburse the following outpatient diagnostic and laboratory services if provided by non-Quest Diagnostics providers:

- Pathology services
- Laboratory services with valid prior authorization from CHCN
- Place of service 24, Ambulatory surgical center
- Sensitive services as defined by Medi-Cal
- Diagnostic and laboratory services explicitly detailed in provider contract

Most medically necessary diagnostic and laboratory services provided by Quest Diagnostics for CHCN Anthem members do not require prior authorization. Any genetic testing requires prior authorization. In addition, see attached updated prior authorization grid, also available on provider portal, CHCN Connect, linked here: https://portal.chcnetwork.org/UM-Authorizations-Resources

For CHCN Alameda Alliance for Health (AAH) members, please refer to the AAH Provider Manual.

If you have any questions, please contact CHCN Provider Services or providerservices@chcnetwork.org.

Community Health Center Network

Provider Claim Dispute Resolution Mechanism
(Provider Claims Appeal Process)

Community Health Center Network (CHCN) dispute resolution process as it relates to the submission and resolution of a provider dispute.

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

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

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

Note: Claims that are denied due to provider's claim submission error or omission (e.g. missing/incorrect CPT, ICD-9-CM or place of service codes) do not qualify for the Provider Claim Dispute Resolution Mechanism. These should be resubmitted within the time period for claim submission as "Corrected Claim" with a brief explanation of the error either noted on the claim or as an attachment.

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

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

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

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

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

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

Verifying Membership Eligibility

There are two ways you can verify member eligibility.

1. **Using CHCN's Web Portal**
    a. Obtain Web Portal access by completing the form and faxing it to 510-297-0209. Once your request has been reviewed and processed, you will receive an email from CHCN with your login and password information.
    b. To log on to CHCN's Web Portal; using your browser, go to https://connect.chcnetwork.org. The Web Portal homepage provides clinic news, calendar of upcoming events, links to CHCN clinic websites, links to Managed Care downloadable reports and more.
    c. To view **Eligibility Lookup**:
        - Enter last name, date of birth OR health plan ID. *Search can be performed by entering any combination of these data elements*

2. **Contact the health plan directly:**
    a. Ask for a Customer Service Representative
    b. Have the member's name, date of birth, and member ID available.

Alameda Alliance for Health Medi-Cal Group Care	**877-932-2738 or 510-747-4567**
Blue Cross Medi-Cal	**800-407-4627**

Complaints/Grievances/Appeals

POLICY:

It is the policy of the Community Health Center Network to acknowledge, investigate and resolve all member and provider, complaints and appeals received by The Community Health Center Network (CHCN) in a timely fashion while recognizing and respecting member rights throughout the process. The CHCN will comply with specific health plan contractual requirements with regard to the handling and reporting of complaints and appeals.

PURPOSE:

To provide for a timely and organized system for resolving member's and provider's complaints and to provide for the appropriate processing of appeals.

DEFINITION OF TERMS:

Complaint: An initial verbal or written concern of a member regarding quality of services rendered by a CHCN clinic provider or staff member, e.g., rude behavior, delays in care, etc. CHCN will attempt to resolve all complaints within thirty (30) days.

Grievance: A complaint that has not been resolved to the satisfaction of the member or provider through the Member Complaint Process.

Appeal: A written or verbal request of reconsideration made by a member or provider following an authorization decision outcome.

PROCEDURE:

1. Member Initiated Complaint

Members are encouraged to provide feedback on the quality of services received within the Network. The member may directly address the complaint with his/her provider or may submit a complaint to CHCN. Welcome packets sent to new members from their clinics include instructions on contacting CHCN with a complaint.

All grievances/complaints filed by CHCN members will be immediately forwarded to the Health Plan within twenty-four (24) hours or the next business day. Members will also be informed that they can call or write the Health Plan directly.

For members of other health plans:

a. CHCN to acknowledgement receipt of the complaint within 5 days by sending the member an acknowledgement letter and or following up with a phone call.

b. Complaint issues will be resolved within thirty (30) days of receipt. If unable to resolve within 30 days, there will be documentation that all reasonable efforts have been made to resolve the complaint. See notification of the health plan in step "d".

c. CHCN will notify the individual clinic and the Network QM committee of any complaints received. Complaints regarding CHCN providers will be reviewed and

resolved by the QI Committee following guidelines as adopted in the Quality Classification System for the Peer Review Process.

d. CHCN will forward grievances to the health plan within twenty-four (24) hours or the next business day. The member's health plan (QI Dept) will also be given copies of any necessary accompanying documentation, steps in the investigation and the classification as determined by the CHCN QI Committee.

e. When the member requests an urgent grievance process, CHCN will notify the health plan immediately and forwarded any pertinent information to the health plan's QI department within one (1) business day.

2. Physician/Provider Initiated Complaint

a. Providers are encouraged to assist with quality improvement efforts by providing information regarding any aspect of the network or health plan operations.

b. The provider may submit a complaint to the CHCN via telephone or written correspondence.

c. CHCN staff will assist in resolving the complaint or refer the complaint to the appropriate plan management staff.

d. Non-clinical issues will be resolved within five (5) working days of receipt.

e. Clinical issues will be resolved within thirty (30) working days of receipt by the CHCN QM/UM Director, the CHCN Medical Director or designee or have documentation of reasonable efforts to resolve the complaint.

f. The provider will be notified in writing of the resolution. The correspondence will also inform the provider of the right to further consideration if the provider is not satisfied with the resolution.

3. Appeals

All authorization appeals will be handled following the policy "Authorization Appeals" on the next page.

Authorization Appeals

Policy:
Appeals and complaints from members and providers regarding denial of requested medical services shall be documented and addressed in a systematic and timely manner.

Scope:
All authorization appeals from both members and providers regarding services denied for lack of medical necessity or non-covered benefit.

Expedited appeals situations are considered when the appeal regards 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, and can include requests for experimental and/or investigational treatment.

Procedure:
Expedited Appeals:

- The member is notified in writing of their right to inform the Department of Managed Care of their complaint at any time.
- The appeal is immediately referred to the Medical Director or designee in instances where the Medical Director is not available.
- The member, provider, and Department of Managed Care will receive a written statement on the disposition or pending status of the appeal no later than 3 business days from the receipt of that appeal.

Non-expedited Appeals:

- Providers and/or Members may submit appeals in writing or by telephone to CHCN.
- All appeal information is logged into the services appeal log.
- Member and provider will be mailed a letter of acknowledgement within five days from the QI /UM department.
- The UM Supervisor will pull all documents regarding the requested services for review by the QI Director and/or Medical Director.
- Only the Medical Director may uphold a denial.
- Resolution will take place within 30 days of receipt of the appeal.
- A letter will be sent to the member and provider explaining the resolution and any further appeals process.
- Members and providers may appeal to their health plan or the department of managed care in any instances where the resolution is unacceptable.
- All documentation regarding the appeal will be kept in a separate file by the Director of QI/UM.

External Review:
In addition, all members may request an independent, external review for any referral that is denied, modified or delayed because of a lack of medical necessity. When CHCN is notified that the member is requesting an external review, UM staff will notify the health plan within 1 to 2

business days. At the time of notification, UM staff will provide any necessary information the health plan may need to proceed with the external review process.

Members are made aware of their right to an independent, external review, within the body of the denial letter with the following language:

> "You may request an independent medical review ("IMR") of disputed health care services from the Department of Managed Health Care ("DMHC") if you believe that health care services have been improperly denied, modified, or delayed by the Plan or one of its contracting providers. A "disputed health care service" is any health care service eligible for coverage and payment under your subscriber contract that has been denied, modified, or delayed by the Plan or one of its contracting providers, in whole or in part because the service is not medically necessary".

Additional instructions for the IMR are provided in the denial letter.

Member Rights and Responsibilities

Purpose:

The member rights and responsibilities policy has been developed to ensure that the most appropriate cost-effective care is comprehensively provided by the CHCN providers in the network, and that the care is responsibly received by the CHCN members.

Scope:

The member rights and responsibilities policy will be included in the CHCN provider manual and member services handbook as appropriate. The policy also will be posted in CHCN provider offices.

Policy:

CHCN participating providers and members will abide by the rights and associated responsibilities of the members in the process of health care service delivery.

All CHCN providers and members will be provided with a copy of the Member's Rights and Responsibilities Policy. The providers and members also will be notified of revisions or updates in these documented rights and responsibilities.

Member information will be well-designed, comprehensible, and written in languages that represent the major population groups served by the CHCN.

Member's Rights

A CHCN Member has the right to:

- Know their rights and responsibilities
- Know about services, doctors and specialists
- Have access to their medical records, according to state and federal laws
- Have an honest talk with their doctor about all treatments, regardless of their cost or whether their benefits cover them
- Be treated with respect all the time
- Have their privacy protected by everyone in the Network
- Know that all information is kept confidential
- To choose a primary care provider
- Refuse care from a primary care provider or other care givers
- Help make decisions about their health care
- Make a living will (advance directive)
- Receive family planning services
- Be treated for sexually transmitted diseases (STDs)
- Get emergency care outside of our network, according to Federal Law
- Get health care from a Federally Qualified Health Center (FQHC)
- Get health care at an Indian Health Center
- Get no cost interpreter services; including services fro the hearing impaired
- Tell us what they don't like about our health plan or the health care they get

- Appeal our decisions about their health care
- Tell us what they don't like about our rights and responsibilities policy
- Ask the Department of Social Services for a Fair Hearing
- Choose to leave the health plan

Member Responsibilities

The CHCN Member has the responsibility to:

- To make an appointment with their doctor within 120 days of becoming a new member for an initial health assessment
- Give their doctor the information they need for treatment
- Learn as much as they can about their health
- Follow the treatment plans the patient and doctor agrees to
- Follow the doctor's advice about taking good care of themselves
- Use appropriate sources of care
- Bring their ID card with them when they visit their doctor
- Treat their doctors and other care givers with respect
- Know and follow the rules of their health plan
- Know that laws govern our health plan and regulate services
- Know that we can't discriminate against them because of your age, sex race, national origin, culture, language needs, sexual orientation or health

Member Access

POLICY

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

SCOPE

All CHCN managed care patients and providers.

PROCEDURE

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

- Clinic's location and telephone number
- Hours of operation
- How to contact the clinic after hours
- How to select a Primary Care Provider
- How to make an appointment
- Services available at the clinic
- How referrals to specialists are made
- What to do in case of an emergency
- How to submit complaints

In addition, managed care patients new to the clinic are sent cards requesting that they schedule an appointment for a new patient exam within 120 days.

PROCEDURE: Access Oversight

Access Standards

CHCN monitors appointment availability using the Department of Managed Health Care Provider Appointment Availability survey tool for primary and specialty care providers. Providers must meet the following state standards:

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

- Urgent primary and specialty care appointments available within 48 hours days of request

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

After Hours Care

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

Alameda Alliance for Health
Building Healthy Communities One Family at a Time

If you have a problem with your health plan or the care you receive, fill out this form and mail it to:

Member Services Department
P.O. Box 2818
Alameda, California 94501-0818
Tel: 510.747.4567 Fax: 510.747.4504

CUSTOMER COMPLAINT FORM*

Customer Name			Alliance ID #
Address Street		City	Zip
Day Tel.#	Alternate Tel.#		Date of Birth
Name of Person Filing Complaint (if not the same person as above)			Tel.#
Where Problem Occurred			Date Problem Occurred

Please describe the problem you had.

(attach extra pages if needed)

How have you tried to resolve this problem?

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

Signature Date

NOTE: The California Department of Managed Health Care is responsible for regulating health plans. The Department of Managed Health Care has a toll-free number **1-800-400-0815** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free numbers **1-800-735-2929 (TTY)** or **1-888-887-5378 (TTY)** to contact the Department. The Department's Internet website **(http://www.hmohelp.ca.gov)** has complaint forms and instructions online.

If you have a grievance against the Alliance, you should call us first and use our grievance process before contacting the Department of Managed Health Care. If you need the Department of Managed Health Care's help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by the Alliance, or a grievance that has not been resolved for more than 30 days, you may call them for assistance. The Alliance's grievance process and the Department of Managed Health Care's complaint review process are in addition to any other dispute resolution procedures that may be available to you and your failure to use these processes does not preclude your use of any other remedy provided by law. No member may be discriminated against or disenrolled from the plan solely because he/she has filed a complaint.

*If you need help with this form call (510) 747- 4567.

Alameda Alliance for Health
Building Healthy Communities One Family at a Time

Member Services Department
P.O. Box 2818
Alameda, California 94501-0818
Tel: 510.747.4567 Fax: 510.747.4504

A Member's Guide to the Complaint/Grievance Process

Your happiness with your health care is important to us! Please call our **Member Services Department** first if you have a complaint about your health care services. We want to help you. The number to call is:

(510) 747- 4567

Step 1: Complaint Process

Tell the Member Service Representative (MSR) that you have a complaint. The MSR will ask about the problem and get started on solving it. We will send you a letter within 5 days after receiving your complaint. The letter will tell you the status of your complaint and give you the name of a person to contact with questions. In most cases, a MSR will contact you with a solution to the problem in 30 days or less.

Step 2: Grievance Process

If you are unhappy with the solution from Step 1 or want to avoid the complaint process, you may file a grievance with a MSR at any time. Our Grievance Coordinator (GC) will look into your problem further and offer a fair solution within 30 days of getting your call or letter. If you do not like the GC's solution, you may ask to be heard by the Health Care Quality Committee.

Step 3: Health Care Quality Committee Hearing

Here, your problem will be looked into by a group of people who work on health care quality issues. This group may include doctors, consumers, and plan staff. You or your representative will have a fair chance to state your case in person or in writing at the next scheduled meeting. However, if your request is received fewer than 15 business days before that meeting, you will be scheduled to appear the following month. If you are unhappy with the result, you may appeal to a subcommittee from our Board of Governors.

Step 4: Appeal to the Alliance Board

Here, you may state your case to a subcommittee from the Alliance Board of Governors no fewer than 15 business days after the Alliance receives your request. This group will give their recommendations to the entire Board for a decision at the next meeting. The Board is the final decision making group in our plan. It is made up of health care providers, community leaders, and members.

Throughout this Process You Have the Right to:

- Be treated with respect
- Give us your views
- Have materials translated & interpreter services
- Represent yourself or have someone else represent you
- Propose a solution
- Look at the file documenting your complaint
- See plan policy manuals, protocols & procedures
- Request appeals verbally if you prefer not to write

Expedited Matters

Any complaint involving an imminent and serious threat to a member's health will be addressed by the MSR within 3 days of receiving the complaint. These cases include, but are not limited to, severe pain, potential loss of life, limb, or major bodily function. You may contact the Department of Managed Health Care right away and tell them about this kind of complaint.

♦ Medi-Cal Managed Care Ombudsman (Medi-Cal Members Only)

If you feel the Alliance has not solved your problem, you may call this State office at 1-888-452-8609. Their office hours are from 8:00 a.m. and 5:00 p.m. They offer help to Medi-Cal members in managed care plans.

♦ State Fair Hearings (Medi-Cal Members Only)

You may also file a request for a State Fair Hearing at any time within 90 days of the action that you are complaining about.

You may ask a MSR for help in filing a State Fair Hearing request. You may also call the Department of Social Services at 1-800-952-5253. If you need a teletypewriter (TDD), call 1-800-952-8349. The request can be sent to: California Department of Social Services, State Hearings Division, P.O. Box 944243, Mail Station 19-37, Sacramento CA 94244-2430.

♦ Department of Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health plans. The DMHC has a toll-free number **1-800-400-0815** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free numbers **1-800-735-2929 (TTY)** or **1-888-887-5378 (TTY)** to contact the DMHC. The DMHC's Internet website can be found at **(http://www.hmohelp.ca.gov)** and has complaint forms and instructions online.

If you have a grievance against the Alliance, you should call us first and use our grievance process before contacting the DMHC. If you need the DMHC's help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by the Alliance, or a grievance that has not been resolved for more than 30 days, you may call the DMHC for assistance.

The Alliance's grievance process and the DMHC's complaint review process are in addition to any other dispute resolution procedures that may be available to you. Your failure to use these processes does not preclude your use of any other remedy provided by law.

♦ Independent Medical Review

The Alliance has a process for external independent reviews of its decisions that deny, modify, or delay members' health care, including those that involve experimental or investigational services. You can have access to this process free of charge when **ALL** of the following (A through C) are true:

A. (1) A provider has recommended treatment, **OR**
   (2) You have received urgent care or emergency care from a provider, **OR**
   (3) You are requesting treatment for a condition for which you have been seen by an in-plan provider, even though the provider may not be recommending the treatment, **OR**
   (4) You are requesting an experimental or investigational service for a life threatening or seriously debilitating condition.
B. The treatment must have been denied, modified, or delayed by the Alliance based on medical necessity.
C. You have filed a complaint or grievance with the Alliance regarding the denial, modification or delay of the treatment request. The complaint/grievance process must have offered you a resolution or been in process for at least 30 days. In the case of expedited reviews (see page 1), the complaint/grievance process will be resolved within 3 days.

Note: a decision not to participate in this process may cause you to lose any statutory right to pursue legal action against the Alliance regarding the disputed healthcare services.

Please Note: Call our Member Services Department at any time if you need somebody to explain any part of this "Member's Guide." The phone number is (510) 747-4567.

Instructions: Please complete this form and attach any related documentation.
Mail to: *Blue Cross of California, P.O. Box 60007, Los Angeles, CA 90060-0007*
Attn: Grievance Coordinator. You may also file a grievance by telephone by calling the phone number printed on your Blue Cross Identification Card.

Member Grievance Form - Medi-Cal and Healthy Families

(You will be sent a response within 30 calendar days of the receipt of this form by Blue Cross)

Date:

Member Name: Member ID No./CIN No.:

Address:

Phone No.:

Information About The Grievance

(This information becomes part of the permanent record; write clearly and legibly. Use additional sheets of paper if necessary.)

Date of incident:

Describe what happened:

Signature of member *(Parent or Guardian if the member is a minor)*

X Date:

If you need assistance with this form, please call the phone number on your Blue Cross identification card.

** please read the back of this form for additional options.*

How to Use Our Provider Portal CHCN Connect

For staff of CHCN member community health centers and business partners of CHCN, this is your gateway to accessing CHCN managed care information. Information on our various collaborative projects are also available here. You must be a registered and authorized user to gain access to Network information. Information here includes:

- CHCN Clinic News
- Access to Managed Care Services Information
- CHCN Network Meeting Agendas and Minutes
- Upcoming Events and Announcements
- Past Presentations and Educational Materials
- Useful Links

Access: Using your browser go to https://portal.chcnetwork.org/Login The home page provides: clinic news, calendar of upcoming events, links to CHCN clinic websites and a place to login and register for login access to Managed Care Services.

Calendar: The calendar of upcoming events provides clinics with information regarding CHCN's meetings and trainings along with access to agendas and minutes on a yearly basis. Just click on the name of the event for more information and/or export to your personal calendar.

CHCN Health Centers: Using the links to CHCN's seven clinics websites you can directly go to each clinics home page.

Managed Care Services: These services are intended to provide the staff of CHCN clinics and CHCN business partners access to necessary data and information. To gain access to Managed Care Services, you must fill out the Request Access Form. The form is available for downloading. This will assist CHCN in determining and assigning your appropriate access rights.

These services provide member and provider lookups specific to your clinic or site. You can submit authorization requests. You will be able to view member eligibility, claims, authorizations and provider information depending on your access rights. Information provided is the most current and is updated daily.

You will need to familiarize yourself with the policies and procedures regarding data retrieval, transfer and storage. Go to the HIPAA section for information on proper use and dissemination of patient data.

Eligibility Lookup: Just click on Member Search for easy up to date eligibility information. Enter last name, first name, date of birth and health plan ID then click on the Search button. You must enter data in at least one field. To narrow your search results, enter data in as many fields as possible. Health plan ID is either the eleven-digit patient ID for the Alliance or the nine-digit certification number for Blue Cross. Once the search is completed the member information will appear. Eligibility can be verified by the effective or term date. The member's primary care clinic and health plan information is also available.

Click on Details to print out eligibility information. You can also click on the box marked Claims and Auths to access this member's claim and authorization history.

Claim Status: Click on Claims Search link to access claim status information. Enter your search criteria in the appropriate space then click on the Search button. You must enter data in at least one field. To narrow your search results, enter data in as many fields as possible.

By clicking on Details you can access more specific information including diagnosis code, amount paid, and provider information.

Authorizations: Click on Authorizations Search link to access authorization information and/or status. Once again enter your search criteria in the appropriate space (as defined above) then click on the Search button. You must enter data in at least one field. To narrow your search results, enter data in as many fields as possible.

By clicking on Details you can access more specific information.

Remittance Advice RAs): Click on Data Downloads link to access explanation of benefit information. Enter Tax ID number in the appropriate space then click on GO. Then select a date and check number and click on GO to access specific check information.

Specialty Provider Directory: To access CHCN's Specialty Provider Directory click on the Specialist link. Search by Provider Last Name, by City or by Specialty. Access to CHCN's Specialty Network is available on both the public and secured sites.

Authorization Submission: Click on the authorizations app icon to access the authorization dashboard. From the dashboard you can select to create a new authorization, revise, edit or copy an existing authorization as well as print approval and denial letters.

CHCN CONNECT PROVIDER PORTAL

Our CHCN Connect provider portal (https://portal.chcnetwork.org/Login?returnurl=%2f) offers; the specialty provider directory, a resource library for providers, eligibility verification, claims inquires, authorization status checks with features such as a secure platform to submit **online prior authorization requests**, and user account self-management.

Please identify a **Local Administrator** for your group. The role of s Local Administrator is to add new staff accounts, deactivate accounts and grant access rights to the different features offered in CHCN Connect. The Local Administrator is the gatekeeper for all accounts for the group. Once the local admin account is created you can make changes in CHCN Connect faster without having to contact CHCN.

If you are the person for the job please email us at portalsupport@chcnetwork.org with your **First Name, Last Name, Phone Number, Group Name, Tax ID, and Organization NPI**. Once the Local Administrator for your group is set up in our system he or she will be notified via e-mail.

To view our On Demand training on how to use CHCN Connect please click on the link below.

PLAY RECORDING (18 min)
https://chcn.webex.com/chcn/ldr.php?RCID=8143e1694827fa247031d3c7f3304e7a
Recording password: (This recording does not require a password.)

Thank you,

CHCN Connect Support Team

Provider Satisfaction Survey Administration

Policy:

The Community Health Center Network (CHCN) is a management services organization for its eight participating community health centers. CHCN's mission is to provide these services at the highest quality to support the work of the health centers, contracted specialists, and the members and communities in which they serve. CHCN conducts a patient satisfaction survey at least every two years to obtain feedback on the quality of services it provides.

Scope:
All contracted providers receive surveys from CHCN.

Procedure:
Provider Services will be responsible for ensuring that each contracted provider and appropriate operations staff at the clinics receives a satisfaction survey to complete (see attached survey).

An established deadline and fax number for responses will be printed on the survey.

Surveys will be conducted for general categories of specialty or primary care provider.

Questions on the survey will rate each area of operations within CHCN including: member eligibility, utilization review, claims processing, and quality improvement.

Results of the surveys will be summarized and analyzed by Provider Services. The results will be shared with the Board of Directors, Medical Directors, Clinic Managers, and Fiscal Managers at the clinics,

Physician/Provider Initiated Complaint

a. Providers are encouraged to assist with quality improvement efforts by providing information regarding any aspect of the network or health plan operations.

b. The provider may submit a complaint to the CHCN via telephone or written correspondence.

c. CHCN staff will assist in resolving the complaint or refer the complaint to the appropriate plan management staff.

d. Non-clinical issues will be resolved within five (5) working days of receipt.

e. Clinical issues will be resolved within thirty (30) working days of receipt by the CHCN QM/UM Director, the CHCN Medical Director or designee or have documentation of reasonable efforts to resolve the complaint.

f. The provider will be notified in writing of the resolution. The correspondence will also inform the provider of the right to further consideration if the provider is not satisfied with the resolution.

Interpreter Services

Alameda Alliance for Health and Blue Cross of California interpreter services to members who need assistance communicating with their physician. Physicians are discouraged from using members' friends or family as interpreters.

Alameda Alliance for Health (AAH)

Requesting Interpreter Services:

- To arrange for interpretive services for CHCN/AAH members, contact AAH Member Services Department at **510-747-4567** as soon as the need is identified.
- Requests should be made at least three (3) working days prior to the member's appointment for face-to-face interpretation. If face-to-face interpretation cannot be arranged, telephonic interpretation will be arranged.
- The following information should be submitted at the time of the interpreter request:
    - Name and subscriber number of the patient
    - Language needed
    - Gender of the patient and if there is any preference for the gender of the interpreter
    - Date and time of appointment
    - Approximate length and reason for the appointment
    - Name of Provider
    - Phone and fax number of contact person in Provider office
    - Provider's offices address, including department, floor and/or room number, if applicable.

Anthem Blue Cross (ABC)

Arranging Telephonic Interpreter Services:

- Call the BC Customer Care Center at **1-800-407-4627** to arrange for telephonic interpreter services and/or services for the hearing impaired.
- Provide the member's subscriber number.
- Explain the need for an interpreter and state the language.
- Wait on the line while the connection is made.
- Once connected to the interpreter, introduce the member, explain what help is necessary, and begin the dialogue.

Arrange Face-to-Face Interpreters:

- Contact the BC Customer Care Center at **1-800-407-4627** to schedule a face-to-face interpreter and/or sign language interpreter for a patient.
- A minimum of 72-hour advance notice is required for the service(s). Any cancellations require at least a 24-hour notice. In emergency situations or where an in person interpreter or signer is unavailable and absolutely necessary, the BC Customer Care Center may be contacted with less than a 72 hour notice and every attempt will be made to coordinate the services.

Alameda Alliance for Health

INTERPRETER SERVICES QUICK REFERENCE GUIDE

Alameda Alliance for Health provides no-cost interpreter services for all Alliance Covered Services. Interpreters are available 24 hours a day, 7 days a week. Your patient must be an Alliance member to receive interpreter services. Please confirm patient's eligibility before requesting services.

Using professional interpreter services is good medicine.

- Alameda Alliance strongly encourages the use of professional interpreters.
- Using a professional interpreter reduces the chance of mis-communication that may result from using an untrained interpreter, such as a patient's family member.
- If a member declines interpreter services, please document the refusal in the medical record, as required by the California Department of Health Care Services and the California Managed Risk Medical Insurance Board.

HOW TO ORDER FACE-TO-FACE INTERPRETER SERVICES

- The Alliance covers any language, including American Sign Language.
- Call the Alliance Member Services department at **510-747-4567** to schedule an interpreter.
- You may also use the Request for Interpreters Form and fax it to Alliance Member Services at **1-855-891-7172.**
- We ask for **72 hours advance notice**. Same day requests may be possible for urgent situations.

HOW TO ORDER TELEPHONIC INTERPRETER SERVICES

- Call the Alliance's interpreter vendor, International Effectiveness Centers (IEC), at **1-866-948-4149**
- When prompted for a provider ID number, inform the IEC representative that you are an Alliance provider.
- Provide the IEC representative with the member' s 9-digit Alliance ID number

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

Please submit this request to:
Alliance Member Services Department
Fax: 1-415-788-4829
Phone: 510-809-3986

Alameda Alliance for Health
Request for Interpreter Services
Please fill out the form completely

Date of request:_____ Alliance provider making request:_____

Contact person in provider office: _____
Name / Title

Phone / fax / email for contact person: _____/_____/_____
Phone Fax Email

Please schedule interpreter services for the following:

Alliance member: _____
Last name First name

Alliance member ID number:_____ Language needed:_____

Date of appointment:_____ Time of appointment:_____

Name of provider / facility:_____

Address, department, floor, and/or suite:_____
Be as specific as possible

City:_____

Phone and fax number:_____/_____

Nature of appointment (*chemo, radiology, specialist, etc.*):_____

Approx. length of appointment:_____ *Interpreter preference: Male / Female / No preference

*Preferred Interpreter Name (if applicable): _____
Please note that interpreter of choice may not be available

Tips for Working with Interpreters

- Brief the interpreter in private before the member's visit. Provide relevant information about the member.
- Encourage the interpreter to ask questions or clarify a message whenever necessary.
- Address the member directly. Avoid directing all comments to the interpreter.
- Talk in short sentences. Discuss one concept at a time.
- Be patient. Careful interpretation may require the interpreter to use long phrases. It can take more words or time to describe a concept in another language.
- Avoid using medical jargon when possible. It may be difficult for the interpreter and member to understand.
- Be aware of nonverbal cues from the member, such as head nodding, smiles, body position, etc. These may indicate how much information is being understood.

Tips for Communicating with Patients Who Speak Limited English

- Speak slowly, not loudly.
- Organize what you are going to say first. Use short, simple sentences. Keep in mind that what is said at the beginning and end of a discussion is remembered most.
- Face the patient and watch facial expressions and body language. If these don't agree with the words the patient is using, or if the patient's expressions indicate that he or she does not understand you, slow down and start again.
- Try to ask questions that cannot be answered "yes" or "no." Instead, ask questions in a way that requires the patient to respond with information. For example, ask questions that begin with "why," "how," or "what." The answers you get will help you know whether the patient properly understands the question.
- Rephrase and summarize often.

Anthem Blue Cross
Health. **Join In.**

Interpreter Services Desktop Reference

Keep this guide handy for use with members enrolled in Anthem Blue Cross publicly funded programs. Interpreter services are free. Please see other side for individual language aids for patients.

Telephone Interpreters

During business hours, members and providers may call the Customer Care Center at **1-800-407-4627** (outside Los Angeles County) or **1-888-285-7801** (inside Los Angeles County). After-hours, call the 24/7 NurseLine at **1-800-224-0336**.

1. Give the customer care associate or the help line nurse the member's ID number.
2. Explain the need for an interpreter and state the language.
3. Wait on the line while the connection is made.
4. Once connected to the interpreter, the associate or the help line nurse introduces the Anthem Blue Cross member, explains the reason for the call, and begins the dialogue.

Face-to-Face Interpreters Including Sign Language

Members and providers may call the Customer Care Center at the appropriate numbers above to schedule services during business hours. Seventy-two business hours are required to schedule services, and 24 business hours are required to cancel. Providers may also schedule by e-mailing **ssp.interpret@wellpoint.com.** Registration with our secure e-mail is required. Please type "secure" in the subject line.

TTY and Relay Services (for Members with Hearing or Speech Loss)

During business hours, members may call the Anthem Blue Cross TTY line at **1-888-757-6034**. After business hours, members may use the 24/7 NurseLine TTY at **1-800-368-4424** or the California Relay Service number at **711**.

Show this to your patient. If you know the appropriate translation, point to it. Then, call Anthem Blue Cross interpreter services.

English
One moment please while I call an interpreter.
This service is free.

Spanish
Espere un momento mientras me comunico con un intérprete. Este servicio es gratuito.

Arabic
انتظر لحظة من فضلك بينما أتصل بمترجم.
هذه الخدمة مجانية.

Armenian
Մի րոպե, խնդրում եմ, մինչ ես կզանգահարեմ թարգմանչին: Այս ծառայությունը անվճար է:

Chinese
請稍候，我將致電給口譯員。
這是免費服務。

Farsi
لطفاً در حالیکه با یک مترجم تماس می گیرم، لحظه ای تأمل کنید.
این سرویس مجانی است.

Hmong
Thov tos ib pliag cia kuv nrhiav ib tug txhais lus.
Qhov kev pab txhais lus no koj tsis tas them nyiaj.

Khmer
សូមចាំមួយភ្លែត ពេលខ្ញុំហៅអ្នកបកប្រែម្នាក់ ។
សេវានេះ មិនគិតថ្លៃទេ ។

Korean
제가 통역사에게 전화하는 동안 잠시만 기다려 주십시오.
이 서비스는 무료입니다.

Russian
Прошу Вас подождать, пока я вызову переводчика.
Эта услуга предоставляется бесплатно.

Tagalog
Sandali lang po habang tumatawag ako ng isang tagapagsalin-wika. Ang serbisyong ito ay walang bayad.

Vietnamese
Xin quý vị vui lòng chờ trên đường dây eđể tôi gọi một thông dịch viên. Đây là dịch vụ miễn phí.

Free Interpreting Services

Free interpreter services are available to members enrolled in Anthem Blue Cross publicly funded programs.

Telephone Interpreters

During business hours, members and providers may call the Customer Care Center at (800) 407-4627.
After-hours, call MedCall at (800) 224-0336.

- Give the customer care associate the member's ID number.
- Explain the need for an interpreter and state the language.
- Wait on the line while the connection is made.
- Once connected to the interpreter, the associate or MedCall nurse introduces the Blue Cross member, explains the reason for the call, and begins the dialogue.

Face-to-Face Interpreters Including Sign Language

Members and providers may call the Customer Care Center at **(800) 407-4627** to schedule services during business hours. Seventy-two business hours are required to schedule services, and 24 business hours are required to cancel. Providers may also schedule by e-mailing **ssp.interpret@wellpoint.com**. Registration with our secure e-mail is required. Please type "secure" in the subject line.

TTY and Relay Services (for Members with Hearing Loss or Speech Impairment)
During business hours, call Blue Cross' TTY line at **(888) 757-6034**.

Interpreter Services Attendance Verification Form (Word)

Program Resources

- **Interpreting Services Free**
  This 1-page brochure spells out the following phrase in 12 different languages: "If you need an interpreter, point to your language and we will call one for you. This service is free."
- **Interpreter Services Desktop Reference**
  Includes a program description, tips for working with an interpreter, and a page in 12 languages that reads "One moment please while I call an interpreter. This service is free.
- **Request/Refusal Forms for Interpretive Services**

  - **Arabic**
  - **Armenian**
  - **Chinese**
  - **English**
  - **Farsi**
  - **Hmong**
  - **Khmer**
  - **Korean**
  - **Russian**
  - **Spanish**
  - **Tagalog**
  - **Vietnamese**

Language Assistance Program Notice

Provider medical groups (PMGs) and Independent Physician Associations (IPAs) that have delegated responsibilities, such as utilization management, should include Anthem Blue Cross' State Sponsored Business language assistance notice with benefit-related communications to members.

- **Cultural and Linguistics Collaborative and ICE Assessment Tool**
- **Language Assistance Program Quick Reference Guide**
- **HFP Language Assistance Program Notice**
- **AIM and MRMIP Language Assistance Program Notice**

Transportation Services

Alameda Alliance for Health (AAH)

Medical Transport Services

Medical transport is transport that is medically necessary. Benefits include:

- **Emergency** transport – Ambulance transport to the nearest hospital is covered if the member has reason to believe that the medical problem is an emergency, and that the problem calls for emergency transport. This includes ambulance transport services supplied through the "911" emergency response system
- **Non-emergency** transport – May be covered when the member:
    - Moves to or from a hospital or skilled nursing facility for an authorized admission.
    - Needs to go to and from the member's home to a scheduled medical appointment.

All requests for non-emergency transportation require prior authorization. The Alliance uses the Medi-Cal Criteria for Medical Transportation to review requests for nonemergency transportation. The transportation must be arranged by Alliance Member Services and provided by an approved service provider. Please call at least three business days before your scheduled appointment and as soon as possible in the case of urgent appointments. The Alliance will approve only the lowest cost type of non-emergency medical transportation that is adequate for your medical need and is available at the service level required.

Exclusions:

- Transport to the home unless medically necessary and authorized by the Alliance.
- This benefit does not cover transportation solely for the member's convenience. An Alliance doctor must certify that your medical condition meets the Alliance criteria for coverage of non-emergency transportation.

To request transportation services from Alameda Alliance Health, please call the Member Services department at **510-747-4567** or **1-877-932-2738** at least five (5) business days (Monday-Friday) before your appointment. Or call as soon as you can when you have an urgent appointment. Please have your member ID card ready when you call.

Anthem Blue Cross Medi-Cal

Customer Care Center – 1-800-407-4627

Non-emergent transportation to medical appointments is a covered service by Anthem Blue Cross Medi-Cal for Medi-Cal members living in Alameda and Contra Costa Counties. Transportation requests are assessed on an individual basis according to objective criteria for need. Anthem Blue Cross will coordinate with transportation providers to assure that the transportation needs are met. Members and Providers should call the Customer Care Center at 1-800-407-4627.

Plan your trip to better health!
Anthem Blue Cross offers transportation benefits at no extra cost

Dear Member:

Thank you for being an Anthem Blue Cross member. It's hard to stay healthy if you can't get to doctor appointments. We want to help.

You may already be getting rides to and from medically necessary appointments. To start or continue using your transportation benefits on or after November 17, 2015, call us at 1-877-931-4755 (TTY 1-866-288-3133).

You can schedule your transportation 30 days in advance. You can even schedule up to two trips per call. Let us know the following when you call:

- Your ID number
- The date and time of your appointment
- The address and phone number of where we are taking you
- If you need to bring any equipment with you, like a wheelchair or oxygen tank
- If you need any special assistance with your transport

The Physician Certification Statement (PCS) is required for all nonurgent, routine trips.

If you have questions or need more information, call the Member Services number on your ID card or go to www.anthem.com/ca/medi-cal.

Sincerely,

Anthem Blue Cross

Initial Health Assessments (IHA)

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

The goals of the SHA are to assist providers with:

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

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

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

Periodicity

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

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

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

Pediatric Members:
Members 0–17 years of age must complete the SHA during the first scheduled preventive care office visit upon reaching a new SHA age group. PCPs must review the SHA annually with the

patient (parent/guardian or adolescent) in the intervening years before the patient reaches the next age group.

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

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

Assessment Components

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

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

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

PCP Responsibility

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

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

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

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

Documentation by PCP

The PCP must sign, print his/her name, and date the "Clinic Use Only" section of a newly administered SHA to verify that it was reviewed and discussed with the member.

The PCP must document specific behavioral-risk topics and patient counseling, referral, anticipatory guidance, and follow-up provided, by checking the appropriate boxes in the "Clinical Use Only" section.

The PCP must sign, print his/her name, and date the "SHA Annual Review" section of the questionnaire to document that an annual review was completed and discussed with the member.

A member's refusal to complete the SHA must be documented on the age-appropriate SHA questionnaire by:

- Entering the member's name (or person completing the form), date of birth, and date of refusal in the header section of the questionnaire.
- Checking the box "SHA Declined by Patient."
- Having the PCP sign, print his or her name, and date the "Clinic Use Only" section of the SHA.
- Keeping the SHA refusal in the member's medical record.

Additional Resources

Instruction Sheet for Provider Office (attached)

DHCS Policy Letter 13-001 Requirements for the SHA/IHEBA may be accessed at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2013/PL13-001.pdf

DHCS Frequently Asked Questions can be accessed at: http://www.dhcs.ca.gov/formsandpubs/forms/Documents/MMCD_SHA/GenDocs/SHA_FAQs.pdf

STAYING HEALTHY ASSESSMENT (SHA)

Instruction Sheet for the Provider Office

SHA PERIODICITY TABLE

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

SHA COMPLETION BY MEMBER

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

PATIENT REFUSAL TO COMPLETE THE SHA

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

SHA RECOMMENDATIONS

Adolescents (12-17 Years)

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

Adults and Seniors

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

PCP RESPONSIBILITIES TO PROVIDE ASSISTANCE AND FOLLOW-UP

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

REQUIRED PCP DOCUMENTATION

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

OPTIONAL CLINIC USE DOCUMENTATION

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

Child Health and Disability Prevention (CHDP)

Preventative Health Program for Infants, Children & Teens

Purpose

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

Eligibility

All Medi-Cal recipients from birth to age 21 are eligible for CHDP scheduled periodic health assessments and services. CHDP provides a schedule of periodic health services to non-Medi-Cal children and youth from birth to age 19 years whose family income is equal to or less than 200 percent of the federal income guidelines. All children and youth are eligible for health assessments based on the same schedule or periodicity used for Medi-Cal children and youth.

Access to CHDP Providers

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

Standards

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

Additional Information and Resources

To find out more about CHDP services please contact your county CHDP office.

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

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

Department of Health Care Services CHDP Overview can be accessed at the following link:
http://www.dhcs.ca.gov/formsandpubs/publications/Documents/CMS/pub141.pdf

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

Health Information Portability and Accountability Act

Guidelines

Community Health Center Network has instituted HIPAA-based guidelines in its operations, and has conducted HIPAA education for our member health centers in privacy, security, electronic transactions, identifiers and code sets.

CHCN requires the use of HIPAA compliant code sets, identifiers, and transactions. CHCN has available guides for the HIPAA compliant electronic transmission of data. CHCN Companion and HIPAA ASC x12N Implementation Guides are available at http://www.chcnetwork.org/ManagedCareServices/InformationforProviders/EDI/tabid/164/Default.aspx .

For more information regarding CHCN and HIPAA please contact our HIPAA Security and Privacy team at 510.297.0288 or contact our Electronic Data Interchange team at 510.297.0296.

DEFINITION OF MANAGED CARE TERMS

Average Length of Stay (ALOS): The average number of days in a hospital for each admission.

Authorization: A formal process to obtain approval for a specific service to be paid by either the health plan or the provider group that is financially responsible for the services according to a health plan contract.

Bed Days Per 1000: The number of inpatient days per 1000 health plan members.

Capitation: A stipulated dollar amount established to cover the cost of health care delivered to a person. The negotiated per capita rate is usually paid monthly to a health care provider. The capitated amount can be adjusted for age, sex, and other variables.

Credentialing: A process of review to approve a provider who applies to participate in a health plan. Specific criteria and prerequisites are applied in determining initial and ongoing participation in the health plan.

Encounters: A face-to-face meeting between a covered person and a health care provider where services are provided.

Enrollee: A person who is covered by the health plan. May be referred to as a member.

Exclusive Provider Organization (EPO): A program in which contracts are established with providers of medical care. Providers under such contracts are referred to as exclusive providers. Members are usually not allowed to use non-contracted providers. The exclusive providers are reimbursed fee-for-service for the care provided.

Health Plan: A health maintenance organization, preferred provider organization, insured plan, self-funded plan or other entity that covers health care services.

Health Maintenance Organization (HMO): An entity that provides offers or arranges for coverage of designated health services needed by plan members for a fixed, prepaid amount.

Individual Practice Association (IPA): A legal entity that is created for the purposes of individual providers obtaining managed care contracts. The providers in the IPA provide the medical care out of their own practices.

Management Services Organization (MSO): A legal entity that provides practice management, administrative and support services to individual physicians or group practices.

Member Months: A count which records one member for each month the member is effective.

Members: Participants in a health plan (subscribers, enrollees and eligible dependents) who make up the plans enrollment.

Network Provider: Physicians, hospitals, and other health care providers who contract with a health plan to provide health services to persons covered by a particular health plan.

Per Member Per Month (PMPM): A managed care reporting methodology that is used to capture

the frequency of an event for each member on a monthly basis. Utilization and financial data may be reported in this format. A variation of this methodology is Per Thousand Members Per Month (PTMPM). It is the same concept but is based on a thousand members.

Per Member Per Year (PMPY): A managed care reporting methodology that is used to capture the frequency of an event for each member on a yearly basis. Utilization and financial data may be reported in this format. A variation of this methodology is Per Thousand Members Per Year (PTMPY). It is the same concept but is based on a thousand members.

Point-of-Service (POS): A health plan allowing the covered person to choose to receive a service from a participating or non-participating provider, with different benefit levels associated with the use of participating providers. POS plans can be provided several ways using HMOs and/or PPOs.

Preferred Provider Organizations (PPO): A program in which contracts are established with providers of medical care. Providers under such contracts are referred to as preferred providers. Usually, the benefit contract provides significantly better benefits (lower co-payments) for services received from preferred providers. Members are allowed to use non-preferred providers but usually pay higher co-payments and deductibles.

Primary Care Physicians: A physician whose practice is devoted to family practice, general practice, internal medicine, or pediatrics. An obstetrician/gynecologist may be considered a primary care physician.

Quality Assurance: A formal set of activities to review and affect the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.

Referral: The recommendation by a physician and/or health plan for a covered person to receive care from a different physician or facility.

Risk Contract: A medical services agreement between the health plan and a provider group to provide a defined scope of health services for an agreed upon capitation rate. The contract can be for primary care, professional services (primary, specialty, and ancillary services), or global (professional services and hospital). If the cost of care provided exceeds the capitation rate, the provider group accepts the financial loss. If the cost of care provided is below the capitation rate, the provider group keeps the financial gain.

Risk Sharing: An agreement between the health plan and a provider group to share in the excesses and/or losses of a specific risk pool. A risk pool is a defined account to which revenues and expenses are posted. Some arrangement may be for an upside risk (sharing excesses) only.

Stop-loss Insurance: Insurance coverage taken out by a health plan or provider group to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year.

Utilization Review: A formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.