PROVIDER MANUAL

2021

CHOC Children's
CHOC.ORG | LONG LIVE CHILDHOOD

INTRODUCTION TO MEDI-CAL, CALOPTIMA AND CHOC HEALTH ALLIANCE

Medi-Cal

Medi-Cal is California's version of the federal Medicaid program for low income families, children and persons with disabilities. Medi-Cal provides a core set of health benefits, including primary and specialty care, hospital services, immunizations, pregnancy-related services and nursing home care.

Medi-Cal Managed Care Program

The Department of Health Care Services (DHCS) contracts with a managed care health plan to administer services through established networks of organized systems of care, which emphasize primary and preventive care. These plans have networks of providers, including doctors, pharmacies, clinics, labs, and hospitals. Members must use the providers in their network when care is needed.

Website: www.medi-cal.ca.gov

CalOptima

CalOptima is a county organized health system (COHS) that administers health insurance programs for low-income children, adults, seniors and persons with disabilities in Orange County. As a Medi-Cal managed care health plan, CalOptima is funded by the state based on periodic fixed payments for each recipient enrolled in Medi-Cal.

Website: www.caloptima.org

CHOC Health Alliance (CHA)

CHA is a Physician Hospital Consortium (PHC) that coordinates medical services for Orange County's pediatric and young adult Medi-Cal recipients from birth to 21 years of age. CHA is comprised of CHOC Children's Hospital of Orange County and the CHOC Physicians Network (CPN), an independent organization of contracted primary care physicians, specialists, ancillary providers and allied health professionals.

Website: www.chochealthalliance.com

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Disclaimer: This manual is revised periodically. For the most recent version, please visit the CHA website at www.chochealthalliance.com. In the event of a conflict or inconsistency between a provider's contract and this manual, the terms of the contract take precedence.

SECTION A: CONTACT INFORMATION

A1: CHOC Health Alliance

Resources	Contact Information
Administrative Offices	(714) 565-5100
Member Services Available 24/7	(800) 424-2462
Member Services Hearing Impaired TTY / TDD	(800) 735-2922 English (800) 855-3000 Spanish
Provider Services Monday – Friday: 8 am-5 pm	(800) 387-1103
Provider Relations	providerrelations@choc.org
Claims Department	(800) 387-1103, **Option 1**
Claim and Payment Appeals Provider Dispute Resolution (PDR)	(800) 387-1103, **Option 1**
Prior Authorization Department	(800) 387-1103, **Option 2**
Website	www.chochealthalliance.com
Provider Portal (EZ-NET)	https://eznet.rchsd.org

SECTION A2: CALOPTIMA

Resources	Contact Information
General Information	(714) 246-8500
Main Location	505 City Parkway West Orange, CA 92868
Customer Service	(888) 587-8088
Provider Resource Line	(714) 246-8600
Website	www.caloptima.org
Behavioral Health	(855) 877-3885
MedImpact Healthcare Systems *Pharmacy Benefit Manager*	(844) 282-5330

SECTION A3: OTHER PROGRAMS AND SERVICES

Resources	Contact Information
Denti-Cal	(800) 322-6384
Vision Service Plan (VSP)	(800) 615-1883
Vaccines for Children	(877) 243-8832
Regional Center of Orange County (RCOC)	(714) 796-5100
Orange County California Children's Services (CCS)	(714) 347-0300
Orange County Mental Health Plan	(800) 723-8641
Help Me Grow	(866) 476-9025

SECTION B: TOOLS AND RESOURCES

Section B1: Provider Relations (PR)

Provider Relations (PR) serves as a liaison between CHA and the provider community. Please feel free to reach out to them for any assistance you may need, including, but not limited to:

- Demographic changes
- Provider additions and terminations
- Authorization status
- Payment inquiries
- Member disenrollment
- Quality improvement and patient satisfaction
- Provider Incentive Program
- Provider and staff training

Contact your dedicated PR representative or email the PR team at providerrelations@choc.org.

Section B2: Website

Access CHA resources on our website at www.chochealthalliance.com. Resources include, but are not limited to:

- Provider portal link and registration form
- Provider training
- Prior Authorization, Provider Dispute Resolution (PDR) and other forms
- Best Practices and HEDIS® tools
- Claims and payment information

Section B3: Provider Portal

EZ-NET Services

EZ-NET is CHA's secure provider portal. To access your account, visit https://eznet.rchsd.org. Use EZ-NET to:

- Verify member eligibility and member's aid code
- Submit authorizations
- Check authorization status
- View claim status

Registration and Support

To register for an EZ-NET account:

- Visit www.chochealthalliance.com
- Download and complete the EZ-NET User Request form
- Fax the completed form to (858) 309-6279
- Once access is granted, a notification with instructions will be emailed to the new user

For access and training, contact Provider Relations at providerrelations@choc.org.

SECTION C: MEMBER SERVICES

C1: Member Eligibility

Providers must verify a member's eligibility on each date of service and prior to rendering services. If a member is not eligible, you may not receive payment for services provided on that date.

Verifying eligibility

Providers have multiple options for verifying a member's eligibility:

Eligibility Verification Systems	
Medi-Cal	Website: www.medi-cal.ca.gov Phone (AEVS): (800) 456-2387
CalOptima	Website: www.caloptima.org (see "CalOptima Link") Phone (IVR): (800) 463-0935
CHOC Health Alliance (CHA)	Provider Portal (EZ-NET): https://eznet.rchsd.org Phone: (800) 387-1103

C2: Primary Care Provider (PCP) Assignment

PCP Selection

New members can select a PCP at the time of enrollment by calling CHA Member Services at (800) 424-2462. If no choice is made, CHA auto-assigns the member using an algorithm that considers the members place of residence, primary spoken language, and other similar factors.

PCP Change

Members can change their PCP at any time by calling CHA Member Services at (800) 424-2462. The member, member's parent or legal guardian must make the PCP change request. The provider or office staff cannot make the request on behalf of the member.

Member Disenrollment

If the member-provider relationship is no longer positive and collaborative, the PCP can request the member's disenrollment (i.e. removal) from their panel.

- Member Disenrollment Criteria:
    - Non-compliance: Member repeatedly does not follow the recommended treatment and/or established office policies (missed appointments policy, etc.)
    - Disruptive behavior: Member or member's legal guardian exhibits threatening or inappropriate behavior towards the provider, staff or other patients
- What to Do Next:
    - Mail, fax or email a letter to Provider Relations stating detailed information on the reason(s) for requesting disenrollment
    - Mail a certified letter to the member stating the reason(s) for disenrollment
    - If the request fits the criteria, CHA will notify the member to select a new PCP

Until the change is complete, the current PCP must provide continued medical treatment or urgent care services to the member, for up to 30 days.

SECTION D: SERVICES COVERED BY CALOPTIMA

D1: Pharmacy Services

CalOptima administers pharmacy services for CHA members through a Pharmacy Benefit Manager, called MedImpact. For more information on approved medications, pharmacy locations and member benefits, please call Pharmacy Management at (714) 246-8471 or visit www.caloptima.org.

D2: Behavioral Health Services

CalOptima manages behavioral health treatment and outpatient mental health services for mild to moderate conditions. Severe cases may be referred to the Orange County Health Care Agency for specialized services.

Service	Access	Details
Outpatient Mental Health Services	CalOptima Behavioral Health: (855) 877-3885	• Treatment of mild to moderate mental health conditions • No prior authorization needed to start treatment
Behavioral Health Treatment (BHT)	CalOptima Behavioral Health: (855) 877-3885	• Treatment of autism spectrum disorder (ASD) • Services include applied behavioral analysis (ABA) and other evidence-based services • No prior authorization needed
Mental Health Services (Severe Cases)	Orange County Health Care Agency (HCA): (800) 723-8641	• Treatment of severe health mental conditions • Services directly through the Orange County Mental Health Plan (MHP) • Recommendation from a licensed provider is required

SECTION E: CLAIMS

E1: Claim Submission Requirements

CHA Contracted Provider

Providers must submit claims and encounters to CHA for ALL services.

Medi-Cal Guidelines

Electronic and paper claims must follow Medi-Cal billing guidelines. For more information, visit www.medi-cal.ca.gov.

Timely Filing

File a claim on an electronic or paper form within **90 calendar days** of the date of service, unless otherwise specified by your contract. Failure to follow these guidelines may result in denial and nonpayment. (Non-contracted providers are subject to Medi-Cal billing guidelines.)

E2: Electronic Claim Submission

File claims and encounters electronically with one of our contracted vendors. To register for an account, contact Office Ally or Change Healthcare.

Vendor	Payer ID	Contact	Website
Office Ally	CHOC1	(866) 575-4120	www.officeally.com
Change Healthcare	33065 or SCH01	(866) 363-3361	www.changehealthcare.com

E3: Paper Claim Submission

If you must send a paper claim, mail it to the following address:

Rady Children's Hospital – San Diego
Attn: CHOC/CPN – Claims
P.O. Box 1598
Orange, CA 92856

E4: Claim Status and Processing Time

Processing Time

The standard processing time for a claim is 30 business days from the date CHA receives the claim.

Status Updates

To check claim status:

- **Online**: Go to EZNet at https://eznet.rchsd.org/
- **Phone**: Contact the Claims Department at (800) 387-1103, Option 1

E5: California Children's Services (CCS) in the Whole Child Model (WCM)

Claim Requirements:

- Submit all claims to CHA for CCS services in the WCM
- Only include CCS diagnosis codes on claims for CCS services
- Prior authorization numbers must be included on claims

E6: Corrected Claims

What is a corrected claim?

A corrected claim is a resubmission of an existing claim. The corrected claim tells CHA that you are rebilling a previously submitted claim with the correct codes and/or modifiers, with the goal of payment.

Corrected Claim Submission

- Make the changes to the CPT, ICD-10, modifiers, etc. on a new paper form
- Stamp "corrected claim" on the document
- Mail the corrected claim to:

  Rady Children's Hospital – San Diego
  Attn: CHOC /CPN – Claims
  P.O. Box 1598
  Orange, CA 92856

E7: Provider Complaint Process

CHA and CalOptima maintain a multi-level complaint process to review and resolve provider disputes for claims payment.

Provider Dispute Resolution (PDR)

A PDR is a provider's written request to CHA challenging or appealing a payment or denial of a claim. Disputes must be received within 365 calendar days from CHA's action that led to the dispute (or the most recent action if there are multiple actions).

- PDR Submission
  - Download the Provider Dispute Resolution request form at www.chochealthalliance.com
  - Fill out the form and attach supporting documentation
  - Mail the completed form and documents to:

    Rady Children's Hospital
    Attn: CHOC /CPN – Provider Appeals
    3020 Children's Way, Mail Code 5144
    San Diego, CA 92123

- Receipt, Review and Resolution
    - CHA will acknowledge receipt by mail within 15 calendar days. If you do not receive an acknowledgment letter, contact CHA Provider Services at 800-387-1103.
    - CHA then reviews the PDR request to determine whether to uphold or to overturn the initial decision.
    - Once the decision is made, CHA will issue a dispute determination letter by mail within 45 days.

Second-Level Appeal

Providers who disagree with CHA's decision, may file a second-level appeal with the CalOptima Grievance and Appeals Resolution Services (GARS).

For additional resources on how to file a second-level appeal, visit www.caloptima.org/ForProviders/Resources/ProviderComplaintProcess.

SECTION F: PAYMENT

F1: Payment Disclaimer

Reimbursement for services is dependent on:

- Authorization of services
- Member eligibility
- Medical necessity
- Provider's contract

F2: Payment Models

What is Capitation?

Capitation is the fixed payment amount that a provider receives per-member-per-month (PMPM). It covers a defined scope of services (by procedure code) and varies based on a member's age and gender. Capitated services in CHA include:

- Most routine primary care services (e.g., sick visits)
- Most laboratory services (e.g., blood tests)

What is Fee-For-Service (FFS)?

Fee-For-Service (FFS) is the payment amount that a provider receives for Medi-Cal covered services not included under capitation. Services paid FFS include:

- Child Health and Disability Prevention (CHDP) services
- Certain "carve-out" primary care services (e.g. x-rays and minor surgical procedures)
- All services rendered to members with a Seniors and Persons with Disabilities (SPD) aid code
- Services rendered by Specialists, Ancillary Providers, and Hospitals

CHA pays providers according to the current Medi-Cal fee schedule. For more information visit, http://files.medi-cal.ca.gov/pubsdoco/rates/rateshome.asp.

F3: Coordination of Benefits (COB)

Coordination of benefits (COB) is required when a member is covered by one or more health insurers in addition to CHA. CHA is the payer of last resort and should be billed after all others.

Billing CHA and Other Health Coverage:

- First, file the claim with the primary insurer.
- If the primary insurer issues a partial payment or denial, submit a claim with a copy of the Explanation of Benefits (EOB), including the payment details, to CHA.
- If appropriate, CHA will pay the remaining balance up to the Medi-Call allowable amount.

F4: Member Billing

Federal and state law **prohibits** providers from charging or collecting payment from Medi-Cal eligible members for covered services, which includes, but is not limited to:

- Copayments, coinsurance or deductibles required by the member's other health coverage
- Pending or disputed claims
- Missed, canceled, or same day appointments
- Completing paperwork or forms related to the delivery of medical care, including but not limited to:
    - Immunization cards
    - Sports physical forms, or history of physical forms required by school
    - Disability forms
    - Forms related to Medi-Cal eligibility
- Other fees acquired while providing covered services to a Medi-Cal member

F5: Payment Vendor:

ECHO Health/Change Healthcare

The easiest and quickest way to receive payment from CHA is to register with our contracted vendor and choose a preferred payment method. Please see details for registration below:

- Visit the Provider Payments Portal at www.providerpayments.com. This portal is available for all methods of payment and offers detailed payment information, such as the Explanation of Provider Payment (EPP).
- Call ECHO Health at (888) 834-3511. Be sure to select a method of payment for both capitation and fee-for-service.

F6: Payment Methods

Electronic Funds Transfer (EFT)

Payments transmitted directly from CHA to the provider's bank account.

Virtual Card

Payments issued on a one-time-use virtual credit card. Standard merchant fees may apply.

Paper Check

Payments issued on a paper check and mailed to the provider's designated address.

F7: Support

Inquiry Type	Contact
General questions	CHA Provider Services: (800) 387-1103
Electronic Funds Transfer (EFT)	ECHO Health Customer Service: (888) 834-3511
Virtual card	ECHO Health Card Services: (877) 260-3681

SECTION G: REFERRALS AND AUTHORIZATIONS

G1: Services Requiring Prior Authorization

What is a direct referral?

A member may be sent to another contracted CHA practitioner for **consultation** without prior authorization from CHA, with the exception of Dermatology, Orthopedics and Podiatry Specialists.

What is a prior authorization?

Services that require prior approval by CHA before those services are rendered.

If approved, the authorization stays active for a specified date range and may expire. For extension requests, complicated cases or any questions, contact CHA Provider Services at (800) 387-1103.

Services requiring prior authorization

For the most up-to-date information, download the CHA Quick Reference Guide available on our website - www.chochealthalliance.com.

Specialist Services	
• Hospital-based procedures • Dermatology services	• Orthopedic services (excluding fracture care) • Podiatry services • All office-based services (excluding E&M)

Other Services	
• Out of network providers • Inpatient services • Acupuncture • Audiology, • Hearing Testing • DME • Dialysis • Electromyography • Enteral and Parental • Genetic Testing • Hearing Aids	• Home Health/Hospice • Infusion • Injectable drugs, Chemotherapy • Medical and Incontinence supplies • Non-emergency medical transportation • Nutrition • Orthotics and Prosthetics • Radiology (excluding x-rays) • Therapy services (Physical, Occupational, Speech) • Chiropractic services

G2: Requesting Prior Authorization

How to Submit Prior Authorizations

- Electronic Submission
  - Go to https://eznet.rchsd.org/EZ-NET60/Login.aspx
  - Sign in to your EZ-NET account
  - Under the Auth/Referrals tab, click Auth Submission
  - Fill out each section, attach relevant medical records and submit
- Fax Submission
  - Visit www.chochealthalliance.com to download and print the CHA Prior Authorization Form. Fax the completed form to (855) 867-0868.

Prior Authorizations for CCS Services in the WCM

CHA will process and approve authorizations for both CCS and Medi-Cal services. To simplify this process for providers:

- CHA created Condition-Specific Authorization Groups (CSAGS) for common CCS diagnoses
- Providers are only required to submit a single authorization request for these medical diagnoses
- CHA will follow existing prior authorization guidelines for all services, whether under CCS or Medi-Cal

Authorization Processing Time:

- Urgent Authorizations: within 72 hours
- Routine Authorizations: within 5 business days
- Retro-Authorizations: within 30 calendar days

Authorization Denial and Reconsideration

Providers may request reconsideration of a denial by submitting a formal appeal to CHA. Contact CHA Provider Services at (800) 387-1103 for more information.

Providers may contact a physician reviewer to discuss adverse determinations. The name of the reviewing physician and contact information is included in the authorization denial or may be obtained by contacting CHA Member Services at (800) 424-2462.

SECTION H: CARE MANAGEMENT SERVICES

H1: Care Management and Coordination

The Care Management Team at CHOC Health Alliance is comprised of Nurses, Social Workers, Physicians and Patient Care Coordinators who work to facilitate care coordination to our members and families. The team provides assessment, evaluation , planning , facilitation, and advocacy to promote the best possible outcomes for our member. Once the care management referral is received our staff assigns the member to a level of case management services based on their specific needs and case complexity.

H2: Referrals for Care Coordination and Case Management

Who qualifies for services?

Case Management is an "opt in" program available to any member or family struggling to cope with medical, social, or emotional challenges related to an acute or chronic illness. All CHA members qualify, newborn to 21 years of age.

Referral Submissions

- **Fax or Email**: Fill out the Care Coordination/Case Management Request form and fax to (714) 628-9119 or email the form to CHACM@choc.org.
    - To access the request form, visit the CHA website at www.chochealthalliance.com
    - Include the member's relevant clinical records along with the form

H3: Contacting a Case Manager

Once a case is open, the referring provider will be notified by the assigned case manager. We encourage you to communicate with your member's case manager whenever necessary.

H4: When is a Case Closed?

The case is closed once the member achieves their goals, loses eligibility, ages out of CHA or stops participating.

SECTION I: SPD PROGRAM

I1: What is the SPD Program?

The Seniors and Persons with Disabilities (SPD) program addresses a special population of members living with chronic illness, or developmental, physical, and/or cognitive challenges.

I2: How are Members Classified as SPD?

- Department of Health Care Services (DHCS) assigns an aid code(s) to each Medi-Cal member; these codes are used to identify SPD members
- CalOptima contacts each SPD member to complete a health needs assessment
- Based on the assessment, CalOptima assigns a level of complexity (Basic, Care Coordination, or Complex Case Management)
- CalOptima sends the case to CHA's SPD program for assignment to a Patient Care Coordinator (PCC). PCCs provide ongoing assistance to the member and member's family (i.e. "concierge" services)

I3: Program Services

- Help to connect SPD members to services needed
- An Individual Care Plan (ICP) driven by parent concerns and medical recommendations, facilitated by a CHA nurse
- ICPs are sent to each member's PCP. The PCP reviews the ICT's medical recommendations and provides any additional input within 72 hours of receipt.
- CHA holds Interdisciplinary Care Team (ICT) meetings based on the ICP. PCPs are encouraged to attend Interdisciplinary Care Team (ICT) meetings via phone or in-person when possible.

SECTION J: CALIFORNIA CHILDREN'S SERVICES AND WHOLE CHILD MODEL

J1: California Children's Services (CCS)

What is CCS?

CCS is a statewide program that arranges and pays for medical care, equipment and other services for children and young adults under 21 years of age who have certain serious medical conditions.

What medical conditions are eligible?

Eligible conditions include severe physical disabilities resulting from congenital defects or those acquired through disease, accident or abnormal development. Examples include cerebral palsy, cystic fibrosis, cancer, heart conditions and orthopedic disorders.

Who determines eligibility?

The Orange County Health Care Agency determines CCS eligibility. Please note, CCS eligibility is separate from Medi-Cal eligibility.

For more information on eligibility, visit the Orange County Health Agency's CCS website - www.ochealthinfo.com/phs/about/ccs.

How can I become a CCS paneled provider?

Providers can apply to be CCS paneled through DHCS. Paneling instructions can be found at www.dhcs.ca.gov/services/ccs/Pages/ProviderEnroll.aspx.

J2: Whole Child Model (WCM)

What is the WCM?

The WCM is a program that aims to help CCS children and their families get better care coordination, access to care, and health results. WCM integrates services traditionally covered separately by CCS and Medi-Cal into one health plan. In Orange County, both CCS and Medi-Cal services will be managed by CalOptima and its health networks, like CHA, beginning July 1, 2019.

J3: WCM Services

Prior Authorizations

Prior authorizations for CCS services are the responsibility of each member's assigned health network in WCM. For CHA members, CHA will process and approve authorizations for both CCS and Medi-Cal services. To simplify this process for providers:

- CHA created Condition-Specific Authorization Groups (CSAGS) for common CCS diagnoses
- Providers are only required to submit a single authorization request for these medical diagnoses
- CHA will follow existing prior authorization guidelines for all other services, whether under CCS or Medi-Cal

J4: Billing and Payment

Providers submit all claims to CHA for CCS services in the WCM.

- Providers should only include CCS diagnosis codes on claims if treating a CCS condition.
- Prior authorization numbers are required on claims for processing.
- CHA follows the DHCS payment methodology for CCS-paneled providers.

SECTION K: COMPLIANCE

K1: Medi-Cal Enrollment

The Department of Health Care Services (DHCS) requires all CalOptima providers participating in Medi-Cal to enroll in the Medi-Cal program. This a statewide requirement affecting all contracted CalOptima providers.

Visit http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp to begin the provider enrollment process directly with DHCS.

K2: Credentialing

Initial Credentialing

Prior to participating in the CHA network, providers must become credentialed and approved by the CHA Credentialing and Performance Committee. Physicians, physician assistants, nurse practitioners and ancillary providers are responsible for the completion of CHA's credentialing application along with all required attachments.

Re-credentialing

Re-credentialing occurs every 36 months. A few months before the deadline, you will receive a pre-populated application from CHA's Credentialing Department. You are required to:

- Complete the application and verify that the pre-populated information is correct.
- Send the application to CHA's Credentialing Department for review.

For questions, please email chacredentialing@choc.org.

K3: Compliance Training Requirements

CalOptima requires all contracted providers and staff to complete annual training for the following areas. For more information, visit www.chochealthalliance.com or email providerrelations@choc.org.

- Fraud, Waste and Abuse
- Cultural Competency
- SPD Awareness and Sensitivity

K4: Fraud Waste and Abuse (FWA)

What is Fraud, Waste and Abuse?

- **Fraud**: When someone intentionally deceives or makes misrepresentations to obtain money or property of any health care benefit program
- **Waste**: Inefficiencies that result in unnecessary costs, which are considered a misuse of resources
- **Abuse**: When health care providers perform actions that directly or indirectly result in unnecessary costs to any health care program

In summary, fraud requires intent to deceive, while waste and abuse implies no knowledge of intent or wrongdoing.

K5: Cultural Competency

What is cultural competence?

- Acceptance and respect for differences
- Ongoing development of cultural knowledge and resources
- Understanding of how culture and language may influence health

K6: SPD Awareness

Contracted providers and staff agree to:

- Serve all members with compassion and respect
- Ensure communications, physical spaces, services and programs are accessible to people with special needs, including visual, hearing, cognitive and physical disabilities
- Be the member's partner in health care

SECTION L: ACCESS AND AVAILABILITY

L1: Appointment Access Standards

Providers are responsible to be available during regular business hours and have coverage after-hours.

Emergency and Urgent Care Services

Type of Care	Standard
Emergency Services	Immediately, 24/7
Urgent Care Services	Offered within 24 hours of request

Primary Care Services

Type of Care	Standard
Urgent Appointment	Offered within 48 hours of request
Routine Appointment	Offered within 10 business days of request
Physical Exams and Wellness Visits	Offered within 30 calendar days of request
Initial Health Assessment (IHA) Staying Health Assessment (SHA)	Offered within 120 calendar days of CalOptima enrollment

Specialty and Ancillary Care

Type of Care	Standard
Urgent Appointment	Offered within 96 hours of request
Non-Urgent Specialty Care	Offered within 15 business days of request
First Prenatal Visit	Offered within 10 business days of request
Non-Urgent Ancillary Services	Offered within 15 business days of request

L2: Telephone Access Standards

During Business Hours

Description	Standard
In-coming calls	Answer phone calls within 30 seconds
Returning general phone calls	Return phone calls within 24 hours
Returning urgent messages	Return urgent phones calls within 30 minutes
Emergency phone calls	Refer members to the nearest emergency room
In-coming calls	Answer phone calls within 30 seconds

After Business Hours

Description	Standard
After-hours access	PCP or designee must be available 24/7 to respond to emergent calls
Live attendant	If an emergency, instruct the member to call 911 or go to the nearest ER
Recorded message	Recorded messages must include: "if you feel that this is an emergency, hang up and dial 911 or go to the nearest ER."

SECTION M: PEDIATRIC PREVENTIVE SERVICES

M1: Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

The federally mandated EPSDT Program provides comprehensive and preventive health care services for children under age 21. EPSDT is key to ensuring that children and adolescents receive preventive, dental, mental health, developmental, and specialty services.

- **Early**: Assessing and identifying problems early
- **Periodic**: Checking children's health at periodic, age-intervals
- **Screening**: Providing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems
- **Diagnostic**: Performing diagnostic tests to follow up when a risk is identified
- **Treatment**: Control, correct or reduce health problems found

M2: Child Health and Disability Prevention (CHDP)

The CHDP program oversees the screening and follow-up components of the federally mandated EPSDT program for Medi-Cal eligible children and youth. PCPs are required to ensure that all age and risk appropriate preventive services are provided, including, but not limited to:

- Immunizations following Federal and California State Standards
- Education of the importance of CHDP services
- Referrals for those with developmental disabilities for appropriate services
- Document each CHDP assessment in the medical record (paper or electronic)
- Report CHDP visits by recording the applicable current procedural terminology (CPT) preventive codes when submitting claims and encounters

M3: CHDP FAQs

Q: Which Periodicity Schedule should providers follow?

A: CHA will reimburse providers according to Bright Futures Periodicity Schedule, developed by the American Academy of Pediatrics (AAP).

Q: Is an authorization necessary before rendering CHDP services?

A: No, an authorization is not required.

Q: Will a provider be paid if an examination is performed is prior to its "due date"?

A: CHA will reimburse for services performed prior to the "due date."

SECTION N: REQUIRED HEALTH ASSESSMENTS

N1: Initial Health Assessment (IHA)

What is the IHA?

The IHA consists of a:

- Comprehensive health history
- Assessment of health education needs
- Physical assessment
- Specific evaluation including, tests, immunizations, counseling, follow-up and treatments

PCPs must perform the IHA within 120 calendar days of a member's enrollment in CalOptima.

N2: Staying Healthy Assessment (SHA)

What is the SHA?

The SHA consists of seven (7) age-specific questionnaires available on our website – www.chochealthalliance.com and the DHCS website - www.dhcs.ca.gov.

The SHA assists PCPs in:

- Identifying and tracking individual health risks and behaviors
- Targeting health education
- Counseling interventions
- Providing referrals and follow-up

For any questions, please contact providerrelations@choc.org.

SECTION O: HEDIS® PERFORMANCE

O1: What is HEDIS®?

HEDIS® consists of a set of performance measures used by

health plans that compare how well a plan performs in these areas:

- Quality of care
- Access to care
- Member satisfaction

O2: CHA and HEDIS® Performance

Why is HEDIS Important?

HEDIS® ensures we are offering quality preventive care and service to our members. By proactively managing patients' care, you can effectively monitor their health and identify issues that may arise with their care.

We work with our providers to continuously improve performance on HEDIS® scores. Contact PR to review your performance and find opportunities for improvement.

For more information and resources, contact PR at providerrelations@choc.org or visit www.chochealthalliance.com.