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ABOUT THE PROVIDER MANUAL

California Kids Care (CKC) furnishes a Provider Manual (Manual) and regular updates to all CKC Providers. The Manual and updates serve as a source of information to contract Network Providers regarding CKC’s covered services, program policies and procedures, relevant statutes and regulations, access and contact resources, special requirements, the Member Grievance and Appeal, and State Fair Hearing process.

The purpose of this Manual is to familiarize participating Providers and their staff with CKC’s underlying philosophy, objectives, operations, and mission. It is designed as a reference tool to assist Providers with the administrative tasks related to providing comprehensive, effective, and quality medical services to CKC Members. CKC reserves the right to revise these policies and procedures at its sole discretion. If you have any questions regarding the information contained within this Manual, call the Provider Services Representative (PSR) (see listing at the end of this section labeled “Who to Call Reference List”).

ABOUT CALIFORNIA KIDS CARE

California Kids Care and California Children’s Services

CCS Demonstration Pilot project

For more than 80 years, California Children’s Services (CCS) has set the standard for funding and coordinating outstanding healthcare services for California’s children with special healthcare needs. Due to rising healthcare costs, CCS and other stakeholders, are seeking new approaches to improve the quality of care and also to implement more cost-effective care management with an emphasis on a greater value of each healthcare dollar spent. Recent surveys and focus groups of children, youth, and families served by the CCS program have revealed areas for potential improvement in:

- Improved access to necessary services;
- Promoting Family-Centered Care;
- Providing a Medical Home for each child; and
- Improved care coordination between primary and specialty providers.

About California Kids Care

CKC is a program of Rady Children’s Hospital - San Diego (RCHSD) that provides coordinated healthcare services to condition-specific, CCS-eligible Members in San Diego County. CKC’s ethos is based on the Patient and Family-Centered Medical Home model to improve the health status of CKC Members. The Medical Home model is an approach that evolved from the core understanding that a well-organized, proactive clinical team working in tandem with patients and families is better able to address the Member’s preventive and disease management needs.

1 CCS eligible conditions included in the California Kids Care program are Hemophilia, Sickle Cell Anemia, Cystic Fibrosis, Diabetes (Diabetes enrollment based on under 10 years of age), and Acute Lymphoblastic Leukemia.
CKC strongly supports the national “triple aim” of healthcare services innovation:
1. Improved outcomes for individuals;
2. Improved health of the population served and satisfaction; and
3. Greater efficiency and reduced costs of providing appropriate services.

The cornerstones of the philosophy underlying the CKC program are:
- Build upon what is already working well;
- Reduce waste and duplication of effort;
- Improve access to care and quality of care;
- Continually test care models for improving care and services; and
- Incorporate strategies that prove effective in improving overall delivery of services.

An important feature of CKC is the program’s approach to treating the “Whole Child” throughout the continuum of care as opposed to the more traditional, fragmented approach, only managing care for a single medical condition without considering the comprehensive medical needs of the child. CKC implements Condition Specific Care Pathways for services throughout the continuum of care. The program emphasizes coordination of services and management of comprehensive medical care in order to successfully address the patient’s complex, chronic healthcare needs. These pathways, along with condition-specific registries for monitoring adherence to Care Plans and goals, will help CKC to facilitate improvements to managing care for chronic needs patient populations.

This Manual contains information and resources that will assist CKC Providers in furnishing the necessary covered healthcare services to CKC Members consistent with the tenets of this program. The CKC Manual provides information, by section, on Members Services; Member Grievances and Appeals process; Claims filing, payment policies and coordination of benefits; Provider Grievances process; Covered and Non-Covered Services; Utilization Management (UM); Provider Services; Quality Improvement; Health Education, Cultural, Disabilities and Linguistic Services. The CKC Manual and updates shall serve as a source of information to contracting and subcontracting healthcare Providers regarding Medi-Cal services, policies and procedures, statutes, regulations, telephone access, special requirements, and the Member grievance, appeal and State Fair Hearing process.

**Parental Involvement**
CKC ensures that delivery of medically necessary health care is done in ways that support the development of trusting relationships between Providers and Members. Consideration to factors such as promoting continuity of Providers, and allowing adequate time at visits to encourage Provider-family dialogue and the management of care coordination issues.

The following list of core elements of family-centered care must be integrated
into Provider practices:
- **Respect and Dignity**: Providers listen to and honor patient and family perspectives and choices.
- **Information Sharing**: Providers communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- **Participation**: Patients and families are encouraged and supported in participating in care and decision-making at all levels.
- **Collaboration**: Providers collaborate with patients and families at all levels of health care, including: care of an individual child; program development, implementation and evaluation; and policy formation.

**Service Area**
CKC service area covers the County of San Diego.

**WHO TO CALL REFERENCE LIST**

Providers are encouraged to use these resources to verify Member eligibility:

**For Medi-Cal Program**
24-hour State Automated Eligibility Verification System
(800) 456-2387
[www.medi-cal.ca.gov](http://www.medi-cal.ca.gov).

For additional questions, call CKC at 1-844-225-5430 (TTY 711) or go to [www.EZNET.rchsd.org](http://www.EZNET.rchsd.org)

For assistance with the following services, contact the CKC Member/Provider Services department at 1-844-225-5430 (TTY 711).

**Member Services** Benefits information, Explanation of Benefits (EOB), PCP selection/change, eligibility, complaints

**Provider Services** Capitation questions, fee schedule, contracts and contract terms, credentialing and re-credentialing, participation request, access and availability, provider survey

**Claims** Claims submission, status, payment inquiries, Provider disputes

**Quality Department** Provider site and medical record review, peer review, Quality Improvement Projects/Data Collection (HEIDIS), Member Satisfaction Survey (CAHPS)

**Health Services** Authorizations for medical services

**Health Education/Cultural, Linguistic Services** Interpreter services, health education brochures, health education classes
PROGRAM ENROLLMENT INFORMATION

Children enrolled as Members in CCS may be eligible and enrolled into the CKC program based on the following criteria:

- Resides in San Diego County;
- Medi-Cal eligible; and
- Has an eligible CCS condition included in the CCS Demonstration Pilot project, as of July 1, 2018.²

CCS Members residing in San Diego County that are identified to participate in the CKC program will be offered enrollment in CKC without disruption of current services. The San Diego County CCS Program will continue to determine a Patient’s eligibility for CCS.

Enrollment in the CCS Demonstration Pilot project does not reduce a child’s services or coverage if he or she is already in the CCS program. CCS patients who participate in the CKC program will receive a Welcome Packet and Member Identification Card (Member ID Card) that includes the name of their Primary Care Provider (PCP).

² Hemophilia, Sickle Cell Anemia, Cystic Fibrosis, Diabetes (under 10 years), and Acute Lymphoblastic Leukemia
Members of the CKC program can be identified through their CKC Member identification card (ID Card).

The ID Card contains certain important information:

<table>
<thead>
<tr>
<th>Name</th>
<th>Person Eligible to receive benefits from CKC</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID #</td>
<td>Member identification number assigned by CKC</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Practitioner of the CKC Member</td>
</tr>
<tr>
<td>PCP Telephone</td>
<td>PCP’s Phone number</td>
</tr>
<tr>
<td>Effective Date</td>
<td>When the information on this card becomes effective</td>
</tr>
<tr>
<td>Claims</td>
<td>If submitted paper claims, forward to the address listed</td>
</tr>
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**Member Eligibility**

It is the Provider’s responsibility to verify the Member’s eligibility for the CKC program at the time of service. Reimbursement for rendered services is subject to a Member’s eligibility on the date of service (DOS). To verify a Member’s eligibility, check one of the following options:

- Medi-Cal’s 24-hour State Automated Eligibility Verification System (for Medi-Cal Members only): 1-800-456-2387.
- Medi-Cal’s website (for Medi-Cal and Medicare/Medi-Cal Members only): Eligibility information is available on the State of California’s Medi-Cal website, [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov).
- RCHSD’s EZ Net portal – [www.EZNET.rchsd.org](http://www.EZNET.rchsd.org)

**Provider Definition and Roles**

The PCP must be a general practitioner, internist, a pediatric medical specialist, or subspecialist appropriate to the child’s CCS-eligible medical condition. The PCP assures the provision of the initial health assessment and subsequent primary care services, and is responsible for directly overseeing all aspects of the Member’s health care. This includes:

- Primary care;
- Preventative services;
- Initial Health Assessment;
• Diagnosis and treatment of illness and conditions unrelated to the treatment of the CCS-eligible medical conditions;
• Determining the medical services necessary to correct, treat and/or ameliorate the Member’s CCS-eligible medical condition;
• Working with the patient and family, as well as the CKC Care Navigator and CKC Team, to develop a comprehensive, Whole-Child Care Plan;
• Working with the assigned Care Navigator to assure appropriate referral and access set up with Pediatric Specialists and subspecialist;
• Participating in all medical case management functions including multidisciplinary care conferences and/or family conferences; and
• Additional services as needed.

The Member may elect to allow a Specialist to act as a Member’s Medical Home. If a Member elects this option, the Specialist must meet the following criteria in order to serve as a Member’s primary care assigned Medical Home:
• The Specialist has received appropriate training and/or has relevant recent experience in the provision of primary care services.

PCPs and Specialists are responsible for identifying Members that require services and referring to network and community providers as appropriate. This includes referring Members to CKC Care Navigators for care coordination, providing relevant medical and demographic information. Providers shall collaborate with Care Navigators, ensuring effective communication across all care providers, Members and family members, PCPs, and Specialists that are acting as the patient’s medical home, and shall continuously monitor their assigned Members and related care coordination activities to ensure Member needs are met.

The CKC Care Navigator ensures that children in the CKC program are supported through a care management model that facilitates a family-centered care approach for children with certain CCS eligible chronic medical conditions and coordinates care to meet their comprehensive, holistic healthcare needs. CCS beneficiaries will be educated and informed of how to access family resource centers, family empowerment centers, and Member informing materials by their CKC Care Navigator. The Care Navigator will assist with the utilization of services and materials.

The CKC Care Navigator is also responsible for working with a Member’s provider to coordinate both CCS and non-CCS care needs, including:

• Referral into the appropriate medical case management programs, ongoing monitoring of the enrollee’s status in these programs and coordination and linkage with or to other appropriate Providers or resources;
• Making referrals and ensuring authorization of services;
• Identification and prevention of gaps in care; and
• Transition planning is implemented for all CCS eligible enrolled patients with a medical condition expected to last beyond the 21st birthday

**PROVIDER NETWORK**
CKC continuously monitors and assesses the adequacy of the Provider Network to assure that the Provider Network meets access requirements for Members. A PCP may be assigned a maximum of 2,000 total Members. When a PCP reaches the enrollment limit, the PCP’s panel is closed to new enrollment until the PCP’s Membership drops below the maximum level. State regulations require CKC to ensure the Provider Network meets the following Provider to Member ratios:

- Primary Care Physician 1:2,000
- Mid-level Provider 1:1,000

A PCP can limit the growth of their enrollment by requesting to close their panel. When a Provider closes their panel, the Provider is no longer open for the auto assignment default process or Member choice selection. Exceptions may be made. If a Provider would like an exception, please contact CKC Member and Provider Services.

In addition, CKC has the capability of closing a Provider's panel if the Provider experiences access issues or has failed a facility site review. The Provider’s panel will be re-opened upon satisfactory progress in accordance with an approved corrective action plan (CAP).

CKC performs a continuous assessment of Provider Network adequacy that takes into consideration time and distance access standards, current availability of accepting new Members, and threshold language capabilities in the Provider Network system. For additional information regarding access standards, refer to the Timely Access Standards section of this Manual. Access standards are also included in the PCP and Specialist rights and responsibilities section. For information regarding threshold language capabilities, refer to the Member Translation Services section.
PRIMARY CARE PHYSICIAN SELECTION PROCESS

CKC ensures that each Member has a PCP. The PCP serves as the Medical Home for Members. The Medical Home is where care is accessible, continuous, comprehensive, and culturally competent.

As soon as a CKC Member becomes eligible or are enrolled in the CKC program, the Member is encouraged to select his or her own PCP. If a Member does not have a PCP, CKC Member Services Representatives, Patient Care Coordinators and/or Care Navigators are available to assist Members with the PCP selection process.

Within 30 days of the effective date of enrollment in the CKC program, each Member must choose their PCP. The effective date of enrollment is the date that CKC receives notification from the Department of Health Care Services (DHCS) of the eligibility of a beneficiary to receive specific CCS covered services. Members may select a PCP outside of the contractually stipulated time and distance standards. CKC will work with a Member to establish continuity of care with a Member’s prior PCP after enrollment in CKC (please see below Section on Continuity of Care for Non-participating Providers).

If a Member does not select a PCP within 30 days, the CKC program will assign the Member to an appropriate PCP. This assignment will take place within 40 days of the effective date of Member enrollment in the CKC program. The CKC program must assign in accordance with contractually stipulated time and distance standards and Member’s cultural and linguistic needs.

When Medi-Cal CCS Members are enrolled in the CKC program, a new Member Welcome Packet is mailed to the CKC Member. Members are given a choice of a PCP by CKC. If the Member does not select a PCP, CKC will assign a PCP for the Member.

Members may elect to continue an established relationship with a CKC participating provider, or choose a new PCP from the CKC Provider Directory.

If a CKC Member requests to change their PCP during the month, a change will be made effective as follows:

- Changes requested prior to the 10th of the month will be made effective on the first day of that month.
- Changes requested on or after the 10th of the month will be made effective on the first day of the following month of the request.

Exceptions may be considered upon request, when deemed appropriate.

CONTINUITY OF CARE FOR NON-PARTICIPATING PROVIDERS

As required by California law, if CKC determines that continuing treatment with a non-participating CKC Network Provider, such as a doctor or hospital, is medically appropriate, CKC can provide continuity of care for the new Members. In such cases, the CKC contracted Provider may be required to coordinate a Member’s care with a non-contracted Provider.
A new Member may request permission to continue receiving medical services from a non-participating Provider if he/she was receiving this care before enrolling in the CKC program and if the Member has one of the following conditions:

- An acute condition. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider within the CKC Provider Network, as determined by CKC in consultation with the CKC Provider and the non-participating Provider, and consistent with good professional practice. Completion of covered services shall not exceed 12 months from the effective date of enrollment in the CKC program.
- A pregnancy, including postpartum care. Completion of covered services shall be provided for the duration of the pregnancy.
- A terminal illness. Completion of covered services shall be provided for the duration of the terminal illness. Completion of covered services may exceed 12 months from the effective date of enrollment in the CKC program.
- The care of a newborn child between birth and age 36 months. Completion of covered services shall not exceed 12 months from the effective date of enrollment in the CKC program.
- Performance of a surgery or other procedure that the Member’s previous plan authorized as part of a documented course of treatment and that has been recommended and documented by the non-participating provider to occur within 180 days of the effective date of enrollment in the CKC program.

Members should contact the CKC Member Services Department to request continuing care. CKC will request that the non-participating Provider agree to the same contractual terms and conditions that are imposed upon CKC participating Providers providing similar services, including payment terms. Continuity of care does not provide coverage for benefits not otherwise covered under this agreement. Any requests for out of network services should be requested under a prior authorization. The Members will receive written notification of the decision regarding their request for Continuity of Care, including all appeals and grievance opportunities for any adverse benefit determination.

**CONTINUITY OF CARE FOR TERMINATION OF PROVIDER**

CKC will provide continuity of care for covered services rendered to a Member by a Provider who no longer participates in the CKC Provider Network if the Member was receiving care from this Provider prior to the Provider’s termination and if the Member has one of the following conditions:

- An acute condition. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider in the CKC Provider Network, as determined by CKC in consultation with the CKC Member and the terminated Provider, and consistent with good professional practice. Completion of covered services shall not exceed 12 months from the Provider’s contract termination date.
- A pregnancy, including postpartum care. Completion of covered services shall be provided for the duration of the pregnancy.
• A terminal illness. Completion of covered services shall be provided for the duration of the terminal illness. Completion of covered services may exceed 12 months from the time the Provider stops contracting with the CKC program.
• The care of a newborn child between birth and age 36 months. Completion of covered services shall not exceed 12 months from the Provider’s contract termination date.
• Performance of a surgery or other procedure that CKC had authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the Provider’s contract termination date.

Continuity of care will not apply to Providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity. The terminated Provider must agree in writing to provide services to a Member in accordance with the terms and conditions, including reimbursement rates, of his or her agreement with CKC prior to termination. If the Provider does not agree with these contractual terms and conditions and reimbursement rates, CKC is not required to continue the Provider’s services beyond the contract termination date.

Members should contact the CKC Member Services Department to request continuing care. CKC will request that the non-participating Provider agree to the same contractual terms and conditions that are imposed upon CKC participating Providers providing similar services, including payment terms. Continuity of care does not provide coverage for benefits not otherwise covered under this agreement. Any requests for out of network services should be requested under a prior authorization. The Members will receive written notification of the decision regarding their request for Continuity of Care, including all appeals and grievance opportunities for any adverse benefit determination.

MEMBER RIGHTS AND RESPONSIBILITIES

Members of the CKC program have certain Rights and Responsibilities, which are established and enforced by the California DHCS, CKC Policies and Procedures, and in Provider contracts between Providers and CKC.

Members of CKC are informed that they have the following rights:

• Respectful treatment and privacy. You have the right to be treated with respect, giving due consideration to your right to privacy and need to maintain confidentiality of your medical information. You also have the right to be free of any form of restraint or seclusion used as a means of coercion, discipline, or retaliation.

• Choice and involvement in your care. You have the right to participate in decision making regarding your own health care, including your right to refuse treatment. You have a right to receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or benefit coverage. You also have the right to make advance directives.

• Have access to health care. You have a right to be provided with information about CKC and its services, including covered services. You also have the right to choose a Primary Care Provider within CKC’s Network.

• Have access to special services. You have the right to have access to a women’s health specialist and Minor Consent Services. You also have a right to receive care from an out of network certified nurse mid-wife or certified nurse practitioner if you can’t get care from the providers in our network.
• **Have access to family planning services.** You have the right to have access to family planning services, Federally Qualified Health Centers (FQHC), American Indian Health Services Facilities, sexually transmitted disease services and emergency services outside CKC’s Provider Network.

• **File a complaint also known as a grievance.** You have the right to file grievances verbally or in writing about CKC or the care you received. You also have the right to request an expedited grievance in instances that may involve a serious threat to your health such as severe pain, loss of limb and or life.

• **File an appeal.** You have the right to request a review and resolution of an appeal within 60 days when CKC or a CKC delegated entity denies, delays or modifies a requested service. The appeal can be requested orally, but must be followed by a written appeal. You may also request an expedited appeal if you think waiting 30 days will cause severe harm to your health.

• **File a State Hearing.** You have the right to request a State Hearing if you have filed an appeal and received a “Notice of Appeal of Resolution” letter telling you that CKC will still not provide services, or you never received a “Notice of Appeal of Resolution” letter telling you of the decision and it has been past 30 days. You also have the right to information about how to get an Expedited State Hearing.

• **Information in your language.** You have the right to request an interpreter at no charge to you. You should not use children to interpret for you. You also have the right to get this Member Handbook and other information in another language or format (such as audio, large print, or Braille).

• **Access your medical records.** You have the right to have access to and, where legally appropriate, receive copies of, amend or correct your medical records.

• **Know your rights.** You have a right to exercise these rights without adversely affecting how you are treated by CKC providers or the State. You also have a right to receive information about your rights and responsibilities, and to make recommendations about these rights and responsibilities.

Members of CKC are informed that they have the following responsibilities:

• **Treat your provider with respect and courtesy.** You are responsible for treating your provider(s) and their staff in a respectful and courteous way. You are responsible for showing up to your appointments on time. If you’re unable to make an appointment, you must call your provider at least 24 hours before the appointment to cancel or reschedule.

• **Treat CKC staff with respect and courtesy.** You are responsible for treating CKC staff in a respectful and courteous way. You are responsible for making requests, such as for transportation, in advance, and calling CKC to cancel any transportation if you have to cancel or reschedule your medical appointment.

• **Play an active part in your care.** You are responsible to provide, to the extent possible, information that CKC and its medical providers need in order to care for you. You are responsible for talking to your medical provider about things you can do to improve your overall health.

• **Understanding treatment options.** You are responsible to understand problems and participate in developing mutually agreed upon treatment goals to the degree possible.

• **Calling your provider.** You are responsible for calling your provider for appointments when you need medical care, including routine checkups.

• **Listen and work with your provider.** You are responsible for telling your medical provider about your medical condition and any medications you are taking. It is important that you provide as much information as possible to allow your Medical Home
Team to have the information they need to care for you or your child. By working with you Medical Home Team, there are things that you can do to improve your or your child’s overall health. You are also responsible for following instructions for the care you have received from your medical and other providers.

- **Use the Emergency Room (ER) only in an emergency.** You are responsible for using the emergency room in cases of an emergency or as directed by your provider.
- **Report wrongdoing.** You are responsible for reporting fraud or wrongdoing to CKC. You can do this without giving your name by calling CKC’s hotline at 1-844-225-5430 (TTY 711), 24 hours a day, 7 days a week. You can also call the Department of Health Care Services Medi-Cal Fraud and Abuse Hotline toll-free at (800) 822-6222.

**MEMBER DISENROLLMENT**

Enrollment in CKC will be offered to those Members diagnosed with a qualifying CCS condition managed by CKC.

Disenrollment of a Member is mandatory when:

- The Member is no longer eligible for CCS.
- The Member’s place of residence has changed to outside CKC’s service area.
- The Member and the family/legal guardian’s legal place of residence are outside the designated service area.
- The Member is placed in foster care, although voluntary enrollment in the CCS Demonstration Pilot project can be maintained if the Member remains in the geographic service area of CKC.
- A change in the status of a patient’s CCS-eligible medical condition as determined by the CCS Program.
- The Member is no longer financially eligible for Medi-Cal.
- The Member becomes eligible for and is enrolled in a commercial health maintenance organization (HMO) provided through parental employment that serves as the primary coverage.

CKC may recommend disenrollment when it becomes impossible for the CKC’s Network Providers to adequately render services to a Member because of one of the following:

- The Member or parent/legal guardian physically assaults one of CKC’s staff, contracting Provider staff, other CKC Member, or threatens another individual with a weapon on the CKC’s premises.
- The Member or parent/legal guardian is repeatedly verbally abusive to contracting Providers or ancillary and administrative staff or to other CKC Members.
- The Member or parent/legal guardian is disruptive to CKC operations, in general.
- The Member or parent/legal guardian habitually uses Providers not affiliated with CKC for non-emergency services without required authorizations.
- The Member has allowed the fraudulent use of Medi-Cal coverage under the plan, which includes allowing others to use the Member’s plan identification card to receive services from CKC.
- The Member needs related services to be performed at the same time; not all related services are available within the Network; and the Member’s PCP or another Provider determines that receiving the services separately would subject the Member to unnecessary risk.
Such disenrollment shall become effective on the first day of the second month following receipt by DHCS of all documentation necessary, as determined by DHCS, to process the disenrollment, provided disenrollment was requested at least 30 calendar days prior to that date. Exception is regarding major organ transplants (other than kidney transplants), for which disenrollment shall be effective the beginning of the month in which the transplant is approved.

Enrollment shall cease no later than midnight on the last day of the first calendar month after the Member’s disenrollment request and all required supporting documentation is received by DHCS. On the first day after enrollment ceases, the Provider is relieved of all obligations to provide covered services to the Member under the terms of the CKC Provider Network provider agreement.

A Provider may request disenrollment of a Member from their practice for the following reasons:

1. Inappropriate Behavior – Behaviors that are considered disruptive and/or verbally abusive:
   a. Examples of disruptive or verbally abusive behaviors:
      i. Yelling and/or screaming;
      ii. Ethnic slurs;
      iii. Foul language; or
      iv. Physical or verbal threats of violence
2. Failure to comply with medical advice or recommended treatments where the Provider believes they are placing their health at risk (See Discharge Criteria below).
3. Excessive missed appointments (See Discharge Criteria below).
4. Fraudulent activities aimed at receiving benefits under their health plan, or related to prescription use (See Discharge Criteria below).

Prior to requesting discharge, the provider must contact CKC to request assistance from CKC in addressing behaviors that may be verbally abusive or disruptive. To request assistance, the Provider office should contact the CKC Member Services Department, or reach out to their CKC Provider Relations Representative. The Provider must complete the “Provider Request for Assistance/Disenrollment Form” and submit to CKC via fax, securely e-mailed, or mailed. The Provider may also initiate contact with CKC by phone, but formal documentation must be submitted before any disenrollment request may be considered.

CKC will review documentation submitted and address inappropriate behavior with the Member or Member family, and will provide Member or Member family with behavior parameters to continue with the Provider practice if appropriate. CKC will send a letter to both the Member and the Provider, documenting the decision.

**Discharge Criteria** – The following behaviors are generally considered appropriate criteria for discharge, but each case shall be considered individually. Staff included in the review process may include Member Services, the assigned Care Navigator, the Medical Director, or Provider Relations.

1. Fraudulently receiving benefits under a health plan contract.
2. Fraudulently receiving and/or altering prescriptions, theft of prescription pads, or photocopying prescriptions.
3. Physically abusive behavior exhibited to the Provider or office personnel.
4. Threatening behavior exhibited in the course of needing or receiving care.
5. Credible threat of the Member’s intent to initiate or pursue legal action (not including a state hearing) against the Provider and/or his/her associates.
6. Refusal by the Member to follow recommended medical treatment where the Provider believes there is no alternative treatment and that refusal will severely endanger the health of the Member. This situation cannot be improved by repeated attempts by CKC staff to intervene, and in the judgment of the Chief Medical Officer or designee, a change in provider would clearly benefit the Member’s health status.

7. A determination by CKC’s Care Navigator and the Chief Medical Officer or designee that deterioration in the doctor/patient relationship has occurred to the point where continuation might result in adverse consequences to the Member’s health or to the safety of the provider or provider’s staff.

8. Documented evidence that the Member had been discharged from the practice site before the Member became CKC eligible.
   a. If a Member has been previously discharged from a practice, it is the responsibility of the practice to notify CKC within sixty (60) days of the Member’s initial assignment.
   b. Exceptions to the sixty (60) day period can be made on a case-by-case basis. The provider’s capitation payment is recouped.

9. Disruptive or verbally inappropriate behavior to the provider, office staff or other patients if counseling and corrective action by the Provider has been ineffective. For assistance with inappropriate behavior refer to the section above regarding requests for assistance.

10. Excessive Missed Appointments, defined as:
    a. Three (3) or more missed appointments within a six (6) month period OR
    b. Four (4) or more missed appointments within the previous twelve (12) month period, IF
    c. The provider has made a good faith effort to correct the Member’s behavior.
       i. Good faith effort is defined as at least one verbal and one written warning or at least two written warnings.
       ii. All verbal and/or written warnings must inform the Member that continued missed appointments will result in discharge.
       iii. Provider office must provide documentation of the verbal warning and one written warning or two (2) or more written warnings.
       iv. The verbal and/or written warnings must be within the specified timeframes of the missed appointments.
       v. Exceptions: Missed appointments due to an inpatient hospital stay or appointments cancelled 24 hours in advance are not considered missed appointments for the purpose of this policy.
    d. If the Provider has multiple locations and/or practices, the provider must specify on the Discharge Request Form if the discharge applies to all locations and/or practices or specific locations and/or practices.

CKC provides an explanation of the expedited disenrollment process for a Member qualifying under the conditions specified under 22 CCR 53889(i), which includes services under the foster care or adoption assistance programs, as well as Members already enrolled in another Medi-Cal, Medicare or commercial managed care plan, is included in the CKC Member Handbook.

The CKC disenrollment process is based on current CCS practices.
CKC Members are culturally and linguistically diverse, representing many different countries and ethnic groups. Providers may access telephonic interpreters for the threshold languages of the CCS Demonstration Pilot project of Arabic, Spanish, Tagalog, and Vietnamese by calling CKC Member Services. This service is available 24 hours a day, 7 days a week. Assistance for the hearing impaired can be accessed telephonically through the California Relay Service (711).

Face-to-face interpretive services are also available for CKC Members, including the hearing impaired, by calling CKC Member Services at 1-844-225-5430 (TTY 711) no less than five (5) to seven (7) days in advance.

**MEMBER COMPLAINTS**

CKC is committed to assuring that CKC participants are satisfied with the service delivery and quality of care they receive. CKC has an established grievance process to address participant’s concerns or dissatisfaction about services provided, Provider of care, or any aspect of the CKC program. Members and Providers may contact CKC Member Services to request a copy of the CKC internal policy and procedure relating to grievances.

CKC handles all grievances in a respectful manner and will maintain the confidentiality of a CKC participant’s grievance at all times throughout and after the grievance process is completed. Information pertaining to grievances will only be released to authorized individuals.

This section describes the procedures that Members and their authorized representatives may use to submit complaints to CKC. The information is included in this Manual since Providers may file complaints on behalf of Members, or offer assistance to Members in filing complaints. The section begins with definitions and then details the grievance and appeals processes. CKC does not discriminate against or disenroll Members for filing Complaints. CKC has interpreter services available to assist Members with language barriers.

**MEMBER GRIEVANCES AND APPEALS**

**Grievances-Member Complaints**

Members have the right to submit Complaints to CKC. A Complaint is any oral or written expression of dissatisfaction with any CKC service – clinical or non-clinical – a Member receives or regarding reimbursement for a bill that a Member has paid. A Complaint can be a grievance or an appeal or both.

A grievance is a complaint expressing dissatisfaction with any aspect of CKC’s or a Provider’s operations, activities, or behaviors – including quality of care concerns – regardless of whether any remedial action is requested or can be taken. A grievance may be filed by a Member with CKC either directly, or by referral from an advocacy group, and may be filed either verbally by telephone or in person, in writing via mail, or electronically via CKC’s website. Grievances may also be communicated directly to Providers and be resolved by a Medical Group or facility.
An Organization Determination is any decision made by or on behalf of CKC regarding the payment or provision of a service a Member believes he or she is entitled to receive. An Organization Determination is made in response to a request for Prior Authorization submitted by a Provider and may include approval, denial, deferral, or modification of the request.

An appeal is a complaint that deals with the review of an adverse Organization Determination of a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care service, or on any amounts the Member must pay for a service.

Members may submit a grievance to CKC if they are dissatisfied with any aspect of CKC’s or a Provider’s operations, activities, or behaviors.

Filing a Grievance
A Member or a Member’s caregiver can submit a grievance in writing or verbally directly with California Kids Care or within any California Kids Care Provider office, within 180 calendar days of the incident or action that is the subject matter of the grievance. Members are encouraged to submit their grievance in writing utilizing the Member Complaint/Grievance Report form (Complaint/Grievance Report). If the Member chooses this option, provider office staff will inform the Member that he/she may use the office phone to contact CKC for assistance with filling out the form. CKC will provide any reasonable assistance to our Members in providing interpreter services and toll-free numbers that have adequate TTY-TTD and interpreter capability.

Grievances can be submitted to:

California Kids Care
Rady Children’s Hospital – San Diego
Grievance and Appeals Resolution Services
3020 Children’s Way, MC 5149
San Diego, CA 92123-4282
Phone 1-844-225-5430
www.cakidsicare.org

The Member may also submit the grievance verbally by speaking to a CKC Member services representative. If the Member chooses this option, the Provider’s office staff will allow the Member to use the office phone to contact CKC. If a Member requests to file a grievance in the Provider’s office, the Provider will supply the Member with a Member Report of Complaint/Grievance form. The Provider must send the form to CKC on the day of receipt. The Provider office staff employee receiving the grievance must ensure that complete details of the grievance are documented. In the event of insufficient information, CKC Quality Management representatives will take reasonable efforts to obtain the missing information. All information will be held in strict confidence and will not be disclosed to CKC program staff or contracted Providers, except where appropriate to process the grievance.

If the Member is a minor, or is incompetent or incapacitated, the parent, guardian conservator, relative or other designee of the Member, as appropriate, may submit the grievance as an agent of a Member. The Provider may join with or otherwise assist the Member in submitting a grievance, and may advocate on behalf of the Member. Following the submission of the grievance, the Member or Member’s family may authorize the Provider to assist, including advocating on behalf of the Member.
It is the responsibility of the QM Department to ensure that confidentiality is maintained, documentation is complete and accurate, and the grievance process is implemented and completed according to policy and procedures. This includes ensuring that the medical record does not include any reference to the fact that the Member elected to file a grievance with CKC.

**Processing Grievances**

Once a grievance is filed, within five (5) calendar days, a Grievance and Appeals Coordinator will send an acknowledgment letter to the Member confirming the Coordinator’s receipt of the Member’s grievance. The Grievance and Appeals Coordinator will investigate the grievance, which may include notifying the Member’s Provider of the grievance, if applicable.

Within five (5) days, the CKC QM Department will also acknowledge receipt of the Member’s grievance. Any services that were authorized will continue to be provided until the complaint is resolved. CKC QM Department will maintain in its files copies of all grievances and responses.

**Notification and Initial Investigation of Grievance**

The Staff that received the grievance will notify CKC Quality Management staff within one working day of receipt of the grievance. Quality Management staff is responsible for coordinating the investigation, designating the appropriate staff members(s) to take corrective actions, and reporting the grievance to the interdisciplinary team. Quality Management staff will acknowledge receipt of the Member’s grievance in writing within five (5) days of receipt of the grievance (Letter for Receipt of Grievance). When necessary, CKC will acknowledge receipt of the grievance by telephone. Quality Management staff will notify the management or supervisory staff responsible for the services or operations that are the subject of the grievance.

Grievances related to medical quality of care will be immediately submitted to the CKC Medical Director for appropriate action. When grievances related to services provided by a CKC contracted Provider arise, CKC Quality Management staff notifies the contracted Provider’s Quality Management staff. When a grievance involves a violation of a CKC Member’s rights, CKC Quality Management staff will notify the CKC Director to begin investigation of the grievance.

**Resolving Standard Grievances**

CKC will resolve grievances within thirty (30) days of a Member’s or a Member’s family/designee submittal of a written or verbal grievance. Once CKC has made a decision regarding the grievance, the following procedure will be followed:

- The QM Department will mail a written notice of the proposed resolution to the Member family that includes information about the Member family’s right to request a State Hearing (Letter for Resolved Grievance).
- The action/decision included in the Letter for Resolved Grievance form is the conclusion of CKC grievance resolution process.
- The CKC Quality Management staff will document details of the grievance resolution in the CKC Grievance Log.
- CKC Medical Director or designee will make a decision regarding the grievance within thirty (30) days.
• Quality Management will communicate the decision in writing to the Member within thirty (30) days.

Decision Maker
The grievance decision maker will not have been involved in any previous level of review or decision making in matters either relating to the subject matter of the grievance or in preliminary review of the grievance.

The decision maker in the following cases must be a health care professional with the appropriate clinical expertise of a Member’s condition or disease:
  • A grievance regarding denial of an appeal for expedited resolution;
  • Grievance that involves clinical issues; or
  • Appeal of a denial based on lack of medical necessity.

The notification letter will also inform Members that they may appeal the decision that CKC has made if the Member is not satisfied with the decision. In the event resolution is not reached within thirty (30) days, Quality Management will notify the Member in writing within thirty (30) days of the status of the grievance and will provide the Member with an estimated completion date for resolution of the grievance (Letter for Pending Grievance).

24-Hour Grievance
A grievance received by staff that does not involve a coverage dispute, disputed healthcare service involving medical necessity, or experimental or investigative treatment and that is resolved by the close of the next business day is considered to be a 24-hour grievance. Such grievances are exempt from the requirement from written acknowledgment and are processed and recorded in the same manner as all other grievances not classified as urgent. Written information regarding the resolution of such grievances is sent to the Member. 24-Hour Grievances that are resolved to the satisfaction of the CKC Member and/or the Member’s representative, by the close of the next business day after a grievance is filed, are exempt from the requirement to send written acknowledgments and written responses to the CKC Member. Final resolution will be documented in the CKC Member Grievance log.

Making a Determination
CKC will issue a resolution letter within thirty (30) days of receipt of the grievance. Appropriate administrative review and follow-up will continue until all actions stated in the resolution have been completed.

Urgent Grievances
In the event the grievance qualifies as an “urgent grievance” or when a Member’s rights have been violated, CKC staff will expedite the review process to a decision within 72 hours of receiving the grievance. In the case of urgent grievances, consideration is given to the Member’s medical condition when determining response time. CKC Member Services will attempt to contact the Member by telephone on the same day as the determination of the resolution and provide the Member with verbal notice of the resolution. CKC will notify the Member and/or his/her representative in writing of the resolution of the urgent grievance. The Member will be notified verbally and in writing if resolution is not
possible within 72 hours. The written notification for delay will include the reason for the delay and the timeframe for when the grievance will be resolved.

The CKC Member and his/her representative are informed both verbally and in writing of their right to notify DHCS and DMHC of the grievance. In these cases, the CKC Member may ask to speak to the Grievance and Appeals Coordinator immediately. The Grievance and Appeals Coordinator will consult with appropriate CKC staff and respond to the grievance within 24 hours of CKC’s receipt of the original grievance.

Annual Review
The QM Department will coordinate an annual review of the grievance process. The grievance systems are reviewed regularly for appropriate processing of grievances and for identification of possible trends or patterns within grievances received. Tracking and trending reports are reviewed on a monthly basis. The process shall be reviewed with the CKC Family Advisory Board, contracted Providers, CKC stakeholders and updates to processes are implemented as appropriate.

Submitting Grievances to the Department of Managed Health Care
Members may submit grievances to the DMHC under the following conditions:
- They disagree with the decision made by CKC; or
- CKC has not resolved the grievance within the thirty (30) day time frame.

To submit a grievance to the DMHC, a Member must complete a Consumer Complaint Form, which can be accessed at www.dmhc.ca.gov/gethelpp, and submit it via fax or mail to:

Department of Managed Health Care
California HMO Help Center
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
(916) 229-0465 Fax

CKC will abide by the decision made by the DMHC and will work to complete the actions recommended by the DMHC as quickly as possible.

Appeals
CKC is committed to ensuring that a Member, a Member’s representative or a treating Provider has the right to appeal a decision to deny, defer or modify a particular care-related service or its decision not to pay for a service received by a Member.

CKC will handle all appeals in a respectful manner and will maintain the confidentiality of a Member’s appeal at all times throughout and after the appeals process is completed. Information pertaining to appeals will not be disclosed to program staff or contracted Providers, except where appropriate to resolve the appeal.

Contracted Providers are accountable for all appeal procedures established by CKC. CKC monitors contracted Providers for compliance with this requirement on an annual basis or on an as needed basis.
As a CKC contracted Provider, you may file an appeal on behalf of a CKC Member, but you cannot charge a Member for performing this service. An authorized representative of the Member may also request an appeal.

**Definition of an Appeal**
An appeal is a request for review of an action taken with respect to decisions made by CKC regarding non-coverage of, or nonpayment for, a service including denials, reductions or termination of services. An appeal may be filed verbally, either in person or by telephone, or in writing. The appeals process may take one of two following forms:

- A standard appeal means a standard review process for response to, and resolution of, appeals as expeditiously as the participant’s health requires, but no later than forty-five (45) days after CKC receives an appeal; or
- An expedited appeal occurs when a participant believes that his or her life, health, or ability to regain maximum function would be seriously jeopardized, absent provision of the service in dispute. CKC will respond to the appeal as expeditiously as the participant’s health condition requires, but no later than 72 hours after it receives the appeal.

The 72-hour timeframe may be extended by up to fourteen (14) calendar days for either of the following reasons:
- The Member requests the extension; or
- CKC justifies to the State administering agency the need for additional information and how the delay is in the interest of the participant.

**Action**
An action is defined as:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner;
- Failure of a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) to act within the timeframes; or
- For a rural area resident with only one MCO or PIHP, the denial of a Medi-Cal Member’s request to obtain services outside the Network:
  - From any other Provider (in terms of training, experience, and specialization) not available within the Network;
  - From a Provider not part of the Network that is the main source of a service to the Member, allowing for the fact that the Provider is given the same opportunity to become a participating Provider as other similarly situated Providers (if the Provider does not choose to join the Network or does not meet the qualifications, the Member is given a choice of participating Providers and is transitioned to a participating Provider within sixty (60) days);
  - Because the only plan or Provider available does not provide the service because of moral or religious objections;
  - Because the recipient’s Provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the Network; and/or
The State determines that other circumstances warrant out-of-Network treatment.

**Notice of Action (NOA)**
An NOA is a formal letter informing a Member that a medical service has been denied, deferred, or modified by a CKC decision.

**Disputed Healthcare Service**
This refers to any healthcare service eligible for payment under the Member's agreement with CKC that has been denied, modified or delayed by a decision of CKC, in whole or in part, due to the finding that the service was not necessary.

**Necessary/ Necessity**
This term refers to 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.

**Representative**
A representative is a person who is acting on behalf of or assisting a Member, and may include, but is not limited to, a family member, a friend, a CKC employee, or a person legally identified as Power of Attorney for Healthcare/Advanced Directive, Conservator, and Guardian.

**Right to Challenge Determinations**
Any Member who is dissatisfied with a CKC determination regarding the status of a service or benefit may request an appeal of this determination. This is true for determinations regarding both pre-service and retrospective authorizations and usually is the result of a denial. As a CKC contracted Provider, you may file an appeal on behalf of CKC Members, but you cannot charge Members for performing this service. An authorized representative of the Member may also request an appeal.

CKC distinguishes between standard appeals and appeals that require expedited review in cases where standard time frames would jeopardize a Member's life, health, or ability to regain maximum function. Refer to the appropriate appeals procedures if you would like to submit an appeal.

**General Information on Appeals**
CKC has primary responsibility for maintenance of the procedures, review of operations, and utilization of any patterns of appeals to formulate policy changes and procedural improvements in the administration of the CKC program. CKC will continue to furnish the Member with all services at the frequency provided in the current Care Plan during the appeals process. While an appeal is pending, if services are not being provided and if CKC reverses a decision to deny, limit, or delay services, CKC will provide the disputed services promptly, and as expeditiously as the Member's health condition requires. CKC will not discriminate against a participant solely on the grounds that an appeal has been filed.

CKC ensures that a Member is able to access and participate in the appeals process by addressing the linguistic and cultural needs of its participants, as well as the needs of participants with disabilities. CKC will ensure the following:
If the person filing the appeal does not speak English, a bilingual staff Member will be available to facilitate the process. If a staff person is not available, translation services/interpreter will be made available;

All written materials describing the appeal process are available in the following San Diego County threshold languages: English, Arabic, Spanish, Tagalog, and Vietnamese; and

CKC maintains a toll-free number 1-844-225-5430 (TTY 711) for the filing of appeals.

CKC will provide written information about the appeal process to a participant and/or his/her representative upon enrollment, and at least annually thereafter, whenever CKC denies, defers, or modifies a request for services or denies payment for a service. Information includes, but is not limited to:

- Procedures for filing an appeal, including participant’s external appeal rights;
- Telephone numbers for the filing of appeals in person or by telephone; and
- Location where written appeals may be filed.

A statement regarding that any method of transmission of appeals information from one CKC staff to another shall be done with strictest confidence, in adherence with the Health Insurance Portability and Accountability Act (HIPAA) regulations.

**Member Notice of Action**

CKC will provide each Member written Notice of Action (NOA) when a request by a Provider for authorization of any medical service is denied. The NOA will be mailed within ten (10) days of the decision. The NOA will include:

- The action that CKC or its contractor has performed or intends to perform;
- The reason for the action;
- A citation of the specific contract provision, statute or regulation that supports the action;
- The method by which a hearing to contest the action may be obtained;
- The Member’s right to be self-represented or be represented by an authorized third party such as legal counsel, relative, friend or any other person;
- The Member’s or Provider’s right to file an appeal;
- The Member’s right to request a State Fair Hearing;
- Procedures for exercising the Member’s rights to appeal or grievance;
- Circumstances under which an expedited review is available and how to request it;
- The Member’s right to have benefits continue pending the resolution of the appeal;
- How to request benefits be continued; and
- The circumstances under which the Member may be required to pay the costs of these services.

**Notice of Action Options**

If a Member receives a NOA, the Member has three options:

- Members have ninety (90) days from the date on the NOA to file an appeal. Members may request a State Fair Hearing regarding the NOA from DHCS, Office of Administrative Hearings within ninety (90) days of the NOA.
- Members may request an independent medical review (IMR) regarding the NOA from the DMHC. An IMR may not be requested if a State Fair Hearing has already been requested for that NOA.
Members may file an appeal regarding a NOA and request a State Fair Hearing regarding that NOA at the same time.

Procedure
The appeal process is available to any Member, his/her representative or treating Provider, who disputes denial of payment for a service or the denial, deferral or modification of a service by a PCP or any Provider who is qualified to make referrals. An appeal for denial, deferral or modification of a service or payment for a service may be filed verbally or in writing. A Member and/or his/her representative may verbally request an appeal by speaking to the Medical Director, Administrator, Care Navigator, Care Coordinator, Social Worker or other care team Member.

At the time of denial or at any time upon request, CKC provides a participant and/or his/her representative with an “Appeal for Reconsideration of Denial” form. The participant and/or his/her representative complete the form, which constitutes a written request to appeal CKC decision.

The Care Navigator will assist the participant and/or his/her representative in filing an appeal in the event assistance is required.

Standard and Expedited Appeals
An appeal may be filed as a “standard appeal” or an “expedited appeal”, depending on the urgency of the case. A standard appeal may be filed verbally or in writing with any CKC staff within ninety (90) calendar days of a denial of service or payment. An expedited appeal may be filed verbally or in writing to CKC if the participant or a treating physician believes that the participant’s life, health or ability to regain maximum function would be seriously jeopardized without provision of the service in dispute. In the case of an expedited appeal, the QM Department (QM Department) will immediately contact the Medical Director by telephone.

The QM Department notifies the California Kids Care Administrator and/or the CKC Medical Director of the appeal. Appeals related to disputed healthcare services should be directed to the CKC Medical Director.

CKC will continue to furnish the disputed service if the following conditions are met:
- CKC is proposing to terminate or reduce services currently being furnished to the Member; and
- The Member requests continuation of the service with the understanding that he/she may be liable for the cost of the contested service if the determination is not made in his/her favor. (See “Appeal for Reconsideration of Denial” for participant’s decision.)

Acknowledgment of Receipt of Appeal
The CKC program will acknowledge a standard appeal in writing (see Forms: “Acknowledgement of Receipt of Appeal”) within five (5) working days of the initial receipt of appeal by California Kids Care. For an expedited appeal, the QM Manager informs the Member or representative within three (3) business day by telephone or in person that the request for an expedited appeal has been received and explains his/her additional appeal rights, as applicable.
Documentation of Receipt of Appeal
All appeals expressed either verbally and/or in writing will be documented on the day that the appeal is received or as soon as possible after the event or events that precipitated the appeal in an CKC Appeal Log (see Forms: “Appeal Log”). Appeals are documented on the “Appeal for Reconsideration of Denial” form by the Member, his/her representative or by a treating Provider, on behalf of the Member. Complete information must be provided so that the appeal can be resolved in a timely manner. In the event of insufficient information, CKC will take all reasonable steps to contact the Member, and/or his/her representative or other appropriate parties to the appeal to obtain missing information in order to resolve the case within the designated timeframes for an expedited and standard appeal.

Reconsideration of Decision for Service Request or Payment of a Service
An appeal will be reviewed and decided by an appropriately credentialed and impartial third party who was not involved in the original action and who does not have a stake in the outcome of the appeal. All individuals involved with the appeal, including the Member or their representative, will be given written notice of the appeals process and reasonable opportunity to present evidence or submit relevant facts for review to CKC, either verbally or in writing. Members will be given the opportunity before and during the appeals process to examine their case file, including medical records and other documents and records considered during the appeals process. For a “standard appeal”, the Medical Director or Administrator will inform the participant in writing of the decision to reverse or uphold the decision within forty-five (45) calendar days of receipt of an appeal, or more quickly if the participant’s health condition requires. For an “expedited appeal” supported by a physician, CKC will make a decision regarding the appeal as promptly as the participant’s health condition requires, but no later than 72 hours after receipt of the request for appeal.

If a participant’s request for expedited appeal is not supported by a physician, the CKC Medical Director will decide if the Member’s health situation requires making a decision within 72 hours. If the participant's health does not warrant an expedited appeal process, CKC/ Medical Director will notify the participant within 72 hours that the appeal will be treated as a standard appeal.

The Medical Director or Administrator will make a reasonable effort to provide oral notice of the expedited appeal decision and will provide the Member and/or his/her representative and DHCS with a written statement of the final disposition or pending status of an expedited appeal within 72 hours of receipt of an appeal. In the event the 72-hour timeframe must be extended, CKC will provide justification to the DHCS for need of the extension. CKC will notify the Member both verbally and in writing of the pending status and reason for the delay in resolving the appeal. The Member will be notified of the anticipated date by which the appeal decision will be determined. CKC may extend the timeframe to resolve an appeal by up to fourteen (14) days if there is a need for additional information and the delay is in the Member’s interest.

Determination of an Appeal
When the decision of an appeal is in the Member’s favor, that is, the Director’s decision to deny, defer, or modify a service or payment of a service is reversed, the following applies:
- Medical Director/Administrator provides a written response to the Member and/or representative, sent by mail, within forty-five (45) calendar days of receiving a standard appeal or sooner if the Member’s health condition requires (See Forms: “Notice of Appeal Resolution”).
• CKC will provide authorization to get the disputed service or provide the service as quickly as the Member’s health condition requires, but no later than forty-five (45) calendar days from the receipt of the request for a standard appeal.
• For an expedited appeal, CKC will provide the Member with permission to obtain the disputed service or provide the service as quickly as the Member’s health condition requires, but no later than 72 hours from the receipt of a request for an expedited appeal.
• If the decision to deny payment for a service is reversed by CKC, then payment will be made within sixty (60) calendar days of receiving the Member’s or representative’s request for a standard or expedited appeal.

Pursuant to 42 CFR 438.424, if CKC or the Fair Hearing Officer reverses a decision to deny authorization of services, and the Member received the disputed services while the appeal was pending, CKC or the State must pay for those services, in accordance with State policy and regulations.

When the decision of an appeal is not in favor of the Member, that is, the decision to deny, defer or modify provision or payment of a service is upheld, or if the participant is not notified of the decision within the specified time frame for a standard or expedited appeal, the QM Coordinator will do the following:
• Notify in writing, at the time the decision is made, and within forty-five (45) days from the date of the request for a standard appeal and within 72 hours for an expedited appeal (See Forms: “Notice of Appeal Decision”);
  o The participant and/or his/her representative; and
  o DHCS.
• Notify the Member and/or his/her representative in writing of his/her appeal rights through the Medi-Cal program (See Forms: “Information for Participants about the Appeal Process”). Offer to assist the Member or the Member’s representative in choosing which external appeal route to pursue (if desired) and to assist in preparation of appeal.
• Forward the appeal to appropriate external entity.

External Review Options for Appeal
External Appeal Process: State Fair Hearing. If the participant and/or representative choose to appeal using the Medi-Cal external appeal process, CKC staff will assist the participant and forward the appeal to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430
Telephone: (800) 952-5253
Facsimile: (916) 229-4410
TDD: (800) 952-8349

CKC will not discontinue services for which an external appeal has been filed until the external appeal process has concluded. However, if CKC’s initial decision to deny, discontinue or reduce a service is upheld, the Member may be financially responsible for the cost of the disputed service provided during the external appeal process. If a Member and/or his/her representative request a State Hearing, he or she must ask for it within ninety (90) days from
the date of the NOA ("Notice of Action for Service"). A Member and/or his/her representative may speak at the State Hearing or have someone else speak on the Member’s behalf, including a relative, friend or an attorney.

CKC is required to provide written position statements whenever notified by DHCS that a Member has requested a State Hearing. CKC will designate the Medical Director or Administrator to make testimony at State Hearings whenever notified by DHCS of the scheduled time and place for a State Hearing. One or more plan representatives with knowledge of the Member’s condition and the reason(s) for the action, which is the subject of the expedited State Hearing, shall be available by phone during the scheduled State Hearing. If the NOA or grievance resolution notices are not in English, fully translated copies shall be transmitted to DHCS along with copies of the original NOA and grievance resolution notice.

**State Hearing**

Members or their authorized representatives have the option of filing a State Hearing with the Department of Social Services if they disagree with CKC’s decision regarding approval of a requested service. A State Hearing is an appeal with an Administrative Law Judge from the Department of Social Services. Expedited State Hearings may also be requested.

Requests for State Hearings can be submitted by telephone at (800) 952-5253 or in writing to:

**State Department of Social Services**
**State Hearing Division**
Post Office Box 944243
Mail Station 19-37
Sacramento, CA 94244-2430
Fax: (916) 229-4110

Requests for expedited State Hearings should be submitted to:

**Expedited Hearing Unit**
**State Hearings Division**
744 P Street, MS 19-65
Sacramento, CA 95814
Fax: (916) 229-4267

A Member may request a State Hearing at any time. Requests for State Hearings must be submitted within ninety (90) days of an action with which the Member is dissatisfied. For standard State Hearings, a decision must be made within ninety (90) days of the request. For expedited State Hearings, a decision must be made within 72 hours.

**Right to a State Hearing**

At any time during the grievance process, whether the grievance is resolved or unresolved, the CKC Member and/or his/her representative may request a State Hearing from the California Department of Social Services. The Member has ninety (90) days from the date of the CKC decision to ask for a State Hearing.
To request a State Hearing:

California Department of Social Services  
State Hearings Division  
P.O. Box 944243, Mail Station 19-37  
Sacramento, CA 94244-2430  
Telephone: (800) 952-5253  
Fax: (916) 229-4410  
TDD: (800) 952-8349

The CKC Care Navigator can help to assist with the State Hearing. If language assistance or interpreters are required, the Member can notify the State Hearings Division for assistance.

**Expedited State Hearing**

An expedited State Hearing involves a faster review of an appeal. A Member can request an expedited State Hearing if he or she disagrees with a decision CKC has made regarding a healthcare service and if proceeding along the normal timelines for resolution of a grievance or State Hearing would endanger the Member's health or life.

For general information regarding questions about an expedited State Hearing, Members can call the California DHCS Ombudsman at 1-888-452-8609 or write to:

Ombudsman Unit  
Medi-Cal Managed Care Division  
Department of Health Care Services  
P.O. Box 997413  
Mail Station 4412  
Sacramento, CA 95899-7413  
Telephone: (888) 452-8609  
TTY: (800) 735-2922

CKC Members have access to successive levels of appeal to contest adverse Organizational Determinations, reconsideration determinations, and redeterminations. These include:

- Review by an Independent Review Entity (IRE);
- Administrative Law Judge (ALJ) hearing; and
- Judicial review.

**Administrative Law Judge Hearing**

In cases where the service being contested has met minimal dollar amount threshold (set annually), the Member, Provider, or authorized representative can request a hearing before an Administrative Law Judge (ALJ). This request must be made within sixty (60) calendar days of receiving notice by the IRE and should be submitted to the Social Security Administration or the IRE. Upon request, CKC can also forward Member’s requests for an ALJ hearing to the IRE.

If the ALJ overturns CKC’s decision, the following timeframes will apply:

- 72 hours to authorize and/or provide service for pre-service appeals;
• 72 hours to authorize payment for pharmacy benefit appeals and thirty (30) days to issue payment; and
• Sixty (60) calendar days to authorize and/or provide service or payment for standard appeals.

Judicial Review
Any party to an appeal, including a Member, Provider, authorized representative, or CKC, can request judicial review of an ALJ decision if: (1) the ALJ denied the request for a review, and (2) the amount of the service in question meets the minimal dollar amount threshold set annually. To request judicial review, the party must file a civil action in a U.S. District Court. If judicial review overturns CKC’s decision, the same timeframes for acting upon the decision as are required for ALJ decisions will apply.

Independent Medical Review (IMR) by DMHC
If you or your Member disagrees with a decision CKC has made on a reconsideration based on medical necessity, or if CKC does not make a decision within the standard 30-day time frame, the Member can request an Independent Medical Review by the Department of Managed Health Care. An IMR may also be requested if CKC denies a treatment because it is experimental or investigational; in this case, the Member does not need to complete CKC’s reconsideration process before requesting an IMR. Information on requesting an IMR can be obtained by calling (888) HMO-2219, or by visiting the DMHC website at www.hmohelp.ca.gov.
Note: A Member who has already participated in a State Hearing is not eligible to receive an IMR from the DMHC. The IMR will review the case to determine whether or not the care requested is medically necessary. A decision on an IMR must be returned within 30 days of the DMHC’s receipt of the IMR application for standard Appeals, or within three business days for expedited Appeals. If the IMR determines that the service is medically necessary, CKC will approve the requested service or make a payment within 5 business days.

CLAIMS
CKC will enter into contracts with Providers in order to fulfill the obligation to provide a full spectrum of healthcare services to Members. As part of its due diligence, CKC will evaluate the prospective provider’s ability to perform the contracted services; oversee and remain accountable for any functions and responsibilities delegated; meet credentialing requirements; and meet the applicable requirements under state law. CKC compensates all Network Providers according to the terms that CKC and Provider negotiate and agree on as compensation for services rendered in the Provider Agreement.

All healthcare providers who participate in the CKC program must register and receive a National Provider Identifier (NPI), be a Medi-Cal provider and CCS Paneled. Providers and medical groups must register their NPI number with the DHCS for each service location to be registered with the CKC program. For information on registering with the DHCS, contact the California DHCS Provider Enrollment Department at MS 4704, P.O. Box 997412, Sacramento, CA 95899-7412 or by calling (916) 323-1945. If you need assistance in acquiring a NPI, contact the National Plan and Provider Enumerator System (NPPES) at (800) 465-3203 or register using the link below.
Your claims must indicate your correct NPI, or they may be improperly paid or denied. If you do not know your NPI, refer to the NPPES website (https://nppes.cms.hhs.gov/NPPES) or contact the Provider Relations Department. As stated above, all providers must also be a provider enrolled in Medi-Cal and CCS Paneled. If you need assistance with becoming a Medi-Cal provider or CCS Paneled, please contact CKC Members Services at 1-844-225-5430 (TTY 711).

Filing a Claim
CKC billing addresses are as indicated below:

**Electronic Claims Submission**
Office Ally Clearinghouse
Payer ID: CKC01
*Professional and Institutional claims accepted*

**Hard Copy Claims**
California Kids Care
Rady Children’s Hospital – San Diego
Attn: Claims Department
3020 Children’s Way, MC 5149
San Diego, Ca. 92123

**Timelines for Claim Submission**
Contracted Providers must submit claims within the specified timeframe as documented in their individual contracts to avoid denial for late billing. Providers are required to submit claims for all services rendered, whether the services are capitated or fee-for-service. It is preferred that claims be submitted electronically through CKC EDI vendor, Office Ally. To register with Office Ally for a login and password to submit electronically, contact Office Ally at (866) 575-4120, Option 3 or [www.officeally.com](http://www.officeally.com)

Non-Contracted providers have one hundred eighty (180) days from DOS to submit a claim to avoid payment reduction or denial for late billing. A current W-9 is required prior to submission of claims.

**Electronic Data Interchange (EDI) Claims**
CKC has contracted with Office Ally to receive electronic data interchange (EDI) claims. Office Ally is a full service clearinghouse offering a web-based service to providers, free of charge. Once a claim is submitted through Office Ally, CKC will return a claims acknowledgment of acceptance or rejection of the individual claim back to Office Ally within two (2) business days of receipt. Providers may view status and reports of individual claims by logging onto Office Ally’s web-based portal at [www.officeally.com](http://www.officeally.com). Enrollment with Office Ally is required. To register for a login and password to submit electronically, contact Office Ally at:

Office Ally
(866) 575-4120
Option 3
[www.officeally.com](http://www.officeally.com)
Paper Claims
The CMS 1500 (02/12) form is used to bill professional services provided to our Membership. Effective April 1, 2014, CKC will only accept the new CMS 1500 (02/12) claim form. It is very important to include your appropriate NPI Number when submitting claims. A copy of a CMS 15 (02/12) form is in the Appendix.

For information on how to complete the CMS-1500 (02/12) claim form, visit the National Uniform Claim Committee (NUCC) website at www.nucc.org.

The CMS-1450 (UB04) claim form is used to bill facility services provided to our Membership. A copy of the UB-04 claim form is in the Appendix. For information on how to complete the UB-04 claim form, visit the National Uniform Billing Committee (NUBC) website at www.nubc.org.

- Receipt of paper claims are scanned by our outside vendor, Imagenet LLC, Inc. and acknowledged when the file is loaded into EzCap with a system generated claim number using the mail received date from CKC.

Claims Receipt Verification
For verification of claim status the Provider may do the following:
- For claim filing requirements or status inquiries call 1-844-225-5430 (TTY 711); or
- Providers may verify claims receipt by accessing the Provider Portal at:
  www.EZNET.rchsd.org (login credentials are required)

Please note the following timeframes and acknowledgements:
- Allow two (2) working days of the receipt of an electronic claim;
- Allow fifteen (15) working days of the receipt of a paper claim; and
- Acknowledgement of electronic claims is provided via a 277CA file and/or Bowman Interface Log Report to the sender/clearinghouse.

Payment Policies

Methods of Reimbursement for Contracted Providers
CKC may pay providers on a fee-for-service or capitated basis, based on the contractual agreement between CKC and the individual Provider/group.

- Capitated Arrangements
CKC will pay a capitated provider a monthly capitation payment for the delivery of covered services during the term of his/her agreement based on the number of Members assigned to the provider on the first day of the month. Payments will be mailed by the 20th day of the month following receipt of capitation payment from DHCS and will reflect any appropriate adjustments for enrollment increases or decreases during the previous month. Questions concerning monthly capitation payments should be directed to the attention of the CKC Provider Relations Team.
• **Fee-for-Service Arrangements**

CKC will pay a fee-for-service provider a payment for each approved claim that is submitted. Claims will be reimbursed per Medi-Cal guidelines and rates in effect on date of service (DOS).

Authorization does not ensure payment if the Member is not enrolled on DOS and/or services performed exceed authorized services. The provider must verify Member enrollment prior to rendering service.

Reimbursement depends on authorization requirements, the Member’s enrollment on the DOS, plan policies and procedures, and plan limitations and exclusions as stated in the rules and regulations governing the plan or non-allowable charges.

**Methods of Reimbursement for Non-Contracted Providers**

• **Letter of Agreement (LOA)**

Pre-authorized services are paid at the agreed upon rate and in accordance with the Letter of Agreement (LOA) between CKC and the provider of service.

If an LOA is not on file, CKC Provider Relations will attempt to negotiate a rate with the Provider of service. If successful, the claim(s) is paid at the negotiated rate, less any non-allowable charges.

• **Urgent and Emergency Services**

All urgent and emergency services, that are the risk of CKC for payment, will be paid at 100% of the applicable Medi-Cal fee schedule in effect on DOS, less any non-allowable charges.

• **Non-Emergent Services**

CKC does not negotiate rates for services that require prior authorization and were rendered without a prior-authorization. The Claims Examiner will deny the claim for lack of prior authorization.

**Identifying Payable Claims**

A payable claim is defined as a complete and clean claim that has been adjudicated in EZ Cap to be paid:

- “Complete claim” means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: “reasonably relevant information” as defined by Section 1300.71(a) (10) of Title 28 of the California Code of Regulations “information necessary to determine payor liability” as further defined in section (a)(11).
- “Reasonably relevant information” means the minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan’s or the plan’s capitated provider’s liability, if any, and to comply with any government information requirements.
- “Information necessary to determine payer liability” means the minimum amount of material information in the possession of third parties related to a provider’s billed services that is required by a claims adjudicator or other individuals with appropriate
training, experience, and competence in timely and accurate claims processing to
determine the nature, cost, if applicable, and extent of the plan’s or the plan’s capitated
provider’s liability, if any, and to comply with any governmental information
requirements.

- Incomplete claims or claims that require additional information are contested in writing
  by CKC in the form of an EOB to the provider. If CKC needs additional information
  before the claim can be adjudicated, the necessary information must be submitted
  within three hundred sixty five (365) days of the date of the EOB that reflects the
  contested claim, in order to have the claim considered by CKC. To submit additional
  information for a claim, mail additional information, along with a copy of the claim to:

  California Kids Care
  Rady Children’s Hospital – San Diego
  Attn: Claims Department
  3020 Children’s Way, MC 5149
  San Diego, Ca. 92123

- A claim becomes a payable claim when the last piece of information needed to process
  the claim is received by CKC.
- In some circumstances, a claim may be pended for the following:
  o System Hold (Status 2). EZ-CAP puts a claim on system hold for the following
    reasons;
  o The service date is outside of the patient’s eligibility period;
  o A service requires an authorization;
  o The authorization that is being referenced by this claim is denied, deferred,
    canceled, requested, or on system hold; or the authorization payment status is
    closed;
  o The service was performed after the authorization expiration date;
  o The financial amount for this claim causes the total claim amount against an
    authorization to exceed the total authorized financial amount;
  o The number of units on this claim causes the total claim units against the
    authorization to exceed the total requested/authorized units;
  o The claim may be a duplicate claim;
  o The provider’s contract was not in effect on the service date;
  o The yearly or lifetime limits for a particular Benefit type for this Member are
    exceeded by this claim;
  o Member is on Provisional status; or
  o Manual Hold (Status 3). An Examiner may place a claim on hold for LOA,
    authorization research, documentation review or dollar amount review.

- Electronic claims may be rejected and returned to the clearinghouse. Common reasons
  for rejects are:
  o Invalid data (Procedure codes, Diagnosis, etc.);
  o Member not eligible on DOS;
  o Provider not eligible on DOS;
  o Duplicate submission; or
  o Missing elements (NPI, Tax ID, etc.)
Emergency Claims

Claims for emergency services are identified with place of service 23 on the CMS-1500 claim form or revenue code 450-451 on the UB04 claim form. Emergency services are payable claim when the last piece of information needed to process the claim is received by CKC. Claims for emergency services are not reviewed for medical necessity and/or down coded for level of service.

An emergency medical condition is a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Emergency services means covered inpatient and outpatient services;
- Furnished by a Provider qualified to furnish emergency services; and
- Needed to evaluate or treat an emergency medical condition.

Payment for Non Contracted Physician Urgent and Emergent Services

- Any provider of outpatient emergency services that does not have in effect a contract with a Medicare/ Medi-Cal Managed Care entity must accept as payment in full no more than the amount that would have been paid if the outpatient service had been provided under the State’s fee for service a Medicare/ Medi-Cal Managed Care program.
- CKC shall pay for those services provided by a non-contracting emergency physician that are required to treat the Member’s condition in the Emergency Room. CKC will reimburse the non-contracting physician at the applicable Medi-Cal rate in effect on DOS.
- CKC may not deny payment for treatment obtained when a Member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition. Further, the Contractor may not deny payment for treatment obtained when a representative of the Contractor instructs the Member to seek emergency services.
- CKC shall reimburse for emergency services received by a Member from non-contracting Providers, for treatment of an emergency medical condition, until the Member’s condition has stabilized sufficiently to permit discharge, and/or referral and transfer, in accordance with instructions from the CKC. The attending emergency physician, or the Provider treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on the CKC. Emergency services shall not be subject to prior authorization by CKC.
- All urgent and emergency services, that are the risk of CKC for payment, will be paid at 100% of the applicable Medi-Cal fee schedule in effect on DOS, less any non-allowable charges.

Claims Payment Timeframes

CKC pays 100% of all clean claims within forty-five (45) working days from the date of receipt.
- **Reduction in Payment for Non-Contracted Providers**
  - Claims received during the seventh through ninth month after the month of service will be reimbursed at 75% of the payable amount.
  - Claims received during the tenth through twelfth month after the month of service will be reimbursed at 50% of the payable amount.
  - Claims received after the twelfth month following the month of service will be denied.

- **Interest Payments**
  Claims should be paid within forty-five (45) business/working days from the date of receipt. Claims that are paid on or after the 46th business/working day will automatically require interest based on the adjustment situation.

  Please note that forty-five (45) business/working days is defined as the days worked from the date of receipt to the date the check and EOB are mailed. Weekends and the following holidays are not to be counted when calculating processing days:


  **Interest payments are calculated with at the rate of fifteen percent (15%) per annum for the period of time that the claim payment is late.**

  Example:
  
  \[
  \text{# of Delayed Days} \times \text{Total Claims Payment} \times \text{Interest Rate (15%)/365} \\
  \text{Date stamp on Claim: } 04/01/2017 \\
  \text{Date Claim is Due: } 06/04/2017 \\
  \text{Today’s Date: } 07/01/2017 \\
  \text{Date of Check Run: } 07/02/2017 \\
  \]

  \[
  28 \text{ (delayed days)} \times 24.00 \text{ (claims payment)} \times 0.000411 \text{ (interest rate)} = 0.28 \\
  \]

  
  $24.00 \text{ (claims payment)} + 0.28 \text{ (interest)} = 24.28 \text{ (claims payment including interest)}

  The interest must be paid on the same check as the claim requiring an interest payment. If the interest is not paid on the same check as the claim payment, an additional $10.00 fee must be added to the interest payment.

  All Emergency claims requiring interest are paid at the greatest of 15%/365 or 15.00 for each twelve (12) month period or portion thereof on a non-prorated basis.
Claims Payment and Notification
CKC provides notice of its approval/payment decisions to providers on a weekly basis via a Remittance Advice. Electronic claims submitted direct by Providers and/or clearinghouses are also provided an 835 payment file (electronic remittance advice) with HIPAA standard transaction codes for each payment/denial.

Claims Overpayments
If CKC determines that it has overpaid a claim, CKC will notify the Provider in writing through a separate notice clearly identifying the claim, the name of the patient, the DOS(s) and a clear explanation of the basis upon which CKC believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

If the Provider contests CKC’s notice of overpayment of a claim, the Provider, within thirty (30) working days of the receipt of the notice of overpayment of a claim, must send written notice to CKC stating the basis upon which the Provider believes that the claim was not overpaid. CKC will process the contested notice in accordance with CKC’s contracted provider dispute resolution (PDR) process described in Section II above.

If the Provider does not contest CKC’s notice of overpayment of a claim, the Provider must reimburse CKC within thirty (30) working days of the Provider’s receipt of the notice of overpayment of a claim.

CKC may only offset an uncontested notice of overpayment of a claim against Provider’s current claim submission when; (i) the provider fails to reimburse CKC within the timeframe set forth above, and (ii) CKC’s contract with the Provider specifically authorizes CKC to offset an uncontested notice of overpayment of a claim from the Provider’s current claims submissions. In the event that an overpayment of a claim or claims is offset against the Provider’s current claim or claims pursuant to this section, CKC will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

Coordination of Benefits

Billing CKC after Other Health Coverage
These principles must be followed when billing CKC after other health coverage:

- The health coverage benefit that is primary must be used completely;
- CKC may be billed for the balance, including other health coverage co-payments, other health coverage coinsurance and other health coverage deductibles;
- CKC will pay up to the limitations of the CKC program, less the other health coverage payment amount, if any;
- CKC will not pay the balance of a Provider’s bill when the Provider has an agreement with the other health coverage carrier/plan to accept the carrier’s contracted rate as a “payment in full”;
- An EOB or denial letter from the other health coverage must accompany the CKC claim, except for pharmacy providers; and
- The amount, if any, paid by the other health coverage carrier for all items listed on the CKC claim form must be indicated in the appropriate field on the claim. Providers should not reduce the charge amount or total amount billed because of any other health coverage payment.
Other Health Coverage EOB or Denial Letter
When billing CKC for any service partially paid or denied by the recipient’s other health coverage, the other health coverage EOB or denial letter must accompany the claim.

When a service or procedure is not a covered benefit of the recipient’s other health coverage, a copy of the original denial letter or EOB is acceptable for the same recipient and service for a period of one year from the date of the original EOB or denial letter.

A dated statement of non-covered benefits from the carrier is also acceptable if it matches the insurance name and address and the recipient’s name and address and clearly states the benefits not covered.

It is the Provider’s responsibility to obtain a new EOB or denial letter. Claims not accompanied by proper documentation will be denied.

Balance Billing
With the exception of charges for non-covered services delivered on a fee-for-service basis, subject to written disclosure and informed Member consent to assume financial responsibility for non-covered services, Provider shall in no event, including, without limitation, nonpayment by or insolvency of CKC, or breach of this agreement, bill, charge, collect a deposit, or attempt to bill, charge, collect or receive any form of payment or surcharge from any Member for Provider Services.

Provider shall not maintain any action at law or in equity against any Member or DHCS to collect any sums owed by CKC to Provider for services rendered to CKC Members. CKC may require Provider to return to CKC Members all sums collected from the Member, other than any applicable charges for non-covered services. If Provider collects or receives any form of payment, other than for non-covered services, CKC may take all appropriate action to eliminate such payments, including requiring Provider to return the payment and termination of the Provider’s Agreement.

PROVIDER DISPUTES AND GRIEVANCES

A contracted Provider dispute is a Provider’s written notice to CKC:
- 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;
- Seeking resolution of a billing determination or other contract dispute; or
- Disputing a request for reimbursement of an overpayment of a claim.

If a Provider has a dispute regarding a claim submitted to CKC for reimbursement, the Provider may participate in CKC’s PDR process in accordance with Assembly Bill 1455. This process applies to contracted and non-contracted Providers. If a Provider is dissatisfied with aspects of CKC’s operations or with another Provider’s or Member’s activities or behaviors, the Provider may submit a Provider Grievance. Call Provider Services for a copy of the Policy and Procedure.

Each contracted provider dispute must contain, at a minimum, the following information (See Appendix for sample Provider Disputer Resolution Form):
• Provider’s name;
• Provider’s identification number; and
• Provider’s contact information;
  • If the contracted Provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from CKC to a contracted Provider, the following must be included:
    o A clear identification of the disputed item;
    o The DOS; and
    o A clear explanation of the basis upon which the Provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;
• If the contracted Provider dispute is not about a claim, a clear explanation of the issue and the Provider’s position on such issue; and
• If the contracted Provider dispute involves a Member or group of Members, the name and identification number(s) of the Member or Members, a clear explanation of the disputed item, including the DOS and Provider’s position on the dispute, and the Member’s written authorization for Provider to represent the Member.

### Sending a Contracted Provider Dispute to CKC
Contracted Provider disputes submitted to CKC must include the information listed above for each contracted Provider dispute. All contracted Provider disputes must be sent to the attention of Claims Appeals Department at the following:

California Kids Care  
Rady Children’s Hospital – San Diego  
Attn: Appeals Department  
3020 Children’s Way, MC 5149  
San Diego, CA 92123

Provider Disputes are not accepted electronically.

### Time Period for Submission of Provider Disputes
Contracted Provider disputes must be received by CKC within three hundred sixty-five (365) days from the CKC’s action that led to the dispute (or the most recent action if there are multiple actions) that led to the dispute, or
  • In the case of CKC’s inaction, contracted Provider disputes must be received by CKC within three hundred sixty-five (365) days after the Provider’s time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.
  • Contracted Provider disputes that do not include all required information as set forth above may be returned to the submitter for completion. An amended contracted Provider dispute that includes the missing information may be submitted to CKC within thirty (30) working days of the Provider’s receipt of a returned contracted Provider dispute.

### Acknowledgment of Contracted Provider Disputes
CKC will acknowledge receipt of all contracted Provider disputes as follows:
  • Provider disputes will be acknowledged by CKC within fifteen (15) working days of the date of receipt by CKC; and
  • Provider disputes are not accepted electronically.
• **Contact CKC Regarding Contracted Provider Disputes**
  All inquiries regarding the status of a contracted Provider dispute or about filing a contracted Provider dispute must be directed to CKC at 1-844-225-5430 (TTY 711).

• **Instructions for Filing Substantially Similar Contracted Provider Disputes**
  Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:
  - Sort disputes by similar issue;
  - Provide a cover sheet for each batch of similar issues. Individually number and list the required information for the type of dispute for each disputed item within the batch;
  - Number each cover sheet; and
  - Provide a cover letter for the entire submission. The cover letter should describe each Provider dispute and reference the applicable numbered cover sheets.

• **Time Period for Resolution and Written Determination of Contracted Provider Dispute**
  CKC will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) working days after the date of receipt of the contracted Provider dispute or the amended contracted Provider dispute.

• **Past Due Payments**
  If the contracted Provider dispute or amended contracted Provider dispute involves a claim and is determined in whole or in part in favor of the Provider, CKC will pay any outstanding amounts determined to be due, and all interest and penalties required by law or regulation, within five (5) working days of the issuance of the written determination.

**Dispute Resolution Process for Non-Contracted Providers**

• **Dispute Resolution Process**
  The dispute resolution process for non-contracted Providers is the same as the process for contracted Providers as set forth above.

• **Dispute Resolution for Non Contracted Physician Urgent and Emergent Services**
  If a Provider is not satisfied with the CKC determination they may submit a dispute request to DHCS as follows:
  - For resolution, disputed emergency services claims may be submitted to:
    
    **Department of Health Care Services**
    **Office of Administrative Hearings and Appeals**
    **1029 J Street, Suite 200**
    **Sacramento, CA 95814**
    
    - CKC agrees to abide by the findings of DHCS in such cases; to promptly reimburse the non-contracting Provider within thirty (30) days of the effective date of a decision that CKC is responsible for payment of a claim; and to provide proof of reimbursement in such form as the DHCS Director may require.
COVERED SERVICES AND BENEFITS

CKC will provide or arrange for the provision of all medically necessary covered services for Members. These services include: all medically necessary primary and preventive healthcare services, diagnostic assessments, treatment, rehabilitation and follow-up care in addition to the care coordination and case management that are necessary for the appropriate treatment of the CCS-eligible condition.

CKC will coordinate a wide range of related services for the whole child, and is financially responsible for certain services under a capitated risk arrangement with DHCS in accordance with its agreement with DHCS. The matrix on the following page outlines the major service categories and the party financially responsible for these services\(^3\):

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\(^3\) The Care Coordination and Financial Risk matrix outlines major service categories and is not all inclusive of all possible services.
<table>
<thead>
<tr>
<th>Service</th>
<th>Care Coordination</th>
<th>Financial Risk</th>
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<tbody>
<tr>
<td>Pediatric Preventative Services</td>
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<td>Pediatric Specialist Services</td>
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<td>Laboratory &amp; Radiology Services</td>
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<td>Inpatient Hospital Services</td>
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<td>Special Care Center Services</td>
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<td>Minor Consent and Sensitive Services</td>
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<td>Family Planning Services</td>
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<td>Dialysis</td>
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<td>Rehab Therapies (PT, OT, ST)</td>
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<td>Audiology (hearing aids, cochlear implants)</td>
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<td>CKC</td>
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<tr>
<td>Vision Care</td>
<td>CKC/DHCS</td>
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<td>Local Education Agency (LEA) Services</td>
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<td>Drug &amp; Alcohol Services</td>
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<td>Dental Services</td>
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<td>Long-term Institutional Care</td>
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<td>CKC/DHCS</td>
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<tr>
<td>Organ Transplants</td>
<td>CKC</td>
<td>DHCS</td>
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Preventive Services

- **Preventive Care**
  CKC is committed to providing Members with the care necessary to maintain good health and to help Members anticipate and prevent potential health related problems. CKC operates a system of care that ensures the provision of preventive care services including: (1) immunizations; (2) growth and development assessments; (3) health screening; (4) healthcare supervision; and (5) patient and parental counseling about health and psychosocial issues.

- **Individual Health Assessment**
  CKC shall ensure, on an ongoing basis, that after initial implementation, PCPs shall provide an Initial Health Assessment (IHA) to the assigned Member within sixty (60) days of enrollment.

  The IHA shall include performance of the CHDP program’s age appropriate assessment, including the provision of all immunizations necessary to ensure that the Member is up-to-date for age, and an age appropriate health education behavioral assessment.

- **Periodic Health Assessments**
  CKC provides preventive care screenings and well-child visits for all Members at the times specified by the most recent American Academy of Pediatrics (AAP) Bright Futures Guidelines recommendations. The periodic preventive visit includes all age specific assessments and services required by the Child Health and Disability Prevention (CHDP) program, and accompanying age specific health education and behavioral assessment.

  CKC ensures the provision of High Risk Infant Follow-up services, including:
  - Comprehensive history and physical exam;
  - Developmental assessment;
  - Family psychosocial assessment;
  - Hearing assessment;
  - Ophthalmological assessment;
  - Home assessment; and
  - Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

  CKC ensures the provision of EPSDT services and EPSDT Supplemental Services for Members less than 21 years of age, including those who have special healthcare needs.

- **Immunizations**
  CKC ensures the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP). Upon U.S. Food and Drug Administration (FDA) approval of any vaccine for childhood immunization purposes, CKC will develop policies and procedures for the provision and administration of the vaccine within thirty (30) calendar days of the vaccine’s approval date. CKC will provide for the safe administration of the vaccine from the date of its approval regardless of whether or not the vaccine has been incorporated into the Vaccines for Children (VFC) program. Policies and procedures are and will continue to be in accordance with Medi-Cal fee-for-service guidelines issued prior to final ACIP recommendations.
SERVICES PROVIDED IN THE HOME AND COMMUNITY

CKC will also coordinate and provide for the following Home and Community Based Services based on medical necessity and authorized by CKC:

- Intermittent services by a home health agency as prescribed by a Member’s PCP and other treating provider and in accordance with a written treatment plan reviewed by the Physician every sixty (60) days;
- Skilled nursing services by licensed nursing personnel;
- Physical therapy;
- Occupational therapy;
- Speech therapy;
- Home health aide;
- Respiratory care therapy; and
- Medical social services by a medical social worker.

- Hospice
CKC provides the range of hospice services available under the Medi-Cal program in addition to medically necessary treatment services for Members who’s PCP or Specialty Patient-Centered Medical Home has certified that the Members are within the last six (6) months of life.

DURABLE MEDICAL EQUIPMENT

Durable medical equipment (DME), when prescribed by a licensed practitioner, is covered when medically necessary to preserve bodily function essential to activities of daily living or to prevent significant physical disability.

- Rehabilitative Equipment
CKC provides standard and custom DME, specific to the needs of the Member, required for mobility, community access and independence in the home. This equipment may include, but is not limited to: tilt wheelchairs, power chairs, walkers, commodes, positioning equipment, custom wheel chairs, custom wheel chair seating, custom motorized wheelchair bases and batteries. All repairs, replacements due to growth and/or new technology, maintenance, family training, and follow up on the use of the equipment are also the responsibility of CKC.

- Medical Supplies
CKC provides DME, including respiratory equipment, required for the treatment of the Member’s medical conditions in the home. Such equipment may include, but is not limited to: apnea monitors, glucometers, infusion pumps, kangaroo pumps, ventilators, suction machines, gaseous and/or liquid oxygen, specialty beds and mattresses. CKC provides emergency back-up equipment, maintenance of the equipment, and family training in the
use of the equipment. CKC provides those supplies that are necessary for treatment of medical conditions within the home and community, including those supplies that are necessary for the administration of prescribed pharmaceuticals. These supplies shall include, but are not limited to: gauze pads, syringes, infusion sets and catheters.

- **Incontinence Supplies**
  CKC covers the provision of diapers when: (1) A Member is under five (5) years of age and the use of diapers is medically necessary and exceeds the normal use by a Member of the same age; or (2) A Member is five (5) years of age or older and the diapers are medically necessary.

- **Prosthetics and Orthotics**
  CKC covers the provision of prosthetics (devices utilized to replace or enhance a body part of function) and orthotics (devices to correct or prevent deformities, replace a body function, and/or for positioning). These items, specific to the needs of the enrolled population, include, but are not limited to: dynamic splints, shoes, braces, and artificial arms and legs. CKC covers orthotics repairs, adjustments and/or replacements necessary for growth or new technology, usage training, as well as routine clinical check-ups by appropriate clinicians.

- **Augmentative and Alternative Communication Devices**
  CKC covers electronic or non-electronic aids, devices, or systems (in a form most appropriate for the Member) that correct an expressive communication disability that disrupts effective meaningful participation in daily activities. CKC covers assessment by a CCS-approved Speech/Language Pathologist, in conjunction with either an Occupational or Physical Therapist, to determine the necessity and appropriateness of a device. CKC also covers the provision of necessary components, including computer software programs, symbol sets, overlays, mounting devices, switches, cables, connectors and output devices, supplies, training in the use of the device and device repair and modification.

- **Audiology**
  CKC is responsible for diagnostic and ongoing assessment by a CCS-approved communication device specialist, including CCS-approved Otolaryngologists, Audiologists and Speech and Language Therapists. If a Member is a candidate for amplification, then CKC is also responsible for:
  - Hearing aids prescribed for your child’s hearing loss, including those that are beyond the scope of Medi-Cal benefits;
  - Hearing aid accessories, including cords, receivers, ear molds and batteries; and
  - Assistive listening systems, including frequency modulation systems.

- **Cochlear Implants**
  CKC covers pre-cochlear implant evaluation at a CCS-approved Cochlear Implant Center, including audiology testing, speech pathology assessments, psychological assessments, otolaryngological evaluation, and team conferences:
  - Cochlear implant surgery, when recommended by a CCS-approved Cochlear Implant Center;
  - Post-cochlear implant services, including implant orientation, implant mapping and processor programming, speech perception tests, audiological sound field tests, test assistant, interval speech and language evaluations, and aural/oral rehabilitation services;
• Cochlear implant replacement parts and batteries; and
• Cochlear implant speech processor upgrades

TRANSPORTATION SERVICES

▪ Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) to Access Authorized Services
CKC Member’s may qualify for assistance with transportation to and from medical appointments. CKC covers nonemergency transport, by ambulance or wheelchair van and litter van, when there is documentation that your child’s medical condition warrants the use of one of these types of transport rather than private care or public transportation. CKC covers the costs associated with accessing authorized healthcare services when it is determined that there are no other available resources.

If the Member is not able to be safely transported in either routine public or private conveyance, the physician should complete the provided PCS Form, certifying the level of Non-Emergency Medical Transportation that would be most appropriate for the Member (ambulance, litter van, wheelchair van, or air ambulance). If the Member can be transported in routine public or private conveyance, but the family may need assistance with transportation to their medical appointments, the Member can call CKC Member Services, or their assigned Care Navigator for help with arranging transportation.

▪ Maintenance and Transportation (M&T)
Maintenance and Transportation (M&T) benefit for CCS eligible member or member’s family seeking transportation to a medical service related to their CCS‐qualifying condition when the cost of M&T presents a barrier to accessing authorized CCS Services including meals, lodging and other necessary costs (ie parking/tolls etc.) as indicated. Reimbursable services include:

• The cost(s) for the use of a private vehicle or public conveyance to provide access to authorized care that is part of the Care Plan; and
• The cost(s) for lodging (such as a motel room, etc.), and food for your family when needed for access to authorized medical services.

OTHER SERVICES

▪ Vision Care, including Lenses
CKC coordinates eye examinations and vision aid needs. Eyeglasses, contact lenses, low vision aids, prosthetic eyes, and other eye appliances will be provided by DHCS approved vision care providers.

▪ Mental Health
CKC is responsible for the following mental health services:
• Mild to moderate mental health services conducted by the PCP;
• Medically necessary psychotherapeutic drugs;
• Related outpatient laboratory services to treat a diagnosis of mental illness;
• Emergency room professional services, except services provided by psychiatrists, psychologists, LCSW, marriage, family and child counselors, or other specialty mental health Providers;
• Facility charges for emergency room visits that do not result in a psychiatric admission;
• Emergency medical transportation services necessary to provide access to emergency mental health services;
• All non-emergency medical transportation services required by Members to access Medi-Cal covered mental health services, except when the transportation is required to transfer the Member from one facility to another, for the purpose of reducing the local Medi-Cal mental health program’s cost of providing services; and
• Medically necessary covered services after CKC has been notified by a Specialty Mental Health Provider that a Member has been admitted to a psychiatric inpatient hospital, including the initial health history and physical examination required, upon admission, and any consultations related to medically necessary covered services.

### Blood Lead Screens
CKC provides a blood lead screening test to Members at age one and age two, in accordance with CDC/CMS recommendations. CKC documents and will follow up on blood lead screening test results. Should a blood lead screening be refused, the CKC provider shall obtain a signed statement of refusal from the Member’s parent(s) or guardian, and incorporate into the medical record. If a parent or guardian refuses to sign a statement, the CKC provider shall document this, as well as the attempts to obtain a signed statement, in the medical record.

### Clinical Laboratory and Radiology Diagnostic Services
CKC covers all medically necessary clinical laboratory and radiological diagnostic services. Laboratory providers comply with the Clinical Laboratory Improvement Act testing requirements.

### Dialysis
CKC covers the cost of dialysis treatments for Members with kidney disorders or complications.

### Long-term Care
CKC shall cover medically necessary long-term care services provided from the time of admission and up to one month after the month of admission.

### Therapies
CKC covers the following therapies: Speech; Language; Physical; and Occupational Therapy. CKC covers physical and occupational therapy when:
- Short-term physical and/or occupational therapy, with defined time-limited goals, is necessary to improve functional skills, eliminate the need for extension of an inpatient hospital stay and/or to prevent re-hospitalization; or
- Long-term physical and/or occupational therapy, with time-limited goals, is necessary to maintain or prevent deterioration of functional skills.

### Investigational Services
CKC may cover certain investigational services when there is documentation of all of the following:
- Conventional therapy will not adequately treat the condition;
- Conventional therapy will not prevent progressive disability or premature death;
- The Provider of the proposed service has a record of safety and success equivalent or superior to that of other Providers;
- The cost of the investigational service is lower than conventional alternatives;
• The service is not being performed as a part of a research study protocol; and
• There is a reasonable expectation that the investigational service will significantly
  prolong the intended patient's life, or will maintain or restore a range of function suited to
  activities of daily living.

Investigational services are defined as those drugs, equipment, procedures, or services for
which laboratory and animal studies have been completed, and for which human studies are in
progress but:
• Testing is not complete;
• The efficacy and safety of such services in human subjects are not yet established; and
• The service is not in wide usage.

**Kidney Transplant**
CKC covers medically necessary kidney transplants, by a CCS-approved provider and facility,
including pre and post-transplant services, discharge planning all medically necessary
supportive subsequent care.

**Medical Nutrition Therapy**
CKC covers medical nutrition therapy, by a CCS-approved registered dietitian, including
nutritional assessment and the development and implementation of a therapy plan.

**Minor Consent and Sensitive Services**
CKC covers the provision of minor consent and sensitive services for Members under the age
of 18. Minor consent and sensitive services are available within the Provider Network and
Members will be informed of the availability of these services. Minors do not need parental
consent to access these services. Minor consent and sensitive services cover:
• Sexual assault, including rape;
• Drug or alcohol abuse for Members 12 years of age or older;
• Pregnancy;
• Family planning; and
• STDs for Members 12 years of age or older.
• Outpatient mental healthcare is available for Members 12 years of age or older who are
  mature enough to participate intelligently and where either:
• There is a danger of serious physical or mental harm to the minor or others, or
• The Members are the alleged victims of incest or child abuse.

**Family Planning Services**
CKC provides Members of child bearing age with timely access to family planning services.
These services include all methods of birth control approved by the U.S. FDA. Members can
choose to see providers in or out of the CKC contracted Provider Network, without having to
get permission / prior authorization from CKC. Care Navigators can also assist in directing
Members to the DHCS Office of Family Planning (800) 541-5555 that provides consultation
and referral to family planning clinics.

CKC may only provide for pregnancy termination in the following situations:
• If the pregnancy is the result of an act of rape or incest; or
• In the case where a Member suffers from a physical disorder, physical injury, or
  physical illness, including a life-endangering physical condition caused by or arising
  from the pregnancy itself that would place the Member in danger of death unless a
  pregnancy termination is performed.
• **Early Intervention Services**
  CKC will help identify Members who may be eligible to receive services from the Early Start Program. Eligible Members will be referred to the local Early Start Program for early intervention services. Members eligible for the Early Start Program include:
  - Those with a condition known to lead to developmental delay;
  - Those in whom a significant developmental delay is suspected; or
  - Those whose early health history places them at risk for developmental delay.
  The Care Navigators have a collaborative relationship with both San Diego Regional Center and local Early Start Program. The medically necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start Program will depend on the potential eligible condition of the Member. CKC will provide case management and care coordination for the Member to ensure ready access to all medically necessary covered diagnostic, preventive, and treatment services identified in the Care Plan.

• **Targeted Case Management Services**
  CKC determines whether a Member requires targeted case management (TCM) services. If a Member is eligible for TCM services, the Care Navigator or PCP will refer the Member to a regional center or local governmental health program as appropriate for the provision of TCM services. If a Member is receiving TCM services, CKC is responsible for coordinating the Member’s healthcare with the TCM Provider. CKC will also coordinate with TCM provider in order to determine the medical necessity of diagnostic and treatment services recommended by the TCM Provider that are covered services.

• **Local Educational Agencies (LEA)**
  CKC coordinates with Members who receive services through LEAs, local school districts or school sites. These subcontracts with the local school districts or school sites meet the following requirements and address the following issues:
  - The population covered;
  - Practitioners covered;
  - Outreach;
  - Information dissemination;
  - Education responsibilities;
  - Utilization review requirements;
  - Referral procedures;
  - Medical information flows;
  - Patient information confidentiality;
  - Quality assurance interface;
  - Data reporting requirements; and
  - Grievance/complaint procedures.

• **Out-of-State Services**
  CKC is responsible for out-of-state care when:
  - The medically necessary care is not available within the State of California; or
  - there is an emergency out-of-state that arises from an accident, injury, or illness.

• **Advance Directives**
  An "advance health care directive" allows for physicians, family and friends to know plans for health care treatment at the end stages of a Member’s life. The advance directive is a written
document that directs healthcare personal and family regarding the Member’s preferences, desire for diagnostic testing, surgical procedures, cardiopulmonary resuscitation and organ donation. CKC Providers are encouraged to inform Members of advance directives and coordinate with a Member’s Care Navigator for information regarding Advance Directives, if necessary.

**SERVICES NOT COVERED BY CKC AND NON-COVERED SERVICE COORDINATION**

Members will have access to all medically necessary services. Services that are not covered by CKC are still available to Members. What this means is that while CKC is not responsible for payment for these services, CKC will coordinate these services with other local or State of California agencies or providers. Services not received from, referred by, or authorized by CKC or the Member’s PCP, except for those Covered Services that specifically do not need a referral, are not covered. No service is covered unless it is medically necessary.

CKC is not responsible for paying for, but will help coordinate, the following services:

- LEA services;
- Women, Infants and Children (WIC);
- CCS Medical Therapy Program services at CCS MTU;
- Newborn hearing screening services;
- Drug and alcohol abuse services;
- Specialty mental health services;
- Experimental Services that include drugs, equipment, procedures or services that are in a testing phase undergoing laboratory or animal studies prior to testing in humans;
- Vision services;
- Dental services, except when those services are provided by a CCS-approved Physician as part of the correction of a craniofacial anomaly; and
- Organ Transplants (other than kidney).

**UTILIZATION MANAGEMENT**

The CKC Utilization Management Program (UM Program) encompasses management and evaluation of services across the continuum of care. This includes pre-service review and authorization, concurrent and retrospective review of inpatient care including acute care, rehabilitation and skilled nursing, pharmaceuticals, DME, and ambulatory services. The UM Program is designed to:

- Promote the provision of medically appropriate care;
- Monitor, evaluate, and manage resource allocation; and
- Monitor cost effectiveness and quality of the healthcare delivered to our Members through a multidisciplinary, comprehensive approach.

The UM Program supports the CKC mission to provide Members with access to quality healthcare services delivered in a cost effective and compassionate manner. Utilization and Resource Management functions are performed by CKC’s UM Department.
CKC runs a UM program that monitors the utilization of medically necessary covered services. The UM program tracks service use patterns and is intended to promote the best, most efficient use of services. The CKC UM program includes the following features:

- Qualified staff responsible for managing the UM program;
- Using industry standards to approve, modify, defer, or deny requested services;
- Documenting Provider involvement in the development of utilization decision-making process;
- Communicating to Providers regarding procedures and services that require prior authorization;
- Ensuring that all contracting Providers are aware of the procedures and timeframes necessary to obtain Prior Authorization; and
- Utilizing a specialty referral system to track and monitor referrals requiring Prior Authorization.

CKC’s UM Program ensures that medically necessary services are rendered at the appropriate level of care in a timely and cost-effective manner. UM Program activities include prospective, concurrent, and retrospective review of medical care and services as well as assistance for appropriate discharge planning. CKC may delegate UM activities to qualified Provider Medical Groups that meet specific regulatory requirements.

All UM decision making is based solely on the appropriateness of care and existence of coverage. CKC will not reward practitioners or other individuals for issuing denials of coverage for care or services and there are no financial incentives for UM decision makers to encourage decisions that result in underutilization.

CKC requires all authorization requests to be screened by qualified health professionals using decision-making criteria that are objective and based on accepted medical evidence. Medical necessity criteria must be reviewed annually and updated as appropriate. Medical necessity criteria must be available to Network Providers and Members upon request. Services not meeting standard medical necessity criteria are forwarded to the Medical Director or designee for review.

The UM system tracks all referral requests and decisions (authorized, denied, deferred, or modified), and the time frame within which the request for referral was acted upon. This specialty referral system includes non-contracting Providers, as well. CKC ensures that all contracted Providers are aware of the referral processes and tracking procedures. Providers may call 1-844-225-5430 (TTY 711) to obtain copies of the applicable CKC referral policies and procedures.

- **Monitoring for Consistent Review Criteria Application**

  CKC performs ongoing monitoring of clinical and non-clinical UM staff’s application of criteria/guidelines to:

  - Measure the reviewers’ comprehension of the review criteria and guideline application process.
  - Ensure accurate and consistent application of the criteria among staff reviewers, and ensure criteria and guidelines are utilized per policy/procedure.
  - Ensure a peer review process for inter-rater reliability.
The UM staff is responsible for identification of potential or actual quality of care issues, and cases of over- or under-utilization of healthcare services for CKC Members during all components of review and authorization.

- **Monitoring for Over and Under Utilization**
  In an effort to review appropriateness of care provided to Members, CKC tracks and trends various data elements to determine over- and/or under-utilization patterns. The industry benchmark rates are used as guidelines for comparison. Some of the elements reviewed include:
  - Hospital admits/1000
  - Re-admissions
  - Bed days/1000
  - Emergency room visits/1000
  - Urgent Care Visits/1000
  - Encounters per enrollee per year
  - Total Authorizations
  - Denials of Authorizations
  - Deferred Authorizations
  - Modified Authorizations
  - Frequency of selected procedures, as determined by utilization patterns
  - Industry Collaborative Effort Utilization Reports
  - Cultural/Linguistic reports that reflect barriers for access to care or delivery of care

CKC enacts actions to improve performance as a result of these clinical data analysis, and feedback is provided to both entities and individual practitioners so that corrective actions can be taken. CKC continues to monitor for compliance with CAPs and improvements in the care delivery process.

- **Review Criteria, Guidelines, and Standards**
  Standards, criteria and guidelines are the foundation of an effective UM Program. They offer the licensed UM staff explicit and objective "decision support tools," which are utilized to assist during evaluation of individual cases to determine the following:
  - If services are medically necessary
  - If services are rendered at the appropriate level of care
  - Quality of care meets professionally recognized industry standards
  - Consistency of UM decisions

The following standards, criteria, and guidelines are utilized by the UM staff and Medical Director as resources during the decision making process:
  - Medical necessity review criteria and guidelines
  - Length of stay criteria and guidelines
  - Clinical Practice Guidelines
  - Policies and Procedures

- **Decision Support Tools**
  The licensed nursing review staff applies professional judgment during all phases of decision-making regarding CKC Members. "Decision Support Tools" are intended for use by qualified licensed nursing review staff as references, resources, screening criteria and guidelines with
respect to the decisions regarding medical necessity of healthcare services, and not as a substitute for important professional judgment.

The CKC Medical Director evaluates cases that do not meet review criteria/guidelines, and is responsible for authorization/ denial determinations.

CKC’s UM staff clearly document the Review Criteria/Guidelines utilized to assist with authorization decisions. In the event that a provider should question a medical necessity and/or appropriateness of a determination made, any criteria, standards, or guidelines applied to the individual case supporting the determination is provided to the provider for reference.

- **Criteria and Guidelines**

Due to the dynamic state of medical/healthcare practices, each medical decision must be case-specific based on current medical knowledge and practice, regardless of and in addition to, available practice guidelines.

- **Confidentiality**
  Due to the nature of routine UM operations, CKC has implemented policies and procedures to protect and ensure confidential and privileged medical record information. Upon employment, all CKC employees, including contracted professionals who have access to confidential or Member information, sign a written statement delineating responsibility for maintaining confidentiality.

  The CKC and UM staff voice mail systems for utilization review information and the computer Network system are controlled by a secured password system, accessible only by the individual employee.

  The facsimile machines used for utilization review purposes are located within the department to assure monitoring of confidential medical record information by CKC UM staff. CKC has implemented Health Information Portability and Accessibility Policies and Procedures to guide the organization in HIPAA compliance. All records and proceedings of the UM Committee related to Member or provider specific information are confidential and are subject to applicable law regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58.

- **Conflict of Interest**
  CKC maintains a Conflict of Interest policy to ensure that conflict of interest is avoided by staff and Members of Committees. This policy precludes using proprietary or confidential CKC information for personal gain, or the gain of others, as well as a direct or indirect financial interest or relationship with a current or potential provider, supplier, or Member; except when it is determined that the financial interest does not create a conflict.
Fiscal and clinical interests are separated. CKC and its delegates do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care.

- **Concurrent Hospitalization Review**
  All inpatient stays are reviewed to determine the appropriate level of care in accordance with written guidelines. Telephonic and/or on-site chart reviews are conducted at all CKC Hospitals and Skilled Nursing Facilities by licensed UM staff. An initial review of all hospitalizations will occur within one business day of the notification to CKC. Subsequent reviews are conducted as deemed necessary by the UM Nurse to ensure that the length of stay and level of care meet clinical criteria. If the criteria have not been met or medical record documentation is inadequate to authorize continued stay, the nurse reviewer will consult with the patient's attending physician, physician advisors, or other appropriate hospital staff to obtain additional information.

In the event that a Member is admitted to a facility outside the Plan’s Service Area, the Plan’s UM department will work with the Out-of-Area Provider and the Member's Medical Home team to determine when the Member can safely be transferred back into the Service Area and to coordinate the transfer. The UM Nurse reviews admissions at non-contracted facilities telephonically. An on-site review may be conducted if warranted by the complexity of the case. The goal of this review is to facilitate transfer of the Member to a CKC contracted hospital as soon as medically appropriate.

- **Discharge Planning**
  Discharge planning activities are carried out by CKC UM staff in coordination with hospital staff, which may include discharge planners, social workers, or nurse case managers in conjunction with the treatment team.

- **Denial of Services**
  A denial may occur at any time during the review process, prospective, concurrent, or retroactive to services being rendered. Only a physician may issue a delay, denial or modification of services. Providers requiring additional information on denials may contact CKC UM personnel to discuss the case. Notification of a denial to the requesting practitioner must include a clearly defined reason for denial, the criteria utilized in the decision-making process, a statement indicating that the reviewing practitioner is available to discuss any UM denial, and how the requesting Provider can contact a physician reviewer.

- **Automatic Fax Notification**
  A faxed notification is automatically sent within 24 hours of a UM decision, to the Personal Physician and the requesting provider. This notification includes important information on the status of the submitted request. This notification is faxed beginning the day the submitted authorization request is entered in to the system and will be re-faxed each time changes or decisions are made to the authorization request. This type of notification is sent whether the authorization is currently deferred, approved, cancelled, or denied so it is very important to note the status field when interpreting these notifications. See Appendix for a copy of the fax notification.

- **Mailed Notifications**
  - Approval Letters – Letters indicating approval of an authorization are mailed directly to the parent/guardian of the Member each business day. These letters include
information on the type of service, the approved provider, and a customer service phone number for questions regarding the authorization.

- **Delay Letters** – Letters requesting further clinical information, expert review of the request, or other information are mailed to the requesting provider and the Member’s parent/guardian once the request has reached the turn-around-time limit.

- **Carve Out Letters** – There are certain services that are not reviewed by CKC due to contract guidelines. When CKC receives an authorization request for one of these “carved out” services, the authorization request is processed and a Carve Out Letter is mailed to the requesting provider and the parent/guardian of the Member.

- **Denial or Modification Letters** – Letters indicating that an authorization request has been denied or modified are mailed to the requesting provider and to the parent/guardian of the Member. The letter will provide a detailed explanation of the denial or modification reason and will also provide information to the Member on how to file an appeal of the denial directly with their health plan. It will also provide information on the opportunity to discuss the decision with the Medical Director (peer to peer review), including the MD name and phone number.

An example of these letters is in the Appendix.

### Out-of-Network Referrals

When CKC receives a referral for services from an out-of-Network Provider, the UM staff will make an initial attempt to re-direct services to an in-Network Provider. If the requesting Provider(s) agrees to re-direct in Network, the authorization request will be changed to the in-Network provider, and documentation of the requesting provider’s approval to do so, will be noted in the system. If the requesting Provider(s) does not agree to the request for a re-direct, the request will be reviewed for medical necessity, benefit coverage and the availability of in-Network providers.

If the Physician Reviewer determines that services can be rendered in-Network, are medically necessary and are covered services, a modification to your request will be issued. This modification is a denial for the out of network service/provider and a simultaneous approval for an in-network service/provider. All efforts will be made to assure timely in-Network service access. Such efforts may include cooperation between Provider Services, Specialist(s) and Primary Care office managers, Physicians, and UM staff Members.

Out-of-Network requests received after services are rendered will be handled no differently than any other out-of-Network referral request. Refer to the Out-of-Network Care Coordination Policy and Procedure for more detailed information.

**Pharmacy Services**

California Kids Care (CKC) is dedicated to providing high quality, cost-effective pharmaceutical services to Members and to working with Providers to achieve the best clinical outcomes.

- **Pharmacy of Choice**
  CKC contracts with many chain and independent pharmacies throughout San Diego County via its Pharmacy Benefit Manager (PBM), MedImpact, and CKC Members may choose any one of these contract pharmacy providers in the CKC Pharmacy Network for prescription services. Also, see out of Network referrals for using a non-contracted pharmacy. The
preferred pharmacy for all specialty medications is Rady Children’s Hospital - San Diego available through CKC website: www.cakidscare.org.

CKC recommends the services of Rady Children’s Hospital Outpatient Pharmacy due to the specialized clinical services and convenience through mail order/delivery services, extended day-supply of medications, availability of specialty medications and children's medication compounding services. These services are generally not found at other pharmacy locations.

- **Covered Drugs**
  CKC covers all medical necessary medications through the use of a preferred drug list or formulary. These are the medications we prefer the provider to prescribe. Most generic drugs are included in the list. Members and providers can find the list of preferred drugs at www.cakidscare.org.

There are also medications that are not covered, for example, medications for weight loss, cosmetic purposes and infertility are not covered. If a provider orders a medication not listed on the Medication Formulary, the provider may request coverage through the Prior Medication Authorization process described below.

- **Pharmacy Claims Submission**
  Pharmacy Providers are to submit claims online to the CKC contracted Pharmacy Benefit Manager. The information required to submit a claim can be found on the Member’s ID Card. Please note the following PBM claim information to include:

  1. RxBIN: 017142
  2. RxPCN: ASPROD
  3. RxGroup: RCH01
  4. MI Toll-Free Number: 1-844-599-4063 (after hours)

The claim will either be accepted or rejected, as a Medi-Cal plan, CKC Members have no share of the cost for any covered prescriptions they receive.

- **Generic Substitutions**
  Whenever a Federal Drug Administration (FDA)–approved bioequivalent generic drug is available and there are no medical contraindications to Member use of the generic drug, CKC will substitute brand medications with a generic drug. Provider may, for medical reasons, request that a prescription be dispensed as written (DAW), subject to review and approval by CKC.

  In general, if a Member is “intolerant” to a product from one manufacturer, standard protocol requires that a product from another manufacturer should be tried to determine effectiveness with the Member. If it is determined that a brand medication for a Member is medically necessary due to adverse events with all generic forms of the medication by all generic manufacturers, Providers must provide evidence that a MedWatch form has been completed and submitted to the FDA documenting the adverse event experienced with the generic medication but no adverse event with the brand name medication.

- **Medication Authorization and Non-Formulary Medications**
  Some medications require Authorization prior to dispensing. The Authorization policies and procedures for medications are in place to ensure the appropriate, effective, and efficient use
of medications based on the most recent clinical evidence. Medication Authorization requests are reviewed by trained CKC PBM Pharmacy staff. All requests are reviewed and a determination of approval or denial is made within one (1) business day (unless additional information is requested).

Providers may appeal pharmacy medication decisions by providing additional information to the Prior Authorization Department at MedImpact 1-844-599-4063. The appeal must be on CKC Standard Appeal Form, which can be found on the CKC website: www.cakidscare.org. The CKC Standard Appeal form, should reference the original pharmacy request and clearly indicate that the request is an appeal of the original pharmacy decision. Providers should include relevant clinical notes and lab results.

Pharmacy grievances can also be filed by contacting the Provider Services Department at 1-844-225-5430 (TTY 711) or email: providersvcs@rchsd.org. For more detailed information on how to file a grievance, please see the section on Dispute Resolution in this Provider Manual.

To obtain formulary information, Providers should go to the CKC website: www.cakidscare.org.

- **Emergency Medication Overrides**
  CKC allows pharmacies to dispense a five (5) day supply of a medication that is not covered by the CKC formulary in emergency situations and for medical necessity while the Pharmacists works with CKC to obtain Authorization. Contact Pharmacy Services at 1-844-599-4063 or email providersvcs@rchsd.org, subject heading: “Pharmacy Prior Authorization” for this one-time override procedure. CKC will reimburse the pharmacy for up to a one-time fill of three day supply of urgent medication, dispensed to an eligible Member.

  Emergency services are exempt from prior authorization but must be justified according to the following criteria: Any service classified as an emergency, which would have been subject to prior authorization had it not been an emergency, must be supported by a Provider’s statement that describes the nature of the emergency. The Provider’s statement must include comprehensive clinical information about the Member’s condition, and state why the emergency services rendered were considered to be immediately necessary. A statement that an emergency existed is not sufficient. The statement must be signed by a Physician, podiatrist, dentist, or Pharmacist who had direct knowledge of the emergency described in the statement.

- **Specialty Pharmacy**
  Rady Children’s Hospital Outpatient Pharmacy is CKC’s primary specialty pharmacy provider. Specialty medications often require special handling and management, and Rady Children’s skilled pharmacists and nurses offer extra support to our Members who require specialty medications. You can reach Rady Children’s Outpatient Pharmacy at 1-858-966-4060.

  For the most current list of specialty medications that must be obtained through CKC’s Specialty Pharmacy, please go to www.cakidscare.org.

- **Pharmacy and Therapeutics (P&T) Committee and Formulary Management**
  The Pharmacy and Therapeutics (P&T) Committee is responsible for developing, managing, updating, and administering the CKC Formularies. The P&T Committee is comprised of primary care and specialty physicians, pharmacists, and other health care professionals.
Decisions are made based on the most current medical evidence in peer-reviewed literature, safety and efficacy, pharmacoeconomics, and therapeutic need.

The weekly formulary maintenance process involves a review of new products as they become available through national drug databases. These new drug updates include, but are not limited to first time drug entities, line extensions, and new generics. New products undergo review through the P&T committee for clinical utility and appropriateness. All first-time drug entities and line-extensions are clinically reviewed, and PA guidelines are created or revised if needed. New drugs for the formulary inclusion are evaluated based on reviews of individual drug monographs, pivotal clinical trials accompanying the drug monographs, and therapeutic class reviews.

A complete review of the formulary & UM strategies are conducted on a quarterly basis, through the quarterly P&T Committee meeting.

- **Important Reminder on Not Charging CKC Members**
  Providers should never bill a Member in place of submitting a PA. You will be required to reimburse any money collected from an eligible CKC Member. Members should never be told that a medication is not covered by CKC unless a specific denied Prior Authorization Request has been obtained. All medications are potentially covered through the PA process, unless the medication is specifically excluded from the program.

- **Pharmacy Resources**
  Providers can locate additional information on CKC pharmacy policies and procedures as well as pharmacy forms at [www.cakidscare.org](http://www.cakidscare.org). To locate Prior Authorization criteria and other drug limits/restrictions, Providers should access the CKC Formulary at: [www.cakidscare.org](http://www.cakidscare.org).

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**Emergency and Urgent Care**

The PCP is responsible for the care of their patients 24 hours a day, 7 days a week. The PCP or designee must be available in their office or via phone or answering service to appropriately triage and evaluate all non-emergent care. CKC Members with a life or limb-threatening medical emergency should go to the nearest emergency room for care. CKC provides coverage for emergency services that meet the "prudent layperson" standard without prior authorization of these services.

CKC and the prudent layperson standard defines a medical emergency as the sudden, unexpected onset of a medical or behavioral condition causing symptoms of sufficient severity that a prudent layperson with an average knowledge of medicine and health could reasonably expect, in the absence of immediate medical attention, to result in:

- Serious jeopardy to the afflicted person's life or health; or
- Serious jeopardy to the life or health of a pregnant woman’s unborn child; or
- In the case of a behavioral condition, placing the health of such person or others in serious jeopardy; or
- Serious impairment to the afflicted person's bodily functions; or
- Serious dysfunction of any bodily organ; or
- Disfigurement.
Some examples of Medical Emergency include: difficulty in breathing, severe bleeding, blackout, convulsions, apparent poisoning, or fracture.

PCPs are encouraged to educate their Members to contact them prior to obtaining after hours care, unless life or limb-threatening. Should the Member require Urgent Care after hours, PCPs shall refer Members to contracted Urgent Care locations (available on the CKC website).

**AUTHORIZATIONS**

- **Who should submit an Authorization Request?**
  
  Authorization requests should primarily be submitted by the Member’s PCP’s office.

  Requests can also be submitted by specialists and ancillary providers contracted with CKC.

  Requests from out of Network providers may not be accepted and in that case the out of Network Provider would be advised to contact the PCP’s office to ask that the authorization request be submitted to CKC for consideration.

  If the required services are not available with an in-Network, contracted provider then a request for authorization to an out of Network or non-contracted physician can be submitted for consideration. Information included in the request should explain the necessity of receiving services with the out of Network provider. All services with out of Network providers require prior authorization.

  Member requested second opinions with an in-Network or out-of-Network physician will be processed by CKC using authorization guidelines. Physician requested out-of-Network second opinions should be submitted to CKC for authorization review.

- **How to Submit an Authorization Request**
  
  All authorization requests should be submitted to CKC through the secure EZ-Net online portal: [www.EZNET.rchsd.org](http://www.EZNET.rchsd.org) or via fax and must include the appropriate forms and clinical documentation in order to ensure appropriate processing in a timely manner. The EZ-Net User Request Form is available in the Appendix section of this Manual.

  **Fax Number: 1-858-309-7977**

  Authorization requests should include all relevant clinical notes from the specialist or PCP who is requesting authorization.

  Signed prescriptions are required for some authorizations; these include speech therapy, physical therapy, occupational therapy, DME, formula, orthotics, and prosthetics.

 Incomplete authorization forms, missing clinical information (such as progress notes, growth charts or lab results), or missing prescription may delay processing depending upon the type of authorization requested. In these situations, requests will be placed into a “pended” status, which will lengthen the time to process the request.
Requests can be submitted as:
- **Urgent / Emergent** – Requests should only be marked “Urgent” if the treatment is required to prevent serious deterioration in the Member’s health.
- **Routine / Non-Urgent Care** – Requests for authorization of services not yet performed that are not urgent in nature will be processed using routine turnaround time guidelines.
- **Retroactive** – Requests for authorization of services that have already been provided should be marked “Retro” and will be processed using retroactive turnaround time guidelines.

Expected authorization processing timeframes are below:
- **Concurrent Review** of authorization for treatment regimen already in place: Within 24 hours of the decision, consistent with urgency of the Member’s medical condition and in accordance with Health and Safety Code Section 1367.01(h)(3).
- **Retrospective review**: Within 30 calendar days in accordance with Health and Safety Code Section 1367.01(h)(1).
- **Pharmaceuticals**: Within one (1) business day for all drugs that require prior authorization and in emergency situations at least a 72-hour supply of the covered outpatient drug will be dispensed.
- **Therapeutic Enteral Formula for Members Under 21 Years of Age**: Within five (5) working days unless criteria for expedited resolution are present.
- **Routine authorizations**: As expeditiously as the Member’s condition requires but within five (5) working days from receipt of the information reasonably necessary to render a decision. 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 Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member’s interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
- **Expedited authorizations**: For requests in which a provider indicates that following the standard timeframe for Prior Authorizations could seriously jeopardize the Member’s life or health or ability to attain, maintain, or regain maximum function, CKC will make an expedited authorization decision no later than 72 hours after receipt of the request for services. CKC may extend the ‘72 hours’ time period by up to 14 calendar days if the Member requests an extension, or if the Provider justifies a need for additional information and how the extension is in the Member’s interest. Any decision delayed beyond the time limits is considered a denial and will be immediately processed as such.
- **Hospice inpatient care**: 24-hour response

**Provider Services**
The Provider Services Department is responsible for recruiting and credentialing providers; personal provider support; education and training; field visits to provider offices; provider issues resolution; and provider directories. This section discusses general CKC provider...
information including provider rights and responsibilities, credentialing and contracting, provider training and communications.

- **Provider Education and Quality Assurance**
  CKC PPs have received the training necessary to fulfill all of their requirements and responsibilities. Specifically, CKC has policies and procedures that govern how the Provider Network will be informed and educated regarding program requirements. Compliance with the stated standards will be monitored and a CAP implemented if the standards are not met. CKC disseminates the policies and procedures to all Network Providers.

- **Referrals**
  Provider referrals for covered services under CKC shall follow the above Authorization requests procedures. Referral and authorization requests should be tracked in the Member’s Medical Record at the referring provider’s office.

A PCP shall retain responsibility for a Member referred to a Specialist (unless the Specialist is the designated Medical Home) or other practitioner. If a Member requires specialty care, a Provider shall request authorization for a Referral Practitioner to provide consultation, or care, within thirty (30) calendar days after the date of referral for a specified period of time. For all Members, a Provider, including Referral Practitioners, shall follow the CKC Prior Authorization process, where applicable.

For services that do not require a Prior Authorization, Providers, including Referral Practitioners, shall refer the Member to a contracted Network Provider, unless such Provider is unavailable in-Network. Referrals to an out-of-network Provider shall be processed in accordance with the California Kids Care Utilization Management Program policies and procedures.

For Family Planning Services, Members may access Family Planning Services without prior authorization and Members may choose to see providers in or out of the CKC contracted Provider Network. Please refer to the “Other Services” section of this Manual for more information.

For Sensitive Services, Members may access any Provider in the Network and Minors do not need parental consent to access these services. Please refer to the “Other Services” section of this Manual for more information.

When selecting a Referral Practitioner for a Member, please note that a Referral Practitioner shall be credentialed and CCS Paneled. A Referral Practitioner shall not bill a Member for the provision of Covered Services in accordance with Medi-Cal requirements. Referral Practitioners shall:

- Respect a Member’s Rights and Responsibilities as outlined in this Manual;
- Verify a Member’s eligibility at the time authorized services are provided;
- Provide authorized services within his or her scope of practice;
- After examination or provision of authorized treatment:
  - Advise the Member’s PCP of findings and recommended treatment plan or follow-up care;
  - Provide a written report of findings and recommendations to the Member’s PCP within ten (10) working days after rendering services to the Member;
Coordinate authorization with CKC and the Member’s PCP for additional tests or diagnostic studies necessary to complete his or her evaluation of the Member; and
Coordinate authorization with the Member’s PCP and CKC for any additional treatment or follow-up care that may be required.

- Participate in, and accept continuing peer review of medical or surgical services;
- Permit audit or review by the Member’s CKC plan or its agent, the California Department of Health Care Services (DHCS) or its subcontractors, and the United States Department of Health and Human Services, of those services provided to a Member;
- Follow the grievance and appeals procedures, as appropriate, in accordance with CKC Grievance and Appeals policies and procedures, as outlined in this Manual; and
- Designate a back-up Practitioner and provide a mechanism for a Member to access the back-up Practitioner when he or she is unavailable to provide care to the Member after initiation of treatment.

CKC has established a process to monitor the appropriate utilization of medical care and services delivered to Members and ensure that care is monitored, analyzed, and interventions are implemented upon the identification of under and over utilization patterns in accordance with the CKC Over and Under Utilization policy and procedure.

**CREDENTIALING**

**Physician Credentialing**

CKC maintains written policies and procedures for credentialing, re-credentialing, recertification and reappointment of Providers in the CKC Network. CKC ensures that these policies and procedures are periodically reviewed and have been approved by the appropriate governing body, or designee. Responsibility for recommendations regarding credentialing decisions rest with a Credentialing Committee or other peer review body.

In accordance with W&I Code 14182.2(b)(5), CKC ensures that Members will receive care for their CCS-eligible medical conditions from CCS-approved and/or Board Certified/Board Eligible Providers (in the case of PCPs) consistent with the CCS standards of care. These Physician Providers are all CCS-approved and/or Board Certified/Board Eligible in the appropriate specialty or subspecialty.

Responsibility for recommendations regarding credentialing decisions will rest with the CKC Credentialing Committee. The Credentialing Committee consists of the Credentialing Chairperson and a multi-disciplinary team representing primary and specialty care physicians. The Chairperson oversees the credentialing process. The Committee reviews credentialing files and renders a final decision as to whether the Provider meets credentialing standards. The Committee must give thoughtful consideration to the credentialing files that they review before making recommendations. In rendering a decision that denies credentialing to a Provider, the Committee must give specific reasons for denying the credentialing application.

PCP and Specialist Physicians must also have a site review, before the credentialing process is finalized.

- **CCS-Approved Providers**
In accordance with W&I Code 14182.2(b)(5), CKC ensures that beneficiaries enrolled in the CCS Demonstration Pilot project receive care for their CCS-eligible medical conditions from CCS-approved and/or Board Certified/Board Eligible Providers (in the case of PCPs) consistent with the CCS standards of care.

The initial credentialing process for Physicians will include verification of all of the following information:

- The Provider has a current, valid license to practice in the State of California by the Medical Board of California or the Board of Osteopathic Medicine.
- Current Drug Enforcement Agency registration;
- Graduation from medical school, completion of a residency, board certification or board eligible, as applicable;
- Enrollment as a CHDP Provider if serving as a PCP with the intent to provide primary and preventive health care services;
- Work history;
- Current, adequate professional liability coverage and claims history;
- Information from the National Practitioner Data Bank (NPDB);
- Enrollment as a Medi-Cal Provider and history of any sanctions imposed by Medi-Cal, Medicaid or Medicare (providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in the Rady Children’s CKC Provider Network);
- Sanctions or limitations on licensure from State agencies or licensing boards;
- A signed statement by the Provider at the time of application regarding any physical or mental health problems, any history of chemical dependency/substance abuse, history of loss of license and/or felony convictions, history of loss or limitation of privileges or disciplinary actions;
- If the Provider has hospital clinical privileges, the initial credentialing shall include a review of the Provider’s past history of curtailment or suspension of medical staff privileges; and
- NPI verification.

**Re-Credentialing**

CKC Network Providers are credentialed every three years. The process includes re-verification of all of the following:

- Licensure;
- Board certification;
- Admitting privileges at a CCS-approved hospital, if so indicated at the time of the initial participation in the Network;
- Malpractice insurance;
- National Provider Database (NPDB) Information;
- NPI verification; and
- Medicaid/Medi-Cal, or Medicare sanctions, and sanctions or limitations on licensure from State agencies and licensing boards (providers that have been terminated from either Medicaid/Medi-Cal or Medicare cannot participate in the Rady Children’s CKC Provider Network).
- The process includes a signed and dated application by the provider that includes an attestation as to the correctness and completeness of the information.
• Re-credentialing also includes documentation that CKC has considered from other sources pertinent to the credentialing process, such as quality improvement activities, Member complaints, and medical records reviews.
• Office site visits and medical record reviews
• Any disciplinary history
• Attestation
  o Any reason for inability to perform
  o Denial of any illegal drug use
  o History of license suspension

- Confidentiality
The credentialing process is highly confidential and all credentialing staff makes every effort to maintain the confidentiality and otherwise protect from unintended or inappropriate disclosure any confidential information. Providers have the right to contact the Credentialing staff regarding the status of their credentialing application, to correct erroneous information or supply missing information, the right to seek to pro-actively address issues relating to an adverse determination and re-submit request, and right to appeal an adverse decision.

- Adverse Credentialing Decision
If Participation Criteria that have not been met are related to Professional Competence and Conduct, the Credentialing Chairperson will notify the Provider, in writing, of the specific criteria that are not met, and the Provider Agreement may be terminated. If, after further investigation by the Credentialing staff, the Credentialing Committee determines that the health and safety of the patients is threatened by the Provider’s continued participation, then the Credentialing Committee has the authority to immediately suspend the Provider from participation in the Network. The Credentialing Chairperson will immediately notify the Provider, in writing, of the suspension detailing the specific criteria that served as basis for the decision and further notifying the Provider of the right to request a review of the suspension within thirty (30) days. Failure to respond to the notice of suspension or termination within thirty (30) days will automatically result in termination of the Provider Agreement and cessation of Provider’s participation in the CKC Provider Network.

Providers terminated, suspended, or who have had their privileges reduced for medical disciplinary reasons will be afforded that opportunity for a hearing in accordance with Section 809 of the California Business Code. A medical disciplinary cause or reason relates to performance or conduct of a Provider and requires filing a report under Section 805(b) Reporting Requirements: A report will be submitted to the Medical Board of California for any physician found to be non-compliant with CA Business and Professional Code 805.01. Reporting will be done when a final determination is made by a peer review board.

The Following are grounds for immediate termination from the CKC Provider Network:
• Incompetence or repeated gross deviation from the standard of care involving death or serious injury.
• The use, prescription, or administering of any controlled substance or dangerous drug to the extent or in a manner that poses significant risk of serious injury to the patient.
• Repeated acts of clearly excessive prescribing, furnishing, or administering controlled substances or repeated acts of prescribing, dispensing, or furnishing controlled substances without a good faith prior examination of the patient and supporting medical justification.
• Sexual Misconduct.
Where appropriate, in terms of possibility of remediation, the Credentialing Committee may issue a CAP with appropriate time frames for successful execution. Provider’s continuation in the CKC Provider Network is contingent upon successful completion of the CAP.

- **Peer Review Committee**
  The PRC provides guidance and peer input into the CKC Practitioner and Provider selection process and determines corrective actions as necessary to ensure that all Practitioners and Providers that serve CKC Members meet generally accepted standards for their profession or industry. The PRC review, investigate, and evaluate the credentials of all internal CKC medical staff for Membership and maintain a continuing review of the qualifications and performance of all internal medical staff. The PRC includes practicing physicians from the contracted healthcare Provider Network.

  The PRC meets on a monthly basis. The Chairperson of this committee is a physician Member of the commission.

- **Requirements for Credentialing and Regulatory Compliance**
  Providers are required to notify CKC immediately in writing if the following actions are taken against the Provider or any practitioner on the Provider’s staff:
  - Revocation, suspension, restriction, non-renewal of license, certification or clinical privileges.
  - A peer review action, inquiry or formal corrective action proceeding, or investigation.
  - A malpractice action or governmental action, inquiry or formal allegation concerning qualifications or ability to perform services.
  - Formal report to the state licensing board or similar organization or the NPDB of adverse credentialing or peer review action.
  - Any material change in any of the credentialing information.
  - Sanctions under the Medicare or Medicaid/Medi-Cal programs.
  - Any incident that may affect any license or certification, or that may materially affect performance of the obligations under the agreement.

  If the Provider fails to meet the credentialing standards or, if the Provider’s license, certification or privileges are revoked, suspended, expired or not renewed, CKC must ensure that the Provider does not provide any services to Members. Any conduct that could adversely affect the health or welfare of a CKC Member will result in written notification that Provider is not to provide services to CKC Members until the matter is resolved to Rady Children’s CKC satisfaction.

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**PROVIDER RIGHTS AND RESPONSIBILITIES**

**General Provider Rights and Responsibilities**
All Providers agree to render medically necessary services in accordance with the Provider’s scope of practice, the CKC Provider Agreement, the CKC Member Benefits Plan, CKC’s policies and procedures, and other requirements set forth in the Manual. Provider also agrees to abide by and execute the following contractual duties:
• Provider agrees to openly discuss treatment options, risks and benefits with Members without regard to coverage issues.
• Provider will participate in all programs in which the Provider is qualified and has been requested to participate.
• Provider agrees not to unfairly differentiate or discriminate in the treatment of Members or in the quality of services delivered to Members on the basis of Membership in CKC, age, national origin, sex, sexual preference, race, color, creed, marital status, religion, health status, economic status or disability, and source of payment.
• Provider will provide grievance, disputes and appeals information as required by the California DHCS and other appropriate regulatory agencies.
• Provider will actively participate in and comply with all aspects of CKC’s Quality Improvement and UM programs and protocols.
• Provider agrees to comply fully and abide by all rules, policies and procedures that CKC has established regarding credentialing of Network Providers.
• Provider will cooperate with CKC’s Member grievance and appeals procedures, and no punitive action will be taken against the Provider for requesting an appeal or supporting a Member’s request for an appeal.
• Provider is not prohibited or otherwise restricted from advising or advocating on behalf of a Member who is his or her patient.
• Provider warrants that Provider understands and acknowledges that various governmental agencies with appropriate jurisdiction have the right to monitor, audit, and inspect reports, quality, appropriateness and timeliness of services provided under the Provider Agreement with CKC. Provider remains responsible for ensuring that services provided to Members by Provider and its personnel comply with all applicable federal, state and local laws, rules and regulations, including requirements for continuation of medical care and treatment of Members after any termination of the CKC Provider Agreement.
• All relevant medical information will be provided to CKC, without violation of pertinent State and Federal laws regarding the confidentiality of medical records. Such information will be provided without cost to CKC.
• Nothing contained will be construed to place any limitations upon the responsibilities of the Provider and its personnel under applicable laws with respect to the medical care and treatment of patients or as modifying the traditional physician/patient relationship.
• CKC Provider will permit representatives of CKC, including utilization review, quality improvement and provider services staff, upon reasonable notice, to inspect Provider’s premises and equipment during regular working hours.
• Provider will provide CKC, within 14 calendar days of receipt thereof, notice of any malpractice claims involving any current or former Members to which Provider is a party, as well as notice and information specifying settlement of adjudication within 14 calendar days of the Provider being notified of such action.
• Provider agrees to comply with all applicable local, state and federal laws governing the provision of medical services to Members.
• Provider will uphold all applicable Member Rights & Responsibilities as outlined in the Manual.
• Provide for timely transfer of Member clinical records if a Member selects a new PP or if the Provider’s participation in the CKC Network terminates.
• Respond to surveys to assess Provider satisfaction with CKC and identify opportunities for improvement.
• Participate on a Quality Improvement or UM Committee, or act as a specialist consultant in the UM or peer review processes, if mutually acceptable.
• Notify CKC in advance of any change in office address, telephone number or office hours.
• Notify CKC at least sixty (60) calendar days in advance, in writing, of any decision to terminate the relationship with CKC or with the participating Provider or practitioner group. CKC will assist in notifying affected Members of termination and will assist in arranging coordination of care needs.
• Maintain standards for documentation of medical records and confidentiality for medical records.
• Provider agrees to retain all medical records for a minimum of 10 years from the last contracting period or last audit, whichever is latest.
• Maintain appointment availability in accordance with CKC standards.

Provider agrees that in no event including, but not limited to, nonpayment by CKC, insolvency of CKC or breach of Providers Agreement, will Provider or its personnel bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have recourse against a Member or persons (other than CKC) acting on the Member’s behalf. This provision does not prohibit Provider from collecting co-payments from Members or fees for non-covered services delivered on a fee-for-service basis to Members, provided that Member has agreed prospectively in writing to assume financial responsibility for the non-covered services.

**PCP Rights and Responsibilities**

The PCP is responsible for providing primary care services and managing all healthcare needed by CKC Members assigned to them. Maintaining an overall picture of a Member’s health and coordinating all care provided is a key to helping Members stay healthy while effectively managing appropriate use of health care resources. The PCP primary healthcare services include, but are not limited to:

- **Patient care services:**
  - Routine preventive health screenings;
  - Physical examinations;
  - Routine immunizations;
  - Child/teen health plan services (as appropriate);
  - Reporting communicable and other diseases as required by Public Health Law;
  - Behavioral health screening (as appropriate);
  - Routine/urgent/emergent office visits for illnesses or injuries;
  - Clinical management of chronic conditions not requiring a specialist; and
  - Hospital medical visits (when applicable).

- Maintain appropriate coverage for Members 24 hours a day, 7 days a week, and 365 days a year.
- Provide timely access to care. Provider will provide covered health care services in a timely manner appropriate for the nature of a Member’s condition consistent with good professional practice and regulatory requirements as noted in the “Timely Access Standards” section. Refer all Members for services in accordance with CKC’s referral policies and procedures. Documentation of the referral must be noted in the Member’s medical record. In the event there is no appropriate Network Provider or facility for a medically necessary covered service, after acquiring the necessary authorization, the PCP will coordinate the service with a non-Network Provider for the provision of such covered service. Referrals may be made to non-contracted Providers only in situations where the services are medically necessary and when there is no contracted Provider available to provide the necessary services.
• Provide supplies, laboratory services, and specialized or diagnostic tests that can be performed in your office.
• Assure that Members understand the scope of specialty or ancillary services that have been referred and how/where the Member should access the care.
• Communicate a Member’s clinical condition, treatment plans, and approved authorizations for services with appropriate specialists and other Providers.
• Provide access and information to sensitive services (i.e. family planning, STD and confidential HIV/AIDS testing) and minor consent services.
• Consult and coordinate with Members regarding specialist recommendations.
• Safeguard Member privacy and confidentiality in all aspects in accordance with the Health Insurance Portability and Accountability Act (HIPAA), patient privacy, protected health information, security and other related regulations and requirements, and maintain records accurately and in a timely manner.
• Ensure that services are provided in a linguistic and culturally sensitive manner.
• Document in a prominent place in the medical record if a Member has executed an advance health care directive.
• Maintain procedures to inform Members of follow-up care or provide training in self-care as necessary.

Specialist Provider Rights and Responsibilities
When a Member has been referred to a specialist, the specialist Provider is responsible for diagnosing the Member’s clinical condition and managing treatment of the condition. The specialist services include, but are not limited to:
• Keep the PCP informed of the Member’s general condition with prompt verbal and written consult reports.
• Obtain all necessary PCP authorization for subsequent referrals for tests, hospitalization, or additional covered services.
• Deliver all healthcare services available to Members through self-referral benefits.
• Notify the Member’s PCP when the Member requires the services of other specialists or ancillary providers for further diagnosis, specialized treatment, or if the Member requires admission to a hospital, rehabilitation facility, skilled nursing facility or an outpatient surgical facility.
• Communicate a Member’s clinical condition, treatment plans, and approved authorizations for services with appropriate Care Team and/or Medical Home providers.
• Consult and coordinate with Members regarding care recommendations.
• Safeguard Member privacy and confidentiality in all aspects in accordance with the Health Insurance Portability and Accountability Act (HIPAA), patient privacy, protected health information, security and other related regulations and requirements, and maintain records accurately and in a timely manner.
• Ensure that services are provided in a linguistic and culturally sensitive manner.
• Document in a prominent place in the medical record if a Member has executed an advance health care directive.
• Maintain procedures to inform Members of follow-up care or provide training in self-care as necessary.
• Refer all Members for services in accordance with CKC’s referral policies and procedures. Documentation of the referral must be noted in the Member’s medical record. In the event there is no appropriate Network Provider or facility for a medically necessary covered service, after acquiring the necessary Authorization, the PCP will coordinate the service with a non-Network Provider for the provision of such covered
service. Referrals may be made to non-contracted Providers only in situations where
the services are medically necessary and when there is no contracted provider available
to provide the necessary services.

- Provide supplies, laboratory services, and specialized or diagnostic tests that can be
  performed in your office.
- Assure that Members understand the scope of specialty or ancillary services that have
  been referred and how/where the Member should access the care.
- Provide timely access to care. Provider will provide covered healthcare services in a
timely manner appropriate for the nature of a Member’s condition consistent with good
professional practice and regulatory requirements, as noted in the “Timely Access
Standards” section.

**TIMELY ACCESS STANDARDS**

**Appointment Availability Standards**

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Access Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to PCP or designee</td>
<td>24 hours a day, 7 days a week</td>
</tr>
<tr>
<td>Non-urgent Care appointments for Primary Care (PCP Regular and Routine, excludes physicals and wellness checks)</td>
<td>Must offer the appointment within 7 business days of request</td>
</tr>
<tr>
<td>Non-urgent appointments with Specialist physicians (SCP Regular and Routine)</td>
<td>Must offer the appointment within 15 business days of request</td>
</tr>
<tr>
<td>Urgent Care appointments that do not require prior authorization (includes appointment with any physician, Nurse Practitioner, Physician’s Assistant in office)</td>
<td>Must offer the appointment within 48 hours of request</td>
</tr>
<tr>
<td>Urgent Care appointments that require prior authorization (SCP)</td>
<td>Must offer appointment within 96 hours of request</td>
</tr>
<tr>
<td>In-office wait time for scheduled appointments</td>
<td>Less than 45 minutes</td>
</tr>
<tr>
<td>Telephone Wait Time During Business Hours</td>
<td>No more than 10 minutes</td>
</tr>
<tr>
<td>First Prenatal Visit</td>
<td>Must offer the appointment within 5 business days of request</td>
</tr>
<tr>
<td>Child physical exam and wellness checks with PCP</td>
<td>Must offer the appointment within 10 business days of request</td>
</tr>
<tr>
<td>Non-urgent appointments for ancillary services (diagnosis or treatment of injury, illness, or other health condition)</td>
<td>Must offer the appointment within 15 business days of request</td>
</tr>
<tr>
<td>Initial Health Assessment (enrollees age 18 months)</td>
<td>Must be completed within 120 calendar days of enrollment</td>
</tr>
<tr>
<td>Appointment Type</td>
<td>Access Requirement</td>
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<td>and older)</td>
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<tr>
<td>Initial Health Assessment (enrollees age 18 months and younger)</td>
<td>Must be completed within 60 calendar days of enrollment</td>
</tr>
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</table>

**Exceptions:**

**Preventive Care Services and Periodic Follow Up Care:** Preventive care services and periodic follow up care are not subject to the appointment availability standards. These services may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice. Periodic follow-up care includes but is not limited to standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease.

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

**Advanced Access:** The primary care appointment availability standard listed above may be met if the primary care physician office provides “advanced access.” “Advanced access” means offering an appointment to a patient with a primary care physician (or nurse practitioner or physician’s assistant) within the same or next business day from the time an appointment is requested (or a later date if the patient prefers not to accept the appointment offered within the same or next business day).
Triage and After Hours Access Standards

Triage and Screening Services
All PCPs are required to provide triage and screening services by telephone 24 hours per day, seven (7) days per week. Triage and screening services refers to the assessment of a patient by a physician, registered nurse, or other qualified health professional acting within his or her scope of practice (and trained to triage or screen patients), for the purpose of determining the urgency of the patient’s need for care. PPs must provide triage and screening services in a timely manner appropriate for the patient’s condition, but in no event may the wait time for triage and screening services exceed 30 minutes. Note: PPs are permitted to delegate the triage and screening function to providers if such delegation is negotiated and agreed to by the provider in writing.

After Hours Care
The primary care or specialty group must have, at a minimum, continuous, 24-hour telephonic coverage by a health professional. All after-hours answering services or telephonic systems must instruct the contacting Member should they believe they are experiencing a serious medical condition; they should seek immediate care by calling 911 or going to the nearest emergency room. It must also state the length of wait for a return call from the provider (not to exceed 30 minutes).

Covering Physicians
Covering Physicians should be contracted and credentialed by CKC. If there are Members of the coverage group that do not participate with CKC, the participating practice must inform them of the CKC policies and procedures (i.e., billing procedures, address, and prior approval). In addition when billing for services, the non-participating Provider must clearly identify the name of the CKC Provider for whom they are covering. All Providers must make good faith efforts to ensure coverage by a CKC Provider. Non-contracted Providers covering for CKC Providers are prohibited from balance billing.

A method to communicate issues, calls, and advice, from covering Providers to the PCP and the Member’s file, must be in effect at the time of coverage. This communication method should be documented or evidenced by policies and procedures.

General Provider Requirements and Considerations

- Provider Evaluation
  CKC may ask for the instructions given to Provider’s answering service or to hear the Provider’s after-hours message during site visits for medical record reviews. Clarity and content will be assessed by standard DHCS criteria. Evidence of adequate communication of coverage will be assessed at the site reviews. Quality Improvement staff or PSR will follow-up with the Provider’s administrative staff regarding improvements or corrective actions when needed.

- Network Access and Capacity
  CKC will maintain a Network of Providers adequate to meet the comprehensive and diverse health needs of its Members. It will offer an appropriate choice of Providers sufficient to deliver
covered services by determining that there are a satisfactory number of geographically and physically accessible participating Providers.

Geographic and access standards are evaluated annually in compliance with DHCS, DMHC and Centers for Medicare and Medicaid Services (CMS) travel time and distance requirements of thirty (30) minutes or ten (10) miles from a Member’s residence to their PCP.

If a Member experiences access issues, including difficulty in obtaining an appointment with a particular provider on a consistent basis, CKC will reevaluate its Provider Network to ensure that CKC has the appropriate amount of providers geographically located to service its Membership.

Provider Reports
CKC submits quarterly Network Provider reports to DHCS, summarizing changes in the Provider Network. The report updates significant changes to the Network affecting Provider capacity and services, including:

- Change in services or benefits;
- Change in geographic service area or payments; or
- Enrollment of a new population.

The report identifies the number of Providers providing primary care services, Provider deletions and additions, and the resulting impact to:

- Geographic access for Members;
- Cultural and linguistic services, including Provider language capability;
- Number of Members assigned to each Provider; and
- Network Providers who are not accepting new patients.

General Considerations
Provider selection is based on the availability of Providers meeting minimum criteria for credentialing, geographic standards for accessibility, compliance with the Americans with Disability Act, and availability of culturally and linguistically competent staff to meet the needs of the Member population. In the event that a participating Physician with the requisite skill to treat a Member is not available within the accessibility or mileage/timeframe standard, CKC will authorize treatment from a non-participating Provider at no out of pocket expense to the Member.

Health Insurance Portability and Accountability Act
CKC complies with the provisions of HIPAA, the Standards for Privacy of Individually Identifiable Health Information and Security Standards for the Protection of Electronic Protected Health Information, and all other State statutes and regulations relating to the privacy and security of protected health information and personal confidential information currently in effect.

Provider Trainings and Communications
CKC is responsible for the quality of care and satisfaction of its Members as well as the satisfaction of its Network of contracted Providers. CKC’s PSR will deliver all necessary information to Providers after the Provider’s acceptance as a CKC contracted Provider. In addition, PSRs will offer educational training opportunities to Providers on an ongoing basis.
• **Orientation for Newly Contracted Providers**
  
  Upon notification of a Provider's acceptance in CKC’s Provider Network, the Provider Services Department will contact the office to schedule an orientation meeting. The following items will be included in the orientation:
  
  - CKC program overview;
  - CKC Manual;
  - Comprehensive Provider Directory;
  - Review of Covered Services;
  - Authorizations and claims instructions;
  - Member eligibility and verification worksheet;
  - Instructions for using CKC’s website and other helpful websites;
  - PDR process schematic;
  - Quality improvement initiatives;
  - Language assistance programs (LAP) for CKC Members;
  - CKC contacts; and
  - CKC Forms

• **Ongoing Provider Training**
  
  CKC contracted Providers will be educated on new and updated operational and administrative policies and procedures. The ongoing education of Providers will be achieved through Provider newsletters/bulletins, individual meetings, and/or group presentations. Ongoing Provider training may include focused topics. Providers who have a turnover in office staff may request training for new staff Members. It is the policy of CKC to ensure CKC PCPs receive the training necessary to fulfill their roles and responsibilities.

  CKC will:
  
  - Inform the PCPs in the Provider Network regarding the CKC CCS Demonstration Pilot project requirements. Disseminate the CKC Manual to all affected Providers;
  - Inform the PCPs in the Provider Network regarding how compliance with stated standards will be monitored;
  - Inform the PCPs in the Provider Network regarding compliance with an “action plan” if standards are not met;
  - Disseminate policies and procedures to Members and Potential Members upon request;
  - CKC will communicate information of the highest importance via a fax blast and email and/or the Medical Director will email Network physicians directly; and
  - The CKC website will contain the Manual, Member Handbook and Policies. Other important information may also be available on the website.

• **Continuing Provider Trainings**
  
  In order to encourage on-going compliance with the CKC Demonstration Pilot project requirements, CKC will provide an annual refresher course regarding CKC program requirements and make all education and training materials available on-line for year-round self-study.

  Providers who are not in compliance with program requirements may be placed on an individualized “CAP” that shall include required education and training. Trainings may include:
  
  - Cultural Competency;
  - Customer Service; and
  - Other trainings as deemed necessary.
All CKC trainings and educational programs emphasize the following values:

- **Respect and dignity**: Providers are encouraged to listen to and honor patient and family perspectives and choices.
- **Information sharing**: Providers are encouraged to communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families should receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- **Participation**: Patients and families are encouraged and supported in participating in care and decision-making at all levels.
- **Collaboration**: PCPs are encouraged to collaborate with patients and families at all levels of health care, including: care of an individual child; comprehensive, whole-child Care Plan development and monitoring; program development; implementation and evaluation; and policy formation.

### Monitoring Compliance – CKC Requirements

CKC may use the following methods to monitor compliance:

- Member feedback, including Member Satisfaction Surveys;
- Complaint and Grievance Reports;
- Medical Record Reviews;
- Site Reviews;
- Training compliance;
- Performance Evaluations;
- Quality Improvement Programs/Quality Management; or
- Credentialing process

Compliance will be monitored by the QM Department.

### Non-Compliance and Corrective Action Plan

If CKC becomes aware of a participating Provider’s failure to comply with any of CKC participation criteria, the Provider’s file will be called to the attention of the CKC Administrator and Medical Director.

PSR staff will take such steps, if any, as are appropriate to determine whether a compliance issue may exist. CKC PSR staff and/or the Medical Director may perform an investigation that, in their discretion, is appropriate under the circumstances.

If a determination is made that the Provider appears to meet the CKC’s participation criteria, no further action will be taken with respect to the Provider.

If a determination is made that the participation criteria have NOT been met by the physician and, provided that NONE of the reason(s) the Participation Criteria have not been met are related to Professional Competence and Conduct, the following will take place:

- PSR staff will notify the Provider, in writing, of his/her non-compliance;
- The Provider will be informed of the specific criteria not met;
- The Provider will be provided with a specific action plan that may include training and review of applicable federal, State, and CKC policies and/or procedures; or...
• A Corrective Action Plan (CAP) will be issued and the Provider shall have an opportunity to respond within the defined timeframe (which is dependent on severity of non-compliant issue), correcting any factual discrepancies or correctable deficiencies.

The CKC Administrator or Medical Director shall have the discretion to close the CAP, if the Provider responds within the required timeframe correcting any factual discrepancies or correctable deficiencies, and subsequently fulfills the requirements of the CAP.

If, after CKC PSR staff and/or the Medical Director have performed any further investigation that, in their discretion, may be appropriate under the circumstances where the Provider Services Department and Medical Director determines that the CKC Provider Participation Criteria have NOT been met, and provided that ANY of the reason(s) the Participation Criteria have not been met is/are related to Professional Competence and Conduct, it will result in immediate termination of a Provider’s participation as a CKC Network Provider and the CKC Administrator will forward the Provider's file to the appropriate government agencies. If the Provider fails to respond within the thirty (30) day time frame, it will result in immediate termination of his/her Network participation in the CKC Provider Network without further review or appeal by CKC.

- Dissemination of Policy and Procedure to Member

CKC will disseminate CKC policies and procedures, upon request, to Members and potential Members. Members and potential Members can ask Member Services or any CKC staff Member for more information about where to locate information about a policy or procedure. The CKC Member Handbook is available on the CKC website www.cakidscare.org.

QUALITY IMPROVEMENT

The purpose of the CKC Quality Assessment and Improvement Program (QAIP) or Quality Program (QP) is to establish methods for systematically working to ensure that all CKC Members receive high quality health care and to help optimize their health status. Through the QP and in collaboration with CKC providers, CKC strives to continuously improve the structure, processes and outcomes of its health care delivery system.

In addition to developing a CKC QAIP, CKC will participate in the State-led collaborative Quality Improvement Projects (QIP). Development of the focus of each of the QIPs will be done collaboratively with representatives from the State, CKC, including administrators, Network Physicians and families. CKC will be required to submit data related to the QIP to the State.

CKC’s QP has a commitment to quality that relies on CKC senior management oversight and accountability, and integrates the activities of all departments in meeting program goals and objectives. The QP involves Members, participating Providers, regulators, plan sponsors and evaluators in the development, evaluation, and planning of quality activities.

CKC incorporates continuous quality improvement methodology that focuses on the specific needs of CKC customers. It is organized to identify and analyze significant opportunities for improvement in care and services, to develop improvement strategies and to systematically track whether these strategies result in progress towards established benchmarks or goals. Focused QP activities are carried out on an ongoing basis to ensure that quality of care issues
are identified and corrected. Quality studies and monitoring activities are reported through the quality committee structure to CKC’s governing body.

The QAI Program Description is reviewed and updated annually.

- **Quality Improvement Plan Priorities**
  To achieve the stated goals, the following priorities have been identified:
  - Establish structures and systems across the continuum of patient care that supports multidisciplinary performance improvement activities;
  - Establish and maintain mechanisms for assuring effective dialogue between PCPs, specialists, and hospital Providers;
  - Establish and maintain mechanisms for detecting trends, patterns and opportunities to improve, and communicate this information to the appropriate personnel;
  - Once trends, patterns, and opportunities for improvement have been identified, changes are implemented, monitored, and evaluated;
  - Aim to disseminate evidence-based best practice clinical guidelines that may be used by CKC providers; and
  - Specific priorities for study are determined at the Quality Improvement Committee.

**Quality Improvement Structure**

- **Quality of Care Committee**
  The Quality of Care Committee (QOCC) meets quarterly. Minutes are kept for each meeting, and dated and signed by the QOCC Chairperson.

  Key Responsibilities of the QOCC include:
  - Contribute to the review and development of the annual Quality Improvement Plan;
  - Recommend policy decisions, review activities, institute and monitor needed follow-up actions;
  - Provide oversight of the physician/practitioner peer review process;
  - Create / review confidentiality policies and procedures;
  - Provide oversight of the Provider credentialing process to include: recommending to Senior and Clinical Leadership, actions, up to and including termination of Provider Network Membership within CKC;
  - Provide feedback to leadership regarding identified patterns and trends;
  - Make recommendations for improving the process of care and/or enhancing patient satisfaction;
  - Communicate information to providers, when appropriate; and
  - Implement ongoing quality studies based on outcome of review processes, statistical reports and quality assessment procedures.

- **Membership**
  The QOCC is comprised of both primary and specialty care physicians and behavioral health providers. Membership consists of seven (7) physician Members representing medical, surgical and behavioral health specialties. The QOCC is chaired by a physician who is appointed by the Board. The chair facilitates meeting discussion and is a voting Member of the committee. Tenure of the chair is for a three (3) year period. Selected Members will rotate on staggered three (3) year terms. A quorum consists of five (5) members in attendance. Administrative representatives from the functional areas of credentialing, contracting, UM and
HEALTH EDUCATION AND CULTURAL, DISABILITIES and LINGUISTIC SERVICES

CKC appreciates the diverse needs of its Members, including language, ethnicities, cultures, and countries of origin and that Member’s needs may be accompanied by a variety of attitudes, beliefs, and behaviors regarding health and health care. CKC is committed to accommodating this diversity in a manner that accepts and respects differences, while also promoting optimal health outcomes. Moreover, CKC is committed to ensuring that all Members receive high quality health care that is culturally and linguistically appropriate.

▪ Federal Nondiscrimination Requirements
CKC complies with all applicable federal requirements in Section 504 of the Rehabilitation Act of 1973 (29 USC 794), nondiscrimination under federal grants and programs; 45 CFR 84 nondiscrimination on the basis of handicap in programs or activities receiving federal financial assistance; 28 CFR 36 nondiscrimination on the basis of disability by public accommodations and in commercial facilities; Title IX of the Education Amendments of 1972 (regarding education programs and activities); 45 CFR 91, the Age Discrimination Act of 1975; and all other laws regarding privacy and confidentiality.

▪ Provider Responsibility
CKC acknowledges the role that language barriers may present when limited English proficient (LEP) Members receive care. The following cultural and linguistic standards are required of CKC and its Provider Network in order to comply with Title 6 of the Civil Rights Act of 1964 [42 USC Section 200(d)], SB 853 and 45 CFR (Part 80), which are all interpreted to mean: that LEP individuals are entitled to equal access and participation in federally and state funded programs through the provision of language assistance services.

Providers shall ensure equal access to health care services of Members of all ethnic and cultural populations, Members with LEP and Members with hearing or speech impairments. The PCP shall, in policies, administration and services practice the values of:

- Respecting a Member’s beliefs, traditions and customs;
- Recognizing individual differences within a culture;
- Creating an open, supportive and responsive space in which differences are valued, respected and managed; and
- Through cultural competency training, fostering in staff attitudes and interpersonal communication styles that respect a Member’s cultural backgrounds and are sensitive to their special needs.

Providers shall ensure equal access to CKC’s LEP, hearing or speech impaired Members in the following ways:

- Utilization of CKC’s interpreter services, bilingual providers or bilingual clinical staff during discussions of medical information such as diagnosis of medical conditions and proposed treatment options. Untrained or non-clinical staff should not be used to interpret during discussions of medical information;
• Providers shall not encourage the use of family or friends as interpreters, especially minors;
• Providers should not subject Members to unreasonable delays in receiving care when the need for interpreter services is identified by the provider or requested by the Member. Providers shall document the Member’s preferred language, if other than English, in the Member’s medical record;
• Providers shall document a Member’s request or need for interpreter services in the medical record;
• Providers shall document a Member’s refusal of interpreter services in the Member’s medical record;
• Providers shall provide Member informing materials in English and Spanish.
• Providers shall inform a Member of his/her right to file a grievance in the Member’s primary language;
• Providers should ensure that Provider staff that provides interpretation to Members have been assessed and are capable of accurate health care interpretation; and
• Providers should refer Members to culturally appropriate programs and services, as needed.

▪ CKC Responsibility

In order to comply with the California DHCS, the CMS, SB 853 and Title 6 of the Civil Rights Act of 1964 (42 USC Section 200(d) and 45 CFR Part 80), CKC has developed policies that correspond with these mandates and that assist Members in receiving services that meet their cultural and linguistic needs. CKC provides the following services to facilitate effective communication between Members, providers and CKC staff:

• Bilingual Member Services Representatives.
  o CKC has Member Services Representatives that are bilingual in Spanish.
• Use of telephonic interpreters.
  o Members who speak other languages can communicate with a Member Services Representative through MARTI/ Language Line Services.
• Services for hearing impaired or speech impaired Members
  o Members can utilize the Telecommunications Relay Service to communicate with a Member Services Representative, or (711).
  o Members can use MARTI/Language Line services to communication with their doctor.
  o CKC provides hearing/speech impaired Members access to sign language interpreters.
• Use of face-to-face interpreters for LEP Members
  o Members who speak other languages can request the use of face-to-face interpreters when the use of telephonic interpreters would be unsuitable/inappropriate. Each request will be reviewed on a case-by-case basis.
• Bilingual materials.
  o CKC’s Member Handbook and Member Rights and Responsibilities are available in English, Arabic, Spanish, Tagalog, and Vietnamese.
• Diverse Provider Network
  o CKC annually assesses provider and provider office staff’s language capabilities in order to provide Members with information so that they can identify and select providers who speak their language.
• Member Education
Members are informed about their right to file a grievance in their primary language.

Language Assistance Program (LAP) and Access to Interpreter Services

The DMHC (per SB853 of 2003) requires that health plans implement a LAP for enrollees that are LEP. This regulation mandates that interpreter services be offered and available at each patient point of contact, such as at a doctor’s office or when calling a customer service number. Language assistance services are available at no cost to patients and include oral interpreter services at each patient point of contact, such as at a doctor’s office or when calling a customer service number.

Interpreter will be provided for all LEP Members to reduce the effect of language barriers on quality of care. CKC ensures 24-hour access to telephonic interpreter services for all medical and non-medical points of contact.

CKC Members can also utilize in-person sign language interpreter services with advance notice. Further, face-to-face interpreters for LEP Members are available on a case-by-case basis, when the particular circumstances of the individual’s condition make telephonic interpretation unsuitable/inappropriate. All interpreter services are provided free of charge to Members. CKC interpreter services are only available for patients who are eligible CKC Members.

- **Telephonic Interpreter Services**
  Telephonic interpretation is available to CKC Members through the Language Line. Telephonic interpretation can be accessed through provider office exam room phones. If these are not available, any phone, such as a cell phone, can be used. If phone access is an issue contact Member/Provider Services for assistance.

- **How to Use Language Line Services**
  Language Line services should be handled by Provider staff and should be seamless for the Member. Providers may access telephonic interpretation for CKC Members by calling the Language Line Services at (866) 874-3972. The operator will request the following information, (1) Client ID 863280 and Customer ID 19575, (2) Language needed, (3) Office name, and 4) Member name and date of birth.

  For more information on how to access Language Line Interpreters, contact CKC Provider Services.

- **Face-to-Face Language Interpreter Services**
  On rare occasions, the use of telephonic interpreter services for a particular patient might be unsuitable/inappropriate due to the patient’s condition or circumstances (e.g. explaining diagnosis of terminal cancer). In such instances, CKC can authorize face-to-face interpreter services on a case-by-case basis. To arrange such services, Providers may contact CKC’s Provider Services at 1-844-225-5430 (TTY 711). Please provide at least five (5) days notice to request an interpreter whenever possible.

- **Sign Language Interpreter Services**
  To request a sign language interpreter for a CKC Member, providers may contact CKC’s Member Services Department at 1-844-225-5430 (TTY 711). The following information is
required to schedule a sign language interpreter, (1) Member name and Member ID number, (2) date, time, duration and address of appointment, (3) contact person and phone number at Provider site, and (4) description/type of appointment. A confirmation with the interpreter information will be faxed to your office. Please provide at least five (5) days notice to request an interpreter.

**Cultural and Diversity Awareness**
CKC recognizes that the ability to provide services in a culturally and linguistically appropriate manner must be cultivated through training and experience. CKC is therefore committed to providing cultural and diversity awareness information and materials for CKC Network providers. In addition, CKC is also committed to ensuring that providers are informed and aware of ways in which providers enhance the cultural responsiveness and improve access and quality of care for CKC Members. If you would like additional information in this area, contact Provider Services at 844-225-5430 (TTY 711).

- **Monitoring and Enforcement**
CKC recognizes that the provision of culturally and linguistically appropriate health care services is challenging and requires a great deal of coordination. To ensure that CKC’s employees and Providers adhere to its cultural and linguistic services policies and procedures, CKC conducts regular monitoring and enforcement activities regarding staff, provider, and interpreter performance that may include, but are not limited to, consumer satisfaction surveys, review of Member grievances, annual provider assessments, and provider site-reviews. Specifically, CKC monitors documentation in Member’s medical charts on requests or refusals of language interpreter services through Facility Site Review.

- **Assessment of Member Cultural and Linguistic Needs**
CKC acknowledges that the ability to provide culturally and linguistically appropriate care to a Member population is predicated on understanding that population’s cultural and linguistic needs. Accordingly, CKC is committed to conducting regular assessments of its Members’ cultural and linguistic needs, including language preferences, use of interpreters, use of alternative medicines, traditional health beliefs, and beliefs and practices regarding health and health care utilization. The results of these assessments are shared with providers as they become available. Further, if providers have any suggestions, comments or ideas to improve CKC’s activities on addressing Member cultural and linguistic needs, CKC welcomes these ideas.

**Services for Disabled Members**
CKC recognizes that our Members with disabilities have specific needs in addition to their general medical needs. For this reason, we provide services that are integrated within our daily activities of every department, such as access to TRS for our hard-of-hearing Members, large-print materials for our visually-impaired Members, information on which of our providers have wheelchair accessible offices in our provider directory for our wheelchair-using Members, to name a few. Also, our Care Navigation Team focuses on assisting our Members with complex chronic conditions to ensure they receive the care management they need to optimize their health outcomes. If you have CKC Members with disabilities and who need additional services, notify CKC Member Services at 844-225-5430 (TTY 711).
### Glossary

<table>
<thead>
<tr>
<th>Term:</th>
<th>Definition:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>An individual’s ability to obtain medical services on a timely and financially acceptable basis.</td>
</tr>
<tr>
<td>Admissions per 1000</td>
<td>The number of hospitals admissions per 1,000 health plan member. The formula for this measure is: (# of admissions/member months) x 1,000 members x # of months.</td>
</tr>
<tr>
<td>Admits</td>
<td>The number of admissions to a hospital or inpatient facility.</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>Licensed healthcare professional other than physicians, including dentist, nurses, practitioners, physical therapists, optometrists, psychologist, and podiatrists.</td>
</tr>
<tr>
<td>Allowable Costs</td>
<td>Charges for services rendered or supplies furnished by a health provider that qualify as covered expenses.</td>
</tr>
<tr>
<td>Ambulatory Costs</td>
<td>Charges for services rendered or supplies furnished by a health provider that qualify as covered expenses.</td>
</tr>
<tr>
<td>Ancillary</td>
<td>A term used to describe additional services performed related to care, such as lab work, x-ray and anesthesia.</td>
</tr>
<tr>
<td>Average Length of Stay (ALOS)</td>
<td>The average number of days in the hospital for each admission. The formula for this measure: total patient days incurred divided by the number of admissions and discharged during the period.</td>
</tr>
<tr>
<td>Bed days per 1000</td>
<td>The number of inpatient days per 1,000 health plan member. The formula for this measure is (# of days/member months) x 1,000 members x # of months.</td>
</tr>
<tr>
<td>California Kids Care (CKC)</td>
<td>The name of the Rady Children’s Hospital – San Diego pilot program, which is outlined in this provider manual.</td>
</tr>
<tr>
<td>Capitation</td>
<td>A stipulated amount established to cover the cost of health care services delivered for a person. The term usually refers to a per capita rate to be paid periodically, usually monthly, to a health care provider. The provider is responsible for delivering or arranging for the delivery of all health care services required by the covered person under the condition of the provider contract.</td>
</tr>
<tr>
<td>Care Navigator</td>
<td>Care coordination will be led by the Care Navigator in partnership with the child’s lead doctor. The Care Navigator is a Registered Nurse (RN) or Nurse Practitioner (NP) familiar with the medical care and psychosocial needs of children with Special Healthcare Needs. The Care Navigator will also be familiar with the full range of services provided and will work with others members of the care coordination team to assess the needs of the child/youth and family, and to assure the patient/family is aware of and receives the needed services.</td>
</tr>
<tr>
<td>Case Management</td>
<td>A process whereby a covered person with a specific health care needs is identified and a plan that efficiently utilizes health care resources is formulated and implemented to achieve the optimum patient outcome in the most cost effective manner.</td>
</tr>
<tr>
<td>Case Manager</td>
<td>An experienced professional (e.g., nurse, doctor, or social worker) who works with patients, providers and insurers to...</td>
</tr>
<tr>
<td>Terms</td>
<td>Definitions</td>
</tr>
<tr>
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</tr>
<tr>
<td>coordinator</td>
<td>all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.</td>
</tr>
<tr>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>The federal agency responsible for administering Medicare and overseeing the state of Medicaid.</td>
</tr>
<tr>
<td>Concurrent Review</td>
<td>As assessment of hospital admissions, conducted by trained managed care staff via telephone or on-site visits during a covered person’s hospital stay, to ensure appropriate care, treatment, length of stay and discharged planning.</td>
</tr>
<tr>
<td>Co-payment</td>
<td>Payment made by a patient of a flat dollar amount per unit of service at the time of service (e.g. $10.00 per physical office visit. The amount paid id generally nominal, but sufficient to incentives appropriate utilization of health care services.</td>
</tr>
<tr>
<td>Covered Person</td>
<td>An individual who meets eligibility requirements and for whom premium payments are paid for specific benefits under the contractual agreement.</td>
</tr>
<tr>
<td>Credentialing</td>
<td>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.</td>
</tr>
<tr>
<td>Date of Service</td>
<td>The date on which health care services were provided to the covered person</td>
</tr>
<tr>
<td>Drug Formula</td>
<td>A listing of prescription medication that are approved for use and/or coverage by the plan and which will be dispensed through participating pharmacies to a covered person. The list is subject to review and modification by the health plan.</td>
</tr>
<tr>
<td>Durable Medical Equipment (DMR)</td>
<td>Equipment, which can withstand repeated use and is primarily and customarily used to serve a medical purpose. DME is generally not useful to a person in the absence of illness or injury, and is appropriate for home use. Examples of DME include hospital beds, wheelchairs and oxygen equipment.</td>
</tr>
<tr>
<td>Effective Date</td>
<td>The date a contract becomes in force.</td>
</tr>
<tr>
<td>Eligibility Date</td>
<td>The defined date a covered person becomes eligible for benefits under an existing contract.</td>
</tr>
<tr>
<td>Eligible Person</td>
<td>An individual who meets the eligibility requirement specified in the provisions of the contract.</td>
</tr>
<tr>
<td>Emergency</td>
<td>A person’s sickness or injury is of such nature that failure to get immediate medical care could put the person’s life in danger or cause serious harm to the person’s bodily functions. Some examples of medical emergency are: apparent heart attack, including but not limited to severe, crushing chest pain radiating to the arms and jaw; cardiovascular accidents; severe shortness of breath or difficulty in breathing; severe bleeding; sudden loss of consciousness; convulsions; severe allergic reactions; cyanosis; apparent poisoning. Some examples of conditions that are not usually medical emergencies: colds; influenza; ordinary sprains; children’s ear infections; nausea; headaches; a term delivery, whether vaginal or by cesarean section, inside administration or outside the service area, is not an emergency.</td>
</tr>
</tbody>
</table>
| Encounter | A face-to-face meeting between a covered person and a health }
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounter Data</td>
<td>Information submitted to a health plan or medical group by capitated that documents pertinent information about each encounter with a patient.</td>
</tr>
<tr>
<td>Enrollment</td>
<td>The total number of covered persons in a health plan. The term also refers to the process by which a health plan signs up groups and individuals for memberships, or the number of enrollees who sign up in any one group.</td>
</tr>
<tr>
<td>Evidence of Insurability (Enrollment Guarantee)</td>
<td>Proof presented through written statements that an individual is eligible for a certain type of insurance coverage.</td>
</tr>
<tr>
<td>Exclusions</td>
<td>Specific conditions or circumstances listed in the contract or employee benefit plan for which the policy or plan will not provide benefit payments.</td>
</tr>
<tr>
<td>Experimental, Investigational or Unproven procedures</td>
<td>Medical, surgical, psychiatric, substance abuse, or other health care services, supplies treatments, procedures where, drug therapies or devices that are determined by the health plan (at the time it makes a determination regarding coverage in a particular case) to be either: 1.) not generally accepted by informed health care professional in the United States as effective in treating the condition, illness, or diagnosis for which their use is proposed, or 2.) Not proven by scientific evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed.</td>
</tr>
<tr>
<td>Explanation of Benefits (EOB)</td>
<td>The statement sent by a payer listing services provided, amount billed and amount paid.</td>
</tr>
<tr>
<td>Fee-for-Service Reimbursement</td>
<td>The traditional health care payment system under which physicians and other providers receive a payment that does not exceed their billed charge for each unit of service provided.</td>
</tr>
<tr>
<td>Fee Schedule</td>
<td>A comprehensive listing of fee maximums used to reimburse a physician and/or other provider on a fee-for-service basis.</td>
</tr>
<tr>
<td>Gatekeeper</td>
<td>A situation in which a primary care physician, the “gatekeeper”, serves as the patient’s initial contact providers for medical care and referrals.</td>
</tr>
<tr>
<td>Generic Drug</td>
<td>A chemical equivalent copy designed from a brand-name drug that has an expired patent. A generic is typically less expensive and sold under a common or “generic” name of the drug (e.g. the brand name for one tranquilizer is Valium, but it is also available under the generic name Diazepam). Also called generic equivalent.</td>
</tr>
<tr>
<td>CMS 1500</td>
<td>A universal form developed by the government agency known as for providers of services to bill professional fees to health carriers.</td>
</tr>
<tr>
<td>Health Benefits Package</td>
<td>The services and products (coverage) a health plan offers a group or individual.</td>
</tr>
<tr>
<td>Health Plan</td>
<td>1. This is an entity that a group or individual pays a premium to, allowing the group or individual to obtain medical care and health services as outlined in the individual health benefit packages. Some cases the insured will have a</td>
</tr>
</tbody>
</table>

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| **Health Maintenance Organization** | An entity that provides, offers, or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium. Under the Federal HMO Act, an entity must have three characteristics to call itself an HMO:  
   2. An organized system for providing health care or otherwise assuring healthcare delivery in a geographic area.  
   3. An agreed upon set of basic and supplemental health maintenance and treatment services. A voluntarily enrolled group of people |
<p>| <strong>Individual Practice Association (IPA) Model HMO</strong> | A health care model that contracts with an individual practice association entity to provide health care services return for a negotiated fee. The IPA in turn contacts with physicians who continue in their existing individual or group practices. The IPA may compensate the physician on a capitation, fee schedule, or fee-for-service basis. |
| <strong>Inpatient</strong> | An individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician for at least 24 hours. |
| <strong>International Classification of Diseases 10th Edition (ICD-10)</strong> | A listing of diagnosis and identifying codes for reporting and diagnosis of health plan enrollees identified by a physician. The coding and terminology provide a uniform language that will accurately designate primary and secondary diagnosis and provide for reliable and consistent communication. |
| <strong>Length of Stay</strong> | The number of days that a member stays in an inpatient facility. |
| <strong>Managed Care Health Plan</strong> | One or more products which integrate financing and management with the delivery of health care services to an enrolled population; employs or contracts with an organized provider network which delivers services and which (as a network or individual provider) either shares financial risk or has some incentive to deliver quality, cost-effective services; uses an information system capable of monitoring and evaluating patterns of member’s use of medical services and the cost of those services. |
| <strong>Medical Director</strong> | Medical Group or Plan physician responsible for bridging health care delivery between providers and administration, maintaining a provider network for necessary contracted services, direction of utilization and quality management programs. |
| <strong>Medical Home</strong> | Medical Home, also known as the <strong>patient-centered medical home (PCMH)</strong>, is a care model that is designed around patient needs and aims to improve access to care (e.g. through extended office hours and improved communication between providers and patients via email and telephone), increase care coordination and enhance overall quality, while at the same time reducing costs. The medical home relies on a team of providers—such as doctors, nurses, care navigators, nutritionists, pharmacists, and social workers—to meet a |</p>
<table>
<thead>
<tr>
<th>Medical Home Model</th>
<th>Studies have shown that the medical home model’s focus on the whole child and integration of all aspects of healthcare offer potential to improve physical health, behavioral health, access to community-based social services and overall long-term medical condition management.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Necessary</td>
<td>A service or treatment which is appropriate and consistent with diagnosis, and which, in accordance with accepted standards of practice in the medical community of the area in which the health services are rendered, could not have been omitted without adversely affecting the member’s condition or the quality of medical care rendered.</td>
</tr>
<tr>
<td>Member</td>
<td>A participant in the health plan (subscriber/enrollee or eligible dependent) who makes up the plan’s enrollment. Also used to describe an individual specified with a subscriber contract who may or may not receive health care services according to the terms of the subscriber policy.</td>
</tr>
<tr>
<td>Member Month</td>
<td>A count, which records one member for each month the member is effective.</td>
</tr>
<tr>
<td>Non-Participating Provider</td>
<td>A term used to describe a provider that has not contracted with the carrier or health plan to be participating provider of health care. Also known as a non-contracted provider, or out-of-network provider.</td>
</tr>
<tr>
<td>Office Visit</td>
<td>Physician services provided in an office setting.</td>
</tr>
<tr>
<td>Outliers</td>
<td>Those patients with a specific admitting diagnosis that either have a shorter or longer length of stay than the usual range for that diagnosis.</td>
</tr>
<tr>
<td>Outpatient</td>
<td>A person who receives health care services without being admitted to a hospital.</td>
</tr>
<tr>
<td>Participating Provider</td>
<td>A provider who has contracted with the health plan to provide medical services to covered persons. The provider may be a hospital, pharmacy, other facility or a physician who has contractually accepted the terms and conditions as set forth by the health plan.</td>
</tr>
<tr>
<td>Peer Review</td>
<td>The evaluation of quality total health care provided by medical-staff with the equivalent training.</td>
</tr>
<tr>
<td>Per Member Per Month (PMPM)</td>
<td>The unit of measure related to each eligible member for each month the member was effective. The calculation is # of units/member months.</td>
</tr>
<tr>
<td>Physician</td>
<td>Any doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is duly licensed and qualified under the law of jurisdiction in which treatment is rendered.</td>
</tr>
<tr>
<td>Resource Based Relative Value Scale (RBRVS)</td>
<td>The current method of reimbursement under Medicare.</td>
</tr>
<tr>
<td>Whole Child</td>
<td>The Whole Child approach to care is a comprehensive model for care. Rady Children’s California Kids Care seeks to integrate and manage individual care plans specific to the Member that...</td>
</tr>
</tbody>
</table>
address the full spectrum of healthcare issues, not just the CCS-related condition. California Kids Care is committed to really working with each family to develop a patient-specific Care Plan that does everything possible to achieve the best treatment outcomes and overall health status for California Kids Care Members.

### IPA

This is an organization of individual medical practices (physicians) that are formed. The HMO, the practicing physicians or a third party could create the IPA. Typically the HMO pays the IPA a single capitated fee, and leaves provider reimbursement to the IPA. IPA plans are open-panel, and physicians continue to practice in their own locations using their own staff.

### Line of Businesses (LOB)

Line of business identifies what type of insurance the member has, a state or government funded program or one that a person purchases on his or her own.

### Commercial

This is an organization that provides health care to an individual or group. The insurance company charges the purchaser a fee (premium) in exchange for health care coverage.

### Point of Service (POS)

Also known as an open-ended HMO, POS plans encourage but do not require members to use physicians within their network. If the enrollee chooses to use an outside physician, the plan acts like traditional insurance but carries very high co-payments and deductibles. Inside the plan, the negotiated, prepaid fee covers all services when service is obtained through a gatekeeper primary care physician. Enrollees make the decision over which aspects of the insurance plan is used at the time they seek care (the point of service). Which demand for these plans is high and their recent growth has been rapid, it is unclear how often enrollees actually opt to use services outside of the network.

### Health Plan Contracting

When the IPA contacts with a Health Plan, negotiations take place. At the negotiations the capitation rate that is paid to the IPA is decided and financial responsibility is also decided for paying services. A Division of Financial Risk (DOFR) is set up indicating who will be paid for each service. Some services will be the responsibility of the IPA, some will be the responsibility of the Health Plan and then some are determined as a “shared risk”. “Shared Risk” or “Risk Pool” is a pool of money that us out at risk is not expended by the end of the year, some or all of it is retuned to those managing the risk. Two different definitions are in use: 1) A pool of funds set aside as reserves to be used by the end of the contract year, it is usually disseminated to participating providers, and, 2) Legislatively created programs those groups individuals who cannot secure coverage in the private market. Funding comes from government or assessment on insurers.

The Health Plan will also perform audits once or twice a year depending on the health plan, to insure that the IPA is following health plan guidelines and internal policy and procedures.
Appendix

California Kids Care

a program of Rady Children's Hospital-San Diego
FORM TO FILE A STATE HEARING

You can ask for a State Hearing by calling: 1-800-952-5253.
TDD users, call 1-800-952-8349.
Or you can fill out this form and FAX it to State Hearing Support at 916-651-5210 or 916-651-2789.

Or you can mail this page to: California Department of Social Services
State Hearing Division
P.O. Box 944243, MS 9-17-37
Sacramento, CA 94244-2430

For free help filling out this form, call the legal help phone number listed on 'Your Rights.'

I do not agree with the decision about my health care. Here's why:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

(If you need more space, use another piece of paper. Make a copy for your records.)

Check these boxes only if they apply to you:

(1) ☐ I want the person named below to represent me. She/he can see my medical records that relate to this hearing, come to the hearing, and speak for me.

Name: ________________________ Phone Number: ________________________
Address: ______________________

(2) ☐ I need a free interpreter. My language or dialect is:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

(3) ☐ I also want to file a grievance against the health plan. I understand the State will send my health plan a copy of this form.

(4) ☐ My situation is urgent. I need a quick decision and cannot wait 90 days because: (Explain what may happen without a quick decision. As discussed in the "Your Rights" information notice, you will also need a letter from your doctor or health plan if you want an expedited hearing).

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

(5) ☐ Please continue the service my Plan has stopped until my hearing.

My Name: ________________________ My Social Security Number: _____________
Address: ________________________ Phone Number: ________________________

My signature: ________________________ Today's Date: ________________________
(After you complete this form, make a copy for your records.)

Appendix
Confidential Transmission - CKC Referral/Authorization Notification

California Kids Care
Phone: 1-844-225-5430
Fax: 1-858-309-7977

To: Healthcare Provider
From: California Kids Care (CKC)

This report is an update of all referral/authorization records created, changed and/ or updated by California Kids Care. This Referral/Authorization verifies medical necessity only. Payment for services is dependent upon the patient's eligibility /benefits at the time services are rendered. If you’d like to discuss the decision with the physician reviewer, please contact CKC at 1-844-225-5430.

The information contained in this facsimile transmission is intended ONLY for the designated recipients named below. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this transmission is strictly prohibited. If you have received this communication in error, please contact CKC at 1-844-225-5430 IMMEDIATELY to correct your listed fax number.

View the status of your requests online using our EZNET web portal and eliminate faxes! To request user access, call CKC Provider Relations at 1-844-225-5430.

Referral/Authorization Information:
PCP/Requesting Provider:
Requested Provider:
Place of Service:

<table>
<thead>
<tr>
<th>AUTH NUMBER</th>
<th>STATUS</th>
<th>AUTH'D UNITS</th>
<th>AUTH DATE</th>
<th>EXP DATE</th>
<th>DATE ADD/CHANGE</th>
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<td>BIRTH DATE</td>
<td>MEMBER ID</td>
<td>MEMBER PHONE</td>
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<td>QTY REQUESTED</td>
<td>DIAGNOSIS</td>
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</tbody>
</table>

Appendix
NOTICE OF ACTION - About Your Treatment Request

[Dated]

To the Parent(s)/Guardian(s) of:

[Member Name]
[Member Address]
[Member City, State, Zip]

Member Name: [Member’s Name]
Member I.D.: [Member ID Number]
Requesting Provider: [PCP/Auth ID Name]
Date Request Received: [Authorization Received Dated]
Requested Service: [Treatment Description]
Requested Date(s) of Service: [Auth Requested Date] to [Auth Expiration Date]
Authorization Number: [Authorization Number]

Dear [Member’s Name]:

[PCP/Auth ID Name] has asked California Kids Care (CKC) to approve [Treatment Description]. We cannot make a decision yet. This is because [Insert a clear and concise explanation of the reasons for the delay, indicating what further information is needed and/or additional steps need be taken. If further information is being requested, input the deadline for receipt of information.] We expect to let you know the decision on [date]. You will get another letter letting you know the decision at that time.

You may appeal this decision. The enclosed “Your Rights” information notice tells you how. It also tells you where you can get free help. This also means free legal help. You are encouraged to send in any information that could help your case. The “Your Rights” notice tells you the cut off dates to ask for an appeal.

The State Medi-Cal Managed Care “Ombudsman Office” can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call CKC at 1-844-225-5430 (TTY 711).

This notice does not affect any of your other Medi-Cal services.

[Medical Director’s Name]
Enclosure: “Your Rights under Medi-Cal Managed Care” (Enclose notice with each letter)
NOTICE OF ACTION – About Your Treatment Request

To the Parent(s)/Guardian(s) of:

Member Name
Member Address
Member City, State, Zip

Dear [Member’s Name]:

[PCP/Auth ID Name] has asked California Kids Care (CKC) to approve [Treatment Description]. This request is denied. This is because [Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity].

You may ask for free copies of all information used to make this decision. This includes a copy of the actual benefit provision, guideline, protocol, or criteria that we based our decision on. To ask for this, please call CKC Program at 1-844-225-5430 (TTY 711).

You may appeal this decision. The enclosed “Your Rights” information notice tells you how. It also tells you where you can get free help. This also means free legal help. You are encouraged to send in any information that could help your case. The “Your Rights” notice tells you the cut off dates to ask for an appeal.

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This notice does not affect any of your other Medi-Cal services.

[Medical Director’s Name]

Enclosure: “Your Rights under Medi-Cal Managed Care” (Enclose notice with each letter)
NOTICE OF ACTION - About Your Treatment Request

[Health Plan or PPG Tracking Number – optional]

[Name of requesting provider] has asked California Kids Care (CKC) to approve [Treatment Description]. We cannot approve this treatment the way it is. This is because [Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity].

We will instead approve: [Service approved].

You may ask for free copies of all information used to make this decision. This includes a copy of the actual benefit provision, guideline, protocol, or criteria that we based our decision on. To ask for this, please call CKC Program at 1-844-225-5430 (TTY 711).

You may appeal this decision. The enclosed “Your Rights” information notice tells you how. It also tells you where you can get free help. This also means free legal help. You are encouraged to send in any information that could help your case. The “Your Rights” notice tells you the cut off dates to ask for an appeal.

The State Medi-Cal Managed Care “Ombudsman Office” can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call CKC at 1-844-225-5430 (TTY 711).

This notice does not affect any of your other Medi-Cal services.
[Medical Director’s Name]

Enclosure: “Your Rights under Medi-Cal Managed Care” (Enclose notice with each letter)
**NOTICE OF APPEAL RESOLUTION**

Date: [Date]

<table>
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<tr>
<th>Member Name:</th>
<th>[Member’s Name]</th>
<th>Provider’s Name</th>
<th>[Treating Provider’s Name]</th>
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<td>Provider’s Address</td>
<td>[Address]</td>
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<td>[City, State Zip]</td>
<td>Provider City, State, Zip</td>
<td>[City, State Zip]</td>
</tr>
</tbody>
</table>

Identification Number: [Identification Number]

RE: [Service requested]

You or [Name of requesting provider or authorized representative], on your behalf, appealed the [denial, delay, modification, or termination] of [Service requested]. California Kids Care (CKC) has reviewed the appeal and has decided to uphold the decision. This request is still denied. This is because [Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity].

You may ask for free copies of all information used to make this decision. This includes a copy of the actual benefit provision, guideline, protocol, or criteria that we based our decision on. To ask for this, please call CKC at 1-844-225-5430 (TTY 711).

You may appeal this decision. The enclosed “Your Rights” information notice tells you how. It also tells you where you can get free help. This also means free legal help. You are encouraged to send in any information that could help your case. The “Your Rights” notice tells you the cut off dates to ask for an appeal.

The State Medi-Cal Managed Care “Ombudsman Office” can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at CKC at 1-844-225-5430 (TTY 711).

This notice does not affect any of your other Medi-Cal services.

[Medical Director’s Name]

Enclosed: “Your Rights under Medi-Cal Managed Care” (Enclose notice with each letter)
NOTICE OF APPEAL RESOLUTION

[Dated]

To the Parent(s)/Guardian(s) of:
[Member Name]
[Member Address]
[Member City, State, Zip]

Member Name: [Member’s Name]
Member I.D.: [Member ID Number]
Requesting Provider: [PCP/Auth ID Name]
Date Request Received: [Authorization Received Dated]
Requested Service: [Treatment Description]
Requested Date(s) of Service: [Auth Requested Date] to [Auth Expiration Date]
Authorization Number: [Authorization Number]

Dear [Member’s Name]:

You or [PCP/Auth ID Name], on your behalf, appealed the [denial, delay, modification, or termination] of [Treatment Description]. California Kids Care (CKC) has reviewed the appeal and has decided to overturn the original decision. This request is now approved. This is because [Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity].

CKC has 72 hours to give you the service. The State Medi-Cal Managed Care “Ombudsman Office” can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call CKC at 1-844-225-5430 (TTY 711).

This notice does not affect any of your other Medi-Cal services.

[Medical Director’s Name]
Enclosure: “Your Rights under Medi-Cal Managed Care” (Enclose notice with each letter)
NOTICE OF ACTION - About Your Treatment Request

To the Parent(s)/Guardian(s) of:
[Member Name]
[Member Address]
[Member City, State, Zip]

Member Name: [Member’s Name]
Member I.D.: [Member ID Number]
Requesting Provider: [PCP/Auth ID Name]
Date Request Received: [Authorization Received Dated]
Requested Service: [Treatment Description]
Requested Date(s) of Service: [Auth Requested Date] to [Auth Expiration Date]
Authorization Number: [Authorization Number]

Dear [Member’s Name]:

You are currently getting [Service to be terminated]. We cannot approve this treatment anymore. This is because [Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity].

Payment for this treatment will stop on [date].

You may ask for free copies of all information used to make this decision. This includes a copy of the actual benefit provision, guideline, protocol, or criteria that we based our decision on. To ask for this, please call California Kids Care (CKC) at 1-844-225-5430 (TTY 711).

You may appeal this decision. The enclosed “Your Rights” information notice tells you how. It also tells you where you can get free help. This also means free legal help. You are encouraged to send in any information that could help your case. The “Your Rights” notice tells you the cut off dates to ask for an appeal.

The State Medi-Cal Managed Care “Ombudsman Office” can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call us at CKC 1-844-225-5430 (TTY 711).

This notice does not affect any of your other Medi-Cal services.
[Medical Director’s Name]
Enclosed: “Your Rights under Medi-Cal Managed Care” *(Enclose notice with each letter)*
If you still do not agree with this decision, you can ask for a “State Hearing” and a judge will review your case.

You must ask for a State Hearing within **120 days** from the date of this “Notice of Appeal Resolution” letter. But, **if you are currently getting treatment and you want to continue getting treatment, you must ask for a State Hearing within 10 days** from the date this letter was postmarked or delivered to you, OR before the date your health plan says services will stop. You must say that you want to keep getting treatment when you ask for the State Hearing. You will not have to pay for a State Hearing.

You can ask for a State Hearing by phone or in writing:

- **By phone:** Call **1-800-952-5253**. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call **TTY/TDD 1-800-952-8349**.

- **In writing:** Fill out a State Hearing form or send a letter to:

  **California Department of Social Services**  
  **State Hearings Division**  
  **P.O. Box 944243, Mail Station 9-17-37**  
  **Sacramento, CA 94244-2430**

  A State Hearing form is included with this letter. Be sure to include your name, address, telephone number, Social Security Number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell us what language you speak. You will not have to pay for an interpreter. We will get you one.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be able to get an answer within 3 working days. Ask your doctor or health plan to write a letter for you. The letter must explain in detail how waiting for up to 90 days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, make sure you ask for an “expedited hearing” and provide the letter with your request for a hearing.

You may speak at the State Hearing yourself. Or, someone like a relative, friend, advocate, doctor, or attorney can speak for you. If you want another person to speak for you, then you must tell the State Hearing office that the person is allowed to speak for you. This person is called an “authorized representative.”
LEGAL HELP
You may be able to get free legal help. Call the Department of Managed Health Care California Help Center at 1-888-HMO-2219 or TDD 1-877-688-9891. You may also call the local Legal Aid Society in your county at 1-888-804-3536.
YOUR RIGHTS UNDER MEDI-CAL MANAGED CARE

IF YOU DO NOT AGREE WITH THE DECISION MADE FOR YOUR MEDICAL TREATMENT, YOU CAN FILE AN APPEAL. THIS APPEAL IS FILED WITH YOUR HEALTH PLAN.

HOW TO FILE AN APPEAL

You have 60 days from the date of this “Notice of Action” letter to file an appeal. But, if you are currently getting treatment and you want to continue getting treatment, you must ask for an appeal within 10 days from the date this letter was postmarked or delivered to you, OR before the date your health plan says services will stop. You must say that you want to keep getting treatment when you file the appeal.

You can file an appeal by phone, in writing, or electronically:

- **By phone:** Contact California Kids Care (CKC) between Monday-Friday, 8:00 a.m. – 5:00 p.m. by calling 1-844-225-5430. Or, if you cannot hear or speak well, please call (TTY 711).

- **In writing:** Fill out an appeal form or write a letter and send it to:
  
  California Kids Care  
  Rady Children’s Hospital – San Diego  
  Grievance and Appeals Resolution Services  
  3020 Children’s Way, MC 5149  
  San Diego, CA 92123-4282

  Your doctor’s office will have appeal forms available. Your health plan can also send a form to you.

- **Electronically:** Visit your health plan’s website. Go to www.cakidscare.org.

You may file an appeal yourself. Or, you can have someone like a relative, friend, advocate, doctor, or attorney file the appeal for you. This person is called an “authorized representative.” You can send in any type of information you want your health plan to review. A doctor who is different from the doctor who made the first decision will look at your appeal.

Your health plan has 30 days to give you an answer. At that time, you will get a “Notice of Appeal Resolution” letter. This letter will tell you what the health plan has decided. **If you do not get a letter within 30 days, you can ask for a “State Hearing” and a judge will review your case.** Please read the section below for instructions on how to ask for a State Hearing.
EXPEDITED APPEALS

If you think waiting 30 days will hurt your health, you might be able to get an answer within 72 hours. When filing your appeal, say why waiting will hurt your health. Make sure you ask for an “expedited appeal.”

STATE HEARING

If you filed an appeal and received a “Notice of Appeal Resolution” letter telling you that your health plan will still not provide the services, or you never received a letter telling you of the decision and it has been past 30 days, you can ask for a “State Hearing” and a judge will review your case. You will not have to pay for a State Hearing.

You must ask for a State Hearing within 120 days from the date of the “Notice of Appeal Resolution” letter. You can ask for a State Hearing by phone or in writing:

- **By phone:** Call 1-800-952-5253. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call TTY/TDD 1-800-952-8349.

- **In writing:** Fill out a State Hearing form or send a letter to:
  
  California Department of Social Services  
  State Hearings Division  
  P.O. Box 944243, Mail Station 9-17-37  
  Sacramento, CA  94244-2430

  Be sure to include your name, address, telephone number, Social Security Number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell us what language you speak. You will not have to pay for an interpreter. We will get you one.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be able to get an answer within 3 working days. Ask your doctor or health plan to write a letter for you. The letter must explain in detail how waiting for up to 90 days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, make sure you ask for an “expedited hearing” and provide the letter with your request for a hearing.

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