UC San Diego Health

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UC San Diego Health (UCSDH) and UC Riverside Health (UCR) Managed Care Provider Operations Manual 2026

For Providers, Professionals, Facilities and Ancillary Providers

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Welcome

Welcome to the UC San Diego Health (UCSDH) and UC Riverside Health (UCRH) Population Health Services Organization Managed Care (herein known as UCSDH as this is the delegated oversight entity), provider manual. This provider operations manual is a tool and reference guide that allows you and your staff to find important information such as how to process claims and prior authorizations. This manual also includes important contact information essential to your day-to-day operations. Find operational standards, policies, and other online tools, including an up-to-date copy of this manual, website at: health.ucsd.edu/insurance-billing/paying/hmo/

EASILY FIND INFORMATION IN THIS MANUAL USING THE FOLLOWING STEPS:

1. CTRL + F.

2. Type in the key word.

3. Press Enter.

If you have questions about the information or material in this manual, or about our policies, please email: PHSOnetworkmgmt@health.ucsd.edu

Important Information About the Use of This Manual

If there is a conflict between your Agreement and this provider manual, use this manual unless your Agreement states you should use it, instead. If there is a conflict between your Agreement, this manual and applicable federal and state statuses and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UCSDH reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations. This manual will be amended as policies change.

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Key Contacts

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

Mailing Addresses:

UCSDH PHSO or UCR Managed Care
UCSDH PHSO Managed Care
200 W. Arbor Drive, UCSDH 8501
San Diego, CA 92103-8501

Claims Address:
UCSDH PHSO Managed Care
Attn: Claim Department
PO Box 5198
Lake Forest, CA 92630

Provider Dispute Resolution
UCSDH PHSO Managed Care
Attn: Claim Department
PO Box 5198
Lake Forest, CA 92630

Claims	
• Claims Status Inquiry	**(619) 471-9123, Option 1, 1**
• PHSO LINK	**https://ucsdlink.ucsd.edu/EHR-Connect/common/epic_login.asp**
• Payer ID for electronic claim submission	**UCSDH**
• Provider Claims Disputes Inquiry	**(619) 471-9123, Option 1, 1**
Customer Service	
• Phone Number	**(619) 471-9123, Option 2, 3**
• Customer Service Fax	**(619) 471-9077**
• Eligibility/Enrollment Inquiry	**(619) 471-9123, Option 1, 3**
Delegation Compliance Clinical Appeals and Grievances	
• Email	**managedcareumAG@health.ucsd.edu**
• Fax	**(858) 732-0905**

PHSO Network Management Contracts and Providers Relations: PHSOnetworkmgmt@health.ucsd.edu

Credentialing: PHSOnetworkmgmt@health.ucsd.edu

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Health Plan Contact Information

Commercial Plans Currently Accepted (UCSDH only)			
Aetna* www.aetna.com (800)624-0756	Anthem/Blue Cross* www.anthem.com (800)677-6669	Blue Shield* www.blueshield.com (800)776-4466	Cigna* www.cigna.com (800)244-6224
Health Net www.healthnet.com (800)641-7761	United Healthcare* www.uhc.com (800)542-8789	VEBA Direct* https://www.vebaonline.com/veba-direct/ (888)276-0250	
Medicare Plan			
SCAN Health Plan* www.scanhealthplan.com (877) 452-5898			

Glossary of Terms

Access to Care Standards
Guidelines that ensure timely and appropriate access to medical care for members, including preventive care, emergency care, and specialist consultations.

Advanced Diagnostic Imaging
Specialized medical imaging techniques, such as CT scans, MRIs, and PET scans, used for detailed diagnosis and evaluation.

Appeal

A formal process for members or providers to challenge a Health Plan or Medical Group's decision to deny, limit or terminate services, involving Health Plan review and potentially external independent review

Authorization
The process of obtaining approval from the health plan or medical group for specific medical services or treatments before they are provided.

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Capitation
A payment arrangement where healthcare providers are paid a set amount per enrolled member per month, regardless of the number of services provided.

Carve Out

When a service involves separate referral review or pre-certification process and is deemed the responsibility of the Health Plan. Referral will be denied, and will include information as to who the member should contact, at the Health Plan, for prior authorization

Care Connections Hub

A UCSDH team of nurses who call every patient post discharge to ensure that the patient has what they need after an inpatient, skilled nursing facility or ED stay. This team helps with care coordination, patient education, medication review, and appointment scheduling, along with any other post discharge needs that arise.

Claims
Requests for payment submitted by providers to health plans for services rendered to members.

Claims Submission Requirements
Standards that outline the necessary information and timelines for submitting claims, including patient details, diagnosis codes, and dates of service.

Clean Claim
A claim that contains all required information and can be processed without additional requests for information from the provider or patient.

Case Management (CM)

A Managed Care (UCSDH) Registered Nurse or a Social Worker who helps UCSDH patients to connect to care, Health Plan and /or community resources.

Complex Case Management (CCM)
A program designed to assist members with severe medical conditions through coordinated care, support, and resource linkage.

Concurrent Review
A review process performed during a patient's hospital stay to assess the medical necessity and appropriateness of ongoing treatment and discharge planning.

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Credentialing
The process of verifying the qualifications, experience, and professional standing of healthcare providers.

Denial Determination
A decision made by a health plan or medical group to not approve a requested service or treatment, based on established criteria, including but not limited to medical necessity.

Digital Disease Management

A disease management program that includes integrated home devices for passive remote patient monitoring programs to help patients to better manage their hypertension, diabetes and mild to mod depression. Patients who have a UCSD primary care provider consent to enroll in this program with the goal of better self-manage their care. Based on a patient's needs, providers make a referral via an order in EPIC for these services. The program provides devices that are integrated into the medical record, and a team of nurses can track device readings during normal business hours and will outreach patients via phone or text to help coach them with their goals. In addition, patients have access to other devices, pharmacists and health coaching, and wellness APPs.

Discharge Planning
A coordinated process to prepare a patient for discharge from a healthcare facility, ensuring continuity of care and appropriate follow-up services.

Division of Financial Responsibility (DOFR)

A document that outlines the delegated financial responsibility between the Health Plan and UCSDH.

Durable Medical Equipment (DME)
Reusable medical devices, such as wheelchairs, oxygen equipment, or hospital beds, prescribed for patient care and recovery.

Eligibility Administration
Processes to verify and maintain accurate records of members' enrollment and eligibility for healthcare services.

EPIC

UC San Diego Health electronic medical record. Note: Care Everywhere is a tool embedded in EPIC to help pull in clinical information from other health systems.

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Experimental/Investigational Services
Medical treatments, procedures, or technologies that are not yet widely accepted as standard care due to limited clinical evidence.

Fraud, Waste, and Abuse
Activities that involve the intentional misuse of healthcare resources, including false claims, unnecessary services, or overbilling.

Gold Card

A UCSDH centric term for rapid processing of referrals based on embedded logic in our medical record, EPIC, based on member benefit, eligibility and medical necessity to help with accurate and timely referral processing.

Green Card

A UCSDH centric term for services that cost less than $250, is medically necessary and is needed for timely patient care, for example a walker. If a provider has any questions, they should reach out to UCSDH provider relations.

Grievances and Complaints
Formal expressions of dissatisfaction by members regarding the quality of care or services received.

Health Plan
An organization that provides or arranges for coverage of designated health services to members, typically under a contract.

ICD-10 Coding
The International Classification of Diseases, 10th Edition, used for coding and documenting diagnoses and procedures.

In Network (INN)

Refers to UCSDH contracted providers and vendors. UCSDH HMO patients must remain in network whenever possible to avoid delays in referral processing and self-pay.

Interpreter Services
Language assistance services provided to members with Limited English Proficiency (LEP) to ensure effective communication in healthcare settings.

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Medical Necessity
Healthcare services or treatments that are necessary to prevent, diagnose, or treat a medical condition, as determined by clinical guidelines and professional judgment.

Member Rights and Responsibilities
A set of principles outlining the rights members have regarding their care and services, as well as their responsibilities to actively participate in their healthcare.

National Committee of Quality Assurance (NCQA)

A health care accreditation organization. This accreditation gives consumers the information they need to find high-quality healthcare.

Out of Network (OON)

When a patient receives care that is not within UCSDH contracted network. If a prior authorization has not been secured by the patient, provider and/or vendor, UCSDH may deny services as an uncovered OON service.

Peer to Peer Discussion (after denial issued)

A discussion between a patient's doctor and an insurer's medical director, usually by phone, to justify a denied medical service. The goal is for the ordering physician to explain the clinical justification to the payer's physician, in order to have the denial reconsidered and have the service approved.

PHSO Link

UCSDH and UCRH medical record, EPIC, portal for all providers and vendors that are not on EPIC. Using PHSO Link is critical for timely referral processing and authorizations. This is a streamlined approach to referral processing and is far more sophisticated than a regular fax. Providers and/or vendors needing this access should reach out to UCSDH Provider Relations. PHSO Link also provides claim status for all providers, whether they are a registered user or access it through a Guest Link.

Prior Authorization (PA)
A review process conducted before a service or treatment is provided to a patient / member to ensure a referral meets medical necessity and coverage guidelines. This PA ensures timely claims payment.

Provider Dispute Resolution
A process for providers to appeal or contest decisions regarding claims, payments, or other administrative matters.

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Referral
A recommendation made by a physician for a member to receive care from another provider or to obtain specific medical services, such as; durable medical equipment, home health, physical therapy, radiology, prescriptions.

Retrospective Review
A review conducted after medical services has been provided to assess the appropriateness and medical necessity of the care rendered.

Standing Referral
An extended authorization for a member to receive ongoing care from a specialist without requiring repeated referrals for each visit.

Timeliness Claims Submission
The required timeframe within which a provider must submit a claim for reimbursement after rendering services.

Turn Around Times (TATs)

Department of Managed Care mandated referral processing times for commercial and Medicare members for routine and stat referrals

Universal Prior Authorization (UPA)

The UCSDH UM process is designed to support patients with network options for an approved service or consult. This gives patients the right to take an approved referral and seek out a consult from an in-network specialist from an INN list that may be closer to their home or who may have an earlier appointment.

UCSD at Home

A team of providers that perform in-home visits for home confined Medicare patients and certain patients with a commercial Health Plan to help keep them safe and well managed at home. A provider can send a referral to UCSDH via the Population Health order set in EPIC or via PHSO Link.

Utilization Management (UM)
Processes designed to ensure that healthcare services provided to members are medically necessary, appropriate, and efficient. UM processes follow the Health Plan DOFR.

Utilization Review (UR)

Processes designed to ensure a patient's facility stay (hospital, skilled nursing facility, acute rehabilitation) meets medical necessity based on evidenced based criteria

Value-Based Care
A healthcare delivery model that ties provider reimbursement to the quality of care and outcomes achieved, rather than the volume of services provided.

Value Based Care Advisory Group (VBCAG)

UCSDH Quality Improvement (QI) / Utilization Management (UM) Committee. A quarterly meeting that has a cross section of voting providers to review and provide input on QI / UM activities to ensure UCSDH Utilization Management (UM) meets Health Plan compliance standards and mandated Department of Managed Care, State and Center for Medicaid and Medicare (CMS) regulations. Meeting minutes are taken and are available to providers and Health Plan auditors as requested.

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Mission, Vision, and Values

Mission

University of California San Diego Health (UCSDH) and University of California Riverside (UCRH) is committed to delivering exceptional health care within a compassionate environment, aiming to make a significant and measurable impact on the health of individuals in our communities. We allocate our resources to provide high-quality, safe, and cost-effective health care services while upholding social responsibility. Additionally, we advance clinical research, promote population and community health education, train physicians, pharmacists and health care professionals, and support graduate medical education. Through collaboration, we strive to offer a comprehensive continuum of care that enhances community health. This Mission is foundational and encompasses the care provided by your UCSDH Population Health Services Organization (PHSO) Managed Care Network.

Vision

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

Values

We deliver exceptional service at UCSDH and UCRH, our priority is always the patient, with an unwavering dedication to quality. In the evolving landscape of health care, we aim to proactively address the root causes of illness and promote healthy behaviors among those we serve. We empower patients to engage in their own care and make informed choices, standing by them as advocates during their most vulnerable times. Our success is measured by patient satisfaction, their recovery and overall well-being, and the compassion we show to patients, their families, and loved ones.

UCSDH and UCR are committed to respecting the rights and dignity of every individual, including patients, students, faculty, and staff. This commitment is reflected in the university's policies and principles, which emphasize the importance of treating each community member with respect and dignity. The university prohibits discrimination and harassment and provides equal opportunities for all community members and applicants, regardless of their background, culture, or identity. In the context of UCSD Health, this commitment is demonstrated through the provision of compassionate and culturally sensitive care, where patients' cultural, ethnic, and religious beliefs and practices are respected and honored.

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The university's goal is to create a healing environment that is inclusive and respectful of all individuals, and to promote a culture of respect, empathy, and understanding among all members of the UCSDH / UCRH community.

UCSDH and UCRH is committed to providing top-quality care to its patients in a responsible and efficient manner. As a major community health care resource for San Diego and Riverside Counties, the institution is accountable for its use of human, financial, and ecological resources. The organization strives for excellence and collaborates with various stakeholders to improve healthcare delivery. Its goal is to ensure that all members of the community have access to timely, affordable, and appropriate care. This commitment is reflected in UC San Diego Health and UC Riverside Health's strategic goals, which include the pursuit of quality, patient experience, improving access, advancing health equity, fostering a culture of belonging, and efficiency of operations.

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University of California Riverside and University of San Diego Health Partnership

Our partnership between UCSDH and UCRH Medical Group represents a shared commitment to excellence in patient care and community health. By working together, we combine resources, expertise, and innovation to deliver coordinated, high-quality care to the people of San Diego and Riverside counties. This collaboration ensures that patients across both regions benefit from streamlined processes, improved access to care, and a unified approach to managed care services—reflecting our dedication to advancing health and well-being for the communities we serve.

This Provider Manual applies to services provided to patients covered under managed care contracts administered by UC San Diego Health (UCSDH) and the University of California Riverside (UCRH) Medical Group. UCSD Health serves as the Management Services Organization (MSO) for UCRH, and therefore administers all processes, policies, and procedures described in this manual on behalf of both organizations.

Providers should follow the guidelines outlined herein for all UCSD Health and UCR patients.

UCSH Roles and Responsibilities

UC San Diego Health (UCSDH) Population Health Services Organization (PHSO) Managed Care is a Management Services Organization (MSO) that provides full delegation oversight and management of capitated lives for whom UCSDH Medical Group and UCRH have accepted risk. We are also an Accountable Care Organization (ACO) that ties provider reimbursements to quality metrics and reduction in the total cost of care for an assigned population of patients. UCSDH operates under a capitated book of business with both shared and full risk models. UCSDH manages utilization of medical services provided to eligible HMO enrollees assigned to UCSDH / UCRH clinic sites. We partner with fully licensed HMOs that operate within our respective service areas. Our role is to provide comprehensive health care services to our enrolled membership. Health care services are provided by our UCSDH and UCRH Physician Network. This network of high-quality providers in the community helps UCSDH and UCRH expand our footprint in the community and allows access to be nearer to where our patients live. UCSDH and UCRH Affiliates are an integrated network of participating contracted providers (hospitals, physicians, and ancillary providers).

The following are our delegated responsibilities:

- Enrollment and Capitation Oversight
- Utilization Management
- Complex Case Management / Disease Management (Health Plan specific)
- Claims Payment per Division of Financial Risk (DOFR)
- Ancillary, Facility and Professional Contracting

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- Provider and Member Services
- Provider Relations
- Credentialing (Initial/Re-credential)

UCSDH and UCR are committed to meeting the requirements within our contracts, both with our Health Care Service Plan (HCSP) partners and our health care provider partners. Specific departments within UCSDH ensure compliance with the contractual obligations. UCSDH is accredited by the National Committee for Quality Assurance (NCQA) through 2026.

Customer Service

The Customer Service Department serves as the primary point of contact for both members and providers. Their role is diverse and essential to UCSDH Operations. They collaborate with all departments within UCSDH, act as a liaison between members and UCSDH, and manage provider inquiries. Customer Service Representatives are equipped to address a wide range of issues from both members and providers.

Provider Relations

Contracting/Provider Relations performs the following services for UCSDH/UCRH:

- Complex Claim and Utilization Management Issue Resolution
- Contract Analysis
- Contract Negotiation, Implementation, and Interpretation
- Enrollment Issue Resolution
- Liaison Between Health Plans and Contracted Providers
- Provider Education

UCSDH Epic PHSO Link

PHSO Link is an Epic tool that provides access to your patients' clinical data and enables you to share patient information fluidly with UCSDH and UCRH. It exists to expedite coordinated care. PHSO Link is a web-based application. It displays activities that correspond to the management of shared patients with UCSDH. PHSO Link is a tool that provides real-time Web access to your UCRH and UCRH Managed Care patients' information and allows for referral entry for Managed Care patients. You can access your UCSDH and UCRH Managed Care patients' demographics, referrals and/or claim information. PHSO Link is comprised of different web pages, or activities, that correspond to different tasks. The activity that you use depends on what you want to accomplish. For example, if you want to see detailed information about a patient's referral, you can use the Referral Search activity. Providers that sign up for PHSO Link are then expected to

submit referrals via PHSO Link which will support seamless and timely processing of all referrals.

For additional information on accessing UCSD Health Care Link, contact Network Management at PHSOnetworkmgmt@health.ucsd.edu. PHSO Link is only available to contracted providers. For non-contracted providers, UCSDH has a guest link option.

Eligibility Administration

UCSDH is responsible for implementing and maintaining an accurate database of managed care members enrolled with UCSDH contracted medical groups where UCSDH has financial risk or has Utilization Management responsibilities. UCSDH works very closely with the contracted health plans to obtain timely and accurate membership data. There may be a time delay, as UCSDH must rely upon health plans receipt of accurate data. Policies and Procedures are in place to ensure that a member's eligibility is verified by the health plan prior to enrolling a new HMO member in the UCSDH database. Many health plans have contract language, which enables them to retroactively add or terminate an HMO member.

Providing Culturally & Linguistically Competent Care

UCSD Health is dedicated to improving the health and well-being of all our Members, regardless of their social or economic status and is committed to meeting the requirements of Title VI of Civil Rights Act of 1964 with amendments, Section 504 of Federal Rehabilitation Acts, and California Health and Safety Language Assistance Requirements set forth in 1367.04. Programs have been established to effectively address the cultural and linguistic needs of our patients and to ensure services are culturally and linguistically equitable by ensuring enrollees services with limited English proficiency are able to communicate regarding initial determinations and have the same level of access to representatives and information, as members who are proficient in English. (UCSDH UM Policy 039 Interpreter Services/Language Assistance Program)

Provider Access to Language Services

State and federal laws mandate that health plans implement a Language Assistance Program (LAP) for members with Limited English Proficiency (LEP). In compliance with these laws, contracted providers must help members access language services offered by their respective health plans. Language Assistance Program (LAP) information and training documents that include the health plans LAP educational materials are shared at least quarterly with vendors and contracted provider via Provider Bulletins and in-services. LAP information is shared with members on all non-standard vital documents.

Translation Services -UCSDH provides certain Utilization Management and Claims documents that comply with language access regulations and include a DMHC-approved notice of translation services in 15 languages. This notice is included with the following UCSDH produced non-standardized vital documents:

1. UM Denial Notifications, which cover denials, modifications, or delays in service
2. UM Delay Notifications, which request additional information or an expert review
3. Claims Denial Notifications related to Member liability
4. Letters requiring a response from the Member

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5. Provider Termination Letters

Additionally, health plans offer translation services for vital documents, including denial notices, appeal letters, and other plan-related materials. *Relevant laws: CA H&SC Sect. 1367.04, 28 CCR 1300.67.04, ACA Sect. 1157. (*UCSDH Policy UM039 Interpreter Services/Language Assistance Program); Section 1557 of the Affordable Care Act; Title VI of the Civil Rights Act; National Standards on Culturally and Linguistically Appropriate Services, Americans with Disabilities Act, Hill Burton Act,

Interpreter Services - Providers can request interpreters for Members whose primary language is not English, including those needing an American Sign Language interpreter, by contacting the Member's health plan. Requests for face-to-face interpreter services must be made at least five (5) days before the appointment. Please be aware that, despite advance notice, face-to-face interpreters may not be available for all languages. If a face-to-face interpreter cannot be arranged, health plans can offer telephone interpreting services as an alternative.
In addition, UCSDH has the ability to provide 24-hour access to interpretive services for all patients upon request at no charge. UCSDH Interpreter Services can be reached at 619-543-5205 or CRS TTY 711or 800-735-2922

It is important to note that friends or family members, particularly minor children, should not serve as interpreters unless specifically requested by the patient.

Other Resources- Providers can access the free guide Better Communication, Better Care: Provider Tools to Care for Diverse Populations which is available on the HICE (Health Industry Collaboration Effort) website: HICE Provider Toolkit. The tool kit provides guidance for interacting with a diverse patient base, communication across language barriers, and understanding various cultural backgrounds.
(UCSDH Policy UM039 Interpreter Services/Language Assistance Program)

Language Access Program Contacts

To request Interpreter or Translation services for a patient, you may directly contact the Language Access Program representative for the Member's health plan. Below is a list of LAP contact information for each health plan contracted with UCSDH:

Plan	Interpreter Access	Translation Requests *Protect PHI by encrypting e-mails.*
Aetna	(800) 525-3148	(877) 287-0117
Anthem Blue Cross	(888) 254-2721	(800) 677-6669
Blue Shield of CA	(800) 541-6652 *to request onsite interpretation, dial "0" to speak with a provider services agent.*	(209) 371-5838
Cigna	(800) 806-2059	*Send Word document for translation to* Culturalandlinguisticsunit@cigna.com

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Health Net	(800) 641-7761 *Mon-Fri, 8am to 5pm* (800) 546-4570 *afterhours*	626-683-6307
SCAN	(866) 745-5010 *phone interpreter* (800) 559-3500 *face-to-face interpreter*	(800) 559-3500
UnitedHealthcare	(800) 730-7270 *Spanish* (800) 938-2300 *Chinese* (800) 624-8822 *All Other Languages*	(800) 730-7270 *Spanish* (800) 938-2300 *Chinese* (800) 624-8822 *All Other Languages*

You can also contact UCSDH Customer Service at **(619) 471-9123** for assistance in accessing language services for a member through their health plan.

Member Rights and Responsibilities

UCSDH is committed to treating members in a manner that respects their rights. New enrollees and members can request at any time copies of their rights and responsibilities from UCSDH and/ or their provider. (UCSDH Policy QI -047)

1. Members have the right to voice grievances about the organization or the care provided.
2. Members have the right to be provided with information about; the organization, its services, the practitioners providing care, members' rights and responsibilities.
3. Members have the right to make recommendations regarding the Provider Groups Member Rights and Responsibility Policy & Procedures.
4. Members have the right to receive health care that is not influenced by member race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
5. Members will participate in the decision-making process involving their health care. Members have the right to be represented by parents, guardians, family members, or other conservators for those who are unable to fully participate in their treatment decisions.
6. Members have the right to receive education regarding their health care needs, be notified of findings found during physical examination, be notified of potential treatment options (without regards to plan coverage), side effects of treatment, management of symptoms, and to make the final determination regarding their healthcare needs for treatment or non-treatment (among clinically acceptable choices).
7. Members will be treated with and receive quality care that is professionally delivered in a respectful manner and in recognition of their dignity and need for privacy.
8. UCSDH allows open practitioner-patient communication regarding appropriate treatment alternatives and without penalizing practitioners for discussing medically necessary or appropriate care for the patient.
9. Members have the right to obtain the name, qualifications, and titles of the professionals providing their care. This information can be obtained through discussion with the health care provider. If this is not

possible, the patient can obtain information from their Health Plan or the Physician Group.

10. Members are allowed the option of seeking an obstetrics-gynecologist as a primary care physician. Primary Care Physician as defined by Section 14254 of the Welfare and Institutions Code of California and include the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referrals for specialist care. Additionally, this means the Primary Care Physician provides care for the majority of health care problems, including, but not limited to, preventative services, acute & chronic conditions, and psychosocial issues.
11. Member information will be readable, comprehensive, and well designed.
12. UCSDH will ensure that confidentiality of specified patient information and records is protected and maintained.
13. It is the member's responsibility to provide to the extent possible, information that the Participating Medical Group and its practitioners and providers need in order to care for them.
14. It is the member's responsibility to follow the plans and instructions for care that they have agreed on with their practitioners.

UCSDH members have the responsibility to:

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

Medical Management Program: Utilization Management

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The purpose of the Utilization Management (UM) Plan is to ensure consistent delivery of the highest quality health care and member outcomes. This is accomplished through the establishment of fully integrated multi-disciplinary health care networks, and coordination of all clinical and administrative services, under the provisions of the Population Health Services Organization. The effective delivery of quality health care requires broad provider participation in the Utilization Management (UM) process.

Providers and Mental Health practitioners involved in the delivery system and UM process make decisions for patient care based on medical necessity and appropriateness of care and service. UCSDH Managed Care does not compensate or provide financial incentives to practitioners or other individuals conducting utilization review for denials of coverage or service. Signed statements attesting to this statement will be completed by UM decision-makers and will be renewed annually and as necessary. Information stating this fact will be distributed to providers annually and to employees and members on request. Medical decision-making by the Health Plan fiscal and administrative management will not influence staff in their UM oversight, review and decisions.

The UM Plan and Program provides for fair and consistent evaluation of medical necessity, access, appropriateness of care, and efficiency of care; through the use of nationally accepted clinical practice standards. To make utilization decisions, UM uses written criteria based on sound evidence and has procedures for applying these criteria in an appropriate manner. Criteria used includes: CMS National and Local Coverage Determination Guidelines, Health Plan specific guidelines, MCG guidelines, Internal Criteria developed and reviewed by the Value Based Care Advisory Group (VBCAG) which focuses on quality improvement (QI) for our members optimal care outcomes and decision support tools built into the UCSD electronic medical record system, American Psychological Association guidelines for Mental Health and Substance Abuse Treatment, and any other accepted criteria that can assist with decision making. All Guidelines are reviewed annually and as necessary by the Chief Medical Officer and the participating UCSDH and UCRH physicians and are available to providers, members, and the public upon request according to policy.

Network providers are included in the Utilization Management (UM) and Quality Improvement (QI) processes through participation in the various UM committees, which are the functional components of the UM and QI program, with the main oversight committee being the VBCAG). Corrective interventions are strategically employed to ensure that a continuous quality improvement focus permeates the Plan.

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The UM Plan will be approved annually after review by the VBCAG and will be presented as approved to the Board of Directors annually. UCSDH annually evaluates the consistency with which health care professionals are involved in decision making and acts on opportunities for improvement. (UCSDH 2025 UM Plan Description)

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Prior Authorization

Prior Authorization is the process of reviewing medical services before they are scheduled to assess medical necessity, appropriateness, patient eligibility, and benefit coverage. Services requiring prior authorization should not be scheduled until the Provider has received approval from UCSDH.

It is the policy of UCSDH UM to prospectively review all referral requests for elective hospitalization procedures (surgical and diagnostic), and referrals to specialty providers, (including ancillary services which cannot be provided by the Primary Care Provider) and those that are excluded from Gold Card lists.

UCSDH reserves the right to deny payment for services if inaccurate information was provided during the authorization request. Providers must submit requests through PHSO Link ensuring that all relevant medical records and supporting documents are included to prevent delays. For those providers that are not on PHSO Link, there is a fax option (fax: 619-471-9100)
The referral request must be complete and include all appropriate medical documentation related to the request such as medical history related to the diagnosis, results of any previous diagnostic tests (e.g., lab and radiology reports), or other relevant information. If additional information is needed to make a decision, the UM team member will make three attempts to obtain additional information to process the request within the approved timeframes. (UCSDH UM policy 005 Prospective Review)

Prior Authorization is NOT required for:

- Emergency services
- Sexually transmitted disease (STD) services
- Human immunodeficiency virus (HIV) testing

Medical Technology /Experimental/Investigational Therapies

UCSDH is not generally delegated for the review of new medical technologies or experimental/investigational services. For requests related to new technology or assistance with application of existing technology related to medical technology, behavioral health procedures, pharmaceuticals, or devices, or other non-delegated requests, please contact the appropriate Health Plan for information on benefit coverage and assistance with decision-making. (UCSDH UM Policy 005 Prospective Review)

Prior Authorization for Out of Network Inpatient Services

For any out-of-network (OON) hospitalizations, the OON designee must notify the UCSDH Transfer Center and UCSDH has 30 minutes (AB 1203) to respond if they can accept transferring member back into a UCSDH hospital. If a patient is admitted to an OON facility, UCSDH will work with the OON facility during the OON stay and/or attempt to transfer patient INN if patient's complexity warrants the transfer and would benefit from UCSD provider oversight and timely follow up post discharge. UCRH attributed members will have access to hospitals in the Riverside area and will work directly with UCSDH UM for authorization and discharge planning.

Foe all UCSDH Managed Care (MC) members please visit https://health.ucsd.edu/for-health-care-professionals/transfers-referrals-consultations/submit-transfer/for more information PHSO UCSDH reserves the right to transfer a patient once patient stable, following a peer-to-peer discussion as long as there is a bed

available. In addition, the OON hospital designee must fax over a cover sheet that includes the member demographic information, facility information, date of admission and clinical information sufficient to document the medical necessity of the admission to UM at 858-732-0817. Emergent inpatient admission services performed without meeting timely notification and medical necessity requirements or failure to include all the needed documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient admission.

The inpatient OON RN CM is available for timely responses to all UM UR calls when clinical updates are needed to support ongoing authorizations and confirm in network vendors for safe discharge planning. Peer to peer communication can be arranged as needed.

Elective Inpatient Hospitalizations and Outpatient Surgeries

Prior authorization is required for both inpatient and outpatient surgeries with the exception of emergent services, however, notification is required. Retroactive authorization requests for non-emergency services may not be approved if notification is not received. For questions about prior authorization guidelines, please contact UCSDH's Utilization Management department. (UCSDH UM 002 Concurrent Review)

Prior Authorization is required for almost all care. The best practice would be "when in doubt, send a referral".

Gold Card

UM has a streamlined authorization process for referrals. Referrals once received will pass through system logic, we call this process Gold Card. A referral that passes through our Gold Card process will result in an immediate authorization. Over 80% of our referrals are processed through this system logic. The remaining 20% of referrals are manually processed by the UM team for final determination and in accordance with referral processing times. Prior authorization is required for all services to ensure eligibility and benefit coverage verification. It is important that all services are provided within the UCSDH or UCRH network, based on member attribution. Out of network (OON) requests require Medical Director review and is limited to those services that cannot be provided in-network.

Universal Prior Authorization (UPA)

Patients who have a referral for specialty consults and simple in office procedures will receive a UPA letter explaining that the patient can go to the provider listed on the authorization letter or they can access the UCSDH provider network and go to an alternate INN specialist who may be closer to the patients' home or who may have more timely access. This gives patients a greater degree of choice and enhances patient satisfaction.

Outpatient Mental Health & Substance Use Disorder Services

UCSDH PHSO UCSDH may not be delegated or responsible for treatment or services related to management of behavioral health services. If the member has a carve-out benefit, the UCSDH Managed Care Department will

direct the member, provider, and hospitals to request services with the carve-out provider directly, if UCSDH is not delegated to manage those requests.

If responsibility for the behavioral health services is delegated, the UCSDH PHSO UM Department will authorize and direct the member to the appropriate in-network facility and /or provider. Referral decisions are made according to protocols that define the urgency and appropriate setting of care as well as existence of coverage. (UCSDH UM Policy 024 Utilization Management of Behavioral Health Services)

Out of Area Services

UCSDH is generally not delegated or responsible for treatment or services, including emergency care, provided outside of San Diego County. In the event that an Out of Area pre-service request is submitted, the requester is notified immediately and referred to the respective health plan of the member for coordination of referral and case management.

Claims for emergency services will be submitted directly to the member's health plan. (UCSDH UM Policy 005 Prospective Review)

Contacts for UM Personnel

UM staff is available 8 a.m. to 5 p.m. Monday through Friday for inbound calls regarding UM issues, with the exception of approved health system holidays, at 619-471-9123 and then please follow the prompts.
After office hours, Providers may call UM at 858-833-1382 for **URGENT** medical authorizations that cannot wait until normal business hours.

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Referrals and Prior Authorization Timely Processing Standards Review Criteria Hierarchy for Medicare Advantage and Commercial Members

It is the policy of UM to prospectively review all referral requests for elective hospitalization procedures (surgical and diagnostic), and referrals to specialty providers, (including ancillary services which cannot be provided by the Primary Care Provider) and those that are excluded Gold Card lists. The timeliness of UM decision making follows the State and Federal mandated notification timeframes below. UM decisions affecting care when a member faces an imminent and serious threat to his or her health are made within mandated timeframes, after receipt of necessary information.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition **not to exceed 72 hours after receipt of the request.**	Practitioner: Within 24 hours of the decision, not to exceed 72 hours of receipt of the request (for approvals and denials). Member: Within 72 hours of receipt of the request (for approval decisions). Document date and time of oral notifications.	Within 72 hours of receipt of the request. **Note:** If oral notification is given within 72 hours of receipt of the request, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
Urgent Pre-Service - Extension Needed • Additional clinical information required	**Additional clinical information required:** Notify member and practitioner within 24 hours of receipt of request & provide 48 hours for submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made within 48 hours of receipt of information. **Note:** Decision must be made in a timely fashion appropriate for the member's condition not to exceed 48 hours after receipt of information.	*Additional information received or incomplete* Practitioner: Within 24 hours of the decision, not to exceed 48 hours after receipt of information (for approvals and denials). Member: Within 48 hours after receipt of information (for approval decisions). Document date and time of oral notifications.	*Additional information received or incomplete* Within 48 hours after receipt of information. **Note:** If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.

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

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Criteria for Commercial Referral Determinations

Criteria for referral determinations (Review Hierarchy) will be processed in the following order for Commercial line of business:

1. Federal / State Mandates
2. Benefit Coverage
3. Health Plan Medical Policies & Guidelines (i.e. Blue Shield of California Commercial Pharmacy Criteria, etc.) or UCSD Policies and Procedures
4. MCG Criteria/ Guidelines
5. Applicable Policies (National Imaging Associates/ NIA, American Specialty Health/ ASH, National Comprehensive Cancer Network/ NCCN, etc.)

Criteria for Medicare Advantage referral determinations (Review Hierarchy) will be processed in the following order for Medicare Advantage Plans line of business. The Review Hierarchy for Medicare Advantage Plans are:

1. Research the CMS site for National Coverage Determinations (NCD)
2. In the absence of NCDs, CMS website will be reviewed for Local Coverage Determination (LCD) for California State (entire/ southern)
3. In the absence of LCDs, CMS website will be reviewed for Local Coverage Articles (LCAs: Active/ Retired)
4. In the absence of LCAs, Medicare Manuals will be reviewed (Internet only manuals), if appropriate
5. In the absence of any of the above criteria, Milliman Criteria Guidelines (MCG v27) will be used.
   5a. with supporting documentation that other criteria in hierarchy is not available
   5b. must be used in connection with the independent professional judgement of a qualified professional
6. In the absence of MCG criteria, medical necessity will be determined based on available UCSDH Medical Group Policies and Procedures, specifically UM005: Prospective Reviews.
7. If no applicable criteria is found in any of the above databases, the UCSDH Medical Group Managed Care Medical Director may make the decision based on practical experience and/or medical judgement which may include, but is not limited to:

   7a. Health Plan specific policies (which may require working with the Health Plan)

   7b. Nationally recognized consensus-based guidelines (NCCN, etc.)

   7c. Studies from government agencies

   7d. Additional evidence-based guidelines, i.e. United States Preventive Services Task Force (USPTF)

   7e. Evaluations performed by independent technology assessment groups

   7f. Well- designed, controlled clinical studies that have appeared in peer review journals

   7g. Prior decision by the independent review entity.

Practitioners may obtain UM criteria and guidelines by requesting (verbal or written request) criteria via the UCSD PHSO UM phone number (619-471-1923 and follow the prompts) or by UM department email

(managedcareum@health.ucsd.edu). Responses to requests will be made by email, electronic fax and/or mail, as per provider preference (UCSDH UM Policy 015)

Medical Necessity Determination Process/ Value Based Care Advisory Group (VBCAG)

The Medical Directors, board-certified physician consultants, and/or VBCAG physician members (including appropriate actively practicing physicians) make final decisions for all denials and modification of care based on medical necessity), and modifications that are based on medical appropriateness. A medical physician or other health care professional, as appropriate, reviews any non-behavioral health denial of care based on medical necessity. If delegated for behavioral health service determinations, a psychiatrist, doctoral level clinical psychologist, or certified addiction specialist reviews any potential denial of behavioral health care based on accepted guidelines for medical necessity. A behavioral health practitioner is available as needed for any behavioral health needs of the UM program for health plans who delegate behavioral health referral decision making. All physicians hold a current, unrestricted license to practice in California. Criteria used to make the decision are available according to policy to the provider, member, or the public on request. (UCSDH UM Plan 2024)

Medical Necessary or Medical Necessity is defined as health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. (USCDH UM Policy UM026 Prior Authorization Service Denials)

Denial Determination

UM Utilization Review (UR) staff will gather all pertinent information related to the referral. The Medical Director (or physician designee) will review and sign off on all denials and modifications (with the exception of eligibility issues and Not Covered Benefit issues). RN CMs can review and sign off for "Not Covered Benefit" determinations. All physician reviewers will review the specific clinical notes involved in the health care services requested by the provider. The member has the right to appeal the denial or modification of determination. The member's denial/modification letter will include information on the appeal process, including how to initiate an expedited appeal. The requesting provider will be provided with a contact number for the UCSDH Managed Care Medical Director (and/or the physician reviewer/Associate Medical Director) for a peer-to-peer discussion if the requesting provider has questions or concerns about the determination or potential determination/denial. (UCSDH UM Policy 005 Prospective Review)

In the event of a denied inpatient stay while the patient is inpatient, it is required that the inpatient CM notify UM and fax clinical notes to UR CM if a patient should suddenly meet inpatient stay criteria. Once notified UM UR team will review the updated clinicals to make a determination. If inpatient stay is determined to be medically necessity the days of the patient meeting criteria will be authorized and UR process followed. No notice of a timely change in a denied inpatient stay may result in a denial. Note: Any facility who receives a denied stay can follow the Appeal process as outlined on the denied stay letter.

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Approved Authorizations

After the referral request has been reviewed and a decision has been rendered, the decision is entered into the referral, via EPIC. The requesting provider is notified of the decision within one calendar day either by EPIC or facsimile. The requesting provider is responsible for notifying the member of the decision and documenting such notification in the member's medical record. (UCSDH UM Policy 005 Prospective Review)

Inpatient Concurrent Review

UM UR team delivers a consistent process for conducting utilization review of elective, urgent/emergent inpatient admissions, concurrent review, and discharge planning.

The review process will be performed by the UM CM who is a licensed professional that conducts concurrent reviews under the supervision and direction of the UM Program Manager, UM Assistant Director, UCSD PHSO Senior Director, UCSD PHSO Associate Medical Director, or UCSD PHSO Chief Medical Officer. Concurrent review will be performed on all inpatient services for members in collaboration with facility onsite Case Management. Complex inpatient cases meeting catastrophic criteria (an unexpected length of stay (LOS) greater than 10 days or a stay that is exceeding mcg guidelines, a tool for tracking evidenced based LOS) will be reviewed by Medical Director for authorization determination. Concurrent review of inpatient services is intended to ensure that the level of care and treatment is appropriate to the member's condition. Peer to Peer telephone calls is performed when clinicals are not supporting a continued stay

For Out of Network or non-contracted facilities: any members admitted to a non-contracted hospital will be transferred back to a UCSD hospital for continuation of care as soon as possible once the member is stable for transfer, if medically necessary. Concurrent review will start on the day of initial notification. Lack of notification from an out-of-network facility will result in an automatic denial of any bed days accrued prior to notification. The out-of-network facility will be required to submit claims for retrospective review of the denied inpatient days.

The discharge planning process begins as soon as the team is notified of admission. Assessment of the patient's discharge needs and plans for post-hospitalization are developed to ensure a smooth transition for the patient.

For out-of-area facilities: All out of area inpatient admissions are managed by the member's respective health plan. The IPCM will hand off any pertinent information to the health plan regarding members out of area admission. (UCSDH UM Policy 002 Concurrent Review)

Retrospective Authorization Review

UM will perform clinical claims review on claims that have been back flowed from the Claims Department. Medical record review is performed to determine appropriate utilization of services where there is a question regarding medical management, or for cases in which UCSDH was not notified before or during the provided service. Cases for retrospective review are often identified upon receipt of an unauthorized claim. The clinical claims review determinations will be conducted within a timeframe so that mandated claims reimbursement time frames are met. (UM 032 Clinical Claims Review)

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Emergency Services

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

"Emergency Services & Care" means services provided for an emergency medical condition, including a psychiatric emergency medical condition or active labor, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

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

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

A patient is **"stabilized"** or **"stabilization"** has occurred when, in the opinion of the treating physician, or other appropriate licensed persons, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient.

Emergency Services Providers may screen and stabilize a member without prior authorization in order to stabilize an emergency medical condition.

Second Medical Opinions (Medicare Advantage Plans Only)

To meet requirement of section 1383.15 A second medical opinion may be provided by an appropriately qualified healthcare professional in accordance with California Assembly Bill 12; Health and Safety Code

When requested by an enrollee or participating health professional who is treating an enrollee, a health care service plan shall provide or authorize a second opinion by an appropriately qualified health care professional. Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:

1. The member questions the reasonableness or necessity of recommended surgical procedures.

2. The member questions a diagnosis or plan of care for a condition which threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to a serious chronic condition.

3. The clinical indications are not clear or are complex and confusing; a diagnosis is in doubt due to conflicting test results, or the treating provider is unable to diagnose the condition, and the Member requests and additional diagnosis.

4. The treatment plan is process is not improving the medical condition of the member within an appropriate period of time given the diagnosis and the plan of care, and the Member request a second opinion regarding the diagnosis and continuation of the treatment.

5. The member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care. (UCSDH UM Policy UM 009 Second Opinions)

6. UCSDH is not delegated to provide authorizations for second medical opinions for commercial members. Contact the member's health plan for referral and PA guidelines when UCSDH is not the delegated entity.

Standing Referrals

For those identified patients with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling, extended referrals (where allowed by Health Plan) to appropriate specialists will be approved as long as the patient is eligible and meets requirements for medical necessity.

Conditions, such as Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), chemotherapy, end stage renal disease and others, who require prolonged specialized care may be eligible for a standing referral to a specialist. This specialist will have expertise in managing the condition and may also coordinate the member's overall healthcare. (UCSDH UM Policy UM 004 Referrals: Standing, Extended, Withdrawn, Dismissed and Re-Opened)

Palliative Care

Patients needing care to manage the symptoms of a life threatening or serious illness can receive such services in a variety of settings such as the hospital or outpatient setting. Services should be coordinated with the UM PA department.

Hospice and Hospice Medication Management

The PCP remains responsible for Members receiving Medicare certified hospice care to ensure appropriate non-hospice care and services are provided. Should medications be needed for a hospice patient, the hospice will provide medications related to the terminal diagnosis. Examples include medications to manage pain, anxiety, and nausea. NOTE: For commercial members needing hospice, referrals need to be sent to UCSDH UM to ensure health plan contracted hospice provider.

Transplant Services

Providers are asked to send information regarding potential transplants or transplant work up to the UM department. Transplantation may not be the financial responsibility of UCSDH and services must be provided by a Medicare-approved transplant center. The UM department will work with the provider and health plan to ensure appropriate services.

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Complex Care Management

The Complex Case Management program is designated for specific patient populations that meet CCM program criteria and are identified under health plan delegation. The Nurse Case Manager's work as an interdisciplinary team that includes care navigators, medical assistants, social workers, nurse practitioners and pharmacists to provide patient outreach, enrollment and ongoing follow up until the patient's goals are met.

All Nurse Case Managers are licensed registered nurses in the state of California. Social Workers have a minimum of a master's degree in social work. Identification of eligible patients is completed through data analytics including disease registries, embedded risk scores in EPIC, our electronic medical record, claims data, patient self-referral, physician referral, emergency department visits, post hospital or skilled nursing facility discharge. Program follow up includes engagement outreach, voluntary enrollment in CCM program, shared patient care planning based on medical, social and physical needs, patient education, ongoing support, care coordination and program goal evaluation.

The Complex Case program is designed to assist members to become more engaged in their care and help to stabilize emergent or ongoing medical, physical and/or psychosocial barriers by incorporating resources and education to help empower patients reach their individualized health care goals. The Nurse Case Managers work collaboratively with the patient, primary care, specialty providers and pharmacy as appropriate, to create comprehensive patient centered care plans using evidenced based models of practice to support the patient's goals. The Nurse Case Manager assesses; medication management, depression screening, health education opportunities, psychosocial concerns, and internal and external appointment and resource linkage needs. The Nurse Case Manager communicates the plan of care with all members of the interdisciplinary team. (UCSDH Policy HR-062 Complex Case Management Policy, Procedures, and Program Description and Policy UM 008 Case Management)

Digital Health

An innovative UCSDH Population Health (PH) program that supports patients at home in helping them to self-manage chronic conditions such as hypertension, diabetes Type 2 and mild depression. This comprehensive remote patient monitoring (RPM) program provides devices for measurement transmission to the PH team of nurses and to the primary care provider to help with non-urgent health coaching. This program also has pharmacists, UCSDH C.O.A,C,H, mental health and well-being APP for health coach texting and education, along with fit bits, blood pressure monitors and blood glucose monitors for optimal health monitoring. All patients must consent to be enrolled in this program, and they may incur co-pays depending on their insurance.

UCSD at Home

A team of UCSDH Population Health providers who provide home visits to help home confined senior patients get the care that they need to stay safe at home. UCSD at Home providers work with the patient's primary care providers helping to tightly medical manage care for optimal outcomes.

Member Outreach / Welcome Outreach Team

This Population Health team helps with timely patient reminders related to upcoming provider appointments, care gaps and lab and cancer screening that may be due. Our goal is to ensure patients receive timely proactive care.

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Continuity of Care Related to Provider Terminations

UCSDH complies with CA Health and Safety Code Sections 1300, 1367, and 1373, ensuring continuity of care for members who are undergoing treatment with a provider that has been terminated, as well as for new enrollees receiving active treatment from a nonparticipating provider. [Source: CA H&SC 1373.65 and 1373.96 CA. APL 10-013 and 20-001 CFR § 422.111(e); NCQA QI 10]

To ensure continuity and coordination of care, appropriate notification and assistance is provided to UCSD Health Plan Services' affected members who have been seen regularly in the event that their Specialty Care Practitioner/Group is terminated and assists them in selecting a different practitioner or practice. "Regularly" may be defined as 1) a number of visits within a specified time period, 2) serial referral use for the same type of care over a specified period of time.

Staff provide assistance to establish continuity of care and completion of services for newly enrolled members receiving services from non-participating practitioner(s) or provider(s) at the time a member's coverage becomes effective with the medical group. If after sending this notice, the organization reaches an agreement with the terminated provider to renew or enter into a new contract or to not terminate their contract, the organization shall offer affected member the option to return to that provider. This notice may be verbal or written. NOTE: the responsibility of sending the notification to the affected membership lies with the delegated group.

This policy applies to providers who have been terminated for reasons other than medical, disciplinary cause, or criminal activities

UCSDH is responsible for notifying the appropriate Health Plans 90 days prior to the termination date of the provider. The Medicare member is notified at least 30 days prior to the termination of the provider. Commercial members are notified at least 60 days prior to the termination of the provider. Circumstances under which affected members may have continued access to the terminated practitioner or provider. Applicable conditions: An acute condition-a medical condition that requires prompt medical attention and that has a limited duration. A chronic condition that is serious in nature and persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. 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 consistent with good professional practice. Completion of covered services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee. Three trimesters of pregnancy and the immediate postpartum period. Completion of covered services for the Maternal Mental Health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later. Terminal illness. Completion of covered services shall be provided for the duration of a terminal illness. The care of a newborn child between birth and age 36 months. Performance of surgery to occur within 180 days of term or effective date of newly covered enrollee. NOTE: The delegated group policy should include these directives and ensure staff awareness and compliance.

If there is a scenario where PHSO has agreed to help determine continuity of care, this should be added: Denial of requests for continuity of care must be processed in accordance with established UM processes. The organization will not be required to provide continuity of care if the provider does not agree to comply with the contractual terms and conditions and comparable payment rates. (DMHC) (UCSDH Policy UM 030 Continuity of Care)

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Claims & Provider Reimbursement

UCSDH is delegated by specific HCSPs to pay claims. Please refer to the grid below to determine where to submit claims. If you have questions about where to send your claim, please call UCSDH Customer Service at (619)471-9123.

Commercial Plans: * indicate UCSDH contracts only at this time			
Aetna (S)* www.aetna.com www.availity.com (800)624-0756	Anthem/Blue Cross* (S) www.anthem.com www.availity.com (800)677-6669	Anthem Priority* Select (S) www.anthem.com	Blue Shield (S)* www.blueshield.com (800)776-4466
Cigna (S)* www.cigna.com www.availity.com (800)244-6224	Health Net (S)* www.healthnet.com (800)641-7761	Health Net Blue & Gold ACO (F) www.healthnet.com (844)827-3264	
United Healthcare (S)* www.uhc.com www.availity.com (800)542-8789	United Healthcare Alliance (F)* www.uhc.com www.availity.com (800)542-8789	United Healthcare Harmony (F)* www.uhc.com www.availity.com (800)542-8789	
Medicare Plan * UCSDH contract only			
SCAN Health Plan (F)* www.scanhealthplan.com (877) 452-5898			

S= Shared Risk. Submit professional, laboratory, radiology and PT/OT/ST services to UCSDH / UCRH
F= Full Risk Submit most claims to UCSDH

The Claims Department is responsible for accurately and promptly processing claims for which UCSDH is financially responsible. UCSDH utilizes a claim scrubbing software program that automatically applies Medicare Correct Coding Initiative (CCI) edits along with other coding guidelines for appropriate billing practices. This software provides auditing logic for all modifiers allowing payment modifications, if appropriate. UCSDH will process claims based on the industry standards, CPT guidelines, CCI edits, Medicare guidelines and in compliance with State and Federal regulations.

Submitting Claims to UCSDH

We encourage you to submit claims directly to UCSDH via a contracted clearinghouse. Office Ally is our preferred clearinghouse.

Office Ally – Payer ID:UCSDH
www.officeally.com
866-575-4120

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Claims submitted via mail should be sent to:

UCSDH PHSO Managed Care
Attn: Claim Department
PO BOX 5198
Lake Forest, CA 92630

Claims that are not the responsibility of UCSDH (i.e. carve-outs, non-delegated services, incorrect responsible payor, COB, etc.) are forwarded to the responsible payor within ten (10) calendar days.

Plans are required to forward misdirected claims to the appropriate medical group/IPA and medical groups must forward misdirected claims to the appropriate health plan.

Coding Accuracy

As a health care provider, you are expected to report all diagnosis codes that impact the patient's care and ensure these diagnoses are accurately documented in a medical record. This includes the main reason for the episode of care; and all co-existing, acute or chronic conditions; and pertinent past conditions that impact clinical evaluation and therapeutic treatment. Symptoms that are common to the main reportable diagnosis should not be coded. Report ICD-10-CM codes to the highest level of specificity on all billing forms and/or encounter data forms. The Risk Adjustment Payment model implemented by The Centers for Medicare and Medicaid Services (CMS) relies upon the diagnosis code to ensure that physicians and providers are paid appropriately for the services they render to Medicare Advantage Beneficiaries.

Claims Submission Requirements Timeline and Requirements

Contracted providers should refer to their Participation Agreement for timely filing deadlines. Non-contracted providers must file their claims within 180 days of the date of service for commercial claims and 365 days from the date of services for Medicare Advantage claims. UCSDH reserves the right to deny reimbursement of claims submitted beyond this timeframe and shall consider extenuating circumstances or "good cause" for a delay in submission.

The forms CMS 1500, UB-04 or equivalent form shall include, but not be limited to the following data elements:

- Enrollee's name, address, member ID, date of birth, sex, date(s) of service, place of service, diagnostic code(s) and description(s) and the authorization number.
- Procedures, services, or supplies furnished. CPT codes for the current year shall be used for all professional services and HCPCs codes shall be used for supplies, equipment, injections, etc. Items not listed shall be billed utilizing CPT and HCPCs claims submission guidelines
- Rendering health care provider's name, signature or representative's signature, address where service was rendered,
- "Remit to" address, phone number, NPI, taxonomy and federal TIN.

- Box 24J of the CMS-1500 must be populated if the provider is billing under a group/organizational NPI or if the claim is not for DME, Lab or Ambulance
- Box 33 of the CMS-1500 form cannot be a PO Box
- Referring health care provider's name and NPI. All laboratory, DME, imaging and home health claims must include the referring health care provider's name and NPI number
- Box 32 – Service Facility/Location information
- Taxonomy Codes on Institutional claims
- Current National Drug Code (NDC) 11-digit number, NDC unit of measure (F2, GR, ML, UN, ME) and NDC units dispensed (must be greater than 0) for all claims submitted with drug codes. Enter the NDC information for the drug(s) administered in the 24D field of the CMS-1500 Form, field 43 of the UB-04 form,
- Resubmission code is required for all corrected claims. If resubmission code is 6, 7, or 8, field 22 on the CMS 1500 and filed 4 on the UB-04 the original claim number is required.

Additional information needed for a complete UB-04

- Date and hour of admission.
- Date and hour of discharge.
- Member status-at-discharge code.
- Type of bill code (3 digits).
- Type of admission (e.g., emergency, urgent, elective, newborn).
- Current 4-digit revenue code(s).
- Attending physician ID number.

- For inpatient and outpatient services/procedures, complete service information, including line item date of service(s), number of services (days/units) rendered, the specific CPT and HCPCS procedure codes, with modifiers where appropriate, appropriate revenue codes (e.g., laboratory, radiology, diagnostic or therapeutic) and current ICD-10-CM diagnostic codes by specific service code to the highest level of specificity. You must communicate the primary diagnosis for the service performed, especially if more than 1 diagnosis is related to a line item.
- Skilled Nursing Facility Claims require Level of Care
- Home Health Agency claims require the HIPPS code
- Inpatient forms UB04 require at least (1) DRG code
- For ESRD claims, the Box 39 and 41 must be completed to determine reimbursement

Verifying Claim Status

All providers can view claim status online using PHSO Link. Providers without a PHSO Link log in can visit https://ucsdlink.ucsd.edu and click "Check PHSO Claim Status" without the need to log in. Providers who have a PHSO Link log in should follow the instructions provided to them when their log in was created. If you are a contracted provider who would like a PHSO Link log in, please send a request to PHSOnetworkmgmt@health.ucsd.edu. Providers may also contact the UCSDH Customer Service Department at (619)471-9123. Please allow no less than thirty (30) days from the date of submission prior to contacting UCSDH for verification of claim receipt.

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Claims Reimbursement

UCSDH will adjudicate clean Commercial and Medicare claims within the timeframes outlined in the provider agreement or within state and/or federal regulatory timeframes, whichever comes first. A clean claim is defined as a claim that may be processed without obtaining additional information from the provider of service or from the patient.

UCSDH may contest or deny a claim, or portion thereof, by notifying the Provider within state and/or regulatory timeframes, after the Date of Receipt UCSDH will pay all applicable interest and penalties based on said regulations.

Electronic Payment and Remit

UCSDH encourages providers to receive their payments and remits electronically. To sign up for ACH/EFT payment and remits via 835, please contact PHSOnetworkmgmt@health.ucsd.edu

Member Billing

As a provider, you agree contractually to look solely to UCSDH as the source of final payments for managed care patients referred by UCSDH / UCRH contracted medical groups. It is a violation of law to bill HMO and managed care members directly except for deductibles, copayments, coinsurance or for benefits not covered by primary and/or secondary insurance. For benefits not covered by the member's insurance, it is the Provider's obligation to obtain a written waiver from the member prior to rendering any non-covered service.

UCSDH has various contracts with HCSPs. In some cases, members may have Medi-Cal as a secondary payor. It is the Provider's responsibility to verify copayment and coinsurance requirements for both primary and secondary coverage. **Under no circumstances,** should a provider demand or otherwise attempt to collect reimbursement from a member or from other persons on behalf of the member, for any service included in the member's scope of benefits except any applicable copays, deductibles or coinsurance as required under the primary and secondary coverage.

Claim Tracer

A tracer is a claim that UCSDH has no record of receiving, and provider is submitting with proof of timely filing. To submit a Tracer**,** the word "TRACER" must be on the claim form in Box 19 of the CMS-1500 or Box 80 of the UB-04. UCSDH will process the claim and waive timeliness as long as it is submitted within 180 days from the DOS with proof of timely filing. Any tracer received after 180 days from DOS will be denied as "untimely follow up" and provider must write off the claim.

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Corrected Claim

A corrected claim is a replacement of a previously submitted claim that requires a revision to the information submitted on the claim. Common reasons for corrected claims are invalid diagnosis, invalid CPT/HCPC or modifier, or incorrect billed amount. To submit a corrected claim:

- Enter the frequency code in Box 22
- Use 7 for a replacement claim or 8 to void or cancel a claim
- Enter the original UCSD claim number in the "Original Reference Number" box

Failure to enter a frequency code or the accurate UCSD claim number may result in a denial of your claim.

Claim Overpayments

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

To Contest the Notice: If the Provider contests UCSDH'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 UCSDH. The notice must state the basis upon which the Provider believes that the claim was not overpaid. UCSDH will process the contested notice in accordance with UCSDH's Provider Dispute Resolution Process described in this Provider Operations Manual.

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

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

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Provider Dispute Resolution & Resolution Process for Commercial Plans (Contracted and Non-Contracted providers) and Medicare Plans (Contracted Providers only)

Please see section below for Medicare Non-contracted Provider Dispute Resolution

A Provider Dispute Resolution (PDR) is defined as a provider's written notice challenging, appealing, or requesting a reconsideration of a claim (or a bundled group of similar multiple claims that are individually numbered) that has been denied, adjusted, contested, or seeing resolution of a billing determination or other contract disputes or disputing a request for reimbursement of an overpayment of a claim.

Each dispute must be in writing and contain at a minimum the following information:

The written dispute must include:

- Provider Name
- Provider Identification Number
- Provider Contact Information
- Date of Service
- Clear identification of disputed item
- Clear explanation of basis for provider's feeling that the payment, request for overpayment return, request for additional information, contest, denial or adjustment is incorrect

UCSDH responds to PDRs one time. If a provider is not satisfied with the initial determination of the dispute AND the determination is related to medical necessity or utilization review, the provider has the unconditional right to appeal directly to the health plan's dispute process for a *de novo* review within 60 working days of receipt of the dispute determination.

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

By Mail:

UCSDH PHSO Managed Care

Attn: Claim Department

PO BOX 5198

Lake Forest, CA 92630

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Provider Dispute & Resolution Process Timelines

	Commercial Claims	Medicare Claims
Timely Filing	365 days after most recent actional taken on claim	120 days after most recent actional taken on claim
Acknowledgment	15 working days after date of receipt	Not required
UCSD will issue written determination of the dispute	45 working days after date of receipt	30 working days after date of receipt
If a dispute is returned for additional information, provider can submit an amended dispute to UCSD	30 working days after request for additional information	30 working days after request for additional information
If the dispute favors the provider, UCSDH will pay any outstanding monies	5 working days of the issuance of the written determination	5 working days of the issuance of the written determination

Provider Dispute Resolution (PDR) for Medicare Plans for Non-Contracted Providers

Providers Disputes are narrowly defined only as fee schedule disputes. All other disputes are considered appeals and must be submitted directly to the patient's health plan.

Examples of common appeals are:

- Diagnosis code/DRG payment denials
- Down-coding
- Bundling issues and disputed rate of payment
- Level of care or rate of payment denials

Providers may inquire about a provider dispute and speak with the CSD team by calling UCSDH Customer Service at **(619) 471-9123** for inquiries regarding the status of a Provider Dispute, or about filing a Provider Dispute.

UCSDH shall respond to provider disputes for specific claims one (1) time and shall not respond to appeals on specific claims in excess of once.

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Coordination of Benefits (COB) & Order of Benefit Determination

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

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

Dependent Child Covered Under More Than One Plan

- For a dependent child whose parents are married or are living together, whether or not they have ever been married the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.
- For a dependent child whose parents are divorced or separated or are not living together, if a court decree states that one of the parents is responsible for the dependent child's health care expenses or coverage, that plan is primary.

Verifying Eligibility and Benefits

UCSDH members should present services with their insurance identification card issued by their health plan. Health Plan ID cards contain pertinent information about the member's Primary Medical Group (PMG) and co-payments. Prior to rendering services, please verify member eligibility and benefits in one of the following ways:

- Member assigned Health Plan website (access with login & password).
- Contact Health Plan by phone (automated eligibility verification systems)
- Contact UCSDH for Eligibility inquiries at (619) 471-9123, option 1,3.

Please do not rely on the member's health plan identification card as proof of eligibility as information may change.

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Member Copay

- It is the provider's responsibility to collect any applicable copayments.

- Member ID card should indicate any applicable copayment amounts, or you may contact health plan for assistance.

- Payment is contingent upon current eligibility, provider credentialing status and whether or not the service is a covered benefit; authorization does not guarantee payment.

Subrogation: (Third Party Liability)

UCSDH can subrogate in the event a claim results from an injury or loss attributed to the negligence or other action of another party. UCSDH may seek a legal remedy on behalf of the member. Members are required to provide accurate information with regard to their health coverage and failure to do so is considered fraud. UCSDH Providers have direct contact with UCSDH Members, making them the best source of timely third- party liability (TPL) notification to UCSDH. Providers have an obligation to report the existence of other insurance or liability due to an accident or injury caused by a third party. Cooperation is essential to ensure prompt and accurate reimbursement.

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Quality of Care

Quality Management

The purpose of the UCSDH UM Compliance and Auditing Team (CAT) is to maintain a comprehensive, coordinated process that continually evaluates, monitors, and improves the quality of clinical care and service provided to enrollees within the UCSDH health care delivery system.

CAT should be notified immediately if you identify a potential quality or risk management issue. CAT will escalate patient behavioral issues, such as patient disenrollment or discharge from a practice to UM leadership and Provider Relations for appropriate Health Plan compliance of dis-enrollment.

CAT incorporates review and evaluation of all aspects of the health care delivery system.

The following is an outline of several components of the CAT and the focus on UM quality and quality improvement.

Medical Record Review/Documentation Audits

UCSDH will use approved standards that are communicated to providers. Medical record audit activities are often directed to the PCP, however audits of other practitioners and ancillary providers will be conducted as directed by the Compliance, as a result of claims trends, suspected fraud waste or abuse and/or as directed by any of our Medical Director or CAT.

Grievances and Complaints

UCSDH is not delegated for grievances and complaints by any of the Health Plans. UCSDH will maintain a process for resolving enrollee complaints in conjunction with the HCSPs. The Delegation Compliance Department will have overall responsibility for:

- Maintaining and updating grievance policies and procedures
- Review and evaluation of the operations and results of the grievance process
- Review and assessment of trended data for identification and implementation of care service, and/or process improvements
- Utilization of any emergent patterns of grievances in the formulation of policy and procedure changes
- Utilization of any emergent patterns of grievances in the formulation of policy and procedure changes

Recommendations for grievance policy changes will be referred to the VBCAG for review and approval as applicable.

Disruptive Patients and Disenrollment

At times, a patient's behavior may create challenges for the provider. The Centers for Medicare & Medicaid Services (CMS) and contracted health plans have very specific procedures to follow when managing such patients and typically prohibit involuntary termination except in rare and specific circumstances. UCSDH UM will collaborate with providers to address concerns while ensuring the patient's needs are met and will coordinate with the appropriate health plan. Providers must continue to provide and coordinate care for patients, and every effort should first be made to resolve concerns at the practice level. If a patient exhibits violent behavior or threatens violence, law enforcement should be contacted immediately.

Examples of disruptive behaviors include:

Level A - Minor disruptive behavior exhibited while seeking or receiving care from the provider. Failure to pay copays as required by the Health Plan

4.5.2 Level B - Refusal to follow recommended treatment when such refusal (according to the treating physician), endangers the patient's health, or aggravates a condition resulting in more extensive treatment in the future.

4.5.3 Level C - Behavior that is considered disruptive, abusive or threatening. Fraudulent receipt of benefits. (UCSD Policy QI 045)

Organizational Provider Quality Assessments

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

Corrective Action Process

When the Credentialing and Peer Review Committee (CPRC), Medical Management Committee (MM), HCSP or one of the related Review Panels determines that inappropriate care or sub-standard services have been provided or services which should have been furnished have not been provided, the UM Medical Director is responsible for communicating concerns identified by the CPRC Committee and working with the provider to develop a corrective action plan. The UCSDH CPRC Committee reserves the right to terminate a Provider contract. UCSDH also recognizes that HCSPs retain the right to make final decisions on all recommendations pertaining to a provider's participation in the HCSPs delivery system.

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

Preventive Care Guidelines

UCSDH has adopted the US Preventive Services Task Force (USPSTF) Preventive Care Guidelines as the standard that will be used from a utilization and quality perspective. Your review and usage of these guidelines will

ensure best practices for your patients. The link to review these standards is: http://www.ahrq.gov/clinic/prevenix.htm.

Provider Credentialing

UCSDH is fully delegated to perform all credentialing activities for contracted health plans. Providers should email the UCSDH Network Management team at PHSOnetworkmgmt@health.ucsd.edu if they are interested in joining the UCSDH network. All contracted providers must be credentialed by UCSDH. If a claim is submitted and the provider is not credentialed on the date of service, the claim will be denied. If a new provider is joining a group, please notify UCSDH via email at PHSOnetworkmgmt@health.ucsd.edu. Credentialing must be complete prior to rendering any services to UCSDH members; otherwise, claims may be denied.

Each contracted practitioner and allied health care professional (e.g. Physician Assistant and Nurse Practitioner) is re-credentialed no less than every thirty-six (36) months. The credentialing staff will send out a practitioner profile and re-credentialing questionnaire to be completed. In order to maintain an active status as a UCSDH provider, you must complete and return all applications and other requested credentialing documents immediately.

As part of the initial credentialing (and re-credentialing) process and every three years thereafter, the Quality Management (QM) staff conducts Site Visits and Medical Record Reviews. These reviews are also performed if any reportable grievances are identified by the health plan.

Compliance & Privacy

Fraud, Waste and Abuse

UCSDH and UCRH are committed to fostering an atmosphere of integrity, honesty, and ethical behavior. As a healthcare provider, it is essential to understand the importance of preventing and detecting Fraud, Waste, and Abuse (FWA) in the healthcare industry. FWA can have severe consequences, including financial losses, compromised patient care, and damage to the reputation of our organization.

Definition:
Fraud, Waste, and Abuse refer to any intentional or unintentional act that results in the misuse of healthcare resources, including money, goods, or services. These acts can be committed by healthcare providers, employees, patients, or external parties.
Examples of Fraud, Waste, and Abuse:

- **Fraud:** Intentional acts such as:
  - Billing for services not provided or unnecessary services
  - Falsifying medical records or claims
  - Kickbacks or bribes for referrals or services
  - Identity theft or misuse of patient information
- **Waste:** Unnecessary or inefficient use of resources, such as:
  - Overordering or overutilization of medical supplies or services

  - Inefficient billing or coding practices
  - Failure to follow established protocols or guidelines
- **Abuse:** Acts that are not necessarily fraudulent but result in unnecessary costs or harm, such as:
  - Over prescription or misuse of medications
  - Unnecessary hospitalizations or procedures
  - Failure to provide adequate care or follow established standards

Reporting Suspected Fraud, Waste, and Abuse:
If you suspect or witness any activity that may be considered Fraud, Waste, or Abuse, it is essential to report it immediately. Providers and employees can report suspected FWA to the UCSDH whistleblower hotline at universityofcalifornia.edu/hotline or by calling (800) 403-4744. All reports will be investigated promptly and thoroughly, and reporters will be protected from retaliation.
It is our collective responsibility to prevent and detect FWA, ensuring that our healthcare resources are used efficiently and effectively to provide high-quality patient care. By reporting suspected FWA, you can help protect our organization's reputation, prevent financial losses, and promote a culture of integrity and accountability

Notice of Non-Retaliation – You Are Protected

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

Member Privacy & Confidential Information

At UCSDH, we are committed to safeguarding the privacy and confidentiality of our members' health information. As a healthcare provider, it is essential that you understand the importance of protecting patient privacy, not only as a fundamental aspect of quality healthcare but also as a requirement of state and federal law.

All providers are expected to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations from the Department of Health and Human Services - Office of Civil Rights (OCR) that relate to the privacy of protected health information (PHI). This includes, but is not limited to:

- Patient appointment and non-clinical records
- Patient medical records, including electronic health information
- Files containing PHI or other protected information
- Faxes sent and received containing PHI

- Medical claims documents and supporting materials
- Organizational, utilization, quality, or medical staff committee minutes and documentation
- Information received from non-UCSD Health providers and external agencies containing PHI or privileged information

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

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

To maintain the confidentiality of patient information, each provider must establish and maintain a Confidentiality Policy and Procedure. UCSDH reserves the right to request a copy of your Confidentiality Policy and Procedure to ensure compliance with our policies and regulatory requirements.

Reporting Privacy Incidents

Providers must immediately notify UCSDH when they become aware of a suspected or confirmed breach of a patient's protected health information (PHI). Reporting privacy breaches immediately upon discovery is critical to minimizing your risk of penalties and fines. Report all suspected privacy breaches to the UCSDH Compliance Department via email at universityofcalifornia.edu/hotline or telephonically (**800) 403-4744**.

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Nondiscrimination in Health Care

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

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

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

UCSDH and UCRH Providers must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). UCSDH requires Providers to deliver services to UCSDH Members without regard to sex, sexual orientation, gender identity, national origin, ethnicity, religion, race, color, creed, nationality, primary-language, education, disability, age, or any other individually definable factor. This also includes expressions of gender identity, pregnancy, and sex stereotyping.

Providers may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost-care. Providers must not discriminate against enrollees based on their payment status and cannot refuse to serve Members because they receive assistance with Medicare cost sharing from a State Medicaid Program.

Facilities, Equipment and Personnel

Provider offices, facilities, equipment, personnel and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements including the accessibility requirements of the Americans with Disabilities Act (ADA). In addition, the physical access and appearance of the facility, medical record management, and appointment availability will be monitored. A Performance threshold of 95% is expected, and Corrective Action Plans will be required for those not meeting the threshold.

Member complaints related to the quality of practitioners' office sites will be monitored, investigated, and forwarded to the appropriate health plan. (UCSDH QM Policy 046 Facility Site Review)

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Providers' Role & Responsibilities

Access to Care Standards

Medical services will be provided in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. The processes necessary to obtain covered health care services, including but not limited to appointments, telephone responses, after hour care, and prior authorization processes, will be completed in a timely manner that assures the timely provision of covered health care services appropriate for the nature of the enrollee's condition which will ensure consistency between access and UM policies and procedures. The provider will need to have adequate capacity and availability of licensed health care providers to offer member appointments which include meeting the mandated timeframes. (UCSDH QI Policy 042 Access Standards (Appointment, After Hours & Telephone).

Non-Emergent Appointment Access Standards – Medical

Appointment Type	**Time-Elapsed Standard**
Non-urgent appointments for Primary Care Physician (PCP)	Must offer the appointment within ten (10) business days of the request
Non-urgent appointments with Specialist physicians (SPC)	Must offer the appointment within fifteen (15) business days of the request
Urgent Care appointments that do not require prior authorization (PCP)	Must offer the appointment within forty-eight (48) hours of request
Urgent Care appointments that require prior authorization	Must offer the appointment within ninety-six (96) hours of request
Non-urgent appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within fifteen (15) business days of the request

Exceptions: Preventive Care Services and Periodic Follow-Up Care:

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

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Preventive Care Guidelines

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

Advanced Directives

The Omnibus Budget Reconciliation Act of 1990 is intended to provide individuals with information about their state's laws regarding advanced directives and encourage compliance by health care providers with any advance directives. An advanced directive is any written document, made in advance of an incapacitating illness or injury, in which an individual specifically makes choices about health care treatments or names someone to make these treatment decisions if he or she is incapable.

- Under this law, you are required to inform patients about their rights to institute an Advance Directive. The physician must communicate information to each patient regarding the right to institute an advance directive and

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

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ucsdhn.org + health.ucsd.edu