	Provider Manual 2018	
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DMHC TAG: Access and Availability, Quality Management, Utilization Management		

Provider Manual 2018

For:

Physicians

Other Health Care Professionals

Ancillary Providers

Facilities

Contents

Introduction

Using this Guide

The Canopy Health Provider Manual contains essential information on the administrative components of Canopy Health's operations including:

- claims billing and submission, provider disputes, coordination of benefits
- prior authorization and referral information
- health care access and coordination
- quick reference contact information for Canopy Health

Disclaimer

The contents of this guide are supplemental to the *Provider Participation Agreement (PPA) and/or Ancillary Services Agreement (ASA)**. When the contents of this guide conflict with the *PPA or ASA*, the *PPA or ASA* takes precedence. Updates to the information in this guide are made through provider updates or signed letters distributed by fax, the United States Postal Service or other carrier. Provider updates and signed letters are to be considered amendments to this guide.

This guide is not intended to provide legal advice on any matter and may not be relied on as a substitute for obtaining advice from a legal professional.

Definitions

"Emergency medical condition" means a medical condition 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 patient's health in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

(4) "Active labor" means a labor at a time at which either of the following would occur: There is inadequate time to effect safe transfer to another hospital prior to delivery;

"Emergency services and care" means medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical

condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. It also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility. For the purposes of Section 1371.4, emergency services and care as defined in subparagraph (A) shall not apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590) of Part 3 of Division 9 of the Welfare and Institutions Code, to the extent that those services are excluded from coverage under those contracts.

“Health Plan” means any health plan in which Canopy has a plan-to-plan agreement to enroll members.

“In Area” refers to an individual Canopy Health medical group/IPA’s catchment area, including the outpatient facilities and affiliated hospitals of that group or IPA.

“In Network” refers to Canopy Health’s entire alliance comprised of all its contracted Medical Groups/IPAs, hospitals and ancillary facilities.

“In Service Area” refers to the total geography for which Canopy Health is financially responsible for any emergency hospital services; this may be a broader area than that serviced by any individual Canopy Health medical group/IPA, including facilities in the network designated by the parent Health Plan.

“Out of Area” refers to the geography for which the Health Plan is financially responsible for any emergency services/

“State” refers to the state of California.

About Canopy Health

Canopy Health is alliance of physicians and hospitals owned by UCSF Health, John Muir Health, Muir Medical Group IPA, Hill Physicians Medical Group, and Meritage Medical Network. Canopy Health is licensed by the Department of Managed Health Care ("DMHC") as a restricted Knox-Keene entity allowing Canopy Health to accept responsibility for medical costs and management of health plan enrollees. Canopy Health contracts with health plans to create unique insurance products that are high-quality, consumer focused and price competitive, offered for employers, individuals, and other purchasers.

Canopy Health Mission

We are creating an integrated healthcare experience where quality care and coverage are provided by an alliance of top caregivers across the Bay Area, allowing people to access the best options for their personal needs. We do this in a way that is refreshingly clear, by making each unique customer's journey predictable and transparent. We believe that the best healthcare doesn't have to be unpredictable, confusing, and a financial burden.

Canopy Health Online

Canopy Health, on its website, www.canopyhealth.com, provides a directory of its complete provider network. Users can search for physicians, hospitals, and ancillary providers by specialty name, language(s) spoken, zip code, city and distance. For a printed copy of our provider directory please call 888-8CANOPY (888-822-6679) or visit the website where a link is provided to have a printed directory sent via USPS. Canopy Health complies with the requirements of California Health and Safety Code Section 1367.27(c)(2).

Participating Physicians

Canopy Health IPAs/Medical Groups

Canopy Health has contracted with the premier IPA/Medical Groups in the San Francisco Bay Area; Hill Physicians Medical Group (San Francisco, East Bay, Solano) Meritage Medical Network and John Muir Health Physicians Network. There are 3,500+ physicians in the Canopy Health network with offices in Alameda, Contra Costa, Marin, San Francisco, San Mateo, Solano, and Sonoma

Contact information for Canopy Health participating Medical Group/IPAs are provided below:

IPAs	Customer Service Telephone Numbers	Websites
Hill Physicians Medical Group	(800) 445-5747 TTY to Voice: 1-800-735-2929 Voice to TTY: 1-800-735-2922	www.hillphysicians.com
John Muir Health Physician Network	(925) 952-2887 or toll free (844) 398-5376 TDD/TTY: 711	www.johnmuirhealth.com
Meritage Medical Network	(800) 874-0840 TDD/TYY: (800) 874-0840	www.meritagemed.com
Dignity Health Medical Network - Sequoia	(650) 261-2381 TDD/TTY: 711	https://www.dignityhealth.org/bayarea/medical-group/sequoia-physicians-network

Policies and procedures related to quality and utilization management, professional billing and claims, and clinical health services are available at Canopy Health's participating Medical Groups' and IPAs' websites and directly through customer service at the respective provider groups.

Selection and Role of the Primary Care Physician

All Canopy Health members are required to SELECT a primary care physician (PCP) and a participating Medical Group/IPAs at the time of enrollment. For children, a pediatrician or family medicine physician may be designated as the primary care physician. For women, an obstetrician/gynecologist ("OB/GYN") may serve as the designated primary care physician if the OB/GYN agrees to serve in that capacity. Additionally, seniors may designate a gerontologist and those with an AIDS/HIV diagnosis may designate an AIDS/HIV specialist as their primary care physician, if that physician agrees to serve in that capacity. If a member does not choose a PCP, the Canopy Health participating health plan will assign a PCP for the member and their dependents. To change the designated primary care physician, members are required to contact their health plan. Canopy Health members may choose a PCP based on proximity to either their home or work address. Members are required to visit their primary care physician for non-urgent or non-emergency care. Primary care physicians may require a member be reassigned to a different primary care physician if there is concern that the member's home or work address is not close enough to the PCP's location to allow reasonable access to care.

The PCP is responsible for providing and coordinating medical care for their patients, including referrals to specialists, hospitals and other healthcare providers anywhere in the Canopy Health Network.

Specialty Care

Canopy Health provides a comprehensive alliance of physician specialists, available in locations throughout the Bay Area. These specialties include:

- Allergy and Immunology
- Bariatric surgery
- Breast Center
- Cardiology
- Cardiothoracic Surgery
- Colorectal Surgery
- Critical Care Medicine
- Dermatology
- Ear, Nose and Throat
- Endocrinology
- Gastroenterology
- General Surgery
- Gynecologic Oncology
- Hematology/Oncology
- HIV/AIDS Specialist
- Hyperbaric oxygen
- Infectious Disease
- Nephrology
- Neurology
- Neurosurgery
- Obstetrics/Gynecology
- Ophthalmology
- Orthopedic Surgery
- Pain Management
- Palliative Care
- Perinatology
- Physical Medicine (PMR)
- Plastic surgery
- Podiatry
- Pulmonary Disease
- Radiation Oncology
- Reproductive Endocrinology and Fertility
- Rheumatology
- Urology
- Vascular Surgery
- Wound Care

Canopy Health PCPs refer members for specialty services when clinically appropriate. When clinically appropriate, the member's treating physician may refer a member to any participating Canopy Health specialist. Such referrals are entered in each Medical Group/IPA's authorization system. Referrals for some specialty care require prior authorizations. Additional details regarding the Canopy Health Referral Policy are covered in the next section.

Canopy Health Referral Policy

Physicians within the following Medical Group/IPAs participate in the Canopy Health Alliance: Meritage Medical Network, John Muir Health Physician Network, and Hill Physicians Medical Group San Francisco, East Bay and Solano. Canopy Health members being referred within each Medical Group/IPA remain governed by the policies and procedures of that Medical Group/IPA. Canopy Health members referred to Canopy Health specialists outside their home Medical Group/IPA are governed by the policies and procedures defined by Canopy Health. Where there is a conflict between the policies of the Medical Group/IPA and the Canopy Health Alliance Referral Program, the Canopy Health Alliance Referral Program shall take precedence for Canopy Health enrollees.

Both physicians and members may request referral to a specialist, either within the member's home Medical Group/IPA or elsewhere in the Canopy Health alliance. When clinically appropriate, the requesting physician initiates a written or electronic referral that is entered in the member's home Medical Group/IPA authorization system. Such a request will be auto-approved when it meets the Canopy Health Alliance Referral Program policy. Approved authorizations prompt standard notification to both the member and the "referred to" specialist and include details of the referral such as the number of visits, services approved and the time frame before the referral expires.

On a quarterly basis, Canopy Health will report on Canopy Health Alliance Referral Program activity, using Medical Group or IPA encounter data. The review will include volume of visits and utilization of lab, urgent care, specialties, etc. The review will also study trends in members' selection of PCPs, to track potential correlation between PCP changes and members having sought care outside their initially assigned Medical Group/IPA.

Behavioral Health Access, Triage and Referral

Canopy Health is not delegated to provide or oversee behavioral health specialty services for its members. These services are provided by a vendor contracted directly with a members' employer or health plan.

Behavioral health is offered through the following networks for Canopy Health members, based on the member's parent Health Plan and product:

Health Plan and Product	Behavioral Health Carrier
Health Net Blue and Gold	Optum Behavioral Health
Health Net Smart Care	MHN
United Healthcare	Optum Behavioral Health
Western Health Advantage	Magellan

Behavioral health provider networks and delegated plans must follow DMHC policies and procedures, including:

- Providing a telephone intake system for members, which is staffed by trained personnel who are either individually licensed mental health professionals, or are supervised by a licensed mental health professional, and who provide or facilitate appropriate crisis intervention and initial referrals to mental health providers;

- Maintaining policies and procedures and/or training that define protocols for initial referrals to mental health providers;

- Ensuring member access to a behavioral health delivery system through a centralized triage and referral system. This is provided through the member's health benefit plan. Protocols for mental health triage and referral address the level of urgency and appropriate level of care relative to the member's mental status and level of functioning;

- Establishing standards and goals for the timeliness of response to its triage and referral telephone lines and measuring performance against those standards; and

- Ensuring that only qualified licensed clinical staff members make decisions about the type and level of care to which members are referred.

Canopy Health does not require prior authorization for the provision of emergency services and care to a patient with a psychiatric emergency.

Canopy Health Hospitals and Contact Information

Alameda Health System

Alameda Hospital

2070 Clinton Avenue, Alameda, CA 94501

510-522-3700

http://www.alamedaahs.org/

Highland Hospital

1411 E 31st Street, Oakland, CA 94692

510-437-4800

http://www.highlandahs.org/

San Leandro Hospital

13855 East 14th Street, San Leandro, CA 94578

510-357-6500

http://www.sanleandroahs.org/

Dignity Health

Sequoia Hospital

170 Alameda de las Pulgas, Redwood City, CA 94062

855.900.4062

https://www.dignityhealth.org/bayarea/locations/sequoia

St. Francis Memorial Hospital San Francisco

900 Hyde St., San Francisco, CA 94109

415-363-6000

https://www.dignityhealth.org/bayarea/locations/saintfrancis

St. Mary's Medical Center

450 Stanyan St, San Francisco, CA 94117

415-668-1000

https://www.dignityhealth.org/bayarea/locations/stmarys

John Muir Health

John Muir Medical Center, Concord

24 East Street, Concord, CA 94520

925-682-8200

https://www.johnmuirhealth.com/locations.html

John Muir Medical Center, Walnut Creek

1601 Ygnacio Valley Road, Walnut Creek, CA 94598

925-939-3000

https://www.johnmuirhealth.com/locations.html

Marin General Hospital

250 Bon Air Road, Greenbrae, CA 94904

415-925-7000

https://www.maringeneral.org/

San Ramon Regional Medical Center

6001 Norris Canyon Road, San Ramon, CA 94583

925-275-9200

https://www.sanramonmedctr.com/

Sonoma Valley Hospital

347 Andrieux Street, Sonoma, CA 95476

707-935-5000

http://www.svh.com/

UCSF Health

UCSF Benioff Children's Hospital Oakland

747 52nd Street, Oakland, CA 94609

510-428-3000

http://www.childrenshospitaloakland.org/main/maps-locations/20.aspx

UCSF Benioff Children's Hospital at Mission Bay

1975 Fourth Street, San Francisco, CA 94158

415-353-1664

https://www.ucsfbenioffchildrens.org/

UCSF Medical Center at Mission Bay

1855 Fourth Street, San Francisco, CA 94158

415-353-1664

https://www.ucsfhealth.org/

UCSF Medical Center at Parnassus

505 Parnassus Avenue, San Francisco, CA

415-476-1000

https://www.ucsfhealth.org/

Washington Hospital

2000 Mowry Avenue, Fremont, CA 94538

510-797-1111

http://whhs.com/

Inpatient Services

Canopy Health members requiring non-emergent/non-urgent inpatient services may obtain these services at any Canopy Health contracted hospital where their Canopy Health attending physician is credentialed and has hospital privileges. Prior authorization is required for non-emergent/non-urgent admissions to acute or post-acute health care facilities. This process is discussed in more detail in the Utilization Management section of this manual. Care management and discharge planning is a collaborative process between the inpatient facility and the member's Medical Group/IPA.

If a Canopy Health member is admitted to a non-contracted facility, that member may be considered for repatriation to a Canopy Health facility. Such a transfer may take place only when these circumstances apply:

- The member has been medically stabilized;
- The transferring and receiving health care providers determine that no material clinical deterioration of the member is likely to occur during or upon transfer;
- The transferring and receiving health care providers believe that further inpatient health care treatment is medically necessary; and
- The member cannot safely be discharged home.

If a Canopy Health member cannot obtain non-emergent/non-urgent medically necessary inpatient services at a Canopy Health facility, the member's physician may refer the member to a non-contracted facility and the Medical Group/IPA Utilization Management staff may approve

services at a non-contracted facility that can offer such care. Prior authorization and medical review are required for non-emergent/non-urgent inpatient services at non-contracted facilities.

Emergency Services

"Emergency Services" means covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize emergency medical conditions.

All Emergency Services (as defined above) are covered without prior authorization and do not require medical record review. These requests cannot be denied for failure to obtain a prior approval when approval would be impossible, e.g., the member is unconscious and in need of immediate care, or where a prior approval process 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, or 3) serious dysfunction of any bodily organ or part at the time medical treatment is required.

Per California 28 CCR 1300.71.4 (b) and (d):

The following rules set forth emergency medical condition and post stabilization responsibilities for medically necessary health care services after stabilization of an emergency medical condition and until a member can be discharged or transferred. These rules do not apply to a specialized health care service plan contract that does not provide for medically necessary health care services following stabilization of an emergency condition.

In the case when a member is stabilized but the health care provider believes that the member requires additional medically necessary health care services and may not be discharged safely, the following applies:

(1) A health care service plan shall approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half hour of the request.

(2) If a health care service plan fails to approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half-hour of the

request, the necessary post stabilization medical care shall be deemed authorized. Canopy Health shall have the authority to deny payment for delivering new or continued medically necessary care after the patient has been stabilized only if

the health care service plan notifies the treating provider before delivering new or continued care. In that case, the Plan is not obligated to pay for the continued care starting from the time it notified the treating provider about denial of authorization but allowing for time needed to discharge or transfer the member to an authorized facility for ongoing care. The denial of authorization may not have an adverse impact on the efficacy of care or on the member's medical condition.

Canopy Health shall pay for all medically necessary health care services provided to a member that are necessary to maintain the member's stabilized condition until the member is discharged or transferred to another facility for care. All requests for authorizations of medically necessary health care services after stabilization and all responses to such authorization requests will be fully documented in the Utilization Management tracking system of the member's Health Plan. Treating physicians will document provision of all medically necessary health care services in their usual medical record.

When Canopy Health's IPA Utilization Management departments denies requests for authorization of post stabilization medical care at outside facilities and they elect to transfer a member to another health care provider, the following applies:

(1) When a health care service plan informs the treating provider of the plan's decision to transfer the member to another health care provider

(2) the plan shall effectuate the transfer of the member as soon as possible,

(3) Canopy Health pays for all medically necessary health care services provided to a member to maintain the member's stabilized condition up to the time that Canopy effectuates the member's transfer.

A physician or other appropriate practitioner reviews presenting symptoms and discharge diagnoses for emergency services. The Medical Group/IPAs may not restrict emergency medical conditions based on lists of diagnoses or symptoms. Behavioral health care practitioners are available to review psychiatric emergency conditions.

The emergency screening fee (Medical Screening Exam) will be paid in a timely fashion by the responsible party (i.e., the Medical Group/IPA, Canopy Health via its MSO, or Health Plan) for all ER claims when clinical data that would support a higher level of payment is not available. The Medical Group/IPAs have processes to review and address claims payment and provider disputes about emergency room claims that have been denied.

Non-contracted providers are paid for the treatment of the emergency medical condition, including medical necessary services rendered to a member, until the member's condition has stabilized sufficiently to permit discharge or referral and transfer to a contracted facility.

Ambulance services are covered when the member reasonably believed the condition was an emergency.

Out-of-Network Emergency Services

Emergency and urgent services are covered when a member is temporarily out of the service area and requires immediate medically necessary healthcare because 1) the illness, injury, or condition was unforeseen; and 2) it was not reasonable for the member to obtain the services through Network providers given the circumstances. Members can never be balance billed for emergency services.

Under unusual and extraordinary circumstances, services may be considered urgently needed when they are provided within the service area by a non-Network provider when a network provider is temporarily unavailable or inaccessible.

Ancillary Providers and Services

Canopy Health has a network of ancillary providers throughout the San Francisco Bay area. Canopy Health members may access any contracted ancillary provider with a physician referral. Prior authorization is not required for the following ancillary services:

- Urgent care centers
- Routine laboratory tests
- Diagnostic imaging: Plain x-rays and non-contrast ultrasound

Provider Directory and Online Access

The Canopy Health Provider Directory (“Directory”) includes providers currently contracted with Canopy Health. This Directory is available to Canopy Health members, health care providers and

the public without any restrictions or limitations. All Canopy Health enrollees receive full and equal access to covered services, regardless of disability, as required by the Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973. Member questions and concerns should be directed to the member's primary care physician or by calling the Customer Services line at 1-888-8 CANOPY.

Online Provider Directory

The online Directory is easy to navigate and the various sections corresponding to the printed Directory are easily identifiable. Members may want to see all the options in a specific searchable field to maximize accuracy and the probability of finding results through a single search query. For example, members can scroll through a drop-down box to see all specialties before they choose a specialty for their query. Where free text entry for a field makes more sense, this option is offered (such as zip code). Each searchable field is tested in multiple formats to identify the search type that is easiest and most intuitive.

Printed Provider Directory

The printed version of the Canopy Health Provider Directory contains the same information available through the online Directory, organized into the following primary sections in listed below. To request a printed copy of this directory, members and providers may call 1-888-8 CANOPY, log in into www.canopyhealth.com, or by sending a written request to: Canopy Health, 6475 Christie Ave. Suite 560, Emeryville, CA 94608.

Printed Provider Directory Sections:

1. About Canopy Health
2. Choosing a Physician
3. Request a Referral
4. Key Contacts
5. Physician Profiles
6. Acute Care Facilities listing
7. Ancillary Facility listing

This same information may be accessed at the website www.canopyhealth.com, but may be organized slightly differently to facilitate fast and intuitive provider searches.

Provider Directory Updating

Canopy Health meets or exceeds DMHC requirements for updating, maintaining, and ensuring accuracy of the provider profiles in its Directory. Updates to the Directory occur weekly in the online version of the Directory and quarterly in the printed version.

Canopy Health's alliance Medical Group/IPAs are contractually obligated to provide weekly Directory updates. Contracted providers must notify Canopy Health within five (5) business days of status change, such as if they start or stop accepting new patients. The weekly update of the Directory includes notification if there is a change in any of the following:

- Demographic information including name, address, phone number, email address
- If the provider is accepting new patients
- Any change of participation in a health plan or product
- Hospital affiliation
- Group practice membership
- Specialty certification or license status
- If the provider becomes inactive or retires
- Any other information with a material effect on the content or accuracy of the Directory

Directory

The weekly update will also include information received during investigations prompted by a member's or provider's report of an inaccuracy in the Directory. Weekly updates also delete providers from the Directory if they are no longer contracted with the plan, no longer seeing patients, have retired from clinical practice, or experienced other changes impacting their ability to serve as a contracted provider.

Reports of Inaccuracy and Plan Investigation

Canopy Health provides a clearly identifiable and user friendly means for providers and members to report inaccuracies in the Directory. In addition to an annual review process, Canopy Health has a process to allow both members and healthcare providers to notify Canopy Health about potential inaccuracies in the Directory. All reported inaccuracies are investigated promptly, and changes or corrections are updated weekly online and quarterly in the printed directory. Providers are contacted within five (5) days of a reported inaccuracy. Corrections required will be completed within thirty (30) days of being reported, and required changes to the Directory are entered during the next weekly update. Canopy Health documents receipt of the reported inaccuracy, investigative

process and outcome of all investigations. Members who find an inaccuracy in the Directory have three options to report the potential error to Canopy Health:

1. By completing an online form in the member portal, which generates an email that is sent directly to the Canopy Health Customer Service Center.
2. By telephone: 1-888-8CANOPY.
3. By mail: sending notice to the Canopy Health Customer Service Center at 6475 Christie Ave., Suite 560, Emeryville, CA 94608.

Members who complete the online form receive an immediate acknowledgement that their report has been received. These reports are entered in the Canopy Health Customer Relationship Management System as part of Canopy Health's grievance system. If the member reports that a physician is no longer accepting new patients, the Canopy Health Customer Service helps the member to find a new physician. All grievances are tracked, monitored and reported monthly to the Quality Management Committee.

Providers who wish to report an inaccuracy or to make a change to their existing profile in the Directory may do so by:

1. Completing an online form in the provider section of the web portal, which generates an email that is sent directly to the Canopy Health Customer Service Center.
2. Calling the Canopy Health Provider Service Line at 1-844-315-4645.
3. Mailing a report to the Canopy Health Customer Service Center at 6475 Christie Ave., Suite 560, Emeryville, CA 94608.

Providers who complete the online form receive an immediate acknowledgement that their report has been received. Provider submitted updates will be made during the next regular weekly update of the Directory.

Provider Verification

An annual audit will be conducted of all contracted providers, requesting them to review their current profile in the Canopy Health Provider Directory and submit any corrections or changes. Semi-annual audits are conducted of ancillary providers contracted with Canopy Health but not affiliated with a Canopy Health Medical Group. All Canopy Health providers are notified in advance of the audit. Providers are given their current Directory profile, including the networks and plan products they participate in, whether they are accepting new patients or not, their hospital and

group affiliations, specialty and board certification, and demographic information. Providers are asked to confirm their posted information's accuracy and submit any corrections or changes to their Directory listing. Providers must submit a completed response to Canopy Health within 30 business days of receiving their Directory information. Canopy Health may then take an additional 15 business days to verify the provider's information. The process and outcomes of attempts to verify providers' Directory entries is documented. If Canopy Health is unable to verify the provider's information, the provider is notified that she or he will be removed from the Directory unless response is received within 10 days of the request.

Outside of a standard audit process, providers who wish to report an inaccuracy or to make a change to their existing profile in the Directory may do so by:

1. Completing an online form in the provider section of the web portal, which generates an email that is sent directly to the Canopy Health Customer Service Center.
2. Calling the Canopy Health Provider Service Line at 1-844-315-4645
3. Mailing a report about their profile change to the Canopy Health Customer Service Center: at 6475 Christie Ave., Suite 560, Emeryville, CA 94608

Providers who utilize the online form receive an immediate acknowledgement that their report has been received. Provider submitted updates will be made during the next regular weekly update of the Directory.

Provider Obligations and Plan Oversight

If a Canopy Health member contacts a provider seeking to become a new patient and that provider is not accepting new patients, the provider will direct the patient to the Parent Health Plan. Any provider not accepting new patients will contact the Canopy Health Customer Service Center at 1-888-8CANOPY. The customer service representative ("CSR") will ensure Directory errors are forwarded specifically to the individual within the Canopy Health Customer Service Center responsible for resolving Directory changes and/or inaccuracies. This investigation is tracked from receipt of the information regarding the inaccuracy to the final outcomes. All revisions to Canopy Health's Provider Directory, including changes received through the Canopy Health website or Customer Service Center, will be provided to upstream health plans on a weekly basis through a secure ShareFile system.

In all provider agreements, Canopy Health will include a stipulation that if a contracted provider is no longer accepting new patients, or if the provider was previously not accepting new patients, but is currently accepting new patients, the provider is mandated contractually to notify Canopy Health within five (5) business days.
This policy will be updated annually and submitted to the California Department of Health Care for review.

Participating Health Plans

Role of the Health Plan with a Knox-Keene License

Under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), the California Department of Managed Health Care ("DMHC") requires licensure for any entity that assumes global financial risk for professional health services and/or hospital and other institutional health care services. Canopy Health operates under a Restricted Knox-Keene license. This type of license allows Canopy Health to assume global risk by accepting both institutional and professional risk-based capitation payments as subcontractors to unrestricted, full-service plans.

Checking Member Eligibility

Providers are responsible for verifying members' eligibility for all medical services they provide. Providers may verify member eligibility in any of three ways:

- 24 hours/day, 7 days/week through the Canopy Health member's health plan website or telephone number (Information on participating plans follows in this section of the guide).
- Contacting Canopy Health Provider Services between 8:30 a.m. – 5:00 p.m. (Pacific Time) Monday through Friday at 844-315-4645.
- Canopy Health distributes current eligibility lists to participating Medical Groups frequently.

Health Care Identification (ID) Cards

Canopy Health members receive health care ID cards containing information needed for providers to submit claims. Information may vary in appearance or location on the card for different payers or other unique requirements. However, all cards display the following information:

- Identification of Canopy Health alliance
- Member name and ID number; group number
- Health plan
- Claims address
- Copayment information
- Eligibility information
- Phone numbers such as those for Customer Care, Advance Notification and Prior Authorization

Instructions for health care providers: “Please check the Customer’s health care ID card at each visit, and keep a copy of both sides of the health care ID card for your records. Additionally, it is important that you verify eligibility and benefits before or at the point of service for each office visit by calling the customer service number on the member’s ID Care.

Health Plan Partners

Health plan partners with Canopy Health for 2018 include:

- Health Net Blue and Gold
- Health Net SmartCare
- Western Health Advantage
- UnitedHealthcare Signature Advantage

Health Net

Health Net Blue and Gold and Health Net SmartCare HMO members are part of the Canopy Health alliance. Providers can obtain real-time eligibility from Health Net via the Health Net interactive voice response (IVR) system at 1-800-641-7781or the Health Net website at http://www.healthnet.com/portal/provider/home.ndo (or go to www.healthnet.com and select “Providers”).

Comprehensive information on billing, claims and other provider-related concerns can be found on the Health Net website.

Health Net Sample Healthcare Identification (ID) Cards (to be added)

Western Health Advantage

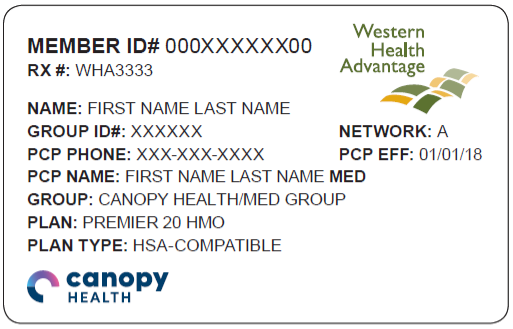
Western Health Advantage is a non-profit provider-owned HMO headquartered in Sacramento, CA. Providers can obtain real-time eligibility from Western Health Advantage through Emdeon’s Electronic Data Interchange (EDI, the exchange of business transactions in a standardized format). For more information visit: https://www.westernhealth.com/provider/electronic-solutions-for-providers/. Providers can also obtain real-time eligibility on Western Health Advantage’s website at https://www.westernhealth.com/provider/ 24 hours a day, seven days a week or by calling 888.227.5942, Monday through Friday from 8:00 a.m. to 6:00 p.m.

Advantage Referral Program

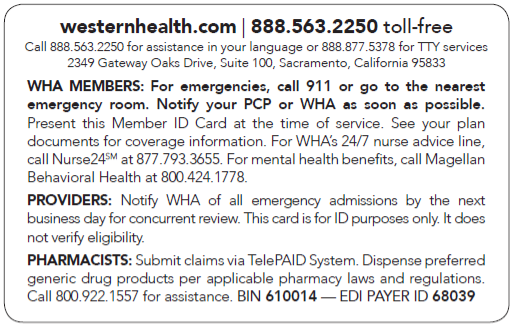
WHA members may exercise freedom of choice of practitioners or providers, within the WHA delegated medical groups. The Advantage Referral Program policy and procedure is available online at https://www.westernhealth.com/provider.

Western Health Advantage Sample Healthcare Identification (ID) Card

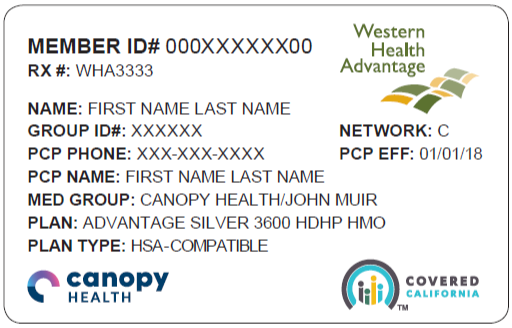
direct/UC enrollee; Canopy PCP



standard back



Covered California enrollee; Canopy PCP



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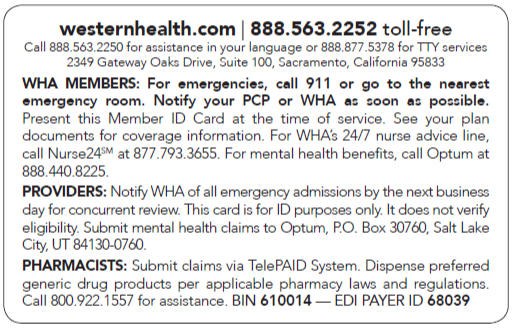
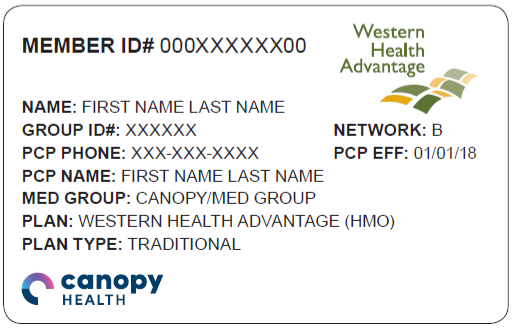


CalPERS enrollee; Canopy PCP



CalPERS back

Disease Management Programs

WHA members are offered disease management programs for asthma, coronary artery disease and diabetes that are managed by Optum®. The programs are voluntary and members can opt-out at any time. For more information visit mywha.org/providerDM or contact Optum at **(877) 793-3655.**

24/7 Nurse Advice

WHA provides access to an advice nurse line 24 hours a day 365 days a year through Optum's Nurse24. California licensed registered nurses skilled in screening and triage services guide members to the most appropriate level of care along with health education services. Members can call **(877) 793-3655** to speak with a nurse or can go online at mywha.org/nurse24 to chat with a nurse.

Preventive Services and Guidelines

WHA members receive health reminder calls and postcards for missed preventive services at least annually. Preventive guidelines are developed based on nationally recognized sources and can be viewed at mywha.org/phgs.

Clinical Practice Guidelines

WHA adopts Optum's guidelines for its disease management programs and Magellan's guidelines for its behavioral health services. To view the guidelines, visit mywha.org/cpgs.

Wellness Program and Health Promotion

WHA offers a web-based health appraisal and self-management tools easily accessed through Optum's wellness portal. Members can learn more at mywha.org/wellness.

WHA distributes annual health promotion materials that cover a wide range of health topics including heart health and adolescent health.

UnitedHealthcare

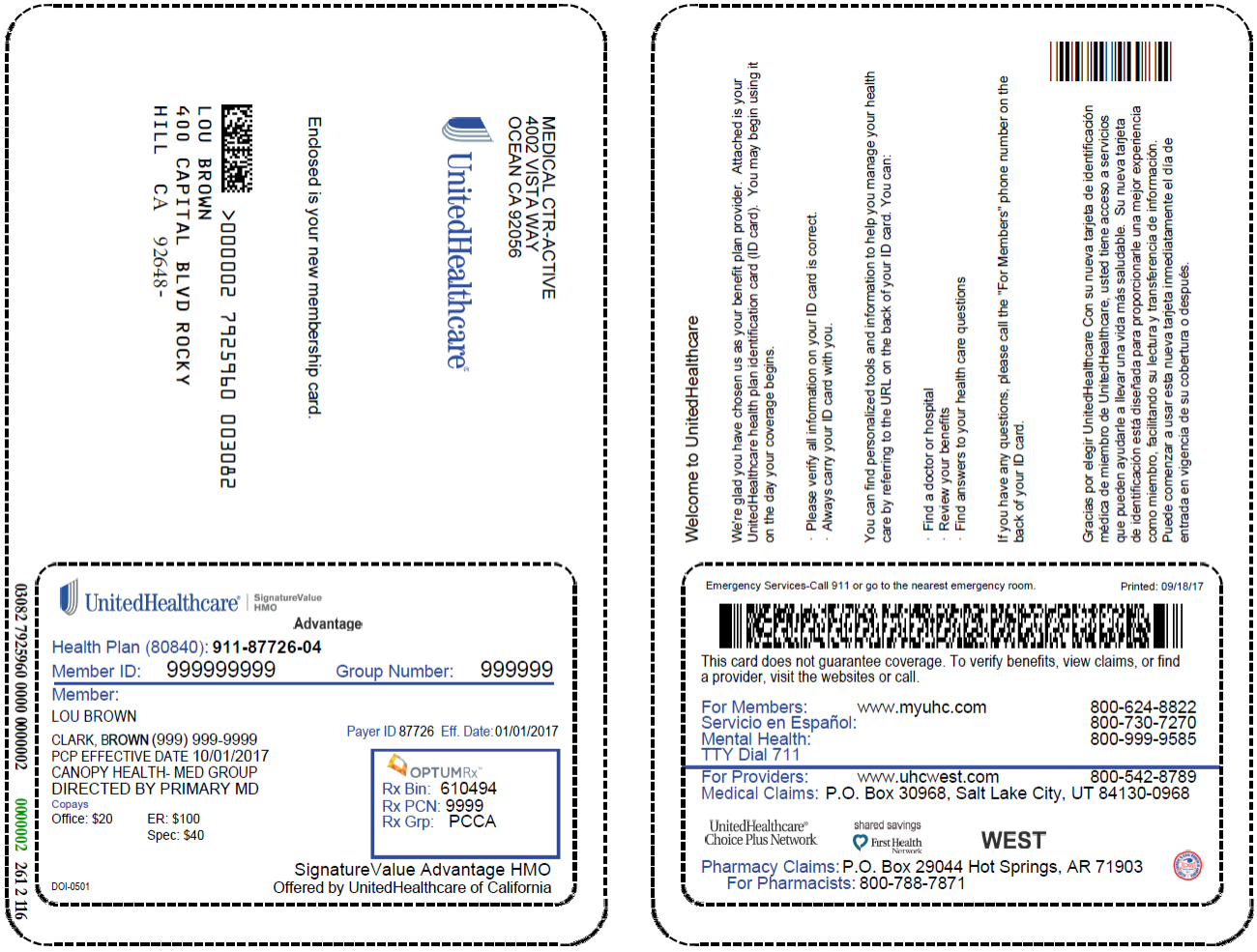
UnitedHealthcare Signature Advantage HMO members are part of the Canopy Health alliance. Providers can obtain the following information from UnitedHealthcare interactive voice response (IVR) system at 877-842-3210 or the UnitedHealthcare provider website at http://www.uhcprovider.com.

- Inquire about a Customer's eligibility or benefits (including copayments, deductibles, past/current coverage, coinsurance, and out-of-pocket information) and obtain a faxed confirmation.

- Check claim status, reason code explanation and claim spending and mailing addresses.
- Update facility/practice demographic data (except TIN).
- Check credentialing status or request for participation inquiries.
- Check appeal or claim project submission process information.
- Check care notification process information.
- Check privacy practice information.

Additional information can be obtained by calling the UnitedHealthcare Signature Advantage Health Plans Provider Call Center at 1-800-542-8789.

UnitedHealthcare Signature Advantage Sample Healthcare Identification (ID) Card



General Billing Information

Filing a Claim: Quick Reference

Providers are encouraged to file claims electronically whenever possible. Submitted claims should provide all required information; those submitted with missing data may result in a delay in processing or denial.

All Canopy Health facility claims are processed by Conifer Value Based Care. Professional claims will continue to be processed by the participating Medical Groups and/or their respective vendors.

Below is a list of key contacts for Conifer Value Based Care:

- Website - www.coniferhealth.com – click Client Login and select Cap Connect. This portal provides access to query and view status on facility claims, authorization/referrals, eligibility status, contracted providers, and other important information.

- Canopy Health Website – www.canopyhealth.com provides general information and a link to the Conifer website for authorizations, claims, and referrals, and also to participating provider's websites.

- Electronic Claims Submission

Clearinghouse	Phone Number	Payer ID
Office Ally	(866) 575-4120	CAPMN
Change Healthcare	(877) 363-3666	95399
MDX	(562) 256-3800	CAPMN
Capario	(949) 852-3400	IP080

- Paper Claim Submissions P.O. Box 260890 Encino, CA 91426
- Appeals & Provider Disputes P.O. Box 261760, Encino, CA 91426
- Claims Department Phone 844-315-4645 or 818-461-5055; IVR available 24/7
- All Other Provider Inquiries 844-315-4645

Clean Claim Guidelines

A “clean claim” is a claim that can be processed without obtaining additional information from the provider of service or from a third party, but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

A claim is considered “clean” when the following conditions are met:

- all required information has been received by Canopy Health
- the claim meets all DMHC submission requirements
- the claim is legible enough to permit electronic image scanning
- any errors in the data provided have been corrected
- all medical documentation required for medical review has been provided

Reasons for claim denial include, but are not limited to, the following:

- duplicate submission
- member is not eligible for date(s) of service(s) (“DOS”)
- incomplete data
- non-covered services

Timely Filing Guidelines

California Code of Regulations Title 28 Rule 1300.71 provides claims submission timelines for Commercial claims as follows:

- Contracted Providers: Billing Limitation –within 90 calendar days (3 months) from the DOS. Refer to each provider's contract for variations in the claims filing limits.
- Non-Contracted Providers: Billing Limitation – withiin180 calendar days (6 months) from the DOS.

Electronic Fund Transfer (EFT)

Canopy Health provides EFT for its providers for facility claims. Providers may contact Conifer Health Provider Services at 1-844-315-4645 or Canopy Health at 1-888-8 CANOPY for information.

Electronic claims: Canopy Health, through its Managed Service Organization ("MSO"), contracts with the following vendors for submission of electronic claims. Additional clearinghouses/vendors may also submit using these channels. The benefits of electronic claim submission include:

- reduction or elimination of costs associated with printing and mailing paper claims
- improvement of data integrity using clearinghouse edits
- faster receipt of claims by Canopy Health, resulting in reduced processing time and quicker payment
- confirmation of receipt of claims by the clearinghouse
- availability of reports when electronic claims are rejected
- the ability to track electronic claims, resulting in greater accountability

Corrected Claims

Providers must correct and resubmit claims to Canopy Health within the 12-month clean claim time frame. When resubmitting a denied claim, the provider must submit a new claim containing all previously submitted lines. The original claim reference number from the remittance advice ("RA") must be included on the claim so that Canopy Health can identify the resubmitted claim. If the claim reference number is missing, the claim may be entered as a new claim and denied for being submitted beyond the initial submission time frame. Corrected claims must be appropriately marked as such and submitted to the appropriate claims electronic processor or mailing address.

Balance Billing

Balance billing is the practice of a participating provider billing a member for the difference between the contracted amount and billed charges for covered services. When participating providers contract with Canopy Health, they agree to accept Canopy Health's contracted rate as payment in full. Billing members for any covered services above and beyond the contracted rate is a breach of contract. Participating providers may only seek reimbursement from Canopy Health members for appropriate cost-share amounts, including copayments, coinsurance, and/or deductibles.

AB72 is the surprise billing legislation that establishes a payment rate, which is the greater of the average of a Health Plan's contracted rate, as specified, or 125% of the amount Medicare reimburses for the same or similar services; and an independent dispute resolution process (IDRP) for claims and claim disputes related to covered services provided at a contracted health facility by a non-contracting individual health care professional for health plan contracts and health policies issued, amended, or renewed on or after July 1, 2017. This legislation limits member and insured cost sharing for these covered services to no more than the cost sharing required had the services been provided by a contracting health professional.

Guidelines for billing Canopy Health members are listed as follows:

- Providers may bill a Canopy Health member when the member knowingly receives non-covered services. The provider must notify the member in advance of the charges and have the member sign a statement agreeing to pay for the services. This signed document should be entered into the member's medical record.
- Canopy Health members must not be balance billed or reported to a collection agency for any covered service that has been provided.

- Providers may not charge members for services that are denied or reduced due to the provider's failure to comply with billing requirements, such as timely filing, lack of authorization or lack of clean claim status.

Providers must not collect copayments, coinsurance or deductibles from members with other insurance such as Medicare or another commercial carrier.

Overpayments

Canopy Health makes every attempt to identify a claim overpayment and indicate the correct processing of the claim on the provider's RA. An automatic system offset, where applicable, might occur in accordance with the reprocessing of the claim for the overpayment, or on immediate subsequent check runs.

If a provider independently identifies an overpayment from Canopy Health (such as a credit balance), the following steps are required to be taken by the provider:

- Send the overpayment refund and applicable details to:

Canopy Health in c/o Conifer Value Based Care
P.O. Box 261760
Encino, CA 91426

- Include a copy of the RA that accompanied the overpayment to expedite Canopy Health's adjustment of the provider's account. It takes longer for Canopy Health to process the overpayment refund without the RA. If the RA is not available, the following information must be provided:

  - member name and Canopy Health member ID number
  - date of service
  - payment amount
  - vendor name and number
  - provider tax ID number
  - reason for the overpayment refund

If a provider is contacted by a third-party overpayment recovery vendor acting on behalf of Canopy Health, the provider should follow the overpayment refund instructions provided by the vendor.

If a provider believes he or she has received a Canopy Health check in error and has not cashed the check, he or she should return the check to the address above with the applicable RA and a cover letter indicating why the check is being returned.

Electronic Data Interchange (EDI) questions

For questions regarding electronic claim submission, please call Conifer Provider Services at 844-315-4645 or the claims clearinghouses at the numbers below (also listed above). Conifer Provider Services Department is open Monday – Friday 8:30-5:00, PST.

Clearinghouse	Phone Number	Payer ID
Office Ally	(866) 575-4120	CAPMN
Change Healthcare	(877) 363-3666	95399
MDX	(562) 256-3800	CAPMN
Caparo	(949) 852-3400	IP080

Claims questions

For automated claim status information, contact the Conifer Health IVR at 844-315-4645, 24 hours/day, 7 days/week.

Additional information

Contact the Canopy Provider Services Center at 844-315-4645, Monday – Friday 8:30 a.m. – 5:00 p.m. Pacific Time with questions regarding third-party recovery, coordination of benefits or overpayments.

Provider Disputes

A provider dispute is a written notice from the provider to Canopy Health that:

- challenges, appeals or requests reconsideration of a claim (including a bundled group of similar claims) that has been denied, adjusted or contested;
- challenges a request for reimbursement for an overpayment of a claim; and/or seeks resolution of billing or other contractual disputes;
- Providers should exhaust all authorized processing procedures and follow the guidelines below before filing a claim dispute with Canopy Health:

- If the provider has not received a RA identifying the status of the claim, he or she should call the Canopy Provider Services Center to inquire whether the claim has been received, processed and is the status.
- Providers should allow ample time following claim submission before inquiring about a claim. However, providers should inquire well before six months from the date of service because of the time frame for initial claim submission and for filing a claim dispute.
- If a claim is pending in the Canopy Health claim system, a claim dispute will not be investigated until the claim is paid or denied. A delay in processing a claim may be cause for a claim dispute on a pended claim provided all claim dispute deadlines are met.

If the provider has exhausted all authorized processing procedures, the provider has a right to request a provider fair hearing through the DMHC.

  - Providers who are contracted with Canopy Health should submit their disputes to DMHC via their process detailed here: http://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan.aspx

- Providers not contracted with Canopy Health should use the "Non Emergency Services Independent Dispute Resolution Process (AB 72 IDRP) through DMHC, detailed here: http://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan/NonEmergencyServicesIndependentDisputeResolutionProcess.aspx

Provider Dispute Time Frame

Disputes are accepted if they are submitted no later than 12 months from the date of payment. If the provider's contractual agreement provides for a dispute-filing deadline that is greater or less than 365 calendar days, the contract timing applies unless, and until the contract is amended.

Submitting Provider Disputes

Providers should submit provider disputes on a Provider Dispute Resolution Request form. If the dispute is for multiple and substantially similar claims, a Provider Dispute Resolution Request spreadsheet should be submitted along with the form. Providers may download an electronic copy of the Provider Dispute Resolution Request form by visiting the Conifer Value Based Care Website.www.coniferhealth.com. The provider dispute form must include the provider's name, NPI ID number, contact information including telephone number, and the number assigned to the original claim. Additional information required includes:

- If the dispute is regarding a claim or a request for reimbursement of an overpayment of a claim, the dispute must include a clear identification of the disputed item, the date of service, and a clear explanation as to why the provider believes the payment amount, request for additional information, request for reimbursement of an overpayment, or other action is incorrect.
- If the dispute is not about a claim, a clear explanation of the issue and the basis of the provider's position.

If the provider dispute does not include the required submission elements as outlined above, the dispute is returned to the provider along with a written statement requesting the missing information necessary to resolve the dispute. The provider must resubmit an amended dispute along with the required missing information.

Canopy Health does not discriminate or retaliate against a provider due to a provider's use of the provider dispute process.

Past Due Payments

If the provider dispute involves a claim and it is determined to be in favor of the provider, Canopy Health pays any outstanding money due, including any required interest or penalties, within 15 business days of the date of the decision. When applicable, accrual of the interest commences on the day following the date by which the claim should have been processed.

Provider Disputes for Authorization Denials

A provider dispute that is submitted on behalf of a member for denial of authorization for services that have not yet been rendered or billed or rendered should be submitted via the member appeals process through the member's Health Plan. The Grievance and Appeals forms for each Health Plan are included in the Exhibits.

For Health Net members, providers should contact Health Net in one of these ways:

- Telephone: Customer Contact Center at 1-800-539-4072 or
- On line: submit a grievance form through www.healthnet.com; or
- By mail: file a complaint in writing to Health Net Appeals and Grievance Department, P.O. Box 10348, Van Nuys, CA 91410-0348.

A provider must send (or already have on file) a signed HIPAA Authorization of Representative form (available at www.healthnet.com). If one is not present, member appeals will route the appeal to provider appeals.

For United Healthcare members, providers should contact United Healthcare in one of these ways:

- Telephone: UnitedHealthcare Customer service at 1-800-624-8822 or
- Complete the Grievance Form for Managed Care Members found at https://www.canopyhealth.com/content/dam/grievance-forms/UnitedHealthcare_CA_Grievance_English.pdf

  And submit it:

  - By mail: Attention: Appeals and Grievances Department, MS CA 124-0160, Cypress, CA 90630-9972 or
  - By fax: 1-866-704-3420

For Western Health Advantage members, providers should contact Western Health Advantage in the following ways:

- Call: Customer Services Department at 916-563-2250 or 888-563-2250, or for TDD/TTY at 888-877-5378 Monday through Friday, 8:00 a.m. – 6:00 p.m.
- Online: Submit the grievance form at mywha.org/grievance or send a secure email through the Western Health Advantage website at mywha.org/secure message.
- Fax: Submit the completed grievance form via secure fax to: 916-563-2207.
- Mail or Hand Deliver: Mail or hand deliver the completed grievance form to:

  Western Health Advantage, ATTN: Customer Services

  2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833.

Resolution Time Frame

Canopy Health, through its health benefit plan, resolves each provider dispute within 45 business days following receipt of the dispute, and provides a written determination.

Dispute Resolution Costs

A provider dispute is processed without charge to the provider; however, Canopy Health has no obligation to reimburse any costs that the provider has incurred during the dispute process.

Utilization Management

Prior Authorization

Participating Canopy Health Medical Groups/IPAs process requests for services requiring authorization for members submitted by their primary care and specialty physicians in accordance with NCQA standards. Canopy Health participating Medical Groups/IPAs enact prior authorization processes for members including inpatient services, as required by the member's health benefit plan. Details regarding referral request handling are outlined in Canopy Health Policy UM-008.

Certain benefited services may be provided by a participating Canopy Health Medical Groups/IPAs to a member without requiring prior authorization. These are specified and uniform across Canopy Health's delegated Medical Group's and IPAs. The list of such services that should be automatically authorized include the following, per DMHC and other regulations:

- Emergency services
- Basic prenatal care
- Family planning services
- Sexually transmitted disease services
- Preventive services
- HIV testing
- Involuntary psychiatric inpatient admission
- Self-referral for behavioral health
- Services provided by the PCP (except procedures requiring prior authorization as listed below).

Referrals for the following services require prior authorization by a participating Canopy Health physician through its Medical Groups/IPAs Utilization Management Departments or its participating health plans. The list below is not all inclusive and may vary depending on individual member's benefit plans.

- Out of network referrals
- Bariatric-related services
- Durable medical equipment, including prosthetics
- Home health and infusion services
- Elective interventional cardiology procedures, including cardiac catheterization and

procedures requiring contrast

- Non-emergent inpatient medical admissions
- Rehabilitation therapies such as physical, occupational, and speech therapy
- Pain management procedures
- Elective interventional radiology procedures requiring contrast administration
- Transplant-related services
- Clinical trials
- Experimental/investigational services and new technologies
- Gender reassignment surgery
- Some level III prescription drugs
- Out of area care

Canopy Health Medical Groups/IPAs conduct the following types of review per their respective policies and procedures, and in coordination with the member's health benefit plan, including but not limited to:

- Prospective Hospital Review
- Concurrent Review of patients admitted to acute care hospitals, rehab facilities and skilled nursing facilities
- Discharge Planning
- Ancillary Services Management

Prior Authorization – Self-Injectable Medications

The Medical Groups/IPAs Utilization Management departments conduct prior authorization for all other services for Canopy Health members that require such authorization except for self-injectable medications. Except for emergency self-injectable medications, all prescriptions and requests for prior authorization for self-injectable medications must be faxed to Dolphin Pharmacy, which will review the request, work with the prescribing physician's office to obtain additional information to support the request, and then will forward this to Integrated Prescription Management (IPM) for processing and utilization review. The State of California now requires health plans and Medical Groups/IPAs to use the standardized Prescription Drug Prior Authorization Form 61-211 for all medication Prior Authorization and step-therapy exception requests. In addition, a separate prescription signed by the prescribing physician must accompany the Prescription Drug Prior Authorization Form 61-211 when requesting prior authorization. IPM follows all standards for content and timelines for conducting utilization review and communicating their decisions. Decision timeframes are outlined below.

Prescription Drugs CA Health & Safety Code section 1367.241 (CA SB 282; 2015-2016) **Exigent circumstances" exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function **OR** when an insured is undergoing a current course of treatment using a non-formulary drug.*	▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request	Practitioner: ▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request ***NOTE:** CA SB282 does not specify timeframes for member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes.*	Practitioner: ▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request ***NOTE:** CA SB282 does not specify timeframes for member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes.*

Prior Authorization Fax for Dolphin: **844-329-6979 or 510-638-7590**

Phone for Dolphin: **510-900-3131**

Prior Authorization Provider Inquiries to IPM: **877-860-8846**

Clinical Hours: Monday – Friday 7 a.m. – 5 p.m. (Pacific Time). Turn-around-times are 24 – 72 hours, depending on the urgency of the request.

Coordination of Benefits

Coordination of benefits ("COB") is required before submitting claims for members who are covered by one or more health insurers other than their primary health plan. Canopy Health follows the applicable regulations regarding coordination of benefits between both commercial and government insurance products.

Participating providers are required to administer COB according to the applicable regulations. The participating provider should ask the member about coverage through another health plan and enter that other health insurance information on the claim.

Providing COB information

For Canopy Health to document member records and process claims appropriately, include the following information on all COB claims:

- name of the other carrier
- subscriber ID number with the other carrier including contact information, primary subscriber, or preferable a COB form from the provider.

If a Canopy Health member has other group health coverage, follow these steps:

- File the claim with the primary carrier, as determined by the applicable regulations.
- After the primary carrier has paid, attach a copy of the *Explanation of Payment (EOP)* or Explanation of Benefits (*EOB)* to a copy of the claim and submit both to Canopy Health within six months from the date of service. COB claims can also be submitted electronically with the details from the other payer ERA appropriately submitted in the 837 transaction COB loops.
- If the primary carrier has not made payment or issued a denial, submit the claim to Canopy Health prior to the timely filing limit of six months from the date of service. If denied based on timeliness, the claims are treated as non-reimbursable and the member cannot be billed.

COB payment calculations

Canopy Health coordinates benefits and pays balances, up to the member's liability, for covered services. However, in cases where Canopy Health is not the primary payer, the dollar value of the

balance payment cannot exceed the dollar value of the amount that would have been paid had Canopy Health been the primary payer.

In some cases, members who have coverage through two carriers are not responsible for cost-shares or copayments. Therefore, it is advisable to wait until payment is received from both carriers before collecting from the member.

Denial Notification

Participating Canopy Health Medical Groups/IPAs shall notify the “referred to” and referring providers and members about authorized services. Providers receive electronic notification through auto fax and through the provider portal and members receive letters through U.S. mail.

If additional data is required prior to authorization of a request for service, the Medical Group/IPA shall send notice to the requesting provider describing specific information required for approval.

Participating Medical Groups/IPAs shall send a notice of denial and notify providers and members about denied authorization requests per the applicable State law to members. Verbal and written notice of denials and communications must meet health plan requirements. Requirements are detailed in Canopy Health Policy UM-008.

Emergencies

Canopy Health provides coverage for emergency services to all members. Emergency services are for covered medical, surgical or psychiatric conditions manifesting themselves by acute symptoms of sufficient severity, such that the member could reasonably expect serious impairment of his or her person from the presenting symptoms without such care. Emergency services to stabilize an emergency medical condition in inpatient and outpatient settings are covered when furnished by a qualified provider.

Emergency services are covered both in-network and out-of-network and do not require prior authorization. Emergency room screening and stabilization services do not require prior approval to be covered by Canopy Health and its participating health plans.

Notification of Admission

All elective acute care hospital and skilled nursing facility (“SNF”) admissions require authorization from the member’s assigned Medical Group/IPA’s Utilization Management Department.

Timeframes for notification are determined by the policies and procedures of each participating Medical Group/IPA. Emergency admissions do not require prior authorization; however, notification should be made to the patient's Medical Groups/IPAs within 24 hours or the next business day of presentation.

Quality and Case Management

Canopy Health collaborates with its contracted physicians, facilities and health plans to ensure adherence to quality standards established by federal, state and local agencies and accreditation entities. Canopy Health establishes annual goals across its alliance to optimize patient care and appropriateness of care for its members. Quality management and case management are discussed in the following sections.

Quality Management Program

The Quality Management ("QM") Program for Canopy Health is designed to review and improve the quality of health care provided to Canopy Health assigned Health Plan members. The "alliance" refers to Canopy Health's partner organizations including medical groups, independent practice associations ("IPAs") and hospitals. All contracted entities, including medical groups, IPAs, hospitals and other health care facilities, are contractually obligated to comply with Canopy Health's quality management policies and procedures. To the extent applicable, the QM Program also monitors and ensures that members receive behavioral health services from their contracted health plan, based on established behavioral health parity regulations and clinical practice guidelines.

The QM Program monitors quality of care, access, continuity and, through its oversight of the Canopy Health Utilization Management Committee, utilization of services offered to Canopy Health members through its network of providers. The QM program conducts structured, comprehensive review of the quality, safety and appropriateness of care delivered by the entire network of clinical services. When necessary, corrective action plans are developed and tracked.

Canopy Health assures that no economic pressure is exerted to cause institutions to grant privileges to health care providers that would not otherwise be granted or to pressure health care providers or institutions to render care beyond the scope of their training or experience.

The QM Program ensures that all treatment decisions rendered by appropriate clinical staff are void of any influence or oversight by the finance departments of Canopy Health providers or by the Canopy Health finance department.

This QM Program document contains the QM standards, policies and procedures, and monitoring activities, and is available to all health care practitioners and alliance participants upon request. Any changes are communicated to providers in writing in a timely manner as required by law or accreditation standard.

The goals of the Canopy Health's QM Program are to:

- Improve the safety and quality of care and service to all members by:
    - ensuring that the quality and continuity of care meet professionally recognized standards of practice and are delivered to all members, and
    - identifying, evaluating and working with Canopy Health providers to correct quality of care problems within all Alliance partner organizations;
- Optimize satisfaction of members and practitioners/providers by assessing, pursuing and monitoring opportunities for improvement;
- Ensure optimized service delivery, including care accessibility, availability, and utilization of services, to meet professionally recognized standards of practice;
- Foster a multi-disciplinary and collaborative approach to quality improvement involving all Canopy Health partnering medical groups, IPAs, hospitals, other providers, and health plans whose services directly affect members' health care quality, service, access, and safety;
- Review and update existing quality related policies and procedures, ensure compliance with all external requirements and standards and create new policies and procedures as needed;

- Maintain systems to collect, synthesize, and report data about quality and service reliably and in a timely fashion from various sources. Sound study designs and statistical techniques are applied when monitoring and developing reports to ensure that appropriate follow-up actions may be taken;

- Monitor procedures ensuring that members do not experience discrimination based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation or source of payment in the delivery of health care services; and

- Ensure the identification, evaluation and planning for individual members is done consistently across all Medical Groups/IPAs wherever this function is delegated to Canopy Health by the Health Plan.

Care Management Program

Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes (NCQA, 2013). MCG Guidelines®, AHRQ and NCQA standards are utilized to identify case types, establish clinical assessment criteria and supportive services for care planning.

Canopy Health's care coordination program include case management for members with complex care needs, whether for chronic conditions or acute ones such as for women with high risk pregnancies and babies in the neonatal intensive care unit. Care coordination efforts and services include consideration of the member's health plan benefits, diagnoses, co-morbidities, psychosocial needs and community program access. The medical groups/IPAs notify and collaborate with PCPs, treating specialists and health plans to coordinate care for members. The goals of Canopy Health's care coordination efforts are to help patients and their families and others in their support network to manage medical conditions and related psychosocial problems more effectively, optimize the member's functional health status, coordinate care across various providers and care settings, eliminate duplication of services, and avoid duplicative and excessive medical services.

Medical Groups/IPAs must pass health plan audits before they are delegated to offer specific types of case management services directly for their members. If the Medical Groups/IPAs is not

delegated to offer case management or chooses not to offer this directly for some or all of its Canopy Health members who are eligible for such services, Canopy Health contracts with a vendor offering case management services that coordinate with that medical group/IPA. Whether offered through the vendor or directly by the medical group/IPA, Care Management services follow the following requirements:

- Care Managers can be accessed during normal business hours. The Medical Groups/IPAs must maintain and coordinate care records among providers to assure access and in accordance with HIPAA and professional standards. Members and/or caregivers communicate with Care Managers through various means (telephone and secure messaging when available). PCPs are notified in writing about a member who meets criteria for and enrollment in care coordination. All patients are informed of their right to refuse case management services. Services offered as part of the program include but are not limited to:
  - Education about the condition
  - Medication reconciliation and self-care-training
  - Assistance with arranging doctor visits/appointments
  - Help with referrals to different care providers or services
  - Assistance with identifying different community support or services available to meet individual needs (In Home Support Service, Community Based Adult Services, Medicare Shared Savings Program, Nutrition Services, assistance with utilities, other community support programs)
  - Help with physician access and involvement in developing a treatment plan
  - Assist members in communicating with their health care providers
  - Advanced illness management and life planning discussion when needed

Complex Case Management

Complex case managers facilitate medical care and offer support for Canopy Health members experiencing critical events or with a diagnosis requiring extensive use of resources, to help members and their caregivers navigate the systems of care.

Members with chronic conditions requiring ongoing care are provided with periodic oversight and coaching to maintain critical health care behaviors.

Case managers will coordinate services to ease transitions of care for members before and after hospitalization for those who at risk for re-hospitalization and/or would benefit from help with follow up appointments.

More information on Canopy Health and its quality management programs is available at www.canopyhealth.com or by calling Canopy Health at 1-888-8CANOPY.

Disease management programs for specific conditions are not delegated to Canopy Health and are offered directly through the Health Plan for members.

Access to Care

The California Department of Managed Health Care requires Knox-Keene licensed entities to adhere to the following standards for timely access to care. All Canopy Health participating providers must meet these standards for appointment and telephone wait times.

Appointment Wait Times

Canopy Health members have the right to appointments within the following time frames:

Type of Appointment	Wait time
Urgent	
• for services that do not require prior approval	48 hours
• for services that require prior approval	96 hours
Non-Urgent	
• Primary care	10 business days
• Specialist	15 business days
• Behavioral health care provider (non-physician)	10 business days
• Other services to diagnose or treat a health condition	15 business days

Telephone Wait Times

- Canopy Health members may call 24-hours-a-day, 7 days a week to talk to a qualified health professional in their medical group/IPA to determine urgency of a health care condition. If the member must wait for a professional to call back, that call must occur within 30 minutes. Phone numbers are printed on the member's ID card.
- During normal business hours, the phone must be answered within ten minutes.

Exceptions

- The purpose of the timely access law is to make sure members receive the care they need. Sometimes members need appointments even sooner than the law requires. In this case, members and PCPs can request that the appointment be sooner.
- Providers may give members a longer wait time if it would not be harmful to their health. It must be noted in the medical record why a longer wait time is necessary and that it will not be harmful to the member's health.
- If a member cannot get a timely appointment in the service area because there are not enough Alliance providers, Canopy Health and the member's medical group must help the member to get an appointment with an appropriate provider out of network.

After- Hours Access

Canopy Health, through its participating providers, contracted health plans and internal processes provides 24 hours a day, 7 days per week telephone triage for immediate clinical support of everyday health issues and questions. The triage or screening waiting time does not exceed 30 minutes. Registered nurses may respond to calls and may: provide protocol-based advice for minor injuries and illnesses, identify emergency health situations, explain medications, and preparing patients for doctor visits.

Canopy Health ensures the immediate availability of and accessibility to emergency health care within the service area, 24 hours a day, 7 days a week. The upstream full-service health plans contracting with Canopy Health offer routine, urgent, and emergency behavioral health services through their contracted behavioral health network, including inpatient and outpatient care. These services include crisis intervention and stabilization as well as psychiatric inpatient hospital services within the service area, 24 hours a day, 7 days a week. Canopy Health and its participating Medical Groups/ IPAs are responsible for fees related for involuntary psychiatric (5150) hospitalizations, as per their contractual Division of Financial Responsibility (DOFR).

General Administrative Requirements

Provider Responsibilities

Participating providers are responsible for:

- providing health care services within the scope of the provider's practice and qualifications, that are consistent with generally accepted standards of practice;
- accepting Canopy Health members as patients on the same basis that the provider accepts other patients (nondiscrimination);
- following the Canopy Health Referral Policy and providing timely communication and feedback regarding member healthcare needs to affiliated physicians;
- obtaining current insurance information from the member;
- adhering to standards of care and Canopy Health policies to perform utilization management and quality improvement activities, including prior authorization of necessary services and referrals;
- informing the member that services may not be covered when referring to physicians outside the network unless prior authorization has been issued;
- cooperating with Canopy Health and its participating providers to provide or arrange for continuity of care to members undergoing an active course of treatment in the event of provider termination;
- operating and providing contracting services in compliance with all applicable local, state and federal laws, rules, regulations, and institutional and professional standards of care, including federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), the anti-kickback statute (section 1128B(b)) of the Social Security Act), and Health Insurance Portability and Accountability Act (HIPAA) administrative simplification rules at 45 CFR parts 160, 162 and 164.

Provider rights to advocate on behalf of the member

Canopy Health ensures that its providers, acting within the lawful scope of their practices, are not prohibited or otherwise restricted from advising or advocating, on behalf of members who are the providers' patients, for the following:

- the member's health status, medical care or treatment options, including any alternative treatment that may be self-administered
- any information the member needs to decide among all relevant treatment options
- the risks, benefits and consequences of treatment or non-treatment
- the member's right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment and to express preferences about future treatment decisions

Nondiscrimination

Canopy Health and its participating providers must not discriminate against any provider that serves high-risk populations or specializes in conditions that require costly treatment.

Encounter Data Submission

All Canopy Health contracted Medical Groups/IPAs are contractually obligated to provide encounter data in a data file format determined by Canopy Health. Encounter is to be submitted monthly to the member's upstream health plan, as well as to Conifer Health VBC. Encounter data is used for regulatory compliance reporting and performance evaluation of the Canopy Health alliance. For information on submission of data files, please contact Canopy Health Provider Services at 844-315-4645.

Member Financial Responsibility

Canopy Health members are responsible for co-pays or coinsurance as determined by their individual employee benefit plan.

Canopy Health providers agree to accept payment per their contract as payment in full. Balance billing for the difference between the contracting amount and billed charges for covered services is

prohibited and is considered a breach of contract, as well as a violation of the PPA and state and federal (ARS 20-1072) statutes. In some instances, balance billing of members can result in civil penalties as stated in ARS 36-2903.01(L).

- Providers may bill a Canopy Health member when the member knowingly receives non-covered services. The provider must notify the member in advance of the charges and have the member sign a statement agreeing to pay for the services and must file the signed statement in the member's medical record.
- Canopy Health members may not be reported to a collection agency for any covered services rendered by a Canopy Health provider
- Canopy Health members may not be charged for services that are denied or limited due to the provider's failure to comply with billing requirements, such as timely filing, lack of authorization, or lack of clean claim status.

Credentialing and Re-credentialing

Credentialing and re-credentialing of physicians and licensed individual practitioners is delegated to Canopy Health's partner medical groups/IPAs. Canopy Health oversees these activities through its Credentialing Committee, chaired by the Canopy Health Chief Medical Officer.

Canopy Health credentials participating ancillary facilities through Conifer Health Solutions. Ancillary facilities are credentialed per the state and federal regulations; such documentation and verification is provided to the Canopy Health Credentialing Committee.

For more information on Canopy Health credentialing policies and procedures, please contact Canopy Health at 1-888-8CANOPY.

Customer Appeals, Grievances and Complaints

Medical appeal or grievance: Canopy Health members who wish to initiate an appeal or grievance about medical services should contact their Health Plan. The Health Plan's Explanation of Coverage (EOC) specifies details about how the Plan addresses appeals and grievances and communicates with members.

Other appeals or grievances: Canopy Health members with an appeal or grievance about mental health and substance abuse, chiropractic, or acupuncture should review their Health Plan's EOC

documents for contact information. See Canopy Health's "Appeals and Grievances Policy" for more details.

Exhibits

Prescription Drug Prior Authorization Form 61-211 (page 64-65)

Grievance and Appeals Forms:

Health Net (page 66-67)
UnitedHealthcare (page 68-69)
Western Health Advantage (page 70-76)

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Plan/Medical Group Name: _____ **Plan/Medical Group Phone#:** (_____)_____
Plan/Medical Group Fax#: (_____)_____

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

Patient Information: This must be filled out completely to ensure HIPAA compliance

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm): _____ Weight (lb/kg):_____	Allergies:
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:	

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:
Address:	City:	State: Zip Code:
Requestor (if different than prescriber):	Office Contact Person:	
NPI Number (individual):	Phone Number:	
DEA Number (if required):	Fax Number (in HIPAA compliant area):	
Email Address:		

Medication / Medical and Dispensing Information

Medication Name:

☐ New Therapy ☐ Renewal
If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?
☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____
☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:
☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location:
☐ Patient's Home ☐ Long Term Care
☐ Physician's Office ☐ Home Care Agency ☐ Other (explain):_____
☐ Ambulatory Infusion Center ☐ Outpatient Hospital Care _____

New 08/13

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

1. Has the patient tried any other medications for this condition? ☐ YES (if yes, complete below) ☐ NO

Medication/Therapy (Specify Drug Name and Dosage)	Duration of Therapy (Specify Dates)	Response/Reason for Failure/Allergy

2. List Diagnoses:	ICD-9/ICD-10:

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage (e.g. formulary tier exceptions) or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date**:_____

Plan Use Only: Date of Decision:_____

☐ Approved ☐ Denied Comments/Information Requested: _____

_____

New 08/13

Health Net of California, Inc

Confidential - Protected Health Information

HEALTH NET MEMBER GRIEVANCE FORM

Name: _____ Date: _____

Subscriber Identification Number: _____ Group Number: _____

Address:

_____

_____

_____

_____

Daytime Telephone No. _____

_____

Participating Physician Group: _____

_____

Please explain in detail the circumstances that led to your dissatisfaction with Health Net of California, Inc. (Health Net). It is essential that you list the dates, persons and facilities involved, as completely as possible. Please include the original copy of any claims or bills received which are related to your issue. (Be sure to make a copy for your records.) Use reverse side or additional paper if necessary. Mail this form and documents to: Health Net, Appeals and Grievances Department, P.O. Box 10348, Van Nuys, CA 91410-0348 or fax to (877) 831-6019.

Problem Statement: Date of Occurrence: _____ Location: _____

Provider Name: _____

Describe the problem/complaint in detail:

_____

_____

_____

_____

_____

Use back of this form if additional space is needed.

Health Net's desire is to provide high quality medical care in the most satisfactory manner possible. To do this, we must be aware of any service difficulties you experience. By filling out this form, you are providing us with necessary information to continually maintain our high standards. We will respond to you in no later than 30 days. If you believe a delay in the decision making may impose an imminent and serious threat to your health, please contact our customer service department at 1-800-522-0088 to request an expedited review.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against t your health plan, you should first telephone your health plan at **1-800-522-0088** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219) and a TDD line (1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

6003757 (8/2013)

CALIFORNIA

Grievance Form for Managed Care Members

Attention Medicare Advantage members – do not complete this form.

You have the right to file a formal grievance about any of your medical care or services. If you want to file, please use this form. *You may submit an appeal for a denial of a service or denied claims within 180 calendar days of your receipt of an initial determination through our Appeals Department.* There is a process you need to follow to file a grievance. UnitedHealthcare, by law, must give you an answer within 30 days. If you have any questions, or prefer to file this grievance orally, please feel free to call UnitedHealthcare Customer Service at 1-800-624-8822 or 1-800-422-8833 (TDHI), Monday through Friday, 7 a.m. to 9 p.m. If you think that waiting for an answer from UnitedHealthcare will hurt your health, call and ask for an "Expedited Review."

CURRENT PERSONAL INFORMATION (please print or type)				
Enrollment or Member ID #		Employer or Group Name		
Last Name	First Name		MI	Date of Birth
Address	Apt #	City	State	ZIP
Home Telephone ( )		Work Telephone ( )		Extension
If someone other than the member is filing this grievance, please provide the following information:				
Name		Daytime Telephone ( )		
Relationship to Member				
Address	Apt #	City	State	ZIP

Due to privacy laws, you will be required to submit authorization of representation indicating you can file a complaint on behalf of the member.

DESCRIBE YOUR GRIEVANCE

Please describe your complaint. Be sure to include specific dates, times, people's and providers' names, places, etc. that were involved. Please send copies of anything that may help us understand your grievance to the address listed below or fax the documents to 1-866-704-3420.

☐ If you attach other pages, please check this box.

NOTICE TO THE MEMBER OR YOUR REPRESENTATIVE

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-624-8822** or **1-800-442-8833 (TDHI)** and use your health plan's grievance process before calling the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of the medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a **TDD (1-877-688-9891)** for the hearing- and speech-impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

If you are a Federal Employee, you have grievance rights through the Office of Personnel Management (OPM) instead of the DMHC. Please reference your Federal Employees Health Benefits (FEHB) Program brochure, which states that you may ask OPM to review the denial after you ask UnitedHealthcare to reconsider the initial denial or refusal. OPM will determine if UnitedHealthcare correctly applied the terms of our contract when we denied your claim or request for service. Send your request for review to: Office of Personnel Management, Office of Insurance Programs Contracts Division 3, 1900 E Street NW, Washington, DC 20415-3630.

SIGNATURE	
Your Signature	Date
Signature of Representative	Date

Please sign and MAIL or FAX to:

ATTN: Appeals and Grievances Department
MS. CA124-0160
P.O. Box 6107
Cypress, CA 90630-9972
FAX: 1-866-704-3420

canopy HEALTH

FILING A GRIEVANCE

Western Health Advantage

PUBLISHED AUGUST 2015

advantage you

Western Health Advantage's goal is to provide its members with the optimum quality and member service experience. To this end, WHA has established a formal process for addressing member concerns, complaints, grievances and appeals.

What is a Grievance?

A grievance is any written or oral expression of dissatisfaction made by you, your representative or your provider regarding your experience with WHA, your medical group or any WHA participating provider.

A "standard" or routine grievance is usually investigated and resolved within 30 calendar days. A "fast track" or expedited grievance is completed within 72 hours from receipt of the formal complaint.

What is an Appeal?

An appeal is a verbal or written formal request to re-review or reconsider a decision that has been made. The appeal can be related to a payment issue, an administrative action, quality of care or service issue or utilization recommendation. Your appeal will be reviewed by a doctor who was not involved in the initial review of the issue. This doctor will make an independent second decision after reviewing all available information. The second decision may agree or disagree with the first decision.

Standard or routine appeals are completed within 30 calendar days. A delay in a final decision may occur if additional information is needed for the reviewer to make an informed decision. Expedited or "fast track" appeals are completed within 72 hours upon request if delaying the appeal decision risks jeopardizing your health. You have the right to request a "fast track" or expedited appeal if your doctor agrees there are health risks in delaying the decision. WHA's Medical Director will make the decision as to whether the appeal will be handled as an expedited or standard appeal.

What is WHA's Grievance and Appeal Procedure?

If you have a complaint with regard to WHA's failure to authorize, provide or pay for a service that you believe is covered, a cancellation, termination, non-renewal or rescission of your membership or any other complaint, please call Member Services for immediate assistance.

If your complaint is not resolved to your satisfaction after working with a Member Services representative, a verbal or written grievance or appeal may be submitted to:

Mail:	Western Health Advantage Attn: Member Services 2349 Gateway Oaks, Suite 100 Sacramento, CA 95833
Secure fax:	916.563.2207
Call:	916.563.2250 or 888.563.2250 888.877.5378 TDD/TTY
Secure email:	mywha.org/securemessage
Online form:	mywha.org/grievance

Please complete the attached form. Be sure to include a discussion of your questions or situation and your reasons for dissatisfaction. Submit the grievance or appeal to WHA Member Services, Grievances and Appeals Department within one hundred eighty (180) days of the incident or action that caused your dissatisfaction. If you are unable to meet this period, please contact Member Services on how to proceed.

If you are appealing a denial of services included within an already-approved ongoing course of treatment, coverage for the approved services will be continued while the appeal is being decided.

If you believe that your membership has been

or will be improperly canceled, rescinded or not renewed, you may request a review by WHA or go directly to the Department of Managed Health Care. If your coverage is still in effect when you submit your grievance, your coverage will be continued while your grievance is being decided, including during the time it is being reviewed by the Department of Managed Health Care. All premiums must continue to be paid timely for coverage to continue. At the conclusion of the grievance, including any appeal to the California Department of Managed Health Care, if the issue is decided in your favor, coverage will continue or you will be reinstated retroactively to the date your coverage was initially terminated. All premiums must be up to date and paid timely.

WHA will send an acknowledgment letter to you within five (5) calendar days of receipt of your grievance or appeal. A determination is rendered within thirty (30) calendar days. WHA will notify the Member of the determination, in writing, within three (3) working days of the decision being rendered. For appeals of denials of coverage or benefits, you will be given the opportunity to review the contents of the file and to submit testimony to be considered. Written notification of the disposition of the grievance or appeal will be provided to the Member and will include an explanation of the contractual or clinical rationale for the decision.

A grievance form and a description of the grievance procedures are available at every Medical Group and Plan facility. In addition, a grievance form will be promptly mailed to you if you request one by calling Member Services. If you would like assistance in filing a grievance or an appeal, please call Member Services and a representative will assist you in completing the form or explain how to write your letter. We will also be happy to take the information over the phone verbally or through a secure message on myWHA.

For detailed information about the grievance and appeal procedure visit mywha.org/grievance or call WHA Member Services at 916.563.2250 or 888.563.2250.

Terminal Illness Conference

If WHA has denied treatment, services or supplies deemed experimental and you have a terminal illness (a condition that has a high probability of causing death within one year or less), you can request a conference as part of the grievance system. Please indicate on the grievance form your request for a conference.

Plan Partner Grievances

If you have a grievance about your dental, vision, mental health, acupuncture or chiropractic services, visit mywha.org/grievance for special instructions.

Language Assistance

WHA wants to ensure all Members have access to the grievance and appeal system. WHA provides free-of-charge verbal and written translation services to those with limited English proficiency or with visual or other communicative impairments. Please contact WHA's Member Services Department for more information or visit mywha.org/grievance for more information.

GRIEVANCE/APPEAL REQUEST FORM

Western Health Advantage

MEMBER NAME | MEMBER ID NUMBER | BIRTH DATE

STREET ADDRESS | CITY | STATE | ZIP CODE

DAYTIME TELEPHONE NUMBER: okay to leave message ❑ YES ❑ NO | ALTERNATE TELEPHONE NUMBER : okay to leave message ❑ YES ❑ NO

NAME OF PERSON FILING (if different than above, please complete the attached Authorized Assistance Form)

RELATIONSHIP | DAYTIME TELEPHONE NUMBER

DEPARTMENT/LOCATION OR MEDICAL FACILITY WHERE ISSUE OCCURRED | DATE(S) ISSUE(S) OCCURRED

PLEASE DESCRIBE THE NATURE OF THE ISSUE(S) (attach additional sheets if needed)

PLEASE EXPLAIN HOW YOU HAVE TRIED TO RESOLVE THE ISSUE(S)

WHAT WOULD YOU CONSIDER A PROPER SOLUTION TO THE ISSUE(S)?

SIGNATURE | DATE

❑ Check here if you are requesting a Terminal Illness Conference.

FOR INTERNAL USE ONLY | NAME OF MEMBER SERVICES REPRESENTATIVE | DATE RECEIVED

Department of Managed Health Care Complaint Process: The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone Western Health Advantage at 800.424.1778 and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (888.HMO.2219) and a TDD line (877.688.9891) for the hearing and speech impaired. The Department's internet website hmohelp.ca.gov has complaint forms, IMR application forms, and instructions online.

If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the California Department of Managed Health Care directly at any time without first filing a grievance with us.

Mail form to: Western Health Advantage, Attn: Member Services, 2349 Gateway Oaks, Suite 100, Sacramento, CA 95833
Secure fax to: 916.563.2207 | Secure email via: mywha.org/securemessage | Available as online form at: **mywha.org/grievance**
For more information: Call 916.563.2250 or 888.563.2250 toll-free | 888.877.5378 TDD/TTY

canopy HEALTH

Western Health Advantage

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

If you have any questions, please call Member Services at 916.563.2250, 888.563.2250 toll-free or 888.877.5378 TDD/TTY.

A. Use this form to authorize Western Health Advantage ("WHA") to use or to disclose your health information to another person or organization.

1. Person (the "Member") whose information is to be disclosed

Member name and address: _____

Member ID number: _____ Date of birth: _____

2. Person (the "Recipient") authorized to receive the Member's information

Recipient's name: _____

Recipient's address: _____

Recipient's relationship to the Member: _____

3. Information to be disclosed to the Recipient

check one: ❍ Any or all information that WHA maintains. This may include information relating to the Member's medical care, diagnosis, providers, insurance or benefit claims/payments, and/or financial/billing information. This does not include Sensitive Information unless specifically approved below.

OR Only the following information, or types of information, WHA maintains (check all that apply):

❍ Claims status ❍ Authorization status ❍ Referral status ❍ Other _____

4. Is the Recipient authorized to receive Sensitive Information as described below?

check one: ❍ NO – PROCEED TO SECTION 5

OR ❍ YES – SELECT ONE (a or b) OF THE FOLLOWING

I specifically authorize the Recipient to receive:

a. ❍ Psychotherapy notes: If you check this box, you may not check any of the other boxes in section b. below. An authorization for the release of psychotherapy notes may not be combined with an authorization for disclosure of any other type of information. PROCEED TO SECTION 5.

OR b. ❍ Complete this section ONLY IF you did not check box 4(a) above and you wish to authorize disclosure of any of the following types of Sensitive Information* (check all that apply):

❍ All sensitive information OR ❍ Abortion ❍ Alcohol/substance abuse** ❍ Genetic information
❍ HIV/AIDS ❍ Mental health ❍ Pregnancy
❍ Sexual, physical, or mental abuse ❍ Sexually transmitted illness

*Note to parents/legal guardians of minors 12 years of age or older: You may be unable to obtain or authorize the use or disclosure of certain types of Sensitive Information about the minor without the minor's own written authorization. This may include the types of Sensitive Information listed above as well as information regarding infectious diseases, rape/sexual assault, and certain outpatient mental health counseling/treatment. If the minor is 17 years of age or older, disclosure of information relating to domestic violence and blood donations also requires the minor's authorization.

**For Recipient of Substance Abuse Information: This information has been disclosed to you from records protected by the Federal Confidentiality of Alcohol or Drug Abuse Records rules (42 CFP part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for release of medical information or other information is not sufficient for this purpose.

5. **Reason for this authorization**

check one: ❍ The information is about me and is to be used or disclosed at my request.

❍ Other (please specify): _____

B. Expiration and revocation

This authorization will remain in effect for one year from the date of your signature below UNLESS a different date is specified here: Month_____ Day _____Year _____

You have the right to revoke this authorization at any time by notifying WHA in writing. Revoking this authorization will not affect information we use or disclose before we receive your revocation request. If this authorization is given by a parent or legal guardian on behalf of a minor, it will expire on the minor's eighteenth birthday.

C. Signature

I have read this form, and I understand and agree to its terms. I direct WHA to use or to disclose the information to the Recipient as directed above. I understand that once my information is disclosed, it could be re-disclosed by the Recipient and may no longer be protected by privacy laws, including the federal Health Insurance Portability and Accountability Act of 1996. I also understand that signing this form is of my own free will.

I understand that WHA may not condition payment, enrollment in a health plan or eligibility for benefits on whether I sign this authorization. I am entitled to a copy of this form.

Signature _____ Date _____

Print name _____

D. Personal or legal representatives or guardians

If this form is signed by someone other than the Member or the parent of a minor, such as a personal/legal representative, guardian or executor, you must also submit legal documentation showing your authority to act on behalf of the Member (or the Member's estate) to authorize the use or disclosure of the Member's health information. Such documentation may include, for example: 1) Durable Health Care Power of Attorney; 2) current, valid documentation of court-ordered guardianship; or 3) other valid legal documentation showing your authority to act on behalf of the Member (or the Member's estate).

Please also complete the following:

Representative's name (print): _____

Relationship to Member: _____

Type of documentation submitted: _____

Keep a copy of this Authorization for your records.

Mail completed form to: Western Health Advantage, Attn: Member Services
2349 Gateway Oaks, Suite 100, Sacramento, CA 95833

Secure fax: 916.563.2207

Secure email via: mywha.org/securemessage – select A Message For: Member Services

Online form at: mywha.org/privacy

Questions? Call: 916.563.2250 | 888.563.2250 toll-free | 888.877.5378 TDD/TTY

FOR INTERNAL USE ONLY Initials:_____ Date Entered:_____

Western Health Advantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Western Health Advantage does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Western Health Advantage:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Member Services Manager.

If you believe that Western Health Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Member Services Manager, 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833, 888.563.2250 or 916.563.2250, 888.877.5378 (TTY), 916.568.0126 (fax), memberservices@westernhealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Member Services Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

Website: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Mail: U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 800.368.1019 or 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ENGLISH

If you, or someone you're helping, have questions about Western Health Advantage, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 888.563.2250 or TTY 888.877.5378.

SPANISH

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Western Health Advantage, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 888.563.2250, o al TTY 888.877.5378 si tiene dificultades auditivas.

CHINESE

如果您，或是您正在協助的對象，有關於Western Health Advantage方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話888.563.2250或聽障人士專線(TTY) 888.877.5378。

VIETNAMESE

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Western Health Advantage, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số 888.563.2250, hoặc gọi đường dây TTY dành cho người khiếm thính tại số 888.877.5378.

TAGALOG

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Western Health Advantage, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 888.563.2250 o TTY para sa may kapansanan sa pandinig sa 888.877.5378.

KOREAN
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Western Health Advantage에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 888.563.2250이나 청각 장애인용 TTY 888.877.5378로 연락하십시오.

ARMENIAN
Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Western Health Advantage-ի մասին, Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք 888.563.2250 համարով կամ TTY 888.877.5378՝ լսողության հետ խնդիրներ ունեցողների համար:

PERSIAN-FARSI
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Western Health Advantage (وسترن هلث ادونتیج) داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. لطفا با شماره تلفن 888.563.2250 تماس بگیرید. افراد ناشنوا می توانند به شماره 888.877.5378 پیام تایپی ارسال کنند.

RUSSIAN
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Western Health Advantage, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 888.563.2250 или воспользуйтесь линией TTY для лиц с нарушениями слуха по номеру 888.877.5378.

JAPANESE
ご本人様、またはお客様の身の回りの方でも、Western Health Advantageについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、888.563.2250までお電話ください。聴覚障がい者用TTYをご利用の場合は、888.877.5378までお電話ください。

ARABIC
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Western Health Advantage، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 888.563.2250، أو برقم الهاتف النصي (TTY) لضعاف السمع 888.877.5378.

PUNJABI
ਜੇਕਰ ਤੁਸੀਂ, ਜਾਂ ਜਿਸ ਕਿਸੇ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਦੇ Western Health Advantage ਬਾਰੇ ਸਵਾਲ ਹਨ ਤਾਂ, ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 888.563.2250 'ਤੇ ਜਾਂ ਪੂਰੀ ਤਰ੍ਹਾਂ ਸੁਣਨ ਵਿੱਚ ਅਸਮਰਥ ਟੀਟੀਵਾਈ ਲਈ 888.877.5378 'ਤੇ ਕਾਲ ਕਰੋ।

CAMBODIAN-MON-KHMER
ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលកំពុងជួយអ្នក មានសំណួរអំពី Western Health Advantage ទេ, អ្នកមានសិទ្ធិទទួលជំនួយនឹងព័ត៌មាន នៅក្នុងភាសារបស់អ្នក ដោយមិនអស់ប្រាក់។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរស័ព្ទ 888.563.2250 ឬ TTY សម្រាប់អ្នកត្រចៀកធ្ងន់ តាមលេខ 888.877.5378។

HMONG
Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Western Health Advantage, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 888.563.2250 los sis TTY rau cov neeg uas tsis hnov lus zoo nyob ntawm 888.877.5378.

HINDI
यदि आप, या जिस किसी की आप मदद कर रहे हो, के Western Health Advantage **के बारे में प्रश्न हैं तो, आपको अपनी भाषा में मदद तथा जानकारी प्राप्त करने का अधिकार है। दुभाशिए के साथ बात करने के लिए,** 888.563.2250 **पर या पूरी तरह श्रवण में असमर्थ टीटीवाई के लिए** 888.877.5378 **पर कॉल करो।**

THAI
หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Western Health Advantage
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย เพื่อพูดคุยกับล่าม โทร 888.563.2250 หรือใช้TTY สำหรับคนหูหนวกโดยโทร 888.877.5378

Revision History:

Version Date	Edited By	Reason for Change
4/1/17	M. Stevens	Creation date
1/5/18	M. Durbin	Updated to include new PBM vendor
1/18/18	A. Kmetz	Updated care coordination and management areas
1/19/18	M. Stevens	Updated with changes from health plan partners
1/22/18	M. Durbin	Added PDR appeal to DMHC information, added exhibits for 61-211 and Grievance & Appeals forms
2/1/18	M. Durbin	Removed paragraph about the WHA advantage referral program