

SHARP Health Plan

2023 Provider Operations Manual

Commercial Plans

January 2023



HELLO

As our trusted providers, we want to acknowledge and thank you for caring for our members. We greatly appreciate your hard work, dedication, and compassion.



Table of Contents

SECTION I	8
Introduction and Overview	8
About Us.....	9
Resource Guide	10
Sharp Health Plan’s Responsibilities	13
Service Area	13
Compliance Program.....	14
Health Care Fraud, Waste, and Abuse Prevention	14
Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule	15
Covered California	16
California Mental Health Parity Law	17
Maternal Mental Health	17
Autism Services	18
SECTION II	19
Sharp Health Plan Benefits	19
Product Overview	20
Benefit Coverage Options.....	20
Health Maintenance Organization (HMO)	20
Preferred Provider Organization (PPO).....	20
Point of Service (POS)	20
High-Deductible Health Plan (HDHP).....	21
Health Savings Account (HSA)–Compatible Health Plan.....	21
Partnerships and Value-Added Services.....	22
Best Health.....	22
Wellness Services	22
Acupuncture	23
Behavioral Health Services	23
Dental Services – Pediatric.....	23
Vision Services – Pediatric.....	23
Global Emergency Services	24
The ChooseHealthy® Program.....	24
MinuteClinic at CVS®	25
Sharp Nurse Connection®	26
Specialty Pharmacy Services Covered under the Pharmacy Benefit	26
Supplemental Benefits.....	27
Acupuncture – American Specialty Health Plans of California, Inc. (ASH Plan).....	27
Chiropractic – American Specialty Health Plans of California, Inc. (ASH Plan).....	27
Vision Services Plan – VSP	27
Enhanced Provider Services	27
Sharp Connect Web-Based Provider Portal	27
Smart Partnership.....	28
SECTION III	29

Member Enrollment and Eligibility	29
Member Enrollment Overview	30
Eligibility Verification	30
Eligibility List	32
Member ID Cards	33
Sample HMO Identification Card with Pediatric Dental	33
Sample HMO Identification Card without Pediatric Dental	34
Sample CalPERS HMO Identification Card	34
Sample Covered California Identification Card	35
Sample City of San Diego / SDPEBA Identification Card	35
Sample Point of Service (POS) Identification Card – (3-Tier)	35
Sample of Teamsters Identification Card	36
SECTION IV	37
Member Services	37
Customer Care	38
Interpreter Services	39
Member Rights and Responsibilities	39
Member Rights	39
Member Responsibilities	40
Primary Care Provider (PCP) Assignment and Selection	40
Member Grievances and Appeals	41
Independent Medical Review (IMR)	47
Independent Medical Review is available in the following situations:	47
Denial of a Health Care Service as Not Medically Necessary	48
Additional Resources for Members	49
HMO Help Center	49
SECTION V	50
Provision of Professional Services	50
Plan Provider Responsibilities	51
Conflicts of Interest	52
Role of the Primary Care Provider (PCP)	53
On-Call Providers Coverage	54
Role of the Specialty and Ancillary Provider	54
Contract Terminations	55
Provider Terminations	55
Contract Suspensions	55
Disabled Member Services	55
Emergency Services	55
Telehealth Services	56
Confidentiality and Disclosure of Medical Information	56
Medical Record Standards	57
Amendment to Member Medical Record	58
Confidentiality and Availability of Medical Records	58
Sensitive Services Information	59

Retention of Medical Records	60
Plan Provider Updates.....	60
Tax Identification Number (TIN) Changes	61
Provider's Panel Status.....	61
Provider's Response to Directory Verification Inquiries.....	61
Credentialing Program.....	62
Credentialing.....	62
Provider Rights during Credentialing	63
Standards and Guidelines	64
Delegated Credentialing/Recredentialing.....	66
Credentialing Appeals Process	66
Recredentialing.....	66
Notifications to Authorities and Plan Provider's Appeal Rights	67
Accessibility and Timeliness Standards to Care	67
Number and Distribution of Primary Care, Specialist, Ancillary Providers and Hospitals	67
Primary Care Provider (PCP) Appointments.....	68
Timely Access to Care.....	69
Appointment Wait Times	69
Rescheduling Appointments.....	69
Extended Wait Times	70
Advance Scheduling.....	70
Telephone Wait Times	70
Interpreter services at scheduled appointments	70
Concerns about timely referral to an appropriate provider	70
Standards for Office Wait Times	70
After-Hours Telephone Access for Primary Care Providers and Behavioral Health Providers	71
Emergency Instructions.....	71
Non-Emergency Instructions	71
Documenting Telephone Calls.....	71
Behavioral Health (BH) Telephone Access	72
Failed Appointments.....	72
Provider-Initiated Member Dismissal	72
Independent Network Providers	72
Plan Medical Groups	73
The Member Dismissal Process.....	73
Approval/Denial of Dismissal Requests	74
Member Dismissal Request Form	76
Culturally and Linguistically Appropriate Services.....	77
Provider Responsibilities for Cultural and Linguistic Services	78
SECTION VI	80
Utilization Management.....	80
Utilization Management Program	81
Referral and Authorization Process	82
Medical and Behavioral Health Services.....	82

Direct Referral	83
Prior Authorization Required	83
Utilization Review	84
Contact Information	85
Prior Authorization Review Timelines.....	85
Provider Notification of UM Decision.....	85
Concurrent Hospitalization Review	86
Discharge Planning	86
Retrospective Authorization Review	86
Emergency Services	87
Denial of Services.....	87
Communication to Providers	87
Second Medical Opinions.....	88
Case Management Program.....	89
Disease Management Program.....	91
Out-of-Network Services.....	91
Delegated Utilization Management	91
SECTION VII	93
Pharmacy Benefit Services.....	93
Formulary.....	94
Pharmacy and Therapeutics (P&T) Committee.....	95
Tiered Copay Programs.....	95
Prior Authorization	96
Step Therapy.....	97
Dispense as Written (DAW) Prescriptions.....	98
Emergency Supply.....	98
Dispensing Limitations.....	99
Vacation Overrides.....	99
Preventive Health Medications.....	99
Prescription Mail Order.....	100
Specialty Medications.....	100
Non-Covered Services and Medications	101
Prior Authorization and Exception Process.....	103
Coverage Determination Notification Process	103
Pharmacy Policies and Procedures (Pharmacy Management Procedures).....	104
FDA Recalls.....	104
Outpatient Injectable Medications.....	105
Pharmacy Benefits Manager (PBM).....	105
Medication Restriction	105
Opioid Management Strategies	106
SECTION VIII.....	107
Quality Improvement	107
Quality Improvement Program.....	108
Quality Management Committee	110

Service and Operational Quality Council.....	111
Participation in the QI Program.....	111
Quality Measurement	112
HEDIS.....	112
BMI Assessment	113
BMI Assessment Codes	113
Counseling for Nutrition and Physical Activity	114
Blood Pressure	114
Diabetic Eye Exam.....	114
HEDIS Medical Record Review.....	114
Clinical Practice and Preventive Health Guidelines	115
Summary of Preventive Care Services	116
All Members	116
Women’s Health	116
Men’s Health	117
Pediatrics.....	118
Preventive vs. Diagnostic Services.....	119
Coverage Limitations and Exclusions.....	120
Preventive Services Monitoring	120
References.....	120
SECTION IX	122
Claims and Encounters.....	122
Claims	123
Claims Address.....	123
Claim Submission Requirements.....	123
Electronic Claims Submissions.....	124
Claim Receipt Verification and Claim Status Inquiries	125
Claims Editing System	125
Claims Policy Administration Module	126
Encounter Data	126
Fee Schedules	127
Adjustment Requests	127
Coordination of Benefits.....	127
Third-Party Liability	128
Member Costs and Out-of-Pocket Maximum	129
Balance Billing	130
Bills for Prenatal Genetic Testing	131
Dispute Resolution	132
Claim Acknowledgement	133
Remittance Advice Summary	134
Remittance Advice Terms	135
Glossary.....	136

SECTION I

Introduction and Overview



About Us

We believe better health insurance matters.

Sharp Health Plan is a nonprofit health plan that has been connecting San Diegans to better health insurance since 1992. As part of the Sharp HealthCare family, we provide direct access to The Sharp Experience[®] with high-quality health care coverage for San Diegans of all ages. Our benefit plans combine affordability and choice, and give members access to valuable plan enhancements, like:

- **After-Hours Nurse Advice** — When members have a health question or concern after regular business hours, a single phone call to our After-Hours Nurse Advice line puts them in touch with a registered nurse.
- **MinuteClinic** — When members need treatment for a minor illness or injury, they can visit a MinuteClinic[®]. Clinics are in select CVS Pharmacy[®] store locations and are staffed by certified family nurse providers. They are open every day, including evenings and weekends.
- **Emergency Travel Services** — When members have medical emergencies while traveling 100 miles or more away from home or in another country, we connect them to doctors, hospitals, pharmacies, and other services.
- **Best Health wellness program** — Best Health[®] is one of a select group of health plan wellness programs in the nation to receive the National Committee for Quality Assurance's (NCQA) accreditation. With Best Health, members can access one-to-one health coaching, classes, and other no-cost wellness services.

Sharp Health Plan is the highest member-rated health plan in California for the eighth year in a row, with the highest member ratings for health care and specialist among reporting California health plans. Visit our [honors, awards and ratings](#) to learn more.

We continually improve the quality of our services and benefits and seek innovative solutions to today's complex health care issues. From helping members find the right health plan and the right doctor, to being a great place to work, we are here to help.

Resource Guide

Resource	Contact Information
General Information	Sharp Health Plan 8520 Tech Way, Suite 200 San Diego, CA 92123 Phone: 1-858-499-8300 Toll-free: 1-800-359-2002 Web: sharphealthplan.com
Appeals & Grievances	Help members with appeals and grievances by contacting Customer Care. Phone: 1-858-499-8300 Toll-free: 1-800-359-2002 Fax: 1-619-740-8572
Attestations & Rosters	For inquiries regarding roster updates or verifications. Phone: 1-858-499-8273 Email: shp.providerattestations&rosters@sharp.com
Capitation	For inquiries about capitation, contact your affiliated Plan Medical Group (PMG). Independent Network providers may contact Provider Account Management. Phone: 1-858-499-8330 Email: provider.relations@sharp.com
Claims (paid by Sharp Health Plan)	Sharp Health Plan Attn: Claims Department P.O. Box 939036 San Diego, CA 92193-9036 Fax: 1-858-636-2276 (Sharp Health Plan does not accept faxed/emailed claims or provider dispute resolutions unless approval is given prior to any documents being sent). Email: shp.claimsresearch@sharp.com

Resource	Contact Information
Claims (third party liability)	Sharp Health Plan Attn: Third Party Liability 8520 Tech Way, Suite 200 San Diego, CA 92123
Contracts	For inquiries about provider contracts, contact Provider Account Management. Phone: 1-858-499-8330
Customer Care	For member or provider assistance, contact Customer Care. Phone: 1-858-499-8300 Toll-free: 1-800-359-2002 Provider Designated Line: 1-844-483-9014 Fax: 1-619-740-8571 Email: customer.service@sharp.com
Eligibility Information	Check eligibility using the Sharp Connect provider portal. Web: sharphealthplan.com/login
Eligibility via Interactive Voice Response (IVR)	Verify eligibility using Interactive Voice Response (IVR) system. Toll-free: 1-800-359-2002, option 1
Fraud, Waste and Abuse	For concerns regarding fraud, waste, and abuse, contact Compliance and Regulatory Affairs. Email: SHPCompliance@sharp.com
Medical Policies	Review medical policies in the Sharp Connect provider portal. Web: sharphealthplan.com/login
Payment Disputes	For inquiries about payment disputes or to complete a Provider Dispute Resolution Form. Phone: 1-858-499-8300 Toll-free: 1-800-359-2002 Email: shp.claimsresearch@sharp.com Web: sharphealthplan.com/for-providers/forms-and-materials

Resource	Contact Information
Prior Authorization – Medical and Behavioral Health Services	<p>Find information about obtaining prior authorization for medical and behavioral health services.</p> <p>Fax: 1-619-740-8111</p> <p>Web: sharphealthplan.com/for-providers/utilization-management</p>
Prior Authorization – Pharmacy Only	<p>Find information about obtaining prior authorization for pharmacy services.</p> <p>Specialty Medications</p> <p>Phone: 1-866-814-5506</p> <p>Fax: 1-866-249-6155</p> <p>Non-Specialty Medications</p> <p>Phone: 1-855-582-2022</p> <p>Fax: 1-888-836-0730</p> <p>Web: sharphealthplan.com/for-providers/forms-and-materials</p>
Provider Account Management	<p>For general assistance and questions about Sharp Health Plan, contact Provider Account Management.</p> <p>Phone: 1-858-499-8330</p> <p>Fax: 1-858-303-9049</p> <p>Email: provider.relations@sharp.com</p> <p>Web: sharphealthplan.com/for-providers</p>
Provider Directory	<p>Report corrections to information in Sharp Health Plan’s Provider Directory by contacting Provider Account Management.</p> <p>Phone: 1-858-499-8330</p> <p>Email: provider.relations@sharp.com</p> <p>Web: sharphealthplan.com/report-incorrect-provider-information</p>
Provider Portal	<p>Access the Sharp Connect provider portal for member eligibility, medical policies, and benefit information.</p> <p>Log in or create an account at sharphealthplan.com/login</p>

Sharp Health Plan's Responsibilities

Sharp Health Plan is committed to serving members and providers with highest quality of service. participating providers have the right to expect the following:

- Respect
- Confidentiality
- Orientation and in-service training (by Medical Group or Sharp Health Plan's Provider Account Management staff)
- Information about changes in policies, procedures, and plan benefits
- Prompt responses to inquiries
- Consideration of your suggestions
- Accurate and timely claims processing
- Timely resolutions of appeals and grievances
- Accurate representation in Sharp Health Plan directories and publications

Much of Sharp Health Plan's success is in credit to our network of dedicated providers. We are committed to providing resources and support to providers needs to serve our members. This Operations Manual is a means of providing the information you need as a partner of Sharp Health Plan's provider network. Providers are also acquainted of new policies, changes within the Plan, and updates through in-service trainings, fax alerts, and notices through our website and web portal at Sharp Connect. Providers who identify additional educational needs are encouraged to contact Provider Account Management at 1-858-499- 8330 or by email at provider.relations@sharp.com.

Service Area

Service Area means the geographic area in which Sharp Health Plan is licensed to provide health services, as approved by the California Department of Managed Health Care. The Sharp Health Plan Service Area includes certain ZIP codes in San Diego County, California and southern Riverside County, California. The Service Area varies based on Plan Network. Sharp Health Plan offers southern Riverside County only in connection with benefit plans offered outside the Covered California Health Benefits Exchange. For more information about Sharp Health Plan's Service Area, please visit our website at sharphealthplan.com/our-plans/service-area or call Customer Care 1-858-499- 8330.

Compliance Program

Sharp Health Plan has a comprehensive commitment to compliance based on trust, integrity, and accountability, which reflects how fundamental components of Sharp Health Plan's business operations are conducted. Regulatory compliance is not an option. It is required. Non-compliance with Sharp Health Plan's commitment and all regulatory statutes undermines the Plan's reputation and credibility with its members, providers, employees, and the community.

The compliance program addresses all aspects of regulatory compliance including quality of care, business ethics, protected health information, health insurance law and employment practices. Compliance training attendance is a vital component of new employee orientation and required annually thereafter for continued employment.

Sharp Health Plan recognizes that its employees and providers are the keys to providing quality health care services and is committed to managing its business operations in an ethical manner, in accordance with contractual obligations, and consistent with all applicable state and federal requirements.

Health Care Fraud, Waste, and Abuse Prevention

Sharp Health Plan is committed to complying with all federal and state statutory, regulatory, and other requirements related to health plan operations. In accordance with state and federal regulations, Sharp Health Plan has a comprehensive plan to detect, correct, and prevent fraud, waste, and abuse.

Fraud, waste, and abuse are defined as:

- **Fraud** – Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud Sharp Health Plan or any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, Sharp Health Plan or any health care benefit program.
- **Waste** – Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to Sharp Health Plan or any health benefit program. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.
- **Abuse** – Includes actions that may, directly or indirectly, result in unnecessary costs to Sharp Health Plan or any health care benefit program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment. The distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors. (*Adapted from Medicare Managed Care Manual, Chapter 21.*)

The purpose of Sharp Health Plan's Fraud, Waste, and Abuse Plan is to detect, prevent, and control fraud, waste, and abuse in order to reduce the cost caused by fraudulent activities, and to protect members in the delivery of health care services. The Fraud, Waste, and Abuse Plan is designed to establish methods to identify, investigate, and report incidents of suspected fraud and/or abuse in Sharp Health Plan's delivery systems.

It is the goal of Sharp Health Plan to improve the detection and investigation of fraud. In pursuit of that goal, we have joined forces with the legal and regulatory community to prosecute those parties attempting to abuse the health care system. Sharp Health Plan monitors, investigates, and corrects possible fraud, waste, and abuse issues.

Help us stop health care fraud. Your support in this area helps us all. If you suspect fraud, please contact our Compliance Department at 1-858-499-8237 or email shpcompliance@sharp.com. Or send a letter to:

Sharp Health Plan
Fraud and Abuse Investigations
8520 Tech Way, Suite 200
San Diego, CA 92123

Reporters of suspected fraud have the right to remain anonymous, if so desired. Just tell us why you think fraud is occurring. Give us the name of the provider or member and tell us what you are concerned about. We take your questions and input seriously. You can help us stop health care fraud.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires covered entities such as health plans, health care clearinghouses, and most health care providers, including pharmacies, to safeguard the privacy of patient information. Covered entities are required to conduct HIPAA Privacy training on an annual basis and to ensure ongoing organizational compliance with the regulations.

A major goal of the Privacy Rule is to ensure that an individual's personal health information is properly protected, while still allowing the flow of health information needed to provide and promote high-quality health care, as well as to protect the public's health and well-being. A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent inappropriate uses and disclosures of Protected Health Information (PHI). The following are examples of appropriate safeguards that providers should take to protect the security and privacy of PHI:

- Ensure that data files are not saved on public or private computers while accessing corporate email through the Internet.
- Ensure that electronic systems for patient mailings are properly programmed to

prevent documents containing PHI from being sent to the wrong recipients.

- Ensure that PHI on all portable devices is encrypted.
- Implement security measures to restrict access to PHI based on an individual's need to access the data.
- Perform an internal risk assessment, or engage an industry-recognized security expert, to conduct an external risk assessment of the organization to identify and address security vulnerabilities.
- Shred documents containing PHI before discarding them.
- Secure medical records with lock and key or pass code.
- Limit access to keys and pass codes.
- Lock computer screens when away from your desk or workstation.
- Refrain from discussing patient information outside the workplace or in public places.

Providers who disclose PHI to another entity may be limited in how this information can be shared. Patients have the right to request to see a list of all persons and organizations with whom their personal health information has been shared. For more detailed information regarding these regulations, go to the Department of Health and Human Services website at hhs.gov/ocr/privacy.

This information regarding HIPAA privacy compliance is provided as a courtesy to the plan providers. While every attempt is made to keep the information as accurate as possible, it is designed for educational purposes only and should not be used as a substitute for legal or other professional advice.

Covered California

Covered California, the California Health Benefit Exchange, has selected Sharp Health Plan as a Qualified Health Plan (QHP) certified to offer coverage through the Exchange for individual and family plans as well as Covered California for Small Business (CCSB) every year since Covered California started accepting enrollment in 2014. Covered California has established standardized plan designs that each QHP must offer on the Exchange. In addition, QHPs must offer identical plans off the Exchange, known as "mirrored" plans.

The benefit plans offered both on and off the Exchange are identified by metal tiers based on the actuarial value of services paid by a QHP. The metal tiers, from richest to least rich in benefits, are Platinum, Gold, Silver, and Bronze, and they range in copayments, coinsurance, and deductibles. Sharp Health Plan also offers on-Exchange health plans for federally recognized American Indians and Alaska Natives (AI-AN) at all metal tiers; out-of-pocket medical expenses are provided at zero cost-share for individuals in this population meeting certain requirements. A minimum-coverage plan (also called a catastrophic plan) is also available for individuals under age 30, or those who meet certain other requirements.

Benefit plans offered by Sharp Health Plan include Copay and Coinsurance HMO plans. Some of the plans qualify as a high deductible health plan (HDHP) that can be paired with a health savings account (HSA).

California Mental Health Parity Law

California law (SB855) broadened the California Mental Health Parity Law. It took effect on 1/1/21 and applies to California health care service plans and disability insurers. The law:

- Requires coverage of the full range of mental illnesses and substance use disorders identified in the most recent versions of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM).
- Requires coverage of "medically necessary treatment" and that "medical necessity" determinations be consistent with generally accepted standards of care applied in mental health and substance use disorder care.
- Requires health plans and insurers to use specified clinical criteria and guidelines for level of care determinations and prohibits the application of additional, different, or conflicting criteria.
- Prohibits limiting benefits or coverage for mental health or substance use disorders to short term or acute treatment.
- Prohibits denying medically necessary services on the basis that they should be or could be covered by a public entitlement program.
- Provides for administrative or civil penalties by the Department of Managed Health Care (DMHC) or the Department of Insurance (DOI).

Maternal Mental Health

California Assembly Bill (AB) 2193 requires that a licensed health care practitioner (provider) who provides prenatal, postpartum or interpregnancy care for a patient shall ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions.

Maternal mental health condition means a mental health condition that occurs during pregnancy, the postpartum period, or interpregnancy and includes, but is not limited to, postpartum depression. AB-2193 also requires that a health plan develop a maternal mental health program designed to promote quality and cost-effective outcomes.

Sharp Health Plan has a maternal mental health program which is designed to assist mothers (prenatal and postpartum) with needs, such as understanding health care benefits, making appointments, and providing health plan and community resources. Sharp Health Plan offers case management services to members who qualify, which includes members with a maternal mental health condition. Referrals will be accepted from any source, including, but not limited to, providers,

members, and hospital staff.

Providers who have a positive screening can direct mothers to a Sharp Health Plan network behavioral health provider. A referral for behavioral health is not required. In addition, providers can refer mothers to Sharp Health Plan's case management department. A case management referral can be made by completing the Case Management Referral form found in the Forms section of the Sharp Health Plan website, or by calling 1-858-499-8300. Sharp Health Plan's maternal mental health program guidelines and criteria are available to providers upon request.

Autism Services

It is the policy of Sharp Health Plan to adhere to the California regulatory requirements for providing coverage for behavioral health treatment for members diagnosed with autism spectrum disorder. Sharp Health Plan is responsible to arrange and provide coverage for medically necessary medical services, such as occupational, physical, or speech therapy, for all diagnoses including autism spectrum disorder. Sharp Health Plan will cover behavioral health treatment, such as applied behavioral analysis (ABA) therapy or evidence-based intensive behavioral health treatment, for members diagnosed with autism spectrum disorder when medically necessary.

SECTION II

Sharp Health Plan Benefits



Product Overview

Sharp Health Plan offers various coverage options for individuals and families, as well as large and small employer group benefit plans. Group health care coverage may be purchased directly through Sharp Health Plan, insurance brokers, CalChoice or the California Health Benefits Exchange. Individual and Family coverage is available directly through Sharp Health Plan, insurance brokers, or the California Health Benefits Exchange.

Benefit Coverage Options

Health Maintenance Organization (HMO)

An HMO is a plan that provides Covered Benefits for a fixed monthly fee, through defined networks of provider groups called plan medical groups (PMGs) from which members choose a primary care provider (PCP) and receive specialty provider care or access to hospitals and other facilities. In some instances, members may select a PCP contracted directly with Sharp Health Plan. The PMG listed on the member's card for these PCPs will be "Independent." HMO members must obtain covered benefits through their PCP and providers affiliated with the PCP's PMG. The PCP is responsible for coordinating and directing necessary care to the appropriate Plan providers.

Preferred Provider Organization (PPO)

A PPO is a plan that has contracts with a network of preferred providers from which members can choose. members do not select a PCP and do not need referrals to see other plan providers in the network.

Point of Service (POS)

A POS plan is a combination between an HMO and a PPO. This plan is known as a POS plan because members have an option between the HMO and the PPO each time, they access services; the type of service is based on the point of service. Sharp Health Plan offers a 2-Tier POS plan and a 3-Tier POS plan.

2-Tier POS

Under a 2-Tier POS plan, members select a PCP responsible to manage and coordinate their care within network. POS plans allow members the flexibility to access a licensed health care provider who may or may not be in the PCP's PMG. Members can choose to receive care within Sharp Health Plan's HMO network (Tier 1) or the Aetna Open Choice PPO network or any other licensed care provider in the U.S (Tier 2).

- Tier 1 is an HMO level of care. Members select any PCP from Sharp Health Plan's HMO Network. The PCP is the main point of contact and is responsible to coordinate care within the assigned PMG. Care that is rendered by providers affiliated with the PCP's PMG (or that is authorized by the PMG) is covered at the HMO level of care. Referral and Prior Authorization may be required.

- Tier 2 is a PPO level of care. Members may direct their own care and access covered services from any licensed health care professional or facility outside the member's PMG without a referral. Members are responsible to ensure provider(s) obtain required pre-certification prior to receiving services to minimize out-of-pocket costs.

For better management of out-of-pocket costs members should be directed to select providers from the Aetna Open Choice PPO Network.

3-Tier POS

Under a 3-Tier POS plan, members select a PCP responsible to manage and coordinate their care within network. The 3-Tier POS plans are similar to the 2-Tier POS plan except it offers flexibility through three distinct options for coverage. members can choose to receive care within Sharp Health Plan's HMO network (Tier 1), the Aetna Open Choice PPO network (Tier 2), or any other licensed care provider in the U.S (Tier 3).

- Tier 1 is an HMO level of care. Members select any PCP from Sharp Health Plan's HMO Network. The PCP is the main point of contact and is responsible to coordinate care within the assigned PMG. Care that is rendered by providers affiliated with the PCP's PMG (or that is authorized by the PMG) is covered at the HMO level of care. Referrals and Prior Authorization may be required.
- Tier 2 is a PPO level of care. Members may direct their own care and access covered services from any licensed health care professional or facility within the Aetna Open Choice PPO Network without a referral. Members are responsible to ensure provider(s) obtain required pre- certification prior to receiving services to minimize out-of-pocket costs.
- Tier 3 is an out-of-network level of care. Members can receive care from any licensed provider not contracted with Sharp Health Plan or the Aetna Open Choice network without a referral. Members are responsible to ensure provider(s) obtain required pre- certification prior to receiving services to minimize out-of-pocket costs.

For better management of out-of-pocket costs members should be directed to select providers from the Aetna Open Choice PPO Network.

High-Deductible Health Plan (HDHP)

An HDHP is a health insurance plan with lower premiums and higher deductibles than a traditional health plan. Some HDHP plans also offer additional wellness benefits or health activities provided before a deductible is applied.

Health Savings Account (HSA)-Compatible Health Plan

An HSA is a tax-advantaged medical savings account available for Members enrolled in a qualified HDHP. Funds contributed to the HSA are not subject to federal income tax at the time of deposit or when used to pay for qualified medical expenses and will roll over and accumulate year to year if

not spent. An HDHP that is qualified (meets certain Internal Revenue Service criteria) can be paired with an HSA to give members the ability to take advantage of these tax savings.

Partnerships and Value-Added Services

Sharp Health Plan's unique services and key partnerships enable us to provide the full array of essential health benefit coverage as well as value added enhanced and supplemental services.

Best Health

Best Health is Sharp Health Plan's comprehensive, integrated, and NCQA-accredited wellness program that drives quality of health care and affordability through employer, and member engagement. Members of Sharp Health Plan may access the following tools and experiences of Best Health at yourbesthealth.com.

- Wellness Assessment: quick and easy assessment to identify potential risk factors
- Health Coaching: free one-on-one access to a telephonic health coach for weight loss, nutrition, stress reduction, and smoking cessation
- Online Wellness Workshops: over 80 different online wellness workshops
- Interactive Health Library: extensive library of topics; health videos, symptom checker and medical decision tools to help guide members in understanding and improving their personal health
- Wellness Workshops and Webinars: guide employees through fun, engaging activities and help them to identify their personal health goals
- Health Tracking: members can track activity using our Best Health mobile app and website or syncing a compatible device
- Alternative Care Discounts: for massage, acupuncture, chiropractic, and dietitians
- Wellness Product Discounts: more than 2,400 health and wellness products

Wellness Services

Sharp Health Plan offers a comprehensive wellness program called Best Health to all Sharp Health Plan members 18 years of age and older. Best Health offers robust online wellness tools; interactive workshops; a comprehensive wellness assessment; fitness, nutrition, and health trackers; and a health library. For those who are ready to take the next step in improving their health, one-on-one health coaching provides members with a dedicated Best Health Coach who will assist them in making positive changes in the areas of healthy weight management, tobacco cessation, healthy eating, physical activity, and stress management.

In addition, all Sharp Health Plan members receive discounts of 15 to 40 percent off over 2,400 health and wellness products, as well as up to 25 percent off alternative care services.

For more information, email besthealth@sharp.com.

Through Sharp Weight Management and Health Education, members also have access to a variety of health education and intervention programs provided at convenient locations throughout San Diego County. Please refer to the Health Promotion Programs flyer available on sharphealthplan.com for descriptions of current health education classes, or call Customer Care at 1-858-499-8300 or toll-free 1-800-359-2002 or customer.service@sharp.com for additional information. Members may telephone Sharp Weight Management and Health Education at 1-800-82-SHARP (1-800-827-4277) for additional information on class descriptions, dates, times, and locations.

Sharp Health Plan is aware that health benefits can be gained by identifying behaviors that promote optimum health and reduce the risk for preventable disease and injury. We recognize that the health education interventions conducted by providers are a critical component of influencing these positive behaviors. To assist providers in that role, information, and resources for working with our members in need of health education counseling and services are provided on a regular basis in newsletters and fax alerts.

Acupuncture

Some Sharp Health Plan members may have coverage for limited acupuncture services for specific conditions related to requirements of the Affordable Care Act.

To find a provider, members should contact American Specialty Health Plans of California, Inc. (ASH Plans) at 1-800-678-9133, or at ashlink.com/ASH/SharpHP

No referral from Sharp Health Plan or the PCP is required.

Coverage for medically necessary acupuncture services may also be available as a supplemental benefit for purchase. No referral is needed to access supplemental benefits. Refer to the Supplemental Benefits section of this manual for more information.

Behavioral Health Services

Behavioral health services include both mental health and substance use disorders. Members have direct access to plan providers for behavioral health services without obtaining a PCP referral. Psychiatric Centers at San Diego is available toll-free at 1-877-257-7273, LifeStance Health is available at 1-858-279-1223, and Independent Behavioral Health providers at sharphealthplan.com or by calling Sharp Health Plan Customer Care toll free at 1-800-359-2002.

Dental Services – Pediatric

Sharp Health Plan members under the age of 19 may have coverage for pediatric dental services as part of the Essential Health Benefits (EHB). Sharp Health Plan has partnered with Delta Dental of California to provide access to dental services for children. Members enrolled in DeltaCare® USA can call **1-855-370-4215** toll-free or go to deltadentalins.com/deltacare to find a dentist.

Vision Services – Pediatric

Sharp Health Plan members under the age of 19 may have coverage for pediatric vision services as part of the Essential Health Benefits (EHB). Sharp Health Plan has partnered with

Vision Service Plan (VSP) to provide access to pediatric vision services. VSP's new pediatric vision plan, VSP® Elements, offers a comprehensive eye exam and quality eyewear annually from a collection of frames designed specifically for our youngest members.

VSP Elements provides a covered-in-full annual eye exam, lenses and a frame from the Otis and Piper Eyewear Collection. In lieu of glasses, elective contact lens services and materials are covered in full (service limitations apply).

Lenses

- Polycarbonate: plastic or glass is covered in full.
- Single vision; lined bifocal; lined trifocal; or lenticular lenses are covered in full.

The following lens enhancements are covered in full:

- Scratch-resistant Coating
- Ultraviolet Coating

Some Sharp Health Plan adult members with specific conditions may have coverage for vision services related to requirements of the Affordable Care Act.

For a complete benefit description and to find a VSP doctor, members can visit vsp.com or call toll-free 1-800-877-7195

Global Emergency Services

Assist America® provides global emergency services for Sharp Health Plan members. The travel assistance services are available worldwide, while traveling domestically or internationally, when members are traveling more than 100 miles from home or in another country for up to 90 consecutive days. Members will contact Assist America for services or Sharp medical management will contact Assist America on behalf of a member traveling to coordinate care. Contact Assist America: within the U.S. by calling 1-800-872-1414, outside the U.S. using +1- 609-986-1234, or by downloading the free Assist America Mobile App for Android and iPhone. The Assist America Reference number is 01-AA-SHP-09073 for general members or 01-AA-SHP-09073M for Medicare/Direct Advantage. *Note: No claims for reimbursement will be accepted.*

The ChooseHealthy® Program

The ChooseHealthy® program provides access to health and wellness promotions and deals to Sharp Health Plan members. The ChooseHealthy program is not insurance.

The program allows members to:

- Save 25% on services from specialty health care providers including acupuncturists, chiropractors, massage therapists, podiatrists, occupational and physical therapists, and dietitians. ChooseHealthy members should check any health insurance benefit

before using the discount program, as those benefits may result in lower costs.

Members may self-refer to a participating provider of their choice.

- Get access to the Active&Fit Direct™ program and find a fitness center, stay active at home with on-demand workouts, and more for just \$25 a month. *
- Get product discounts from 10% – 50% on popular health and fitness brands.
- Members can also join any of the 5,000+ Premium exercise studios with 20% – 70% discounts on most.
- Learn from evidence-based, online health classes and articles offered at no extra cost.

For more information, members can learn more at [ChooseHealthy.com](https://www.choosehealthy.com).

*Plus, an enrollment fee and applicable taxes for standard fitness facilities. Costs for premium exercise studios exceed \$25/mo. and an enrollment fee will apply for each premium location selected, plus applicable taxes. Fees vary based on premium fitness studios selected.

Check your insurance benefits before using the discount program as those benefits may result in lower costs to you. The CHP provides for discounts from participating specialty health care providers. You are obligated to pay for all services but will receive a discount from participating providers for services included in the CHP. The CHP also provides access to the Active&Fit Direct program (“ADP”), which provides discounted access to fitness centers and YMCAs. The CHP does not make payments directly to those participating providers or to the ADP. The CHP has no liability for providing or guaranteeing services and assumes no liability for the quality of services rendered. Availability of <products and> services, and their related discounts, are subject to change; please consult the website for current availability. The CHP is provided by American Specialty Health Group, Inc. and ASH Technologies, Inc. (dba ASH Technologies of Delaware, Inc. in the state of Pennsylvania); all subsidiaries of American Specialty Health Incorporated (ASH). ASH is an independent specialty health organization, offering musculoskeletal health provider networks and programs, fitness center networks and programs, and well-being solutions on behalf of health plans, employers, and other clients.

The ADP is provided by American Specialty Health Fitness, Inc. (ASHF), a subsidiary of ASH. Fitness center/exercise studio participation varies by location and is subject to change. Digital workout videos are subject to change. ASHF reserves the right to discontinue or modify any aspect of the ADP (including, without limitation, the Enrollment Fee(s), the Monthly Fee(s), and/or the Introductory Period) at any time. If we modify a fee, make a material change to, or discontinue the ADP, we will provide you with no less than 30 days’ notice prior to the effective date of the change. ChooseHealthy and Active&Fit Direct are trademarks of ASH.

MinuteClinic at CVS®

MinuteClinic at CVS has more than 14 locations in San Diego and Southern Riverside Counties and over 1100 locations across the nation located inside select CVS Pharmacy® stores to provide convenient access for several basic care services without prior Authorization. Members seeking services need to present their Sharp Health Plan member identification card. The following services are covered by Sharp Health Plan at MinuteClinic at CVS:

- Diagnosis and treatment for common family illnesses such as strep throat, seasonal allergy symptoms, pink eye, infections of the ears, nose, and throat, and sexually transmitted infections
- Flu, COVID, and shingles vaccinations
- Treatment of minor wounds or burns, abrasions, and joint sprains
- Treatment for skin conditions such as poison ivy, ringworm, and acne

Services are available for members aged 18 months or older, but ages for specific services may vary. Members can schedule appointments and find more information about these services, age restrictions and more at <https://www.cvs.com/minuteclinic>.

With the member's permission, a summary of the visit will be sent to their assigned PCP. Visit summaries are also available in Epic "Care Everywhere" or select large interoperability organizations. The MinuteClinic at CVS provider will refer members with more severe symptoms or those requiring treatment in a different setting to their PCP, Urgent Care, or an Emergency Room.

Sharp Nurse Connection®

After regular business hours, weekends and holidays, members can contact the Sharp Health Plan After-hours Nurse Advice line, also known as Sharp Nurse Connection, by calling Customer Care and selecting the appropriate prompt. This after-hours telephone service is staffed with registered nurses to help members decide when and where to seek care and provide medical advice regarding health care questions or concerns. The Primary Care Provider (PCP) receives an electronic notification regarding their assigned members who call Nurse Connection. In some instances, the nurse taking the call may need to speak with the PCP directly regarding a member's health care needs. In those cases, the nurse will contact the PCP's office by telephone. A response to such inquiries must be provided within 30 minutes, to ensure appropriate triage of Sharp Health Plan members. Sharp Nurse Connection is available 5 p.m. to 8 a.m., Monday to Friday and 24 hours a day on weekends and holidays.

Specialty Pharmacy Services Covered under the Pharmacy Benefit

Specialty medications are drugs that may require specialized delivery and administration on an ongoing basis. They are often used to treat complex disease states that require frequent follow-up and monitoring. In addition, drugs that cost the health plan (net of rebates) more than six hundred dollars (\$600) for a one-month (30-day) supply are Specialty medications.

- Specialty medications may be dispensed for up to a maximum of a 30-day supply.
- Specialty medications require Prior Authorization.

Specialty medications covered under the pharmacy benefit can be filled at a pharmacy that is in the Sharp Health Plan Specialty network. Sharp Health Plan's preferred pharmacy is CVS Specialty Pharmacy. In most cases, Specialty pharmacies deliver medications by mail. If medications are filled at CVS Specialty Pharmacy, members may request to pick up their prescription at a CVS retail pharmacy of their choice. This allows the member to obtain the medication at a retail location.

Supplemental Benefits

Supplemental benefits are additional services available for purchase under group plans. The services supplement traditional health coverage and are coordinated by the applicable vendor.

Acupuncture – American Specialty Health Plans of California, Inc. (ASH Plan)

Sharp Health Plan members may have access to medically necessary acupuncture services through a supplemental coverage policy.

- To find a provider, members should contact American Specialty Health Plans of California, Inc. (ASH Plans) toll-free at 1-800-678-9133.
- No referral from Sharp Health Plan or the PCP is required.

Chiropractic – American Specialty Health Plans of California, Inc. (ASH Plan)

Sharp Health Plan members may have access to medically necessary chiropractic services through a supplemental coverage policy.

- To find a provider, members should contact American Specialty Health Plans of California, Inc. (ASH Plans) toll-free at 1-800-678-9133.

No referral from Sharp Health Plan or the PCP is required

Vision Services Plan – VSP

Sharp Health Plan members may have access to vision services through a supplemental coverage policy. Sharp Health Plan offers comprehensive vision coverage through its partnership with VSP. All services are coordinated through VSP. Members enrolled in supplemental vision services can visit vsp.com or call toll-free 1-800-877-7195 for more information.

Enhanced Provider Services

Sharp Connect Web-Based Provider Portal

Sharp Health Plan's web-based provider portal, Sharp Connect, is designed to provide quick and easy access to the information you need to work effectively with our Plan and ensure the best possible service to our members. While this information is as up-to-date and accurate as possible, it does not take the place of the terms of any contract your office or organization may have with Sharp Health Plan.

The Sharp Connect provider portal provides a centralized location for all forms, resources, and tools you need to care for our members. An easy-to-use web-based portal that offers providers 24/7 access to patient eligibility and other provider resources such as:

- Access to specific member benefit/evidence of coverage (EOC)
- Downloadable medical prior authorization forms
- Request pharmacy prior authorization

- Downloadable policies, manuals, and guides
- Quick reference guides
- News and alerts information
- Provider Operation manuals

Register for Sharp Connect on sharphealthplan.com/SharpConnect. For assistance, please contact our Provider Account Management Department at provider.relations@sharp.com or 1-858-499-8330. To ensure compliance with HIPAA security standards, each user must have a unique user ID. We can process your application and assist you with access within 48 business hours of your request.

Smart Partnership

Sharp Health Plan offers special health insurance plans to all plan providers. This Smart Partnership provides an opportunity to offer the same benefits and services to your employees that Sharp Health Plan members receive.

These plans are available for any provider office in Sharp Health Plan's Provider Network that employs from 1 to 100 employees. For rates and additional information, call your insurance broker or Sharp Health Plan's Commercial Sales Department at 1-858-499-8235.

SECTION III

Member Enrollment and Eligibility



Member Enrollment Overview

Sharp Health Plan members select a primary care provider (PCP) affiliated with a specific plan medical group (PMG) upon enrollment. Members who select a PCP affiliated with Sharp Rees-Stealy Medical Group (SRS) or a Community Clinic are assigned to the clinic or medical group, not an individual provider. Sharp Health Plan encourages selection of a PCP located within 30 minutes or 30 miles of a member's residence. In the event a PCP and PMG are not selected at enrollment, Sharp Health Plan will assist with selecting a PCP and PMG who meet the member's needs by attempting to reach the member by telephone. In the event Sharp Health Plan cannot reach the member, the Plan will assign a PCP based on the following factors:

- The member's Plan Network
- The existence of established relationships and family linkages
- The member's residence
- The member's language preference
- The member's age

Members are notified by mail of the plan-assigned PCP and of the right to select a different PCP by contacting Customer Care.

Members may change their PCP at any time. In most cases, members are effective with their PCP on the first day of the next month. For example, if the member calls to select a PCP on May 8, the assignment to that PCP becomes effective on June 1. Exceptions may be made on a case-by-case basis.

Members with newborns may select a PCP or PMG for their newborn effective the first day of the month following the baby's birth. In most cases, newborns are assigned to the mother's PMG until the first day of the month following birth. Verification of eligibility can be obtained by contacting Customer Care.

Eligibility Verification

Unless it is an emergency, plan providers are responsible for verifying eligibility each time a member schedules an appointment and before medical services are provided.

Because events leading to ineligibility can occur at any time, providers are encouraged to verify eligibility on the day services are to be rendered. Specialist should always verify member eligibility on the day of the appointment. Primary Care providers must verify both eligibility and member assignment on the day of the appointment. *Verification of eligibility and/or benefit coverage is NOT a guarantee of payment by Sharp Health Plan.*

All members are issued a health plan identification card, which should be presented each time services are requested. Sharp Health Plan Identification Cards include the following information:

- Member Name
- Member ID Number
- Date of Birth (DOB)
- Coverage Effective Date
- Group Name
- Group Number
- Primary Care Provider (PCP)
 - Except for Sharp Rees-Stealy Medical Group members
- PCP Telephone/After Hours Number
- Plan Medical Group
- Plan Network
- Deductible
- Copayments/Coinsurance
- Medical Claims Mailing Address
- Customer Care toll-free number

Examples of Sharp Health Plan Identification Cards are located on subsequent pages 30-38 within this section.

Although the member ID card is a primary method of identification, possession of the card does not guarantee eligibility, coverage, or benefits. Eligibility to receive services depends on verification from Sharp Health Plan. A new identification card is issued each time a member changes PCP/PMG, but members may forget to present the most recent card when accessing services. Therefore, it is important to verify eligibility with for each visit.

Providers may verify member eligibility through any of the following Sharp Health Plan methodologies:

1. Online via the Sharp Connect provider portal which gives provider offices the ability to view member-specific eligibility information, including effective date, benefits, and copayments. To log on or register for Sharp Connect go to sharphealthplan.com/for-providers. If you are not currently set up for this easy-to-use and secure online resource, please contact Sharp Health Plan's Provider Account Management team at 1-858-499-8330 or provider.relations@sharp.com.
2. Sharp Health Plan's dedicated provider line at 1-844-483-9014 (toll-free). This number is available 24/7 and links to an automated system (called IVR) that allows you to verify

member eligibility status, PCP assignment and copays/coinsurance for most used services.

To use our automated system, call 1-844-483-9014 (toll-free)

- Enter your 10-digit NPI number followed by pound (#)
- Press 1 for provider
- Press 1 for member eligibility
- Enter the patient's 8- or 11-digit member ID number followed by pound (#)
- Press 1 if correct
- Enter the patient's date of birth as a 2-digit month, 2-digit day and 4-digit year followed by pound (#)

Once authenticated, providers will hear the following details for active members:

- Member Eligibility Status
- PCP Name
- Primary Medical Group
- Plan Network
- Member Cost Shares (Copay/Coinsurance)
 - PCP
 - Specialist
 - Urgent Care
 - Emergency Visit
 - Hospital Admission
- Member's Individual Deductible

While listening to the member details, the following navigation options are available:

- Press star (*) to repeat information
 - Press pound (#) to skip to the end
3. If a member insists that they are enrolled in Sharp Health Plan, but the provider is not able to confirm eligibility via Sharp Connect, or via our IVR, please call our Customer Care Department at 1-844-483-9014 and speak to a Customer Care Representative. They are available to assist you Monday through Friday, 8:00 a.m. to 6:00 p.m.

Eligibility List

To ensure the proper management of care for members enrolled with Sharp Health Plan, eligibility files are transmitted regularly to each PMG at mutually agreed-upon intervals. These lists contain

information regarding the member’s enrollment status. It is the responsibility of the PMG to share this information with its PCPs and other contracted providers. In the event of a reported discrepancy between the eligibility file and the member’s current enrollment, please use the options listed above under Eligibility Verification to confirm the member’s current status.

Member ID Cards

Sample HMO Identification Card with Pediatric Dental

SHARP Health Plan

Firstname Lastname Suffix
ID# 92XXXXXXXX-XX
 DOB: MM/DD/YY

Effective: MM/DD/YY
 Group: Group Name
 Group #: Group #

Primary Care Physician (PCP):	Cost Share:	IND	FAM
First Name Last Name XXX-XXX-XXXX	Deductible Out of Pocket Max	\$X,XXX \$XX,XXX	\$X,XXX \$XX,XXX
Plan Medical Group: Plan Medical Group name	PCP Specialist	\$X,XXX \$X,XXX	\$X,XXX \$X,XXX
Network: Network	Hospital Urgent Care ER	\$X,XXX \$X,XXX \$X,XXX	

Please visit sharphealthplan.com for any questions.

Customer Care:
1-800-359-2002

Mental Health Benefits:
1-800-359-2002

Provider Services:
1-800-359-2002

Provider Claims:
PO Box 939036
San Diego, CA 92193

Pharmacy Services:
Members: 1-855-298-4252
Pharmacy: 1-800-364-6331
RxBIN: 004336 | RxPCN: ADV | RxGROUP: RX4150

IMPORTANT:
Sharp Health Plan only covers care by Plan Providers, except for emergency services and out-of-area urgent care. Contact your Primary Care Physician for all other services.

DELTA DENTAL

Dental coverage for members under 19:
1-855-370-4215
DeltaCare USA
PO Box 1810
Alpharetta, GA 30023-1810

Please visit sharphealthplan.com for any questions.

The following information appears on Sharp Health Plan HMO Identification Cards:

- Member Name: member’s Name as entered by the Plan
- ID #: The number assigned to the member by Sharp Health Plan. Commercial member numbers will always start with a “92”
- DOB: Member’s Date of Birth
- Effective: Date the member is eligible with the Plan (not PCP)
- Group Name: The Employer Group associated with the member’s coverage (e.g., employer)
- Group #: The number assigned by the Plan to the Employer Group associated with the member’s coverage
- Primary Care Provider: The provider to whom the member is assigned
- Telephone: The phone number where the PCP can be reached during and after office hours
- Plan Medical Group: The Plan Medical Group to which the member is assigned
- Plan Network: The network of providers and hospitals associated with the member’s benefit coverage
- Deductible: Deductible amount if applicable
- PCP: The Copayment for services provided in a provider’s office
- Specialist: Specialist Copayment amount
- Hospital: Inpatient Hospital Care Copayment amount
- Urgent: Urgent Care Services Copayment amount

- ER: The Emergency Room Services Copayment amount (waived if the member is admitted)

The back of the card includes information specific to the member’s benefit plan and coverage, for example:

- Customer Care: member Phone number (may vary by Employer Group)
- Mental Health Benefits: Phone number for Mental Health Services
- Provider Services: Phone number for Customer Care
- Provider Claims: Address to submit medical claims
- Pharmacy Services: Phone numbers claims routing for Pharmacy Benefit Manager
- Emergent and Urgent Care Services statement
- Dental Coverage Claims address and phone number

Sample HMO Identification Card without Pediatric Dental

SHARP Health Plan

Firstname Lastname Suffix
ID# 92XXXXXXX-XX
DOB: MM/DD/YY

Effective: MM/DD/YY
Group: Group Name
Group #: Group #

Primary Care Physician (PCP):	Cost Share:	IND	FAM
First Name Last Name XXX-XXX-XXXX	Deductible	\$X,XXX	\$X,XXX
	Out of Pocket Max	\$XX,XXX	\$XX,XXX
	PCP	\$X,XXX	
	Specialist	\$X,XXX	
	Hospital	\$X,XXX	
	Urgent Care	\$X,XXX	
	ER	\$X,XXX	

Please visit sharphealthplan.com for any questions.

Customer Care:
1-800-359-2002

Mental Health Benefits:
1-800-359-2002

Pharmacy Services:
Members: 1-855-298-4252
Pharmacy: 1-800-364-6331
RxBIN: 004336
RxPCN: ADV
RxGROUP: RX4150

Provider Services:
1-800-359-2002

Provider Claims:
PO Box 939036
San Diego, CA 92193

IMPORTANT:
Sharp Health Plan only covers care by Plan Providers, except for emergency services and out-of-area urgent care. Contact your Primary Care Physician for all other services.

Please visit sharphealthplan.com for any questions.

Sample CALPERS HMO Identification Card

SHARP Health Plan

Firstname Lastname Suffix
ID# 92XXXXXXX-XX
DOB: MM/DD/YY

Effective: MM/DD/YY
Group: Group Name
Group #: Group #

Primary Care Physician (PCP):	Cost Share:	IND	FAM
First Name Last Name XXX-XXX-XXXX	Deductible	\$X,XXX	\$X,XXX
	Out of Pocket Max	\$XX,XXX	\$XX,XXX
	PCP	\$X,XXX	
	Specialist	\$X,XXX	
	Hospital	\$X,XXX	
	Urgent Care	\$X,XXX	
	ER	\$X,XXX	

Please visit calpers.sharphealthplan.com for any questions.

Customer Care:
1-855-995-5004

Mental Health Benefits:
1-855-995-5004

Provider Services:
1-855-995-5004

Provider Claims:
PO Box 939036
San Diego, CA 92193

Pharmacy Services:
Members: 1-855-505-8110
Pharmacy: 1-855-438-4512
optum.com/CalPERS
RxBIN: 610011
RxPCN: IRX
RxGROUP: CALPSHARP

IMPORTANT:
Sharp Health Plan only covers care by Plan Providers, except for emergency services and out-of-area urgent care. Contact your Primary Care Physician for all other services.

OPTUMRx

Please visit calpers.sharphealthplan.com for any questions.

- Sharp Performance Plus is the name of the CalPERS HMO Product.
- CalPERS members have a unique Customer Care phone number.
- CalPERS members have a customized Sharp Health Plan Web page.
- Pharmacy benefits are covered through OptumRx.
- Please see the page for “Sample HMO Identification card” for more information.

Sample Covered California Identification Card

SHARP Health Plan

Firstname Lastname Suffix
ID# 92XXXXXXXX-XX Effective: MM/DD/YY
DOB: MM/DD/YY Benefit Plan: Plan description

Primary Care Physician (PCP):	Cost Share:	IND	FAM
First Name Last Name XXX-XXX-XXXX	Deductible	\$X,XXX	\$X,XXX
	Out of Pocket Max	\$XX,XXX	\$XX,XXX
	PCP	\$X,XXX	
	Specialist	\$X,XXX	
	Hospital	\$X,XXX	
	Urgent Care	\$X,XXX	
	ER	\$X,XXX	

Please visit sharphealthplan.com for any questions.

Customer Care:
1-800-359-2002

Mental Health Benefits:
1-800-359-2002

Provider Services:
1-800-359-2002

Provider Claims:
PO Box 939036
San Diego, CA 92193

Pharmacy Services:
Members: 1-855-298-4252
Pharmacy: 1-800-364-6331
RxBIN: 004336 | RxPCN: ADV | RxGROUP: RX4150

IMPORTANT:
Sharp Health Plan only covers care by Plan Providers, except for emergency services and out-of-area urgent care. Contact your Primary Care Physician for all other services.

Dental coverage for members under 19:

1-855-370-4215
DeltaCare USA, PO Box 1810,
Alpharetta, GA 30023-1810

Covered California:
For questions about enrolling or premium assistance, call Covered California at 1-800-300-1506.

Please visit sharphealthplan.com for any questions.

Covered California members may contact Covered California directly for questions regarding enrollment or tax credits. Please see the page for "Sample HMO Identification card" for more information.

Sample City of San Diego / SDPEBA Identification Card

SHARP Health Plan

Firstname Lastname Suffix
ID# 92XXXXXXXX-XX Effective: MM/DD/YY
DOB: MM/DD/YY Group: Group name
Group #: Group #

Primary Care Physician (PCP):	Cost Share:	IND	FAM
First Name Last Name XXX-XXX-XXXX	Deductible	\$X,XXX	\$X,XXX
	Out of Pocket Max	\$XX,XXX	\$XX,XXX
	PCP	\$X,XXX	
	Specialist	\$X,XXX	
	Hospital	\$X,XXX	
	Urgent Care	\$X,XXX	
	ER	\$X,XXX	

Please visit sharphealthplan.com for any questions.

Customer Care:
1-888-840-4747

Mental Health Benefits:
1-888-840-4747

Pharmacy Services:
Members: 1-855-298-4252
Pharmacy: 1-800-364-6331
RxBIN: 004336
RxPCN: ADV
RxGROUP: RX4150

Provider Services:
1-888-840-4747

Provider Claims:
PO Box 939036
San Diego, CA 92193

IMPORTANT:
Sharp Health Plan only covers care by Plan Providers, except for emergency services and out-of-area urgent care. Contact your Primary Care Physician for all other services.

Please visit sharphealthplan.com for any questions.

City of San Diego/SDPEBA members have a unique Customer Care phone number. Please see the page for "Sample HMO Identification card" for more information.

Sample Point of Service (POS) Identification Card – (3-Tier)

GROUP NAME
POINT-OF-SERVICE HEALTH INSURANCE CARD

Firstname Lastname Suffix
ID# 92XXXXXXXX-XX Effective: MM/DD/YY
DOB: MM/DD/YY Group #: Group #

TIER 1 NETWORK BY SHARP Health Plan	TIER 2 NETWORK BY
Primary Care Physician (PCP): First Name Last Name XXX-XXX-XXXX Plan Medical Group: Plan Medical Group name	 Plan: Aetna Open Choice PPO

PROVIDER INFORMATION	PHARMACY	MEMBER INFORMATION
Send All Medical Claims: Sharp Health Plan PO Box 939036 San Diego, CA 92193 Provider Call: 1-844-483-9011	Pharmacist Call: 1-800-364-6331 RxBIN: 004336 RxPCN: ADV RxGROUP: RX4150	Customer Care: 1-844-483-9011 Pharmacy Benefits: 1-855-298-4252 Mental Health Benefits: 1-844-483-9011

Provider Network Tier	 TIER 1 Point of Service (POS)	 TIER 2 Aetna Open Choice PPO	TIER 3 Out of Network
Deductible(IND/FAM)	\$X,XXX/\$X,XXX	\$X,XXX/\$X,XXX	\$X,XXX/\$X,XXX
Out of Pocket Max(IND/FAM)	\$XX,XXX/\$XX,XXX	\$XX,XXX/\$XX,XXX	\$XX,XXX/\$XX,XXX
PCP	\$X,XXX	\$X,XXX	\$X,XXX
Specialist	\$X,XXX	\$X,XXX	\$X,XXX
Hospital	\$X,XXX	\$X,XXX	\$X,XXX
Urgent Care	\$X,XXX	\$X,XXX	\$X,XXX

IMPORTANT:
Emergency services and out-of-area urgent care services are covered without Prior Authorization. For urgent care in the Plan's Service Area, call your Primary Care Physician. Some Tier 1 HMO Network services require Prior Authorization. See your Primary Care Physician for information. Tier 2 services are available from Aetna Open Choice PPO providers. Some Tier 2 and Tier 3 Out-of-Network services may require Precertification. Aetna participating doctors and hospitals are independent providers and are neither agents nor employees of Aetna. See your Health Plan Benefits and Coverage Matrix for information.
Plan Website: sharphealthplan.com

The following information appears on POS ID cards:

- Member Name: member’s Name as entered by the Plan
- DOB: Member’s Date of Birth
- Group Name: The Employer Group associated with the member’s coverage
- Group #: The number assigned by the Plan to the Employer Group associated with the member’s coverage
- ID #: The number assigned to the member by Sharp Health Plan
- Effective: Date the member is eligible with the Plan (not PCP)
- Tier 1 HMO Plan Network: The network of providers and hospitals associated with the member’s benefit coverage under the Tier 1 Level of benefit coverage
- Out of Network: Contracted network for Tier 2 benefits
- Primary Care Provider: The provider to whom the member is assigned
- Telephone/After Hours: The phone number where the PCP can be reached during and after office hours
- Plan Medical Group: The Plan Medical Group to which the member is assigned
- Deductible: Deductible amount if applicable
- PCP: The Copayment for services provided in a provider’s office
- Specialist: Specialist Copayment amount
- Hospital: Inpatient Hospital Care Copayment amount
- Urgent: Urgent Care Services Copayment amount
- ER: The Emergency Room Services Copayment amount (waived if the member is admitted)

POS members may seek services at a Tier 1 (HMO) network or a Tier 2 (PPO) network.

- Tier 1 services are subject to Prior Authorization requirements of the Plan Medical Group.
- Tier 2 services may require Precertification
 - Members are responsible for ensuring Precertification is obtained when required. Precertification may be requested by calling Sharp Health Plan.

Sample of Teamsters Identification Card

SHARP Health Plan

Firstname Lastname Suffix
ID# 92XXXXXXXX-XX
 DOB: MM/DD/YY

Effective: MM/DD/YY
Group: Group Name
Group #: Group #

Primary Care Physician (PCP):	Cost Share:	IND	FAM
First Name Last Name XXX-XXX-XXXX	Deductible	\$X,XXX	\$X,XXX
	Out of Pocket Max	\$XX,XXX	\$XX,XXX
	PCP	\$X,XXX	
	Specialist	\$X,XXX	
	Hospital	\$X,XXX	
	Urgent Care	\$X,XXX	
	ER	\$X,XXX	

Plan Medical Group:
Plan Medical Group name

Network:
Network

Please visit sharphealthplan.com for any questions.

Customer Care:
1-800-359-2002

Mental Health Benefits:
1-800-359-2002

Provider Services:
1-800-359-2002

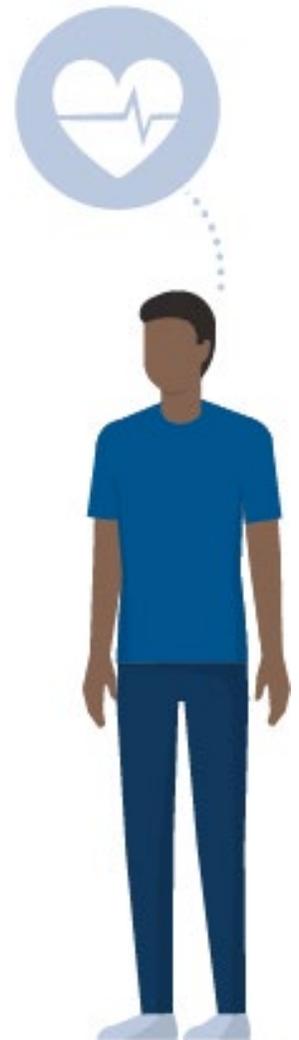
Provider Claims:
PO Box 939036
San Diego, CA 92193

IMPORTANT:
Sharp Health Plan only covers care by Plan Providers, except for emergency services and out-of-area urgent care. Contact your Primary Care Physician for all other services.

Please visit sharphealthplan.com for any questions.

SECTION IV

Member Services



Customer Care

The Customer Care Department is designed to assist both members and providers with all of Sharp Health Plan's Value-Added Services and health plan benefit coordination.

Customer Care can be reached toll-free at 1-800-359-2002 or by email at customer.service@sharp.com. The Customer Care Department has friendly, knowledgeable, and bilingual representatives available Monday through Friday from 8:00 a.m. to 6:00 p.m. Our Customer Care Representatives assist members by answering questions regarding, but not limited to eligibility, general benefits, PCP assignment, and hospital information.

The Customer Care Department can also provide assistance with information about any of the following:

- Status of medical referrals and authorizations
- Premium billing questions
- Health plan options
- Community resources and support groups
- Grievances and appeals process
- ID card replacements

Member pharmacy inquiries are supported by our PBM partner, CVS Caremark. Members may reach CVS Caremark by calling 1-855-298-4252. Members associated with CalPERS, Palomar or Teamsters may refer to the pharmacy information located on the back of their member ID cards for support.

- Retail pharmacy claim inquiries
- Drug coverage inquiries
- Plan design education
- Drug coinsurance questions
- Mail service order status
- Plan benefit overrides
- Escalated member requests
- Eligibility inquiries
- Prescription billing/payment inquiries
- Prescription prior authorizations and formulary exception requests

Interpreter Services

Plan providers may request interpreters for members whose primary language is not English by calling Sharp Health Plan at 1-858-499-8300 or toll-free at 1-800-359-2002. The customer care representative will request the following information:

- Member name, identification number, age, sex, language, and country of origin (to determine the appropriate version of the requested language).
- Provider information, including appointment date and time, office location, name, provider's phone number, and type of appointment (e.g., OB/GYN, well-care, etc.).

For face-to-face interpreting services, requests must be made at least three days prior to the appointment date. However, even with advance notice, face-to-face interpreters for some languages may not be available. If an interpreter is not available for face-to-face interpreting, Sharp Health Plan can make arrangements for telephone interpreting services. Please call Sharp Health Plan at 1-858-499-8300 or 1-800-359-2002 to arrange for timely language assistance services for our members.

Member Rights and Responsibilities

Members are given a Member Handbook upon request that contains a list of member Rights and Responsibilities, which are provided below. Printable versions (in English and Spanish) suitable for distribution to members are also available online at sharphealthplan.com.

Member Rights

Sharp Health Plan members have the right to:

- Be treated with dignity and respect.
- Have your privacy and confidentiality maintained.
- Review your medical treatment and record with your health care provider.
- Be provided with explanations about tests and medical procedures.
- Have your questions answered about your care.
- Have a candid discussion with your health care provider about appropriate or medically necessary treatment options, regardless of cost.
- Participate in planning and decisions about your health care.
- Agree to, or refuse, any care or treatment.
- File complaints or appeals about Sharp Health Plan or the services you receive as a Sharp Health Plan member.
- Receive information about Sharp Health Plan, our services and providers, and member rights and responsibilities.
- Make recommendations about these rights and responsibilities.

Member Responsibilities

Sharp Health Plan members have the following responsibilities:

- Provide information (to the fullest extent possible) that Sharp Health Plan and your doctors and other providers need to offer you the best care.
- Understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.
- Ask questions if you do not understand explanations and instructions.
- Respect provider office policies and ask questions if you do not understand them.
- Follow advice and instructions agreed-upon with your provider.
- Report any changes in your health.
- Keep all appointments and arrive on time. If you are unable to keep an appointment, cancel 24 hours in advance, if possible.
- Notify Sharp Health Plan of any changes in your address or telephone number.
- Let your health care provider or Sharp Health Plan know if you have any suggestions, compliments, or complaints.
- Notify Sharp Health Plan of any changes that affect your eligibility, such as if you are no longer working or living in the Plan's service area.

Primary Care Provider (PCP) Assignment and Selection

All Sharp Health Plan members must select a Primary Care Provider (PCP) to manage their medical needs. Individual family members may choose the same or different PCPs in the following practice areas:

- Medical Doctor (MD), including internist, family practice provider, pediatrician, OB/GYN and general medicine provider.
- Osteopathic provider (DO), including internist, family practice provider, pediatrician, OB/GYN and general medicine provider.
- Members who select a PCP affiliated with a community clinic are assigned to the clinic, not an individual provider within the clinic.
- A member, who is also a provider, may not select themselves as their PCP.

In the event that a member does not select a PCP at enrollment, the Plan will assign a PCP based on the following factors:

- The member's Plan Network
- The existence of established relationships and family linkages
- The member's residence

- The member's language preference
- The member's age

Members are notified by mail of the Plan-assigned PCP and of the right to select a different PCP by contacting Sharp Health Plan Customer Care.

- Generally, a PCP assignment becomes effective on the first day of the present month if the request for a change is received before the 15th of the month and the member has not accessed care with another PCP. For example, if the member calls to select a PCP on May 8, the assignment to that PCP becomes effective on May 1 if the member has not accessed care with a different PCP during May. A PCP assignment becomes effective on the first day of the following month if the request for a change is on or after the 15th of the month. For example, if the member calls to select a PCP on May 20, the assignment to that PCP becomes effective on June 1. Exceptions may be made on a case-by-case basis.
- A member identification card is sent to the member when the PCP assignment is effective and any time thereafter when a PCP change is made. The identification card lists the PCP, the PCP's telephone number, the plan medical group, and the Plan Network.
- Sharp Health Plan encourages members to find a PCP they are comfortable with and stay with that PCP. This way the member and doctor can establish a relationship and the doctor will be familiar with the member's medical history. However, members can change PCPs at any time.
- PCP changes will be made based on the request from the member or the member's parent or guardian. PCP changes cannot be made by a provider or the provider's office staff without authorization from the member, but they can be made from the provider's office if the member confirms the change by telephone.

Member Grievances and Appeals

An important part of Sharp Health Plan's Quality Improvement Program is the mechanism through which members can ask questions and solve problems. Often, members will address their questions directly to their PCP, who can answer many questions without the Plan's intervention. When the PCP cannot resolve a question or problem, the member should be advised of his/her right to file a grievance and instructed to contact Sharp Health Plan Customer Care at 1-858-499-8300 or toll-free 1-800-359-2002, or by email at customer.service@sharp.com.

Providers may occasionally receive grievances directly from Sharp Health Plan members. A grievance is an indication that a member is dissatisfied with an aspect of his/her health care and/or the delivery of care. Grievances received by Sharp Health Plan may include complaints about the quality of health care services rendered or appeals of service denials. Members (or their designees) may call Customer Care or submit their grievance in writing, via email or fax:

Sharp Health Plan
Attn: Grievance Department
8520 Tech Way
Suite 200 San Diego, CA 92123

Toll-free: 1-800-359-2002
Fax: 1-619-740-8572

If the member prefers, he/she can complete the Grievance and Appeal Form available on Sharp Health Plan's website: sharphealthplan.com/Members/file-a-grievance-or-appeal. Plan providers are required to make Grievance and Appeal Forms available to members upon request. Providers may also download a copy of the current form by going to sharphealthplan.com/for-providers/forms-and-materials. The forms are also available by contacting Sharp Health Plan at 1-858-499-8300 or by email at provider.relations@sharp.com.

(Sample copy of the member Grievance & Appeal Form on the next page)



Member Grievance & Appeal Form

Purpose

The purpose of this form is to ask Sharp Health Plan to initiate the Grievance or Appeals process.

Instructions

1. You may file a Grievance or Appeal with Sharp Health Plan up to 180 calendar days following any incident that is subject to your dissatisfaction. Your request will be acknowledged within 5 calendar days of receipt, and resolved within 30 calendar days.

2. If you feel this request is urgent in nature, please contact customer care at 1-800-359-2002.

Examples of urgent requests may include:

- An imminent and serious threat to your health, including but not limited to, severe pain and /or potential loss of life, limb, or major bodily function.
- A concern related to cancellation, rescission or nonrenewal of coverage.

3. Briefly outline the specific details of the problem and identify when the event(s) occurred.

4. Be sure to sign, date and include a Sharp Health Plan member ID number as well as date of birth.

5. Send this completed form and all relevant documents to Sharp Health Plan. Please keep copies of all items sent to Sharp Health Plan for your records.

Examples of relevant documents may include:

- Statements: Premium billing statement or Provider bills
- Proof of payment: Receipts, a copy of the front and back of a canceled check, or credit card statement
- Correspondence: plan notices or enrollee correspondence

Submit

Please submit the finished form by mail, in person, or fax:



By Mail or In Person:

Attention: Appeals & Grievances
Sharp Health Plan
8520 Tech Way, Suite 200
San Diego, CA 92123



By Fax:

Attention: Appeals & Grievances
619-740-8572

If you believe this case is urgent, call Sharp Health Plan immediately toll-free at 1-800-359-2002.

Patient Information

First name:		Last name:		Middle initial:
Member ID#:		Plan medical group:	Birth date: MM/DD/YY / /	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Email address:		Daytime phone number: ()	Evening phone number: ()	
Home address:				
City:		State:	ZIP code:	

Mailing address:		
City:	State:	ZIP code:
Subscriber Information (If subscriber is different than patient)		
First name:	Last name:	Middle initial:
Employer:	Plan medical group:	Birth date: MM/DD/YY / /
ID#:	Daytime phone number: ()	Evening phone number: ()
Home address:		
City:	State:	ZIP code:
Mailing address:		
City:	State:	ZIP code:
Provider Information		
Doctor or provider:		Phone number: ()
Address:		
City:	State:	ZIP code:
Description of Concern		
<p>Briefly outline the specific details of the problem and identify when the event(s) occurred. PLEASE BE SPECIFIC. Please include a statement regarding the outcome desired and what you believe the Plan can do to resolve your concern. If you have copies of documents, bills, checks, or other correspondence related to this problem that may help in the investigation and resolution, please include them with this form. If you need more pages to describe the issue, please attach them to this form.</p>		

Date enrollee received notice that coverage was or will end: (if applicable) / /		Are copies of enrollee correspondence with plan attached? (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are copies of proof of payment for the last paid coverage period attached? (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No		Are copies of plan notices and correspondence received attached? (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Subscriber name: _____		Subscriber signature: _____	
		x	
Date: ____ / ____ / ____			
Parent / guardian name: _____		Parent / guardian signature: _____	
		x	
Date: ____ / ____ / ____			
<p>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 1-800-359-2002 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 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 (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.dmhc.ca.gov has complaint forms, IMR application forms, and instructions online.</p>			
<p>I authorize the below named person to act as my representative in the disposition of this grievance. I understand this authorization will automatically expire upon completion of the appeal or grievance filed on my behalf.</p>			
Patient signature: _____		Date: ____ / ____ / ____	
x			
Authorized representative: _____		Relationship to patient: _____	
Home address: _____			
City: _____		State: _____	
		ZIP code: _____	
 <p>If you need assistance, we're here to help. You can call Customer Care at 1-858-499-8300 or toll-free at 1-800-359-2002. We are available to assist you Monday through Friday, 8 a.m. to 6 p.m.</p>			

Sharp Health Plan's Customer Care Representatives try to answer any questions and/or resolve complaints during the member's telephone call. Sharp Health Plan encourages all members to first discuss questions and concerns with their PCP or other plan providers involved in their care. If Customer Care and the provider cannot resolve the concern, the matter is forwarded to the Plan's Appeal/Grievance Department.

Sharp Health Plan will acknowledge receipt of the grievance within five days and will send the member a decision letter within 30 days. If the grievance involves an imminent and serious threat to the member's health, including but not limited to, severe pain, potential loss of life, limb, or major bodily function, the Plan will provide a response within 72 hours. In most cases, plan providers involved in the member's care will be contacted by the Plan to request medical records or other information needed to research the member's grievance. It is important to respond promptly to such requests, in order to ensure that grievances are resolved within the timelines established by state regulations. Copies of medical records sent to Sharp Health Plan for an Appeal will be provided to the member upon request.

Sharp Health Plan understands that there are two sides to every issue, so it is very important for plan providers to respond to inquiries about member grievances. Sharp Health Plan uses responses from providers to identify opportunities to educate members regarding realistic expectations of access, office wait times, appropriate patient-provider and patient-office staff interaction, etc. The responses also highlight opportunities for Sharp Health Plan to work more closely with providers on interactions that are perceived to be problematic by Sharp Health Plan member(s) and to work together to improve processes.

All clinical grievances (those that require a clinical body of knowledge to render a decision) are reviewed by a physician or other appropriately licensed professional. After a decision is rendered, clinical grievances and the responses to those grievances are blinded and forwarded to the Plan's Peer Review Committee. The Peer Review Committee reviews grievances for appropriateness of the resolution and to identify any trends. If the Peer Review Committee determines that additional follow-up is needed, the plan provider is notified. If the Committee determines member care was impacted, the case is also reviewed during the recredentialing process.

Sharp Health Plan views every grievance as a chance to improve the experience members have with plan providers and vice versa. Sharp Health Plan asks that each plan provider who receives a request from the Plan to respond to a member grievance takes the time to document a full response. Each member grievance is an opportunity to educate, dispel myths, or raise awareness.

Independent Medical Review (IMR)

If care that is requested for a member is denied, delayed, or modified by the Plan or a Plan Medical Group, the member may be eligible for an Independent Medical Review (IMR). If the case is eligible for IMR, information about the case will be submitted to an independent “like” medical specialist not affiliated with the Plan who will review the information provided and make an independent determination. If the IMR specialist determines the service should be approved, the Plan will provide coverage for the health care service.

The IMR process is in addition to any other procedures or remedies that may be available to the member. A decision not to participate in the IMR process may cause the member to forfeit any statutory right to pursue legal action against the Plan regarding the care that was requested. Members pay no application or processing fees of any kind for IMR. Members have the right to provide information in support of the request for IMR. For cases that are not urgent, the IMR organization designated by the Department of Managed Health Care (DMHC) will provide its determination within 30 days of receipt of the application and supporting documents. For urgent cases involving an imminent and serious threat to health, including but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of health, the IMR organization will provide its determination within seven days.

At the request of the IMR expert, the deadline can be extended by up to three days if there is a delay in obtaining all necessary documentation.

Independent Medical Review is available in the following situations:

Denial of Experimental or Investigational Treatment for Life-Threatening or Seriously Debilitating Conditions

If a service is denied because it is deemed to be an investigational or experimental therapy, the member may be entitled to request an IMR of this decision. All of the following conditions must be true:

1. The member must have a life-threatening or seriously debilitating condition. “Seriously debilitating” means diseases or conditions that cause major irreversible morbidity. “Life-threatening” means either or both of the following:
 - a. disease or conditions where the likelihood of death is high unless the course of the disease is interrupted
 - b. disease or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival
2. The provider must certify that the member has a condition, as described in paragraph 1 above, for which standard therapies have not been effective, or for which standard therapies would not be medically appropriate, or for which there is no more beneficial standard therapy covered by the Plan than the proposed therapy.

3. Either (a) the plan provider has recommended a drug, device, procedure, or other therapy that he/she certifies in writing is likely to be more beneficial to the member than any available standard therapies, or (b) the member or a specialist provider (board eligible or certified) has requested a therapy that, based on documentation from the medical and scientific evidence, is likely to be more beneficial than any available standard therapy.
4. The member has been denied coverage by the Plan for a drug, device, procedure, or other therapy recommended or requested as described in paragraph 3 above.
5. The specific drug, device, procedure, or other therapy recommended would be a covered service, except for the Plan's determination that the therapy is experimental or investigational.

If there is potential that a member would qualify for IMR under this section, the Plan will send the member an application within five days of the date services were denied. To request IMR, the member should return the application to the DMHC. The treating provider will be asked to submit the documentation described in paragraph 3 above. An expedited review will occur if the provider determines that the proposed therapy would be significantly less effective if not promptly initiated. In such cases, the analyses, and recommendations of the experts on the panel will be rendered within seven days of the request for IMR.

Denial of a Health Care Service as Not Medically Necessary

Members may request an Independent Medical Review if the member believes that health care services have been improperly denied, modified, or delayed by the Plan or one of its contracting providers. A "disputed health care service" is any health care service eligible for coverage that has been denied, modified, or delayed by the Plan or one of its plan providers, in whole or in part, because the service is not medically necessary.

The Plan will provide the member with an IMR application form with any Appeal findings letter that denies, modifies, or delays health care services because the service is not Medically Necessary. To request an IMR, the member should return the application to the DMHC. The application for IMR will be reviewed by the DMHC to determine whether the case meets all the following conditions:

1. The plan provider has recommended a health care service as medically necessary.
2. The member received an Urgent Care or Emergency Service that a provider determined was Medically Necessary, or the member was seen by a plan provider for the diagnosis or treatment of the medical condition for which the IMR is requested.
3. The disputed health care service has been denied, modified, or delayed by the Plan or a plan provider, based in whole or in part on a decision that the health care service is not Medically Necessary.
4. The member filed an Appeal with the Plan and the Plan's decision was upheld or the Appeal remains unresolved after 30 days. If the Appeal requires expedited review, it may be brought immediately to the DMHC's attention. The DMHC may waive the

requirement that the member follow the Plan's grievance process in extraordinary and compelling cases.

Additional Resources for Members

HMO Help Center

The California Department of Managed Health Care ("Department") is responsible for regulating health care service plans. If a member has a grievance against the Health Plan, the member should first telephone the Plan toll-free at **1-800-359-2002** and use the Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not negate any potential legal rights or remedies that may be available to the member. If the member needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by the Plan, or a grievance that has remained unresolved for more than 30 days, the member may call the department for assistance. members may also be eligible for an Independent Medical Review (IMR). If eligible for an 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 (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department's website www.dmhc.ca.gov has complaint forms, IMR application forms, and instructions.

SECTION V

Provision of Professional Services



Plan Provider Responsibilities

Sharp Health Plan relies on plan providers to provide high-quality health care service and care in the following manner:

- Provide services only as medically necessary in accordance with generally accepted medical, surgical, and scientific practices and community standards.
- Provide and coordinate continuity of care in the member's best health interest.
- Maintain quality standards for all health care services.
- Provide all services in a culturally competent manner.
- Ensure that office sites where care is provided is physically accessible to patients with disabilities, has adequate parking, restroom facilities, seating, and a well-lit waiting area.
- Ensure office areas where care is provided is maintained, clean, and orderly at all times.
- Maintain open provider-patient communication regarding appropriate treatment alternatives or when recommending any procedure which plan provider deems medically appropriate. The provider communication does not guarantee coverage, as an authorization of said treatment may be required.
- Effectively communicate with members regarding their health care needs.
- Encourage members to be active in decisions about their own treatment.
- Be accessible to Sharp Health Plan members, including emergency access via telephone per section, Timely Access to Care standards, below.
- The PMG or provider's office, as appropriate, is responsible for notifying members when telehealth services are available and responsible for explaining the process to be used to schedule a telehealth visit.
- Ensure that the member provides either verbal or written consent prior to receiving care via telehealth and that the consent is documented in the chart note.
- Members should be notified at the time of scheduling an appointment about any cost-sharing associated with a telehealth visit.
- Assist members who may be dissatisfied with his/her health care and/or the delivery of care to report their grievance to the Plan and to make Grievance Forms available to members upon request. (Refer to Section IV: Member Services – Member Grievance and appeals).
- Maintain licensures and other applicable credentials as required by law and Plan's policy.
- Verify each member's eligibility prior to rendering services unless it is an emergency. Refer to Section III: Member Enrollment and Eligibility.

- Cooperate with Sharp Health Plan's Medical Directors or designee in the review and supervision of the quality of care administered to plan members.
- Respond within the designated amount of time to all requests for information related to potential quality of care issues and/or peer reviews.
- Maintain and preserve all records, including but not limited to medical and billing records, as required by law and medical standards.
- Provide medical histories, financial, administrative, and other records of Sharp Health Plan members as requested by Sharp Health Plan or Sharp Health Plan's designee.
- Actively participate in the Plan's quality and utilization management initiatives.
- Treat all members with respect and provide health care services without discriminating based on health status, race, religion, color, national origin, gender, age, disability, marital status, sexual orientation, and source of payment or any other unlawful category.
- Notify Sharp Health Plan within five (5) business days of any change in practice, including but not limited to a change of group affiliation, name, address, telephone number, type of practice, willingness to accept new members, and/or languages spoken.
- Respond within 30 business days to Sharp Health Plan's annual or bi-annual request for affirmative updates, or risk deletion from the provider directory.
- Comply with this provider manual and the terms of your agreement.

Conflicts of Interest

Plan providers are expected to conduct their affairs to avoid Conflicts of Interest by maintaining appropriate and ethical relationships with third parties, including patients and their families, other health care providers, as well as suppliers, pharmaceutical companies, device manufacturers, and subcontractors ("vendors") so that no third-party has, or appears to have, an opportunity to inappropriately influence plan providers' decisions and activities.

A plan provider must not currently have and will not have throughout the term of any agreement with Sharp Health Plan, any direct interest that may present a conflict in any manner with the performance of services required under the agreement. Plan providers should carefully consider all financial and personal interests that are or may potentially lead to a Conflict of Interest and should be disclosed. Plan providers must conduct their affairs to avoid Conflicts of Interest and must respond appropriately when Conflicts of Interest actually or potentially arise.

A plan provider has a continuing obligation to disclose the existence and nature of any actual or potential Conflict of Interest he or she may have. Each plan provider has an individual responsibility to disclose any potential Conflict of Interest and it is the expectation that each plan provider be in

compliance with all federal and California regulations related to referrals required for the provision of certain covered services, including Federal and California anti-kickback and anti-self-referral laws, and other rules and regulations related to conflicts of interest. Please contact us at provider.relations@sharp.com or 1-858-400-8330.

Role of the Primary Care Provider (PCP)

Primary care providers (PCP) are responsible for providing certain basic health care services to Sharp Health Plan members. The PCP has primary responsibility for coordinating the member's overall health care, which may include care planning during the member's transition of care from one care setting to the next, as well as ensuring the appropriate use of pharmaceutical medications. All Sharp Health Plan members must choose a PCP or clinic at the time of enrollment, or one will be chosen for them.

The PCP provides primary care, including preventive health care, treatment for acute illnesses, minor accidents, and follow-up care for ongoing medical problems. In addition, the PCP manages all the health care provided to the member, such as initiating referrals for specialty care and coordinating follow up after inpatient discharge to assure continuity of care. The PCP's responsibilities include the following services:

- Provide member's primary health care services.
- Provide coverage 24 hours a day, seven days a week (members are instructed to contact the PCP prior to seeking care in all cases except emergencies. members should be referred to the nearest emergency department for Emergency Services and to the nearest contracted Urgent Care facility for Urgent Care Services that cannot be addressed in the PCP's office. PCPs are not responsible for identifying a contracted Urgent Care facility when a member is outside the Plan's Service Area).
- Refer members to a participating specialist when specialized care is indicated. Women enrolled in Sharp Health Plan may self-refer directly to an OB/GYN affiliated with the member's Plan Medical Group for obstetric and gynecologic services.
- Manage behavioral health issues within scope of a PCP.
- For those members, whose requirements are out of scope of a PCP, assist members with obtaining Behavioral Health care services. Behavioral Health is a self-referral to our network providers, including Psychiatric Care at San Diego (PCSD), LifeStance Health, and Independent Behavioral Health providers. If further assistance is needed, refer member to Sharp Health Plan Customer Care at 1-858-499-8300 or toll-free 1-800-359-2002 and/or the SHP member portal (sharphealthplan.com).
- Request Authorization for referrals, services, procedures, and medications when required by the Plan.

- Review and incorporate the specialist's documentation into the member's primary medical record.
- Use contracted network laboratories and radiology services.
- Notify members of test results and document the notification in the medical record within 72 hours of receipt and acknowledgement of the results.

On-Call Providers Coverage

The PCP shall provide coverage for Sharp Health Plan members 24 hours a day, seven days a week and shall make coverage arrangements with another provider (preferably one who is also contracted with Sharp Health Plan and in the member's Plan Medical Group) in the event of the provider's absence. A PCP contracted directly with Sharp Health Plan shall notify the Plan in advance, or as soon as is reasonably possible, of the use of a non-participating provider in a coverage arrangement.

It is the responsibility of the PCP to ensure that the covering provider will comply with the Plan's peer review procedures and accept the fee from Sharp Health Plan as payment in full for services delivered to the member (except applicable Copayments). Capitated providers must make arrangements directly with the covering provider for payment of all Covered Benefits provided to Sharp Health Plan members. Covering providers must not bill Sharp Health Plan members for Covered Benefits.

Role of the Specialty and Ancillary Provider

Collaboration between the PCP and specialty or ancillary providers is crucial to achieve continuity of care. When a member requires or requests specific services, treatment, or referral for specialty or ancillary services, the PCP is responsible for reviewing the request for medical necessity and referring the member to the appropriate contracted provider defined by the member's affiliated PMG or Sharp Health Plan.

The specialty provider may provide treatment authorized by the referral, which may include ordering appropriate lab tests, imaging services, or therapies. Services must be performed at a contracted facility with appropriate authorization, if required. The specialist is responsible for contacting the PMG or Sharp Health Plan for necessary authorizations. The specialist is responsible for documentation of the services provided, including results of any diagnostic studies or procedures and recommendations for treatment or follow-up. The specialist is responsible for discussing any results of ordered labs or tests with the member. The specialist is also responsible for sharing records with the member's PCP.

Contract Terminations

Terminations may be initiated by either the provider, plan medical group, or the Plan. All parties are required to continue to provide services as outlined within the contract until the effective termination date. A minimum of 120 days prior written notice is required for contracted primary care providers, specialty and ancillary providers, and medical groups, unless otherwise noted in the contract. It is not necessary for termination dates of hospitals to be strictly at the end of the month; they are pursuant to the termination provision in the agreement. Please refer to your contract for details on terminations.

Provider Terminations

Contracted providers must provide Sharp Health Plan with 45-day advance notification of any provider terminations within their practice. A minimum of 45 days is required to allow for 30-day advance notification to Sharp Health Plan members. The Plan sends its members letters notifying them of changes to primary care providers only. Specialists are reviewed internally to ensure continuity of care for impacted members. Terminations will be processed for the last day of the month.

Providers affiliated with a delegated plan medical group (PMG) should send term notifications to the PMG. Providers contracted directly with Sharp Health Plan should send written notifications to Provider Account Management via email at provider.relations@sharp.com or fax at 1-858-408-9444.

Contract Suspensions

In lieu of termination, the Plan may suspend a contract. Suspensions can occur until conditions of reinstatement, as determined by the Plan, have been satisfied.

Disabled Member Services

The Americans with Disabilities Act (ADA) requires public accommodations, including the professional office of a health care provider, to provide goods and services to people with disabilities on an equal basis as people without disabilities. For inquiries or assistance, please contact Sharp Health Plan Customer Care Department at 1-800-359- 2002.

Emergency Services

An Emergency Medical Condition is 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:

- Placing the patient's health in serious jeopardy; or

- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services are those covered benefits, including emergency services and care provided inside or outside the service area that are medically required on an immediate basis for treatment of an Emergency Medical Condition.

The PMG shall take into consideration the presenting and discharge diagnosis when reviewing emergency service claims for a potential retrospective denial. The determination is based on a reasonable layperson's determination of an emergency not on the treating provider's assessment. Retrospective denial of services for what appears to the reasonable layperson to be an emergency is prohibited.

Telehealth Services

California state [law](#) defines telehealth as a method of delivering health care services and public health through communication technologies that allow for the ability to diagnose, consult, treat, educate, facilitate care management, and self-management as it relates to a patient's health care.

It is required that providers obtain either verbal or written consent from the member for the use of telehealth services prior to providing care via telehealth. Consent for telehealth services must be documented in the chart note. In addition, members should be notified at the time of scheduling an appointment about any cost-sharing associated with a telehealth visit.

Additional information regarding telehealth can be obtained from the [Department of Managed Health Care Services](#).

Confidentiality and Disclosure of Medical Information

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires all providers and health care professionals to make reasonable efforts to limit the disclosure of Protected Health Information (PHI), or individually identifiable health information that is transmitted or maintained, in any form or medium. The HIPAA Privacy Rule has established that written member authorization is required for any use or disclosure of PHI that is not related to treatment, payment, or health care operations. The person or entity that is seeking to obtain medical information must obtain authorization from the member and is to use that information only for the purpose it was requested and retain it only for the duration needed.

Plan providers shall ensure that their policies and procedures related to HIPAA compliance are up to date. Detailed information can be obtained from the Department of Health and Human Services as well as other resources including the American Medical Association.

Medical Record Standards

Sharp Health Plan medical records standards are measurable and are based on relevant regulatory requirements and evidence-based best practices. These medical record documentation standards promote consistency in practice and support the communication of clinical information among practitioners for continuity and coordination of care. The standards are:

1. All medical record entities must be legible and should establish the stated diagnosis from the included history and physical findings.
2. The therapies noted should be current therapies.
3. Drug allergies and idiosyncratic medial problems are conspicuously noted.
4. Pathology, laboratory, and other diagnostic and screening reports are available and noted in the assessment if abnormal or significant.
5. The health professional responsible for each entry is identifiable and each entry is dated.
6. Consultation and progress notes are available and noted as reviewed.
7. Health care treatment recommendations are noted as having been provided to the patient.
8. Appropriate preventative care is documented.
9. Discussion about advance directives or a copy of the advance directives is in the chart.
10. Two patient identifiers are on each page of the medical record.
11. Consent, either verbal or written, for telehealth visits.

Medical records shall reflect the following:

1. All services provided directly by a provider who provides health care services.
2. All ancillary services and diagnostic tests ordered by a provider.
3. All diagnostic and therapeutic services for which a member was referred by a provider, such as but not limited to:
 - a. Home health nursing reports
 - b. Specialty provider reports
 - c. Hospital discharge reports
 - d. Physical therapy reports

4. Each provider visit shall include the documentation of:
 - a. Medical history and physical
 - b. Vital signs
 - c. Height and weight measurements
 - d. Allergies and adverse reactions
 - e. Problem list
 - f. Current Medications
 - g. Clinical finding, evaluation, and plan for each visit
 - h. Preventive services/high-risk screening

Amendment to Member Medical Record

According to Health and Safety Code section 123111, an adult patient can write an "Addendum" to their medical file and request the file placed in his or her medical record. Patient shall have the right to provide to the health care provider a written addendum with respect to any item or statement in his or her record that the patient believes to be incomplete or incorrect. The addendum shall be limited to 250 words per alleged incomplete or incorrect item in the patient's record and shall clearly indicate in writing that the patient wishes the addendum would be a part of his or her medical record.

The health care provider shall attach the addendum to the patient's record and shall include the addendum whenever the health care provider makes a disclosure of the allegedly incomplete or incorrect portion of the patient's record to any third party. The new information, signed and dated by the patient, shall be placed in the file and the original information should not be removed.

Confidentiality and Availability of Medical Records

All medical records are required to be organized and stored in a manner that allows easy retrieval. Medical records should be kept in a secure location that allows access to authorized personnel only. Plan providers and their employees are required to receive periodic training in member information confidentiality and must sign confidentiality statements. Plan providers must also have policies and procedures in place to protect and ensure the confidentiality of member information at all times. In addition, plan providers must have a written policy regarding the release of medical records.

Sensitive Services Information

Providers must adhere to the Confidentiality of Medical Information Act and have policies and procedures in place to protect the confidentiality of a protected individual's information related to sensitive services.

Providers must:

- Not require a protected individual to obtain the primary subscriber or other enrollee's authorization to receive sensitive services or to submit a claim for sensitive services if the protected individual has the right to consent to care.
- Direct communications regarding a protected individual's receipt of sensitive services as follows:
 - Directly to the protected individual's designated alternative mailing address, email address, or telephone number; OR,
 - In the absence of a designated alternative mailing address, email address, or telephone number: to the address or telephone number on file in the name of the protected individual.
 - Communications (written, verbal or electronic communications) regarding a protected individual's receipt of sensitive services shall include:
 - Bills and attempts to collect payment.
 - A notice of adverse benefits determinations.
 - An explanation of benefits notice.
 - A plan's request for additional information regarding a claim.
 - A notice of a contested claim.
 - The name and address of a provider, description of services provided, and other information related to a visit.
 - Any written, oral, or electronic communication from a plan that contains protected health information.
- Inform protected individuals who request that communications regarding sensitive services be sent to an alternative mailing address that they must contact Sharp Health Plan and their plan sponsor in order to request such a change.
- Not disclose medical information related to sensitive health care services provided to a protected individual to the primary subscriber or any plan enrollees other than the protected individual receiving care, absent an express authorization of the protected individual.
- Permit and accommodate requests from protected individuals for confidential communication in the form and format requested, if readily producible in the requested form and format, or at alternative locations.

Retention of Medical Records

Medical records and patient related data shall be retained in a locked storage area according to the following time periods:

Chart Type	Retention Requirement
Adult Patient	10 years
Minor Patient (< 18 years of age)	Until 1 year after the 18 th birthday, but not less than 10 years
X-rays	10 years

Plan Provider Updates

To keep provider directories and member records current, Sharp Health Plan or the provider's affiliated PMG must be notified in writing within five business days of any of the following changes:

- There is a new or additional office location
- There is a new, modified billing or mailing address
- There are new or modified office email addresses
- Provider leaves (terminates), joins another clinic, medical group, including employment by a federally qualified health (FQHC) center or primary care clinic
- Plan provider specialty or board certification status changes
- Changes in languages spoken, non-English, by provider or in-office staff
- Change in plan provider's panel status
- Change in practice name or ownership
- Changes in practice Federal Tax Identification Number (TIN)
- Adding/updating age restrictions
- Updating Office hours
- Updating Phone Number(s) and/or Fax Number
- Updating Telehealth Modalities/Status

- Updating Directory Suppress Status
- Updating AHP Supervising Physician

Notice of any of the above-mentioned changes and the applicable effective date shall be submitted to the affiliated PMG or if contracted directly to Plan's Provider Account Management to provider.relations@sharp.com. Updates may also be conducted via the Sharp Connect provider portal at sharphealthplan.com/SharpConnect or by mailed to:

Sharp Health Plan
Attn: Provider Account Management Department
8520 Tech Way, Suite 200
San Diego, CA 92123

Tax Identification Number (TIN) Changes

TIN changes shall be submitted in writing in a federal W-9 form (available at the IRS website, IRS.gov). Federal guidelines require Sharp Health Plan to have this form before any payments can be made using the new TIN. In some instances, a new agreement between Sharp Health Plan and the plan provider may be necessary.

Provider's Panel Status

Primary care provider's (PCP) may close their panels to new members with notice provided within five business days. Notice should be sent to the provider's affiliated PMG or Sharp Health Plan's Provider Account Management Department if the provider is part of the Independent Network. The closed panel will be noted in the next printing of the Provider Directory and the next scheduled update of the online directory. The PCP shall notify Sharp Health Plan or the PMG in writing within five business days when he/she elects to reopen the panel to new members. If a plan provider is contacted by an enrollee or potential enrollee seeking to become a new patient and the plan provider is not accepting new patients, the plan provider or his/her staff member shall direct the enrollee or potential enrollee, to both the Plan for additional assistance in finding a provider with an open panel or to the Department of Managed Health Care (DMHC) to report any inaccuracy with the Plan's directories.

Provider's Response to Directory Verification Inquiries

Sharp Health Plan will contact provider groups and independent providers quarterly to validate provider information listed in the Plan's directories. Providers must attest within 30 business days of the original request, even if there are no changes or risk removal from the next publication of the provider directories. Failure to respond to the request may result in delay of payment or reimbursement of a claim. The Plan will notify providers ten days in advance prior to removal from the directory but will revoke the action if the plan providers respond within the ten-day notification period.

Credentialing Program

Credentialing and recredentialing files are processed by Sharp Health Plan's NCQA-certified Credentialing Verification Organization (CVO). Final credentialing approval is coordinated through Sharp Health Plan's Peer Review Committee, under the guidance of the Chief Medical Officer. Sharp Health Plan retains the right to approve, suspend, and terminate individual plan providers and sites. The Sharp Health Plan process meets the California State and NCQA credentialing requirements.

Credentialing

Sharp Health Plan or a delegated entity credentials all Sharp Health Plan affiliated providers. Providers must meet the Plan criteria for acceptance and are required to maintain compliance with all standards as a condition for continued participation.

To begin the credentialing process, providers are required to submit a completed signed California Participating Provider Application with the following attachments:

- Licensure to practice in California
- Addendums A, B, and F
- Current DEA certificate
- Proof of professional liability insurance (with a minimum of \$1M occurrence and \$3M aggregate)
- A provider-written explanation of malpractice suits filed against the provider to include case number; court number; a brief narrative case summary of the charge, facts, status, and outcome Revised Jun. 2022 for Aug. 31, 2022, Commercial Plans 65
- A signed release granting the Plan access to records of any medical society, medical board, college of medicine, hospital, or other institution, organization, or entity that does or may maintain records concerning the applicant
- A signed statement by the provider at the time of application regarding any physical or mental health problems, any history of chemical dependency/substance abuse, history of loss of license and/or felony convictions, and/or history of loss or limitation of privileges or disciplinary actions
- Work history over the last 5 years with explanation of any gaps in employment that exceed 6 months
- Sharp Health Plan Admitting Arrangements Form indicating hospital privileges are valid, current, unrestricted, and in good standing at a Plan contracted hospital, or have a Plan-approved admitting arrangement

- Current Board status with documentation
- Medical staff membership or affiliations

The Plan-contracted NCQA-certified Credentialing Verification Organization (CVO) initiates the credentialing process and completes the primary source verifications in accordance with NCQA standards and other pertinent information supplied or collected during the application process.

Per NCQA, providers must provide requested information in a timely manner to process their applications. The CVO/Plan will initiate four attempts to contact providers to obtain required information within 60 days. If providers are non-responsive and do not provide all required information after four attempts, the CVO/Plan will consider the providers as non-responsive, and their application will be closed. Providers in the initial credentialing cycle may re-apply. Existing providers in the recredentialing cycle will be terminated, per NCQA guidelines, and may reapply as a new applicant.

Provider Rights during Credentialing

The following rights apply to providers during the credentialing process.

1. The right to review information submitted to support an application.

Providers and applicants have the right to review information obtained from outside sources, such as malpractice insurance carriers or state licensing boards, to support their credentialing application. Sharp Health Plan's delegated Credentialing Verification Organization (CVO) is not required to make available information obtained from references, recommendations, or peer-review protected information.

2. The right to correct erroneous information.

If information is obtained during the credentialing process that varies substantially from the information submitted by the provider, Sharp Health Plan or CVO notifies the provider of the discrepancy via certified letter. The applicant is notified by the credentialing department in writing within 30 calendar days of receipt of the discrepant information. The notification includes a description of the discrepancy, the source of the information as appropriate and the provider's right to correct erroneous information submitted by another party. Sharp Health Plan and/or CVO is not required to reveal the source of information that was not obtained to meet verification requirements or if federal or state law prohibits disclosure.

3. The right to receive status of a credentialing or recredentialing application, upon

request.

Providers and applicants are notified of the right to receive status information from a statement on the provider application stating requests may be made in writing or by telephone. The CVO staff responds to requests in writing within ten business days after the receipt of the request. The response to providers does not include disclosure of information prohibited by law, references, recommendations, or other information that is peer-review protected.

The credentialing information is presented to the Peer Review Committee for review and approval. The Peer Review Committee meets quarterly. Providers are notified in writing of the Peer Review Committee's decision. Final credentialing approval is granted by the Sharp Health Plan Board of Directors, which also meet on a quarterly basis.

No applicant is automatically entitled to participate with the Plan via participation with a Medical Group or professional organization, via board certification or via staff membership or privileges for a particular health facility or practice setting.

Standards and Guidelines

At a minimum, the following requirements must be met for the Plan to consider acceptance of the applicant for participation in the Plan's network:

- Acceptable compliance with general guidelines
- A participation agreement in the form prescribed by the Plan and signed by the provider
- The provider applicant has not been rejected or terminated by the Plan within the previous twelve months
- No felony, misdemeanor convictions nor evidence of committing other act involving moral turpitude, dishonesty, fraud, deceit, or misrepresentation
- Unrestricted license to practice in California
- Use of Plan facilities for his/her regular practice and routinely makes rounds at participating facilities. If the provider does not have privileges at a Plan hospital, he/she must have formal admitting arrangements with a plan provider who does.
- Listing of office locations, names, and addresses of associates in the practice of medicine or osteopathy, and any provider or other plan provider who provides on-call services.

Additionally, primary care providers (PCPs) and specialty providers are required to meet the following standards to be considered for participation in the Plan's network:

- Current unrestricted license to practice medicine or osteopathy in California
- Current, valid federal Drug Enforcement Agency (DEA) certificate

- Current staff membership, clinical privileges, and admitting privileges granted by a Plan hospital within the service area or arrangements with a plan provider who has such privileges
- Graduation from medical school and completion of a residency for MDs and DOs. (An exception may be made for a provider who has only completed a rotating internship, if the provider agrees to be classified as a general provider and practices in an underserved area of the county.)
- Documentation of board certification (if applicable). Providers will provide ongoing documentation of certification, at the time of application and at a minimum of every three years thereafter, by the appropriate Board for provider specialty or of active and current involvement in the Board certification and examination process.
- Professional liability insurance policy of not less than \$1,000,000 per incident and \$3,000,000 per year
- 24 hour-a-day coverage for all plan members with another participating primary care provider or with another plan provider who agrees to abide by the guidelines of the Plan
- PCPs must be able to perform the following in the office setting:
 - EKG (pediatric offices as appropriate)
 - Office gynecology including routine pelvic and pap smears (pediatric office excepted)
 - Blood draws (not applicable if using national lab contract)
 - Minor surgery to include incision and drainage of abscess and suture of superficial lacerations
- Availability and accessibility to include:
 - Minimum of 20 hours each week of regularly scheduled office hours for treatment of members for a one-provider practice and minimum of 30 hours for a practice of two or more providers
 - Response time to calls not greater than 30 minutes after notification
 - Ability to accept a minimum of 250 new members at time of application
 - No more than an average of five patients scheduled and seen each hour for routine office visits for adult medicine and six patients per hour for pediatrics
- Compliance with state continuing education requirements
- Absence of felony convictions, sound moral character, and in good professional standing in the community
- Provision of quality, appropriate, and timely care
- Supportive of the philosophy and concept of managed care and of Sharp Health Plan

- Good standing with Centers for Medicare and Medicaid Services (CMS) in any state in where they have been licensed

Delegated Credentialing/Recredentialing

Sharp Health Plan delegates credentialing/recredentialing to the following entities: Sharp Rees-Stealy Medical Group, Greater Tri Cities IPA, Optum Care Network-North County SD, Sharp Community Medical Group, Psychiatric Centers at San Diego, LifeStance Health, Rady Children's Health Network and Family Health Center of San Diego. Delegation status is granted only to entities that perform the credentialing/recredentialing activities according to NCQA standards. Annual credentialing delegation oversight audits are conducted by Sharp Health Plan or by NCQA-accredited health plans in California via the Health Industry Collaboration Effort, Inc. (HICE) shared delegation oversight credentialing audit process.

Credentialing Appeals Process

Sharp Health Plan's appeal process allows for adverse credentialing decisions to be discussed and understood, and for any errors to be corrected. This process ensures providers will be treated fairly and uniformly.

Recredentialing

According to NCQA standards, a review of credentials for recredentialing plan providers is performed no less than every three years. Recredentialing applications are distributed approximately six months prior to the recredentialing period is to expire. The Plan or Credentialing Verification Organization (CVO) can take up to 180 days to process a recredentialing application. For a provider to keep the application on active status, the provider must supply the needed information within three months prior to their recredentialing date.

The CVO/Plan will initiate four attempts to contact providers to obtain required information within 60 days. If providers are non-responsive and do not provide all required information after four attempts, the CVO/Plan will consider the providers as non-responsive and their application will be closed. Providers in the recredentialing cycle will be terminated, per NCQA guidelines, and may reapply as a new applicant.

Plan providers are responsible for producing adequate information for a complete evaluation of experience, background, training, and ability to perform as a clinician without limitations, including physical and mental health status as allowed by law. Sharp Health Plan uses a universal reapplication and only information that may have changed since the last credentialing will be requested.

Please contact Sharp Health Plan's Provider Account Management Department at 1-858-499-8330 or provider.relations@sharp.com for a complete copy of the Plan's provider credentialing policy or for answers to questions regarding the credentialing process.

Notifications to Authorities and Plan Provider's Appeal Rights

In the event that, through a formal peer review process, an adverse action is taken against clinical privileges for contracted health care providers, Sharp Health Plan will report such adverse action to the Medical Board of California (MBC) and the National Practitioner Data Bank (NPDB) in accordance with the Plan's policies and procedures, as well as applicable state and federal law. Sharp Health Plan will also report health care related civil judgments and other adjudicated actions or decisions against network health care providers, providers, or suppliers to the NPDB, in accordance with the Plan's policies and procedures, as well as applicable state and federal law. Sharp Health Plan will promptly notify affected practitioners, providers, or suppliers in the event of such reporting, and in the case of adverse actions, will include information on appeal rights in these communications in accordance with the Plan's policies and procedures, as well as applicable state and federal law.

Accessibility and Timeliness Standards to Care

Appropriate and timely access to health care services for members is a primary concern of Sharp Health Plan. Each office is required to provide a sufficient number of available appointments and adequate telephone capabilities to serve the needs of the members assigned to that office. Provider locations must be accessible to members during posted hours of business. Plan providers shall not unlawfully discriminate against any member based on factors including, but not limited to, race, religion, color, national origin, gender, age, disability, marital status, sexual orientation, or source of payment.

Access standards have been developed to ensure that all health care services are provided in a timely manner. These standards are based on community norms and required by law under California Health and Safety Code Section 1367.03 and Title 28 of the California Code of Regulations rule 1300.67.2.2.

Number and Distribution of Primary Care, Specialist, Ancillary Providers and Hospitals

The Plan maintains a sufficient network of providers and facilities throughout its service area to meet the primary, specialty, ancillary, mental health, inpatient, and emergency service needs of plan members through contracting or referral to ensure timely and geographic accessibility in compliance with the Department of Managed Health Care (DMHC) and the following access standards:

1. Primary Care Providers (PCPs):
 - a. One PCP per 2,000 members
 - b. One PCP within 30 minutes or 15 miles of a member's residence or workplace
 - c. Access threshold is 95%

2. High-Volume and High-Impact Specialists (SCPs):
 - a. One SCP per 5,000 members
 - b. One Obstetric/Gynecologist per 2,000 members
 - c. One SCP within 30 minutes or 15 miles of a member's residence or workplace
 - d. Access threshold is 95%
3. High-Volume Behavioral Health (BH) Providers:
 - a. One Psychiatrist per 2,000 members within 30 minutes or 15 miles of a member's residence of workplace
 - b. One Psychologist per 15,000 members within 30 minutes or 15 miles of a member's residence of workplace
 - c. One Licensed Clinical Social worker (LCSW) per 10,000 members within 30 minutes or 15 miles of a member's residence of workplace
 - d. One Marriage Family Therapist (MFT) per 3,000 members within 30 minutes or 15 miles of a member's residence of workplace
 - e. One Alcohol or Other Drug Addiction (AODA) Counselor per 2,000 members within 30 minutes or 15 miles of a member's residence of workplace
 - f. Access threshold is 90%
4. Hospitals: A contracted hospital with capacity to serve the entire plan member population including emergency services shall be available within 30 minutes or 15 miles of a member's residence or workplace.
5. Ancillary providers: Ancillary services shall be available at locations within a reasonable distance from a member's PCP.

Primary Care Provider (PCP) Appointments

Members are instructed through the Member Handbook and new member orientation calls from Customer Care Department to contact their PCP and schedule an introductory appointment and health assessment. The PCP shall ensure timely access to visits for plan members. If the need for specialty care arises, the PCP is responsible for coordinating all services that fall out of the PCP's scope of practice.

Timely Access to Care

Sharp Health Plan monitors compliance to the access standards through a variety of means. Monitoring methods may include annual mystery caller audits, appeals and grievances, access surveys, and wait-time studies. Plan providers will be monitored annually for access to health care, and monitoring results will be shared with the provider. If deficiencies are identified, plan providers will be asked to respond to a Notice of Non-Compliance to ensure compliance with Plan standards.

Sharp Health Plan is obligated under California law to provide or arrange for timely access to care. Plan provider shall provide appointments and telephone screening services to Sharp Health Plan’s members according to the following guidelines:

Appointment Wait Times

Urgent Appointments	Maximum wait time after request
No prior authorization required	48 hours
Prior authorization required	96 hours
Non-Urgent Appointments	Maximum wait time after request
PCP (Excludes preventative care appointments) Mental health care provider (Psychiatrist)	10 business days
Non-physician mental health care or substance use disorder provider (e.g., psychologist or therapist)	10 business days
Specialist (Excludes routine follow-up appointments)	15 business days
Ancillary services (e.g., x-rays, lab tests, etc. for the diagnosis and treatment of injury, illness, or other health conditions)	15 business days

Rescheduling Appointments

If an appointment requires rescheduling, the appointment shall promptly be rescheduled in a manner that is appropriate for the member’s health care needs and continuity of care, consistent with good professional practice.

Extended Wait Times

Plan providers may extend the applicable wait time for an appointment if they have determined and noted in the member's record that a longer wait time will not be detrimental to the member's health.

Advance Scheduling

Plan providers may schedule appointments in advance for preventive and periodic follow-up care services (e.g., standing referrals to specialists for chronic conditions, periodic visits to monitor and treat pregnancy, cardiac, or mental health conditions, and laboratory and radiological monitoring for recurrence of disease) consistent with professionally recognized standards of practice.

Telephone Wait Times

Service	Maximum wait time
Triage or screening services (24 hours/day and 7 days/week)	30 minutes

Interpreter services at scheduled appointments

Sharp Health Plan provides free interpreter services for members at scheduled appointments whose primary language is not English. Plan providers can request interpreters by calling Customer Care at 1-800-359-2002. Plan providers must make requests for face-to-face interpreting services at least five business days prior to the appointment date. Coordination of interpreter services shall not impose delays on the scheduling of the appointment. In the event that an interpreter is unavailable for face-to-face interpreting, Customer Care can arrange for telephone interpreting services.

Concerns about timely referral to an appropriate provider

If a member is unable to obtain a timely referral to an appropriate provider, the plan provider or member may contact Customer Care at 1-800-359-2002 for assistance.

They may also contact the Department of Managed Health Care to file a complaint about a timely referral to an appropriate provider: 1-888-466-2219.

Standards for Office Wait Times

The maximum wait time for the following services should be:

Office Wait Time	Maximum wait time
PCP and Specialty	Within 30 minutes

After-Hours Telephone Access for Primary Care Providers and Behavioral Health Providers

Sharp Health Plan requires PCP and Behavioral Health (BH) providers or designees to be available so that assigned members have access to urgent and emergency care 24 hours per day, seven days per week. Plan providers must maintain 24-hour, seven days per week telephone access capability to provide immediate response to emergency inquiries by members. Plan providers must maintain a procedure for triaging or screening member telephone calls which includes 24/7 employment of a telephone answering system, answering service and/or office staff that will inform the caller of the following:

- Regarding the wait time for a return call from the provider, and
- How the caller may obtain urgent or emergency care, including how to contact another provider who has agreed to be on call to triage by phone or, if needed, deliver urgent or emergency care.

Emergency Instructions

Every member that calls a PCP's office after normal business hours shall first receive the following emergency instructions, regardless of whether a line is answered by a person or by recording:

- Hang up and dial 911, or
- Go to the nearest emergency room, or
- Hang up and dial 911 or go to the nearest emergency room.

Non-Emergency Instructions

Members who reach a recording at the PCP's office and have non-emergency situations that cannot wait until the next business day should receive the following instructions:

- Stay on the line to be connected to the doctor on call.
- Leave a name and phone number for a call back from a provider or qualified health care professional within 30 minutes.
- Call the PCP at another number.

The waiting time for a member to speak by telephone with a provider, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care, may not exceed 30 minutes.

Documenting Telephone Calls

All members telephone calls shall be documented on a phone message form or within an electronic health record, with the response given documented on the same form.

Documentation of phone calls must be affixed to the progress notes and become a permanent part of the medical record. At a minimum, the phone message record shall include:

- Member name
- Date and time of call
- Member's question/concern
- Advice/response provided
- Signature of individual who triaged the call

Behavioral Health (BH) Telephone Access

Behavioral Health providers will maintain access to BH screening and triage to ensure that members reach a non-recorded voice within 30 seconds. Telephone abandonment rates shall not exceed five percent (5%) at any time. Calls must be returned by a psychiatrist or qualified behavioral health care professional within 30 minutes.

Failed Appointments

Failed appointments are those where a member does not arrive for a scheduled medical appointment, either with or without notice from the member. Failed appointments shall be documented in the member's medical record according to the PMG's or plan provider's written policy and procedure, with provisions for a case-by-case review of members with repeated failed appointments.

Some plan providers have established a missed-appointment fee for their patients. Sharp Health Plan reserves the right to review and approve such policies. Plan providers shall demonstrate that members were notified in advance regarding missed appointment fees and shall waive such fees under extenuating circumstances. Sharp Health Plan does not reimburse plan providers for missed appointment fees.

Provider-Initiated Member Dismissal

Rarely, a plan provider cares for a member who is disruptive or excessively difficult. However, in these instances, plan providers can contact Sharp Health Plan's dedicated provider line at 1-844-483-9014 to request assistance with difficult members. Plan providers are obligated to provide medically necessary care and access to services for as long as the member requires medical care, or until the relationship is ended appropriately. A member may not be dismissed or denied care due to diagnosis, health status/needs, or language barriers. To dismiss a plan member, plan providers must follow Sharp Health Plan's policy as outlined below.

Independent Network Providers

Independent providers must submit a request to the Sharp Health Plan Provider Account Management Department before dismissal of a member. SHP will assist independent plan providers in reassigning members to a new primary care provider (PCP) in a timely manner.

Plan Medical Groups

Member Reassignment to Another PCP within Plan Medical Group

When a member-provider relationship is irreparably damaged, delegated plan medical groups (PMG) should make every attempt to reassign the member to another PMG provider within their network and notify the Plan of the change within five business days. The notification to the Plan on member reassignment within the group must include the member reassignment letter/notification that outlines how the member can change their PCP should they want a different PCP than assigned.

Member Dismissal from Plan Medical Group

If multiple attempts to reassign the member to a different PCP within the PMG network fail, the PMG must submit a **member dismissal form** to SHP in order to have the member dismissed and reassigned to another Sharp Health Plan provider.

Member dismissal will be considered under the following circumstances:

- Member is non-compliant with recommended treatment plans to the extent that member's health is endangered.
- Member demonstrates verbally abusive behavior toward the provider, ancillary or administrative office staff, or to other plan members.
- Member physically assaults a plan provider, staff member, or plan member, or the member threatens any individual with any type of weapon on Plan or provider premises or verbalizes the intent to cause bodily harm. In such cases, appropriate charges should be brought against the member, and a copy of the police report submitted along with the request.
- Member is disruptive to provider or Plan operations with potential for limitations on access to care by other members.
- Member habitually uses non-contracted providers for non-emergency services without required authorization.
- Member refuses to meet financial obligations such as copayments or coinsurance.
- Member attempts to fraudulently obtain health care services, including allowing others to use the member's Plan identification card to receive services.

The Member Dismissal Process

The member dismissal process is as follows:

- The PMG should counsel the member about the conflict or problem prior to requesting dismissal. Counseling should include written education that conveys a clear set of instructions, the compliance requirements, and the consequences, if any, for not following the instructions, placing responsibility for compliance directly on the member.

- The PMG requests authorization to dismiss the member from the panel by faxing a completed [Member Dismissal Request Form](#) to the attention of the Provider Account Management Department at 1-858-303-9049. A copy of the form can be found on subsequent pages of this document. The PCP should not initiate dismissal communication with the member prior to the determination.
- The Member Dismissal Form should be completed and submitted to Sharp Health Plan for approval by the Sharp Health Plan Chief Medical Officer. The form must be completed in full and include supportive documentation detailing the situation prior to any member termination. Supporting documentation may be in the form of copies of medical records, office notes, etc., and may include:
 - Pertinent dates
 - Documentation of conversations
 - Billing statements, including amount due, letters advising members to pay their bill.
 - Documentation of previous attempts to educate member regarding noncompliance with recommended treatment plans or office practices.

Sharp Health Plan will request additional documentation from the plan provider, if necessary. Requests must be fulfilled within five business days. If requests for additional documentation are not fulfilled within this timeframe, the dismissal request will be denied.

Approval/Denial of Dismissal Requests

The process for approvals and/or denials is as follows:

- If the dismissal request is denied, the PMG will receive written notification of the decision within 30 days of Sharp Health Plan's receipt of all supporting documentation.
- If the dismissal request is approved, the PMG will receive written authorization to dismiss the member within 30 days of Sharp Health Plan's receipt of all supporting documentation.
 - After the PMG receives authorization from Sharp Health Plan to dismiss the member, the provider has five business days to provide written notification to the member and to send a copy of such notice to Sharp Health Plan.
 - The notification must include the reason for the dismissal and must not occur before authorization is received from Sharp Health Plan. Members cannot be terminated, or service refused at any point during this process.

Sharp Health Plan will not contact the member for reassignment until Sharp Health Plan has received a copy of the dismissal letter sent to the member by the plan provider. If Sharp Health Plan does not receive a copy of the dismissal letter within ten business days following Sharp Health Plan's approval to dismiss, the dismissal becomes invalid. The PMG can initiate the process again if they wish to pursue the dismissal. The plan provider is required to provide treatment and access to services until

the member selects a new PCP or a new PCP has been assigned. When a PCP dismisses a member, all referral authorizations for that member will be invalidated. The member must contact the new PCP to obtain new referrals and authorizations.

Member Dismissal Request Form



Member dismissal request form

<p>Purpose</p> <p>This form is to be used by a Plan Provider's office to request dismissal of a current Member assigned under a Sharp Health Plan policy.</p> <p>Instructions</p> <p>Please include all supporting details and documentation for dismissal along with this request form. Please refer to the Provider Operations Manual (POM) for additional information regarding the Member Dismissal Process. For questions please contact Provider Relations at 1-858-499-8330.</p>	<p>Submit</p> <p> By Mail: Sharp Health Plan Attention: Provider Relations 8520 Tech Way, Suite 200 San Diego, CA 92123</p> <p> By Fax: Attention: Provider Relations 1-858-408-9444</p>
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Provider information		
Provider name:	Medical Group name:	
Telephone #:	Fax #:	
Provider signature:	Date (MM/DD/YYYY):	Dismissing from entire group? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of person completing form:	Role / title:	
Member information		
Name:	ID number:	Date of birth (MM/DD/YYYY):
Reason for dismissal		
<input type="checkbox"/> Irreparable damage to the physician-patient relationship <input type="checkbox"/> Financial <input type="checkbox"/> Fraud <input type="checkbox"/> Non-compliant <input type="checkbox"/> Abusive or threatening <input type="checkbox"/> Other (specify) _____		

Sharp Health Plan use only	
Date dismissal request received:	Date all supporting documentation received:
Date review completed by Sharp Health Plan CMO:	Date Sharp Health Plan decision sent back to PCP:
If Dismissal is authorized	
Member must elect new PCP by this date:	Date Sharp Health Plan decision sent back to PCP:

01-2021

Culturally and Linguistically Appropriate Services

Effective January 1, 2009, California law (Section 1367.04 of the California Knox-Keene Act and Section 1300.67.04, Title 28, California Code of Regulations) requires that health plans establish a Language Assistance Program (LAP) for members with Limited English Proficiency (LEP). Under this law, contracted providers are required to cooperate and comply with Sharp Health Plan's LAP by facilitating LEP enrollment to access LAP services. Sharp Health Plan provides the following language assistance services at no cost to the member:

1. Linguistic Matching: Members who do not select a Primary Care Provider are automatically assigned to a PCP based on identified language need and geography.
2. Access to Interpreters: Plan providers may request interpreters for members whose primary language is other than English by calling Sharp Health Plan at 1-858-499- 8300 or toll free at 1-800-359-2002. The Customer Care Representative will request the following information:
 - Member demographics, including name, member identification number, age, sex, language, and country of origin (to determine the appropriate version of the requested language)
 - Plan provider information, including appointment date and time, office location, provider's name and phone number, and type of appointment (e.g., OB/GYN, well-care, etc.)
 - Requests for face-to-face interpreting services must be made at least five (5) days prior to the appointment date. In the event that an interpreter is not available for face-to-face interpreting, Sharp Health Plan can make arrangements for telephone interpreting services.
3. Translation of Written Material: Written informational material including the Member handbook, form letters, member newsletters, and medical care reminders are translated into Spanish and other languages as requested, at no cost to the member. Please inform our member's that they may request such translated materials by calling Sharp Health Plan at 1-858-499-8300 or toll-free 1-800-359-2002.
4. Notices Available from the Department of Managed Health Care: Informational notices explaining how members may contact Sharp Health Plan, file a complaint with the Plan, obtain assistance from the Department of Managed Health Care (DMHC) and seek an Independent Medical Review are available in non-English languages through the Department's website. The notice and translations can be obtained online at dmhc.ca.gov for downloading and printing. In addition, hard copies may be requested by submitting a written request to:

Department of Managed Health Care
Attention: HMO Help Notices
980 Ninth Street, Suite 500
Sacramento, CA 95814

Provider Responsibilities for Cultural and Linguistic Services

Health care providers are responsible for ensuring that members fully understand their diagnosis and treatment guidelines regardless of their preferred language. To ensure that all LEP members receive appropriate access to Covered Benefits, plan providers are expected to comply with federal and state requirements regarding cultural and linguistic services. It is not permissible to turn a member away or limit participation because of language barriers, to subject a member to unreasonable delays due to language barriers, or to provide services to LEP members that are lower in quality than those offered in English.

Following the tips below will help providers and their staffs communicate effectively with Limited English Proficient (LEP) members and ensure compliance with federal and state regulations:

- Prior to meeting with a member, look to see if a member's language needs have been documented in the file.
- Document members' language requirements in medical charts.
- Inform member of their right to interpreter services, at no cost to the member, even when a member is accompanied by a family member or friend who can provide interpretation services. Document all requests and refusals in members' charts.
- Remember that a member should never be required to bring his or her own interpreter, and a member's family members should not be encouraged to serve as interpreters. In addition, minors should not be used as interpreters.
- To decrease the wait time and to provide timely access to care, arrange for interpreting services at the time appointments are made.
- Post signs in appropriate languages informing members of the availability of free interpreter services.
- Inform members that they may call Sharp Health Plan to request translated documents at no cost to the member and to register their preferred languages with the Plan.
- Provide periodic training to office staff on cultural competency and use of interpreters.
- Call Customer Care at 1-858-499-8300 if you need assistance providing language assistance services (interpretation, translated documents, etc.) for any of your Sharp Health Plan members.
- If the member declines an interpreter, please document the refusal in the medical record.
- If you would like more information on working with LEP members, there is a

training on the website in the provider section.

- If you're comfortable, please consider sharing your race/ethnicity to the plan. This will not be reported in the provider director but will be shared in the event is trying to find a provider they would like to see.

For additional information or resources about Sharp Health Plan's Language Assistance Program, contact Provider Account Management at 1-858-499-8330 or provider.relations@sharp.com or visit the "Language Assistance" link on the provider page at sharphealthplan.com.

SECTION VI

Utilization Management



Utilization Management Program

Sharp Health Plan’s Utilization Management (UM) Program ensures Medically Necessary services are rendered at the appropriate level of care in a timely and cost-effective manner. UM Program activities include prospective (before), concurrent (during) and retrospective (after) review of medical care and services as well as assistance for appropriate discharge planning. Sharp Health Plan may delegate UM activities to qualified plan medical groups (PMGs) which meet specific regulatory requirements.

All UM decision making is based solely on the appropriateness of care and existence of coverage. Neither Sharp Health Plan nor a PMG shall reward providers or other individuals for issuing denials of coverage for care or services. There are no financial incentives for UM decision makers to encourage decisions that result in underutilization.

Sharp Health Plan and its delegated PMGs require all Authorization requests to be screened by qualified health professionals using decision-making criteria that are objective and based on accepted medical evidence. Medical necessity criteria must be reviewed annually and updated as appropriate. Medical necessity criteria must be available to plan providers and members upon request. Services not meeting standard medical necessity criteria are forwarded to the Medical Director or provider designee for review.

The following PMGs are delegated by Sharp Health Plan for UM functions. Please contact the PMG directly for information regarding referral and authorization requests and requirements.

PMGs	Phone	Fax/Out-of-Network (OON)
Greater Tri-City IPA	1-760-941-7309 1-877-207-7600	1-760-941-7332 OON Coastal Hospitalists 1-760-988-2499
Change name to Optum...Medical Group (PCAMG)	1-760-542-6757	1-866-321-1465 OON Coastal Hospitalists 1-760-988-2499
Rady Children’s Health Network (CPMG)	1-858-309-6270	1-858-309-7977
Sharp Community Medical Group (SCMG)	1-858-499-2550 1-877-518-7264	1-858-636-2227 OON 1-858-636-2210

PMGs	Phone	Fax/Out-of-Network (OON)
SCMG Arch Health Partners	1-858-675-3200	1-858-636-2227
SCMG Graybill & Graybill Temecula	1-760-291-6615	1-760-291-6647
SCMG Inland North	1-858-499-2550	1-858-636-2214
Sharp Rees-Stealy Medical Group (SRS)	1-858-499-2532	1-858-499-5956 OON 1-858-636-2263

Referral and Authorization Process

Medical and Behavioral Health Services

Prior Authorization requests for medical services not handled by the member's Plan Medical Group (PMG) and behavioral health services, referrals, and notifications to Sharp Health Plan may be submitted via fax at 1-619-740-8111. You may find the prior authorization form located on Sharp Connect, our provider portal. If you are not yet signed-up for this easy-to-use and secure on-line resource, please contact Sharp Health Plan Provider Account Management at 1-858-499-8330 or email provider.relations@sharp.com.

Prior Authorization forms are also available on sharphealthplan.com/for-providers/forms-and-materials. Urgent requests may be submitted via fax or by calling Customer Care at 1-858-499-8300 or toll-free at 1-800-359-2002.

PLEASE NOTE: Pharmacy authorization requests must be sent directly to our Pharmacy Benefit Manager (PBM). Refer to Section VII of this guide – Pharmacy Benefit Services.

The Prior Authorization Guide for providers contracted directly with Sharp Health Plan is available on sharphealthplan.com/for-providers/utilization-management and outlines two different types of referral processes for covered services:

Direct Referral

Referral, authorization, or notification to Sharp Health Plan is NOT required. Services must be medically necessary and ordered by the member's PCP or Sharp Health Plan contracted specialist, and services must be referred from and provided by a member's Network Plan contracted provider. No referral form or referral number is required for Direct Referrals.

Prior Authorization Required

Prior Authorization is the process of evaluating medical services prior to the provision of services to determine Medical Necessity, appropriateness, and benefit coverage. Services requiring Prior Authorization should not be scheduled until a provider receives approval from Sharp Health Plan. Sharp Health Plan reserves the right to deny payment for authorized services if it is determined that inaccurate information was provided to support the Authorization request. Requests should be submitted by the requesting provider via Sharp Health Plan's online referral management system.

Requests must be accompanied by all pertinent medical records and supporting documents to avoid unnecessary delays. Medical information, including but not limited to the following, should accompany all prior authorization requests, as appropriate (the records should also be provided to the "refer to" provider to ensure that consulting provider has all pertinent clinical information prior to a member visit:

- Medical history related to the diagnosis
- Results of any diagnostic tests previously performed (including lab and radiology reports)
- Consultation reports related to the diagnosis from other providers
- Information on referrals pending for other providers

Experimental/investigational services are not a Covered Benefit unless they meet the criteria of our Clinical Policy HS-CP-E1 titled Experimental and Investigational Treatment which is available on the provider portal. Providers may submit a completed Prior Authorization request to Sharp Health Plan to determine whether a requested service is considered experimental or investigational.

Certain services require a Service Specific Prior Authorization form. These forms are available under the provider forms section of the provider page on sharphealthplan.com/for-providers/forms-and-materials. Prior authorization requests may be faxed to 1-619-740-8111. Urgent requests may be submitted via fax or by calling Customer Care at 1-858-499-8300 or toll-free at 1-800-359-2002.

Please note: "Second opinion consultation only" Prior Authorizations allow the specialist only one authorized patient visit. No labs, imaging, procedures, or other services are included in the authorization for second opinion, unless specifically approved.

Utilization Review

Sharp Health Plan's UM staff uses a wide range of approved criteria, guidelines, and reference tools to assist in the review of medical necessity including, but not limited to, in the following sequence:

- Member Handbook
- MCG Care Guidelines
- National Comprehensive Cancer Network (NCCN) (Used prior to MCG for Hematology/Oncology Diagnoses)
- Hayes Technology Assessment Criteria
- Recognized Standards of Care from National Professional Organizations
- Peer Reviewed Published Articles

Sharp Health Plan makes medical necessity determinations for behavioral health services by applying the most recent criteria and guidelines developed by the Nonprofit Professional Association for the relevant clinical specialty when conducting utilization review of treatment of mental health and substance use disorders.

More information on Sharp Health Plan's medical necessity criteria can be found at:

- American Society of Addiction Medicine (ASAM): [asam.org](https://www.asam.org)
- Level of Care Utilization System (LOCUS): [locusreporter.com](https://www.locusreporter.com)
- Child & Adolescent Level of Care Utilization System (CALOCUS): [locusreporter.com](https://www.locusreporter.com)
- Early Childhood Service Intensity Instrument (ECSII): [aacap.org](https://www.aacap.org)
- World Professional Associations for Transgender Health (WPATH): [wpath.org](https://www.wpath.org)

Medical policies utilized by the Sharp Health Plan's UM Department in the evaluation of requests for Authorization may be accessed through the [Sharp Connect provider portal](#).

Contact Information

- Sharp Health Plan Utilization Management staff is available 8 a.m. to 5 p.m. Monday through Friday to answer questions from providers and members regarding Utilization Management issues.
- After office hours, providers may call Customer Care at 1-858-499-8300 or toll-free 1-800-359-2002 to be transferred to Sharp Nurse Connection for Urgent medical requests or to CVS Health for Urgent prescription drug requests.
- Callers also have the option of leaving a voice mail message for return call by the next business day.
- Sharp Health Plan staff will identify themselves by name, title and organization name when making inbound or outbound calls about Utilization Management issues.
- The toll-free number 1-800-359-2002 is available 24 hours a day, seven days a week to accept collect calls regarding Utilization Management issues.
- Language Assistance is available through our toll-free Customer Care line at 1-858-499-8300 or toll free at 1-800-359-2002.

Prior Authorization Review Timelines

Sharp Health Plan and its delegated PMGs are required to provide prompt and timely decisions on Prior Authorization requests appropriate to the member's condition.

Determinations are made based upon the established Health Industry Collaboration Effort (HICE aka ICE) standards for turnaround times. Determinations for routine requests are not to exceed five business days from the receipt of the information necessary to make the determination.

Requests that are received as Urgent are adjudicated within 72 hours, and the provider and member are notified within 24 hours of the decision.

Provider Notification of UM Decision

The requesting provider is informed via fax, telephone, or email of the final status of any Authorization request. When a requested service is approved, notification is sent to both the provider and the member. The notification may also be sent to the member's primary care provider. The notification of approval specifies the servicing provider the service authorized, number of treatments, date range for which the authorization is valid, and expected length of stay (if appropriate). Notification is also sent regarding any services that are denied or modified. A copy of the denial or modification letter is sent to the member, facility (if applicable), PCP, and/or specialist. The denial or modification letter includes a clear and concise description of the criteria used to deny or modify the Authorization. All letters of denial or modification include an explanation of the reason for denial or modification as well as a description on how to file an Appeal. For questions regarding

the status of a Prior Authorization request, contact Sharp Health Plan by phone at 1-858-499-8300, toll-free at 1- 800-359-2002, or online via the Sharp Connect application, or the appropriate PMG.

Concurrent Hospitalization Review

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

In the event that a member is admitted to a facility outside the Plan's Service Area, the Plan's UM department will work with the out-of-area provider and (as applicable) the member's Plan Medical Group to determine when the member can safely be transferred back into the Service Area and to coordinate the transfer. The UM nurse reviews admissions at non- contracted facilities telephonically and with electronically transmitted medical records and updates. The goal of this review is to facilitate transfer of the member to a Sharp Health Plan contracted hospital as soon as medically appropriate.

Discharge Planning

Discharge planning is a process that begins at the time of an inpatient admission and includes an assessment of each member's potential discharge needs. Discharge planning activities are carried out by Sharp Health Plan or a delegated PMG's UM staff in coordination with hospital staff, which may include discharge planners, social workers, or nurse case managers in conjunction with the treatment team.

Retrospective Authorization Review

Medical record review to determine appropriate utilization of services may be conducted for cases in which Sharp Health Plan was not notified before or during the provided service.

Cases for retrospective review are often identified upon receipt of an unauthorized claim. Cases may also be identified through requests for retrospective Authorization from out-of-network or out-of-area providers. Retrospective reviews will be processed within 30 working days of receipt.

Emergency Services

Emergency services providers may screen and stabilize a member without Prior Authorization in cases where a member, acting reasonably would have believed that an emergency existed. Sharp Health Plan must be notified within 24 hours of stabilization by contacting Sharp Health Care Out-of-Network Department at 1-858-499-2346.

Denial of Services

A denial may occur at any time during the review process: prospective, concurrent, or retroactive to services being rendered. Only a physician may issue a denial for reasons of Medical Necessity. Nurse reviewers or designated UM Department staff under the supervision of an RN may issue denials for other reasons, such as lack of benefit coverage or member ineligibility. Providers requiring additional information on denials may contact Sharp Health Plan or PMG UM personnel to discuss the case. Notification of a denial to the requesting provider must include a clearly defined reason for denial, the criteria utilized in the decision-making process, a statement indicating that the reviewing provider is available to discuss any UM denial, and a direct phone number to the provider reviewer who adjudicated the case.

Communication to Providers

- Sharp Health Plan communicates changes or updates to policies, procedures, and regulatory requirements to plan providers via:
 - This Provider Operations Manual, which is provided upon contracting with the Plan, and for which updates are posted online at: sharphealthplan.com/pom.
 - Sharp Health Plan Fax Blasts, which are sent directly to provider offices to announce an update to UM criteria posted on the website.
 - Sharp Health Plan Fax Blasts that are sent to the UM Departments of select Medical Groups that prefer to distribute information to their affiliated providers.
- Sharp Health Plan provides required notification to plan providers about:
 - Sharp Health Plan's policy requiring an appropriate provider reviewer to be available to discuss any UM denial decision.
 - How to contact the provider reviewer (by listing a direct phone number in the provider denial letter).
 - The opportunity to discuss a behavioral or non-behavioral health care UM denial decision with a provider or other appropriate reviewer.
 - How to access UM criteria online at sharphealthplan.com.
 - How to connect via email using the Contact Us form at sharphealthplan.com or by calling Provider Account Management at 1-858-499-8330.

- Current information contained in directory listings. It is the provider's responsibility to respond affirmatively or with modifications within 30 business days or risk deletion from the next directory.

Second Medical Opinions

When requested by the member or the plan provider, a second medical or surgical opinion may be covered by Sharp Health Plan after the first opinion by the same specialty has been rendered. There must be a first opinion rendered prior to a request for a second opinion. A second opinion may be requested for any of the following reasons:

- The member questions the reasonableness or necessity of recommended surgical procedures.
- The member questions a diagnosis or plan of care for a condition that threatens loss of life, limb, or bodily function, or substantial impairment, including, but not limited to, a Serious Chronic Condition.
- The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and the member would like to request an additional evaluation.
- The treatment plan in progress is not improving the member's medical condition within an appropriate period of time given the diagnosis and plan of care, and the member would like a second opinion regarding the diagnosis or continuance of the treatment.
- The member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.
- The member or provider treating the member has serious concerns regarding the accuracy of the pathology results and requests a specialty pathology opinion.

Members and plan providers request a second opinion through the Plan or the member's PMG. Requests will be reviewed and facilitated through the Authorization process according to the following:

- If the member requests a second opinion regarding care from a specialist, the second opinion shall be provided by an appropriately Qualified Health Professional of the member's choice within the member's Plan Network (Premier, Performance, Choice, and Value) of the same specialty as the first opinion.
- If an appropriately Qualified Health Professional of the same or equivalent specialty is not available within the Plan Network, the second opinion will be provided by a Sharp Health plan provider who is an appropriately Qualified Health Professional. The Plan shall consider the ability of the member to travel to the provider.
- A second opinion from a non-contracted Qualified Health Professional will be

authorized only when there is not a plan provider who is a Qualified Health Professional.

- The Qualified Health Professional rendering the second opinion must supply the member, PCP and Plan with the consultation report and treatment recommendations in a timely manner. The time frame for submission of the consultant report will be stated in the referral authorization document. If the Qualified Health Professional is unable to comply with the time frame proposed, a written request for extension should be made prior to the expiration of the original time frame or an opinion from another Qualified Health Professional will be sought.
- The Qualified Health Professional rendering the second opinion is limited to consultation only, and no service, procedure, or care will be covered.
- Any costs related to travel, lodging, meals, or incidentals such as parking fees are the member's responsibility and will not be covered by the Plan.

For questions about second opinions or a copy of the Sharp Health Plan's policy, please visit sharphealthplan.com/for-providers/clinical-resources/clinical-practice-guidelines.

Case Management Program

Sharp Health Plan's Case Management Program uses a client/caregiver approach to promote availability of appropriate care and resources while maximizing the member's quality of life and health care benefits. Case Management is a collaborative process with the member, family, provider, and other treating entities, designed to meet the individual's needs while promoting quality outcomes.

Sharp Health Plan offers a Case Management Program for complex cases. Our case management nurses work closely with plan providers to develop and implement the most appropriate treatment plan for the member's needs. Providers interested in referring a member to the Case Management Program can call Sharp Health Plan Customer Care at 1- 858-499-8300 or toll-free 1-800-359-2002, or complete the Case Management referral form available on sharphealthplan.com/for-providers/forms-and-materials. Any individual involved in the care of a member may make a referral to the Case Management Program, including but not limited to, the following:

- Primary Care Provider (PCP)
- Specialist
- Discharge planner
- Plan staff

Each case is considered on an individual basis. Cases not accepted into the Case Management Program are kept on file for future reference.

Referrals to the Case Management Program are screened for medical, psychosocial, financial, and related needs no later than 30 calendar days from the date the member is referred to Case Management. The Case Manager assesses each referral through medical records and discussion with the PCP and other involved parties, as needed. Referrals for case management services include, but are not limited to, the following situations in which care coordination is needed to meet members' needs while promoting appropriate utilization of services and cost-effective outcomes:

- Transplants
- Chronic pain management
- Medication management
- Out-of-Area/Out-of-Network services
- Transgender Services
- Comorbid or complex behavioral health conditions
- Maternal mental health
- Care facilitation
- Social support issues

As appropriate, the Case Manager will facilitate care coordination for members who have the following indicators:

- Three or more acute hospital admissions per year
- Two or more emergency department visits in a three month period
- Non-compliance with medical recommendations and care
- Complex medical needs that require close monitoring
- Behavioral health conditions, including Maternal Mental Health
- Life expectancy of six months or less
- Inpatient hospital stays of greater than ten days
- Complex psychosocial or functional requirements
- Quality issues related to clinical care

When a member is accepted into the Case Management Program, the Case Manager performs the following functions:

- Serves as a liaison and resource for providers and members and their families
- Communicates information to caregivers to obtain consensus on a plan of care
- Develops and coordinates a plan of care with realistic and appropriate goals/outcomes

- Facilitates provider-to-provider communication and other communication when needed
- Manages all Authorizations for services for the assigned member

The Case Manager closes a case when one or more of the following endpoints have been established:

- Services are no longer needed due to resolution of the member's illness or the member's death
- Reasonable goals and objectives in the Plan of Care have been met and the member's condition is stabilized
- Family and other support systems can adequately provide needed services
- Care coordination is ongoing without the need for oversight by the Case Manager
- The member has moved out of the Service Area
- The member declines further Case Management services

Disease Management Program

Sharp Health Plan offers Disease Management Programs for members diagnosed with diabetes and/or chronic cardiovascular conditions, including hypertension and/or hyperlipidemia. Providers can refer a member to the Program by calling Customer Care at 1- 858-499-8300 or toll-free 1-800-359-2002, or by completing the Case Management/Disease Management Referral Form available at sharphealthplan.com.

Out-of-Network Services

For services that are the financial responsibility of Sharp Health Plan, members must be directed to a provider within Sharp Health Plan's contracted network. If a member requires Out-of-Network services because Sharp Health Plan is not contracted with a provider of like specialty, a Letter of Agreement (LOA) must be obtained for the non-contracted provider.

For services that are the financial responsibility of the PMG, the PMG will follow its organization's policy in reference to authorization of Out-of-Network providers. Sharp Health Plan requires all delegated and non-delegated plan medical groups and providers to adhere to Sharp Health Plan's Out-of-Network policy and procedure (Policy HS-MM-121: Referrals to Non-Contracted Providers), available on the [Sharp Connect provider portal](#).

Delegated Utilization Management

When Utilization Management is delegated to another Medical Group, their Utilization Management operations and activities are conducted by their qualified UM staff who must follow all regulatory requirements. Audits occur annually to confirm that key components are in place to ensure that the

delegated entity adheres to Sharp Health Plan requirements and policies. Each delegated organization must have a Utilization Management Program that is approved by Sharp Health Plan's Delegation Oversight Committee, and a signed Delegation Agreement must be in place. Each Delegation Agreement details the key components, processes, and reporting requirements of the delegates. Sharp Health Plan requires all delegated plan medical groups and providers to adhere to Sharp Health Plan's medical and pharmacy management policies, available on the [Sharp Connect provider portal](#).

SECTION VII

Pharmacy Benefit Services



Formulary

Sharp Health Plan maintains a Drug Formulary (or Drug List) designed to support the achievement of positive patient outcomes through the selection of high-quality, cost-effective pharmaceuticals. The Drug Formulary includes drugs that are identified as prescription drug benefits in the member's Evidence of Coverage (EOC). To find the most up-to-date coverage and utilization management information for a drug, visit the Sharp Health Plan website or Sharp Connect and view the searchable Formulary PDF assigned to the member's benefit plan. Updated Formularies and Formulary changes are posted to the website monthly. If your Electronic Health Record (EHR) includes Real Time Benefit Check (RTBC), you can view Formulary status, drug utilization management strategies, and member cost share information through your EHR. You can also run a mock drug claim. If your EHR has not activated RTBC, please check with your EHR vendor.

RTBC allows you to:

- Review member's formulary, plan design and out of pocket cost
- Run a mock claim
- See up to five clinically appropriate formulary alternatives
- Review member deductible status
- View utilization management requirements
- Instantly submit a prior authorization. Approval decisions are provided in as little as six seconds.

Members can log into the Pharmacy Portal on the Plan website to view pricing, utilization management, and coverage information.

The Plan covers drugs listed on the Formulary and prescribed by licensed plan providers operating within the scope of their practice. As the prescribing provider, plan providers are essential to the appropriate use of pharmaceuticals. This includes:

- Choosing the best, most economical drug and dosage form to treat the patient's condition
- Making sure each patient clearly understands the drug's use, the correct dose and possible side effects
- Looking for drug interactions and discontinuing ineffective drugs
- Reviewing each patient's drug list and dosages at every visit
- Carefully monitoring therapeutic drug levels, as necessary

Pharmacy and Therapeutics (P&T) Committee

SHP Formularies are created by our Pharmacy Benefit Manager (PBM). The PBM designs the Formulary and utilization management edits under the guidance of its Pharmacy and Therapeutics (P&T) Committee. The PBM's P&T Committee evaluates the safety, efficacy, and cost-effectiveness of drugs and approves utilization management edits such as prior authorization, step therapy and quantity limits. Sharp Health Plan maintains its own P&T Committee, which conducts oversight of the PBM's Formulary and utilization management decisions on a quarterly basis. The SHP P&T Committee is comprised of pharmacists and providers representing various clinical specialties. Formulary updates are available on sharphealthplan.com.

The PBM P&T Committee may move a drug from preferred to non-preferred status or remove a drug from the Formulary for one or more of the following reasons:

- Withdrawal of a drug licensure by the Food and Drug Administration
- The risk of toxicity outweighs the benefits of the drug as judged by the Committee
- Replacement by another drug with significant advantage regarding efficacy, toxicity, and/or cost
- Low usage of a drug or supply

Recommendations for Formulary or utilization management changes may come from plan members, plan providers, or SHP P&T Committee members. To make a request, please call Customer Care at 1-858-499-8300 or toll-free 1-800-359-2002 or email provider.relations@sharp.com.

Tiered Copay Programs

Sharp Health Plan has several Tiered Copay Programs. The 3 Tier Pharmacy Copayment Program places all covered drugs on one of three tiers. The program gives members and providers a wide range of drug product choices. It is important for the member and provider to work together to determine which drug is most appropriate.

- Tier 1: Medications on Tier 1 have the lowest Copayment. Tier 1 includes formulary preferred generic drugs.
- Tier 2: Medications on Tier 2 are subject to the middle Copayment. This tier includes formulary preferred brand-name drugs and inhaler spacers.
- Tier 3: Medications on Tier 3 have the highest Copayment and include non – preferred generic and brand-name drugs.

Additionally, members pay \$0 for preventive formulary medications listed with an A or B recommendation by the USPSTF or for contraception. These are listed as Tier PV (preventive) on the formulary.

Members with coverage through Covered California or Covered California “mirrored” plans have a 4 Tier Pharmacy Copayment Program. The tiers are:

- Tier 1: Most generic drugs and low-cost preferred brand name drugs.
- Tier 2: Non-preferred generic drugs, preferred brand name drugs, and any other drugs recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost.
- Tier 3: Non-preferred brand name drugs or drugs that are recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.
- Tier 4: Drugs that are biologics, drugs that the FDA or the drug manufacturer requires to be distributed through a specialty pharmacy, drugs that require the enrollee to have special training or clinical monitoring for self-administration, or drugs that cost the health plan (net of rebates) more than six hundred dollars (\$600) for a one-month (30 day) supply
- PV (Preventative): Select drugs covered with no copayment, including certain generic and over-the-counter contraceptives
- MB (Medical Benefit): Drugs covered under the Medical Benefit. Please refer to the medical benefit coverage information

The placement of medications on drug tiers is subject to change throughout the year. When a prescription drug becomes available over the counter, Sharp Health Plan may discontinue coverage of that drug. To find the most up-to-date drug coverage information and utilization management edits for a specific drug visit the Sharp Health Plan website and view a PDF of the formulary assigned to the member’s benefit plan or use the online drug look-up tool.

Prior Authorization

- When a drug requires Prior Authorization (PA) coverage is dependent on member satisfying plan criteria.
- Routine Prior Authorization requests are reviewed within seventy-two (72) hours of receipt of all necessary information.
- Urgent Prior Authorization requests are reviewed within twenty-four (24) hours of receipt of all necessary information.
- PA requests may be submitted by phone, FAX, or electronically through CoverMyMeds.
- Requests should be submitted to one of the numbers listed below.
- Written requests are only accepted when they are on the Prior Authorization Form 61-211, “Pharmacy Authorization or Step Therapy Exception Request”, available on the Provider page at sharphealthplan.com/for-providers/forms-and-materials.

PLEASE NOTE: Any request not submitted on this form will not be reviewed and will be returned to the provider.

- Medication samples and medications obtained outside of the Sharp Health Plan Pharmacy benefit (for example, with a coupon card) do not satisfy prior authorization requirements.

Commercial Plans	Fax number	Phone number
Specialty medications	866-249-6155	866-814-5506
Non-Specialty medications	888-836-0730	855-582-2022
Exchange Plans	Fax number	Phone number
Specialty medications	866-249-6155	866-814-5506
Non-Specialty medications	888-836-0730	855-582-2022

Prior authorization policies and procedures and other utilization management guidelines are available on Sharp Connect.

Step Therapy

The Step Therapy program encourages safe and cost-effective medication use. Plan physicians may request prior Authorization by calling or faxing Sharp Health Plan. The list of Prescription Drugs subject to Step Therapy is subject to change. We will review and make a determination within 72 hours (for routine requests) and 24 hours (for urgent requests) of receipt of the information reasonably necessary and requested by Sharp Health Plan to make the determination for Step Therapy Exception requests. The process is the same as the outpatient prescription drug prior authorization request process.

When a plan provider determines that the drug required under Step Therapy is inconsistent with good professional practice, the plan provider should submit their justification and clinical documentation supporting the plan provider's determination with a Step Therapy Exception Request.

If a request for prior authorization or a step therapy exception is incomplete or relevant information necessary to make a coverage determination is not included, Sharp Health Plan will notify the plan provider within 72 hours of receipt, or within 24 hours of receipt if exigent circumstances exist, what additional or relevant information is needed to approve or deny the prior authorization or step therapy exception request, or to appeal the denial.

If Sharp Health Plan fails to notify a plan provider of our coverage determination within 72 hours for non-urgent requests, or within 24 hours if exigent circumstances exist, upon receipt of a completed prior authorization or step therapy exception request, the prior authorization or step therapy exception request shall be deemed approved for the duration of the prescription, including refills. If a plan provider does not receive a coverage determination or request for additional or clinically relevant material information within 72 hours for standard requests or 24 hours for expedited requests, the prior authorization or step therapy exception request, or appeal of a denial, shall be deemed approved for the duration of the prescription, including refills.

Dispense as Written (DAW) Prescriptions

Sharp Health Plan exclusively covers the generic formulation of covered brand name drugs when available. If its generic is available, a brand name drug will not be covered based solely upon member request. If the request is based on medical necessity, Prior Authorization may be requested and must include the medical justification/explanation for why member cannot use the generic formulation, as well as dates the generic was tried and member’s response to the generic.

If the brand name drug is dispensed with Plan approval or at the request of the plan provider, the member will be charged a higher Copayment (depending on plan design).

Emergency Supply

Requests for emergency prior authorizations and overrides) are handled by the Plan’s Pharmacy Benefits Manager (PBM) Help Desk. If the Plan’s emergency criteria are met, PBM staff may enter an override for up to a 5-day supply of medication. The caller will be advised to submit a prior authorization or exception request for any additional quantity. Help Desk phone numbers for an emergency override are:

Commercial Plan Help Desk	Phone number
Specialty medication	866-814-5506
Non-Specialty medication	855-582-2022
Exchange Plan Help Desk	Phone number
Specialty medication	866-814-5506
Non-Specialty medication	855-582-2022

For quantity in excess of an emergency 5-day supply, requests should be sent to one of the following numbers based on member’s benefit:

Commercial Plan PA/Exception Request	Fax number
Specialty medication	866-249-6155
Non-Specialty medication	888-836-0730
Exchange Plan PA/Exception Request	Fax number
Specialty medication	866-249-6155
Non-Specialty medication	888-836-0730

Dispensing Limitations

The Plan may limit the quantity of a drug covered in a given time period. Limits are based on recognized standards of care such as FDA recommendations for use. If a member needs a greater quantity than the quantity limit, an exception request may be submitted.

Some drugs are designated as maintenance medications. The Plan follows the MediSpan classification system for maintenance designation. Maintenance medications may be filled for up to a 90-day supply through mail order or at certain network pharmacies.

Specialty drugs are limited to a 30-day maximum supply per fill.

Vacation Overrides

The following limitations apply to the member's pharmacy benefit:

- Vacation overrides may be approved for up to a 90-day supply
- Controlled substances may or may not be approved for vacation overrides
- Requests for greater than a 90-day supply will be considered on a case-by-case basis

Preventive Health Medications

Covered preventive medications, as defined by the Affordable Care Act, are covered without member cost share for non-grandfathered plans. Medical necessity and utilization management edits apply.

Preventive medications include:

- Prenatal vitamins
- Fluoride preparations
- Vitamin D supplementation as recommended by the USPSTF

- Folic acid supplementation as recommended by the USPSTF
- Aspirin
- Iron preparations
- Contraceptives and select over the counter (OTC) barrier methods of contraception (Grandfathered plans and certain religious organizations are exempt from covering these products)
- Bowel prep medications
- Medications recommended by the USPSTF, grade A or B, which are covered through the outpatient pharmacy benefit

Prescriptions for over-the-counter items listed above must be written on a prescription and filled at a Sharp Health Plan Network pharmacy to be covered.

Prescription Mail Order

- Sharp Health Plan members have access to a contracted mail order pharmacy to obtain maintenance drugs
- Maintenance drugs are available for up to a 90-day supply through the mail service program
- Maintenance drugs are prescribed to treat or stabilize chronic conditions such as diabetes or hypertension
- Members need a prescription written for a 90-day supply in order to obtain a 90-day supply
- Medications not designated by the Plan as a maintenance medication are not available through mail order. Medications such as antibiotics and controlled substances are not designated as maintenance medications.
- Members are responsible for submitting their prescriptions to the mail order pharmacy. Details on how members enroll for mail order are available on sharphealthplan.com/members/pharmacy-and-prescription-drugs under member Forms.

Specialty Medications

Specialty medications are drugs that may require specialized delivery and administration on an ongoing basis. They are often used to treat complex disease states that require frequent follow-up and monitoring. In addition, drugs that cost the health plan (net of rebates) more than six hundred dollars (\$600) for a one-month (30-day) supply are specialty medications.

- Specialty medications may be dispensed for up to a maximum of a 30-day supply
- Specialty medications require Prior Authorization

Specialty medications covered under the pharmacy benefit can be filled at a pharmacy that is in the Sharp Health Plan Specialty network. Sharp Health Plan's preferred pharmacy is CVS Specialty Pharmacy. In most cases, Specialty pharmacies deliver medication by mail. Members have the option to submit their specialty medication prescription to a CVS retail pharmacy. CVS will send the prescription to CVS Specialty Pharmacy to be filled. The filled prescription will be delivered to the CVS retail location, where the member may pick it up.

Non-Covered Services and Medications

The services and supplies listed below are exclusions and limitations to your Outpatient Prescription Drug Benefits and are not covered by Sharp Health Plan:

1. Drugs dispensed by a person or entity other than a plan pharmacy, except as medically necessary for treatment of an emergency medical condition or urgent care condition.
2. Drugs prescribed by non-plan providers and not authorized by Sharp Health Plan, except when coverage is otherwise required for treatment of an emergency medical condition.
3. Over-the-counter medications or supplies, even if written on prescription, except as specifically identified as covered in this formulary. This exclusion does not apply to over-the-counter products that Sharp Health Plan must cover as a "preventive care" benefit under federal law with a prescription or if the prescription legend drug is medically necessary due to a documented failure or intolerance to the over-the-counter equivalent or therapeutically comparable drug.
4. Drugs dispensed in institutional packaging (such as unit dose) and drugs that are repackaged.
5. Drugs that are packaged with over-the-counter medications or other nonprescription items/supplies.
6. Vitamins (other than pediatric or prenatal vitamins listed in this formulary).
7. Drugs and supplies prescribed solely for the treatment of hair loss, athletic performance, sexual dysfunction, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. (Drugs for mental performance are covered when they are Medically Necessary to treat Mental Health or substance use disorders or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease. Drugs for treatment of hair loss or sexual dysfunction are covered when they are medically necessary to treat mental health or substance use disorders).
8. Herbal, nutritional, and dietary supplements.
9. Drugs prescribed solely for the purpose of shortening the duration of the common cold.
10. Dental products and medications prescribed for a dental treatment (such as mouthwash to prevent gum disease) are not covered. Drugs prescribed by a dentist to treat a medical

condition (such as antibiotics to treat an infection) are covered.

11. Drugs and supplies prescribed in connection with a service or supply that is not a covered benefit, unless required to treat a complication that arises as a result of the service or supply.
12. Travel and/or required work-related immunizations.
13. Infertility drugs are excluded, unless added by the employer as a supplemental benefit.
14. Drugs obtained outside of the United States unless they are furnished in connection with urgent care services or emergency services.
15. Drugs that are prescribed solely for the purposes of losing weight, except when medically necessary for the treatment of morbid obesity or mental health and substance use disorders. Members must be enrolled in a Sharp Health Plan-approved comprehensive weight loss program prior to or concurrent with receiving the weight loss drug and meet plan criteria for coverage, when prescribed for treatment of morbid obesity.
16. Off-label use of FDA-approved Prescription Drugs, unless the drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or the safety and effectiveness of use for this indication has been adequately demonstrated by at least two studies published in a nationally recognized, major peer-reviewed journal.
17. Replacement of lost, stolen, or destroyed medications.
18. Compounded medications, unless determined to be medically necessary and prior authorization is obtained.
19. Brand-name drugs when a generic equivalent is available. Some drugs are commercially available as a brand and a generic version. It is the policy of Sharp Health Plan that when a generic is available, Sharp Health Plan does not cover the corresponding brand drug. Coverage of the brand drug requires prior authorization. If prior authorization is obtained, the member will pay the highest member cost share, depending on member's benefit design.
20. Any prescription drug for which there is an over-the-counter product that has the identical active ingredient and dosage as the prescription drug.

The exclusions listed above do not apply to:

- Coverage of an entire class of prescription drugs when one drug within that class becomes available over the counter.
- Drugs listed in this formulary.

- Over-the-counter products that are specifically covered and listed as a preventive care benefit under California State or federal law. Covered preventive drugs include FDA-approved tobacco cessation drugs and FDA-approved contraceptive drugs. Preventive drugs are provided at \$0 cost sharing subject to certain exceptions. For more information regarding coverage of certain over-the-counter drugs as preventive drugs, please see the Plan Formulary.
- Insulin, glucagon, and insulin syringes. These items are covered when medically necessary, even if they are available without a prescription.
- Items that are approved by the FDA as a medical device.

Prior Authorization and Exception Process

Medically necessary exceptions to prior authorization, step therapy, and quantity limits may be requested and must be submitted using the State of California created Prior Authorization and Step Therapy Exception Request form. The Pharmacy Prior Authorization and Step Therapy Exception Request Form is available at the following link: sharphealthplan.com/for-providers/forms-and-materials. Coverage decisions are made on a case-by-case basis considering the individual member's health care needs.

Drugs not listed in the drug list are non-formulary drugs and are not covered. When it is medically necessary for a member to obtain a medication not on the drug list, the member, the member's authorized representative or the member's doctor may request a formulary exception following the Plan's prior authorization process. Sharp Health Plan will approve or deny the exception request based on medical necessity within 72 hours for standard requests or 24 hours for urgent requests. If a formulary exception request is denied, you have the right to appeal the decision.

Sharp Health Plan's Prior Authorization criteria is available through your Sharp Connect provider portal account. If you are not signed-up for this easy-to-use and secure Internet resource, visit sharphealthplan.com/SharpConnect to register. You may also contact Sharp Health Plan's Provider Account Management Department at 1-858-499-8330 or via email at provider.relations@sharp.com.

Coverage Determination Notification Process

Coverage determination notification may be provided by fax, telephone, or mail. Prescribers will generally be notified by fax. Members will be notified by mail and by telephone. Denial letters include a clear and concise explanation of the denial reason, the criteria used to make the determination, and a description of how to file an appeal.

If we deny a request for coverage of a non-formulary drug, the member, the member's authorized representative or the member's doctor may request a review by an independent review organization (IRO). The request may be given up submitted up to 180 calendar days following the non-formulary drug exception request denial by:

- Calling toll free at 1-855-298-4252
- Mailing a written request to: Attn: Prescription Claim Appeals MC 109 – CVS Caremark P.O. Box 52084 Phoenix, AZ 85072-208
- Faxing a written request to 1-866-443-1172
- Completing the Member Grievance and Appeal form on our website at: sharphealthplan.com

The member will be notified of the IRO's decision within 72 hours for standard requests or 24 hours for expedited requests. The IRO review process described above is in addition to the member's rights to file a grievance or appeal with Sharp Health Plan and to file a grievance or request an independent medical review (IMR) with the California Department of Managed Health Care.

For additional information on how to file an appeal for an adverse determination, please see the section on Appeals and Grievances.

Pharmacy Policies and Procedures (Pharmacy Management Procedures)

Sharp Health Plan's Pharmacy Management Procedures are available online through the Sharp Connect provider portal at sharphealthplan.com/SharpConnect. A printed copy of any Pharmacy Management Procedure is available upon request by contacting Provider Account Management at 1-858-499-8330.

FDA Recalls

The Plan promptly notifies affected members and prescribers when there is a Food and Drug Administration (FDA) Class I or Class II drug recall. Affected members are identified through outpatient pharmacy benefit claims data. The Plan is not able to identify affected members and prescribers if a recall is drug lot specific.

The FDA uses the following definitions for Prescription Drug Recalls:

- **Class I Recall:**
A situation in which there is a reasonable probability that use of, or exposure to, a product will cause serious adverse health consequences or death.
- **Class II Recall:**
A situation in which the use of or exposure to a product may cause temporary or medically reversible adverse health consequences or where the probability of serious adverse health consequences is remote.

Outpatient Injectable Medications

Outpatient injectable medications are covered under the medical benefit except for insulin, glucagon, GLP1 inhibitors prescribed for diabetes, epinephrine pens and some forms of Sumatriptan. Self-injectable medications and drugs or preparations that are not typically self-administered are provided through the medical benefit. Drugs that are given by the intravenous, intramuscular, or subcutaneous route in a provider’s office or outpatient infusion center are provided through the medical benefit. Plan providers are responsible for obtaining outpatient injectable medications. Prior Authorization may be required by Sharp Health Plan Medical Management Department or the plan medical group.

Pharmacy Benefits Manager (PBM)

SHP uses CVSCaremark to manage prescription benefit administration. CVSCaremark reviews Prior Authorization and Exception requests, and CVS Customer Care is available 24 hours a day, seven days a week.

Commercial Plan Customer Care	Phone number
Specialty medication	866-814-5506
Non-Specialty medication	855-582-2022
Exchange Plan Customer Care	Phone number
Specialty medication	866-814-5506
Non-Specialty medication	855-582-2022

Medication Restriction

At the provider’s request and with medical justification based on concern for member safety, member medication coverage may be limited or blocked. Requests may be submitted to the Sharp Health Plan Pharmacy Department and will be reviewed by the Plan Medical Director for approval.

Opioid Management Strategies

Sharp Health Plan safety and quality initiatives include opioid management strategies. The following safety initiatives are in place for Commercial and Exchange plans:

- Opioid naïve members ages 18 and over are limited to a maximum of a seven-day supply
- Greater than a seven-day supply may be obtained with an approved prior authorization request

Cumulative daily morphine milligram equivalent (MME) limitations.

- A Cumulative daily MME value of 90 MME – 100 MME requires the dispensing pharmacist to review the claim for appropriateness
- A Cumulative daily MME of 100 MME or higher requires a prior authorization
- Concurrent use of opioid and benzodiazepine medications OR opioid and buprenorphine medications are subject to prior authorization
- Use of an immediate release (IR) opioid is required prior to use of an extended release (ER) opioid

Patients with cancer related pain, sickle cell anemia, end of life care, or who are in hospice, are exempt from these MME requirements. Prior authorization is not required when obtaining medication used to treat Opioid Use Disorder.

SECTION VIII

Quality Improvement



Quality Improvement Program

Sharp Health Plan's Quality Improvement (QI) Program is based on the mission of the Plan – to offer quality care and services that set community standards, fulfill members' expectations, and ensure that medical services are provided in a caring, effective, cost efficient, and accessible manner. The Plan uses the Continuous Quality Improvement (CQI) process to achieve excellence in quality of care and services. The Sharp HealthCare system has adopted Six Sigma processes and has an integrated CQI culture. The purpose of the QI Program is to promote organization-wide commitment to quality of care and services through ongoing performance improvement activities to identify opportunities for improvement, implement change and reevaluate actions taken. The following CQI processes are employed to achieve this goal.

- Continuous improvement and enhancement of quality care and services through ongoing, objective, and systematic monitoring of both medical and behavioral health care.
- Proactive identification of opportunities for improvement in both the clinical and administrative aspects of SHP operations.
- Change management to address identified opportunities for improvement in a systematic manner and an iterative cycle of re-evaluation to measure/monitor improvement.

The goals of the QI Program are to:

- Promote an organization-wide commitment to quality of care and ongoing performance improvement.
- Continuously improve and enhance the quality of member care through ongoing, objective, and systematic monitoring of both medical and behavioral health care.
- Proactively identify opportunities for improvement in both clinical and administrative aspects of Plan operations.
- Implement change in a well-defined, systematic manner and re-evaluate processes to ensure that improvement has occurred.
- Provide comprehensive oversight of delegated functions to ensure member care delivery and delegated processes are consistent with the values and standards of Sharp Health Plan.
- Promote provider participation in the quality improvement process and assure compliance with Sharp Health Plan standards.
- Include multidisciplinary representation for Quality Committee Membership.
- Implement and evaluate Sharp Health Plan's annual quality metrics, which include HEDIS® and Integrated Healthcare Association (IHA) Align Measure Perform (AMP) clinical quality measures and CAHPS® member satisfaction survey results.
- Facilitate the achievement of public health goals and initiatives.

- Provide an objective and systematic approach to continuous quality improvement that complies with community standards of care and meets applicable regulatory and accreditation requirements and standards.
- Establish standards and monitoring mechanisms to assure access and availability of primary care, specialty care, urgent care, and member services.
- Ensure Plan programs, processes, and delegated plan medical groups and vendors are in alignment with plan, regulatory, and accreditation standards.
- Promote provider and member satisfaction.

The objectives of the QI Program are to:

- Provide health education to promote optimal wellness for all members.
- Collect, analyze, and act on opportunities for improvement using annual standardized quality indicators to include IHA AMP and HEDIS measures and CAHPS® survey results to identify opportunities to improve clinical care and services.
- Systematically review NCQA standards and applicable state and federal regulations, and implement programs, policies, and procedures to ensure compliance.
- Develop, implement, and monitor quality metrics for the enhancement of disease management programs, to include behavioral health initiatives.
- Evaluate outcomes, barriers, resources, published materials, and industry best practices for robust interventions proven to improve care and/or performance; and
- Conduct ongoing monitoring and annual review of delegated functions.

The QI Program provides information and education by various mechanisms to include:

- QI Program Description summary posting on Plan website
- Member newsletter articles
- Special mailings
- Committees with contracted network provider participation
- Plan Medical Group Joint Operations Committee meetings
- Distribution and review of monitoring mechanisms such as oversight audits to include language assistance program, for compliance to Plan standards

The QI Program includes implementation and evaluation of improvement activities for both clinical care and administrative services provided to members. The scope of the program includes the important aspects of care related to member population demographics and risk status. All departments in the Plan are involved in the continuous quality improvement process.

Quality Management Committee

The Quality Management Committee (QMC) provides a comprehensive and systematic structure for monitoring, evaluating, and improving the Plan QI program. Members of the QMC are appointed by the Chief Medical Officer for a minimum of a two-year term. The QMC membership includes multidisciplinary representation from the provider's network. Committee membership consists of:

- Chief Medical Officer (Co-Chair)
- Network providers including representatives from Pediatrics, Behavioral Health, Adult Medicine, and at least one specialist provider
- Senior Medical Director
- Director of Population Health and Medical Management
- Manager of Medical Management
- Director of Quality Improvement (Co-Chair)
- Director of Operations
- Director of Pharmacy Services
- Manager of Network Development and Application Optimization
- Others as appointed by the Chief Medical Officer

The QMC provides quarterly reports to the Board of Directors. The QMC responsibilities include but are not limited to:

- Review and approval of the annual QI Program Description and Work Plan and evaluation of the effectiveness of the QI Program and work plan.
- Implementation and integration of quality improvement studies.
- Review of access and availability monitoring.
- Review of delegation oversight of Plan Medical Group programs per mutually agreed- upon responsibilities.
- Access and availability measurement and analysis to include appointment availability, after-hours access, telephone access and Geo-Access.
- Review and approval of preventive and clinical practice guidelines, UM criteria and medical policies.
- Oversight of utilization management activities including inter-rater reliability monitoring.
- Oversight of case management, disease management, and HEDIS-related interventions and activities; and

- Annual review of various quality improvement studies such as HEDIS measurement rates, CAHPS survey results, ECHO survey results, and Provider satisfaction survey analyses.

The following committees are discussed at QMC:

- Pharmacy & Therapeutics Committee
- Peer Review Committee
- Medical Benefit Policy & Tech Assessment Committee
- Medicare Stars Council

Service and Operational Quality Council

The purview of the Service and Operations Quality Council (SOQ) is the non-clinical operational aspects of quality improvement activities. The SOQ Council is responsible for the review of all non-clinical and operational aspects of satisfaction survey results relating to service quality and monitoring of performance results. The needs of SHP's internal and external customers serve as the focus of review and continuous improvement. Council membership consists of:

- President and Chief Executive Officer
- Chief Medical Officer
- Chief Financial Officer
- Chief Business Development Officer
- Chief Operations Officer

Participation in the QI Program

Participation in QI Program activities is required for all providers. Participation may include providing medical records for various studies such as:

- Annual HEDIS data collection project
- Quality of care Grievances and member appeals

Provider participation may also include providing evidence of preventive health care as appropriate to their membership. Providers may be invited to participate in the review and provide feedback on potential new and/or ongoing QI activities. Providers allow Sharp Health Plan to use their performance data for public reporting, Pay for Performance and other quality improvement activities as needed.

Quality Measurement

Sharp Health Plan has maintained National Committee for Quality Assurance (NCQA) health plan accreditation since 2013. In 2021, Sharp Health Plan was audited by NCQA and successfully completed the audit, improving the audit score from previous years.

Member satisfaction is measured by the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and the Enrollee Experience Survey (ESS) on an annual basis. The CAHPS survey and EES sample frames are audited and validated by our certified HEDIS compliance auditor and reportable results are submitted directly to NCQA and CMS by our certified survey vendor each June. CAHPS survey and EES results are analyzed and reported to the QMC annually. Action plans are implemented as needed to address opportunities for improvement.

HEDIS

Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures used by purchasers of health care to evaluate the quality of care and service provided by health plans and their contracted networks. The National Committee for Quality Assurance (NCQA) HEDIS measures are considered to be the national standard in performance measurement for health plans. HEDIS measures are related to many significant public health initiatives such as:

- Childhood immunizations
- Adolescent immunizations
- Well-child and adolescent visits
- Timely prenatal and postpartum care
- Prenatal Immunizations
- Depression screening for adolescents and adults
- Cervical cancer screening
- Comprehensive diabetes care
- Breast cancer screening
- Chlamydia screening
- Colorectal cancer screening
- Body mass index (BMI) measurement for children
- Potentially inappropriate use of opioids

Sharp Health Plan uses HEDIS rates to guide QI efforts to target areas for opportunity to improve quality of care for our members. Providers are central to the Plan's efforts to improve quality of care and access. We share the same goal to improve overall member health by improving patient care.

Providers can support quality improvement activities in the following ways:

- Educate members about standards of care based on clinical efficacy such as making timely prenatal and postpartum visits, getting recommended cancer screening tests as appropriate by age and gender, and following routine immunization schedules.
- Provide comprehensive care at the time of the visit. For example, if a member comes in for a flu vaccine, review the chart and recommend any other necessary care such as an eye exam for a diabetic or a complete well-child visit for pediatrics.

Promptly submit complete claims and accurate encounter data. Providers receiving capitation payments should submit complete encounter data to accurately reflect all care and treatment provided using the most current, appropriate CPT and ICD-10 coding. Sharp Health Plan’s goal is to decrease the burden of medical record review to ascertain care provided wherever possible. When medical record review for HEDIS data collection audit is required, complete and thorough documentation of the provision of care and services in the medical record is very important.

Documentation precision to ensure that services are appropriately recognized, and appropriate coding will decrease the requests for medical record review during the HEDIS data collection project. All three of the following components should be assessed and documented for well-care visits:

1. A health and developmental history both physical and mental health,
2. A complete physical exam to include BMI and BMI percentiles for children and adolescents, and
3. Age-appropriate health education/anticipatory guidance.

BMI Assessment

Calculate and document BMI percentiles at least annually for children and document BMIs at least every two years for adults in the medical record.

Please use the following ICD-10 codes for billing and encounter data submission. BMI percentile pediatric codes are used for ages 3–17 years old. These percentiles are based on the growth charts published by the Centers for Disease Control and Prevention (CDC). BMI codes are used for persons aged twenty and older.

BMI Assessment Codes

Please use the following codes for anticipatory guidance given to parents of children ages 3–17.

ICD-10 codes	Pediatric BMI Percentiles for Ages 2-19
Z68.51	<u>≤ 5%</u>
Z68.52	<u>5% - <85%</u>
Z68.53	<u>85% - <95%</u>
Z68.54	BMI ≥95%

Counseling for Nutrition and Physical Activity

Description	CPT	ICD-10 codes	HCPCS
Nutrition	97802, 97803, 97804	Z71.3	G0270, G0271, G0447, S9449, S9452, S9470
Physical Activity		Z02.5, Z7182	G0447, S9451

Maintain an up-to-date problem list of current and active diagnoses and active medication and medication allergy lists. Use CPT II codes for documentation of blood pressure readings.

Blood Pressure

CPT II codes	BP Reading
3074 F	Systolic blood pressure <130 mmHg
3075 F	Systolic blood pressure <130-139 mmHg
3077 F	Systolic blood pressure ≥140 mmHg
3078 F	Diastolic blood pressure <80 mmHg
3079 F	Diastolic blood pressure 80–89 mmHg
3080 F	Diastolic blood pressure ≥90 mmHg

Diabetic Eye Exam

Optometrists and ophthalmologists can use CPT II code 3072F for diabetic retinal screening exam with no evidence of retinopathy. Members can schedule an eye exam on an annual basis.

HEDIS Medical Record Review

Sharp Health Plan's goal is to decrease the burden of medical record review to ascertain care provided wherever possible. Sharp Health Plan conducts annual medical record review to support HEDIS measure documentation. These reviews typically occur from March through May. Requests for medical records are coordinated with provider office sites as needed. During this time provider offices may be contacted by Sharp Health Plan's contracted copy service, J & H Copy Services Inc., with a request for medical records or to schedule on-site visits to copy required documentation. Sharp Health Plan's QI Department will make every effort to decrease the intrusion of on-site chart review by conducting a fax campaign for off-site review of medical records during the HEDIS data collection

project period.

Should you choose to use your own vendor to copy the records requested, your office will be responsible for all service fees charged by your vendor.

Clinical Practice and Preventive Health Guidelines

Sharp Health Plan has adopted evidence-based clinical practice guidelines from nationally recognized sources. The guidelines are intended for provider use for diagnostic and treatment purposes for:

- 2017 Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults
- American Diabetes Association Standards of Medical Care in Diabetes – 2022
- 2018 ACC/AHA Guideline on the Treatment of Blood Cholesterol June 2021

The Quality Management Committee approved for adoption the three Behavioral Health clinical practice guidelines that Psychiatric Centers at San Diego has adopted for use by their clinicians:

- The American Psychiatric Association Guidelines
- The American Psychological Association Criteria for Treatment Guidelines
- The American Academy of Child and Adolescent Psychiatry Practice Parameters and Guidelines

Sharp Health Plan is committed to ensuring that members receive timely and appropriate preventive health assessments. Preventive Services are health assessments that include the physical examination of an asymptomatic, healthy member, consistent with The Guide to Clinical Preventive Services, a report of the US Preventive Services Task Force (USPSTF), the Advisory Committee for Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and other clinical preventive service guidelines as applicable or stated by law.

The member's Primary Care Provider (PCP) is responsible for basic medical care management and the provision of an initial and periodic preventive health assessment, unless otherwise indicated. At a minimum, the initial health assessment includes:

- Medical history
- Height/weight
- Blood pressure
- Body Mass Index (BMI) assessment
- BMI percentile assessment for pediatric members, if applicable
- Preventive health screens and tests considered necessary in the best clinical judgment of the provider and consistent with Plan policy (HS-CP-P5 Preventive Services available on sharphealthplan.com).

- Discussion of age-, risk-, and gender-appropriate preventive measures
- Follow-up appointments as needed

Summary of Preventive Care Services

All Members

- Age- and/or gender-appropriate Preventive Medicine visits (Wellness Visits)¹
- Routine immunizations recommended by ACIP²
- Clinicians offer pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition
- Age, gender, and/or risk status-appropriate counseling and/or screening for:
 - Alcohol abuse
 - Aspirin as a preventive measure in adult men and women (actual medication covered under pharmacy benefits)
 - Colorectal cancer for adults of average risk 45-75 years of age
 - Depression
 - Diabetes
 - Diet and nutrition
 - Elevated cholesterol and lipids for members at higher risk
 - Falls prevention for older adults
 - Hepatitis C virus
 - High blood pressure
 - HIV
 - Obesity
 - Syphilis and other sexually transmitted infections for adults and adolescents at higher risk
 - TB screening for pediatrics and adults at higher risk^{3,4}
 - Tobacco use and cessation interventions

Women's Health

- Screening mammography
- Cervical cancer screening
- Genetic counseling and evaluation for the BRCA testing
- Counseling for chemoprevention for women at high risk for breast cancer

- Screening for gonorrhea, chlamydia, and syphilis
- Osteoporosis screening
- For pregnant women:
 - Instructions to promote and aid breast feeding
 - Screening for:
 - Anemia
 - Bacteriuria
 - Hepatitis B virus
 - Rh incompatibility
 - Chlamydia
 - Syphilis
 - Gestational diabetes
 - HIV
 - Asymptomatic bacteriuria
 - Prevention
- Preeclampsia
- Well woman preventive visits to include preconception and prenatal services⁵
- Folic acid supplements for women who may become pregnant (actual medication covered under pharmacy benefit)
- FDA-approved contraception methods and contraceptive counseling⁵
- Human papillomavirus (HPV) screening DNA testing for women 30 years and older
- Breastfeeding support and counseling
- Domestic violence screening and counseling
- Annual human immunodeficiency virus (HIV) screening and counseling
- Annual sexually transmitted infection counseling
- Screening for gestational diabetes for women 24–28 weeks pregnant and those at higher risk that have no prior history of diabetes⁵

Men's Health

- Screening for prostate cancer for men ages 55 and older
- Screening for abdominal aortic aneurysm in men 65–75 years old who have ever smoked
- Human papillomavirus (HPV) vaccine for males ages 9–26¹

Pediatrics

- Measurements³
 - Height and weight
 - Head circumference
 - Weight for length
 - BMI
 - BMI percentile
- Assessments/Examinations/Screening:
 - Anticipatory Guidance³
 - Assessments for:
 - Alcohol and drug use³
 - Developmental surveillance³
 - Psychosocial/Behavioral³
 - Oral health risk³
 - Counseling for:
 - Fluoride for children without fluoride in their water source (fluoride supplements provided through pharmacy benefit)
 - Obesity, including diet and nutrition
 - Skin cancer behavior
 - Education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents
 - Behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs)
 - Gonorrhea preventive medication for the eyes
 - Iron supplementation for asymptomatic children ages 6–12 who are at increased risk for iron deficiency anemia (iron supplements covered under pharmacy benefit)
 - Screening for:
 - Adverse Childhood Experiences
 - Autism³
 - Anemia³
 - Basic vision screening and referral to vision provider if necessary
 - Cervical dysplasia screening for sexually active females

- Developmental/autism³
- Dyslipidemia screening for children at higher risk for lipid disorders³
- Hearing screening³
- Hemoglobinopathies or sickle cell anemia
- HIV screening for adolescents at higher risk
- Lead³
- Major depressive disorders
- Phenylketonuria³
- Sexually transmitted infections³
- Thyroid disease³
- Tuberculosis³

Preventive vs. Diagnostic Services

Certain services may be done for preventive or diagnostic reasons. When a service is performed for the purpose of preventive screening and is appropriately reported, it will be adjudicated under the Preventive Care Services benefit.

Preventive services are those performed on a person who has:

- Not had the preventive screening done before and does not have symptoms or other abnormal studies suggesting abnormalities.
- Had screening done within the recommended interval with the findings considered normal.
- Had diagnostic services results that were normal after which the provider recommendation would be for future preventive screening studies using the preventive services intervals.
- Had a therapeutic service provided at the same encounter and as an integral part of the preventive service (e.g., polyp removal during a preventive colonoscopy).

Diagnostic services will be adjudicated under the applicable non-preventive medical benefit.

Diagnostic services are performed on a person who has or has had:

- Symptom(s) that required further diagnosis.
- Abnormalities on previous preventive or diagnostic studies that require repeat of the same studies within shortened time intervals from the recommended preventive screening time intervals.
- Abnormalities on previous preventive or diagnostic studies that require further diagnostic studies, other than a colonoscopy for a finding on another type of colorectal screening test, which is covered with no member cost sharing.

Preventive services as Covered Benefits are updated as new recommendations and guidelines are issued, revised, or removed by the applicable regulating authority.

Coverage Limitations and Exclusions

- Services not covered under the preventive care benefit may be covered under another portion of the medical, dental, vision, or pharmacy benefit plan.
- Drugs, medications, vitamins, supplements, or over the counter contraceptive barrier methods that are recommended or prescribed for preventive measures are covered under the pharmacy benefit. Examples include, but are not limited to:
 - Aspirin for any indication, including but not limited to, aspirin for prevention of cardiovascular disease.
 - Chemoprevention for any indication, including but not limited to, chemoprevention for breast cancer.
 - Supplements, including but not limited to oral fluoride supplementation and folic acid supplementation.
 - Tobacco cessation products or medications.
- Off-label use for immunization is not covered.
- Examinations, screenings, testing, or immunizations are not covered when:
 - Required solely for the purpose of travel (travel immunizations).
 - Related to judicial or administrative proceedings or orders.
 - Conducted for purposes of medical research, unless covered under an approved Clinical Trial.
 - Required to obtain or maintain a license of any type.
- Services that are investigational, experimental, or not medically necessary are not covered.

Preventive Services Monitoring

The Plan Quality Improvement (QI) department monitors the provision of age-appropriate preventive services via annual HEDIS data collection and other quality monitoring activities. Information from QI monitoring and any action plans developed to improve preventive service compliance are shared with the plan provider or plan medical group.

These guidelines are used in conjunction with the independent judgment of a qualified licensed provider and do not constitute the practice of medicine or medical advice.

References

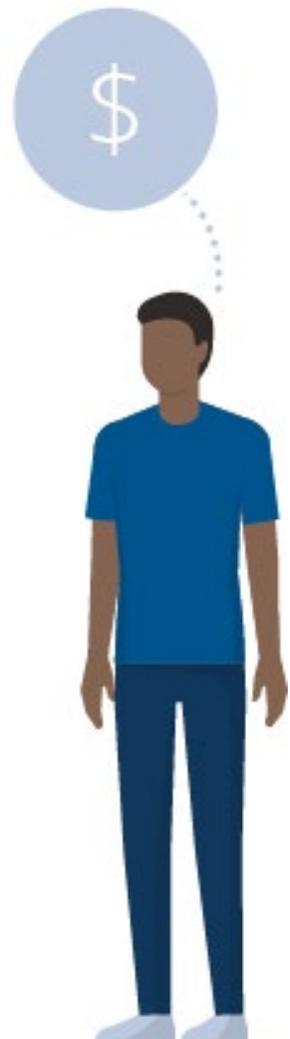
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3. American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care: Bright Futures/American Academy of Pediatrics*. Retrieved August 26, 2021, from Bright Futures: American Academy of Pediatrics: [2021 Recommendations for Preventive Pediatric Health Care | American Academy of Pediatrics \(aapublications.org\)](#)
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To access Sharp Health Plan's Preventive Health guidelines online, go to sharphealthplan.com/for-providers/clinical-resources

SECTION IX

Claims and Encounters



Claims

One of the goals of Sharp Health Plan is to ensure plan providers' claims and payments are processed accurately and in a timely manner, in accordance with industry standards and state and federal regulations. The guidelines in this section of the Provider Manual can help providers ensure their claims are submitted correctly. Providers who are contracted with Sharp Health Plan through an affiliated PMG must follow the requirements outlined by the PMG when billing for services that are the responsibility of the PMG.

As required by Assembly Bill 1455, the California Department of Managed Health Care (DMHC) has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products regulated by the DMHC. Sharp Health Plan has posted a notice of claim settlement practices on sharphealthplan.com. Please review the notice in its entirety. It is intended to inform you of your rights and responsibilities, and procedures related to claim settlement practices and claim disputes.

Claims Address

Claims for services provided to members assigned to entities delegated for claims processing should be mailed directly to the entity. Current claims address for all entities are available in our provider portal, Sharp Connect, at sharphealthplan.com.

Providers contracted directly with Sharp Health Plan should send claims to:

Sharp Health Plan
P.O. Box 939036
San Diego, CA 92193-9036

Claim Submission Requirements

The following is a list of claim timeliness requirements, claims supplemental information, and claims documentation required by Sharp Health Plan. For more information, or to view our policies and procedures, please visit sharphealthplan.com/for-providers/claims-information.

- Contracted providers must submit claims within 90 days or according to their agreement terms. Non-contracted providers have 180 days after the date of service to submit a claim. Claims submitted outside of these time frames may be denied as untimely
- Claims must be submitted on the most current version of standard claim forms CMS 1500 (non-institutional providers and suppliers) or UB-04 or CMS-1450

(institutional providers). Forms should be completed legibly in black ink with standard fonts on forms printed in red “dropout” ink. Please refer to NUCC.org for instructions. No “Superbills” will be accepted or processed

- Submit claims with all reasonably relevant information to determine payer liability and to ensure timely processing and payment
- Non-contracted providers must submit a completed IRS Form W-9 with claims.
- If Sharp Health Plan is the secondary payer, then providers must submit the primary payer explanation of benefits (EOB) with applicable claims to facilitate coordination of benefits

Electronic Claims Submissions

Providers have the option of submitting claims electronically through electronic data interchange (EDI). The advantages of electronic claims submission include the following:

- Prompt acknowledgement of claims receipt
- Improved claims tracking and status reporting
- Reduced turnaround time for timely reimbursement
- Eliminated paper
- Improved cost effectiveness

Claims submitted electronically must be compliant with federal HIPAA transaction standards. Sharp Health Plan does not currently accept claims submitted by a clearinghouse that charges a fee to the Plan.

If a plan provider submits fewer than 1,000 claims a month then the provider may work with an approved clearinghouse from the list below:

Sharp Health Plan Approved Clearinghouses

Capario

Gateway EDI (also known as Trizetto) Office Ally Zirmed

All new EDI submission requests will need to be submitted by filling out an [EDI Provider Request form](#) or the online form on the [Sharp Connect provider portal](#).

Claim Receipt Verification and Claim Status Inquiries

For verification of claim receipt or claim status inquiries:

- Sharp Health Plan will verify the date of claim receipt within two (2) working days of receipt of an electronic claim and within 15 working days of receipt of a hard copy claim. An example of the acknowledgement form is provided on subsequent pages.
- Claim status is provided via an explanation of benefits (EOB) that is included with all payments. An example of the EOB and explanation of terms are provided on subsequent pages.
- Providers can confirm claim receipt and claim status by calling Customer Care at 1-858-499-8300 or toll-free 1-800-359-2002. We are available to assist you Monday through Friday from 8:00 a.m. to 6:00 p.m. To ensure efficient service, the following information is needed at the time of the call: member number, date of service, procedure code, provider name, and claim number (if known). Telephone inquiries are limited to a maximum of five claims per call.

Claims Editing System

The clinical editing system in use is based on multiple-coding support including:

- CPT-4, HCPCS, and ICD-10-CM
- CCI
- AMA and CMS guidelines and industry standards
- Medical policy and literature research
- Input from academic affiliations
- Specialty society recommendations

Every decision is fully supported with a variety of clinical documentation to ensure complete understanding of the system and communication to the provider community. The edits are based on the information provided on the claim. If the claim information is incomplete or invalid, the claim edits will be accurate but may not be the outcome the provider expected.

Most edits are reviewed by coding staff before claims are processed. Please make sure additional documentation to justify coding is included on the claim, such as modifiers and information in box 19 of the CMS 1500 or box 84 of the UB04. Any clinical or operative reports should be attached to validate procedures billed with modifier 59, Emergency Services and unlisted procedures. The additional information will provide the claims examiner with the necessary information to process the claim correctly.

Claims Policy Administration Module

In order to process consistently based on industry-standard guidelines the Policy Administration Module allows the building of custom rules that reflect medical and payment policies. To address the complexity of benefit plan designs, the module allows for the enhancement of code auditing with additional fields and combinations for review or comparison that include:

- Frequency of procedure codes
- Claim lines for code combinations present or not present
- Claim lines for limits based on days before or after the claims date
- Claim lines for the same, different or all providers or the same specialty
- Monitoring for the frequent use of modifier codes

Industry standard guidelines that will be audited via the new Policy Administration Module include but not limited to:

- Denying the Add-On Code without the parent code billed
- Procedure allowed once in a lifetime for certain surgical procedures
- Documentation required when billing modifier 62
- Denying Co-Surgeon (mod 62) codes not payable per Medicare guidelines
- Codes not payable with team surgeon modifier 66
- Denying drug admin codes without the drug billed
- New visit frequency editing

Encounter Data

Sharp Health Plan must receive timely Encounter Data to appropriately track member's Deductibles and out-of-pocket costs, meet reporting requirements, and to monitor the value of services provided under capitation. Plan providers reimbursed under capitation must send encounter data to Sharp Health Plan for each member encounter. Encounter data must be submitted either electronically or on the applicable claim form, following standard claims submission guidelines, within 120 days of the date of service. An EOB is sent to acknowledge all encounter data. See Section VIII for sample EOB and definition of terms.

Capitated providers also receive a Capitation Listing to support the capitation payment.

Encounter data completeness and quality is monitored regularly by the Plan. If problems are identified with the timeliness, quality or quantity of submissions, Sharp Health Plan will contact the capitated provider to review and correct the identified problems.

Fee Schedules

The current Medicare Fee Schedule is available on <https://www.cms.gov/medicare/physician-fee-schedule/search/overview>. The Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule (DMEPOS) can be found on med.noridianmedicare.com. Please refer to Appendix A of your agreement with Sharp Health Plan for details on how these fee schedules and other mutually agreed upon payment rates are used to determine reimbursement. If you have any questions regarding your agreement, please contact:

Sharp Health Plan
Attention: Contracts Department
8520 Tech Way, Suite 200
San Diego, CA 92123 Phone: 1-858-499-8330
Fax: 1-858-636-2276

Adjustment Requests

Please review all explanation codes listed on the EOB to determine if a claim denial was the result of insufficient information or an incomplete claim. Please submit all requested documents or a corrected claim promptly to ensure appropriate, timely reimbursement.

Corrected claims must be identified as such to avoid being identified as duplicates. Providers who feel their claim was processed incorrectly should contact Customer Care at 1-858-499-8300 or toll-free 1-800-359-2002 or shp.claimsresearch@sharp.com for an explanation, or send in an adjustment request with a copy of the claim to the following address:

Sharp Health Plan
Attention: Claims Research
8520 Tech Way, Suite 200
San Diego, CA 92123
Fax: 1-858-636-2276

After reviewing the request, the Claims Research Specialist will advise if an adjustment is necessary. If an adjustment is necessary, the Specialist will forward the request to the Claims Department for processing.

Coordination of Benefits

When a member has coverage under two or more group or Medicare plans, the benefits of these plans will be coordinated so that the total amount paid out does not equal more than the actual cost of treatment. Coordination of benefits is vital in keeping the cost of coverage as low as possible. Prior to billing Sharp Health Plan or an affiliated PMG, providers must bill primary insurance carriers, including Medicare. The provider must include a copy of the other insurance carrier's explanation of benefits with the claim.

Sharp Health Plan will advance providers covered benefits at the time of member medical need, even if the member illness or injury is suspected to be work-related or otherwise covered by a third-party payer. If the covered benefits received by the member are found to be covered by workers' compensation or another third-party payer, the Plan will pursue reimbursement. This requirement is consistent with state law (California Code of Regulations § 1300.67.13 (a)(2) and (3), which prohibits delaying or refusing to provide covered benefits because the member may be entitled to other coverage.

Please review your screening protocols to confirm that Sharp Health Plan members are not denied medical attention due to possible coverage by any other plan or insurer.

In no event will Sharp Health Plan's payment for covered services together with the payment made by the primary carrier exceed the amount that would have been payable if Sharp Health Plan had been the primary carrier. The provider agrees to accept the contracted amount as payment in full, whether that amount is paid in whole or part by the member, Sharp Health Plan, or any combination of payers, including other payers that may pay as primary.

On Medicare claims, Sharp Health Plan reimburses the Medicare Deductible and Coinsurance only up to Sharp Health Plan's normal benefit limit. For commercial payers, Sharp Health Plan will reimburse up to the Sharp Health Plan allowed amount, excluding the member out-of-pocket costs.

Third-Party Liability

If a member is injured in an accident caused by a negligent or intentional act or omission of another person, the Plan will advance Covered Benefits at the time of need subject to an automatic lien by agreement to reimburse the Plan from any recoveries or reimbursement the member may receive from the person who caused the injury. Plan providers may not refuse to provide Covered Benefits to members who are injured by another party. Plan providers may not require members to assign any recoveries or reimbursements to the provider as a condition of receiving care. All claims for services rendered in relation to a third-party liability case should be submitted for processing as described in Sharp Health Plan's Notice of Claims Settlement Practices. The claims will follow normal processing guidelines. Any recoveries related to third party or worker's compensation liabilities will be made by Sharp Health Plan.

Sharp Health Plan must be notified in writing of all potential and confirmed third party and worker's compensation liability cases that involve a Sharp Health Plan member.

Notification must include:

- Member name
- Member identification number
- Date of birth
- Date of injury

- Identification of third party, if known
- Provider name and address
- Date(s) of service
- ICD10 code and/or description of injury
- CPT code and/or description of service(s) rendered
- Billed charges for service(s)
- Any amount paid by other coverage (if applicable)
- Date of denial and reason(s) for any applicable denials from other payers

Send notices of potential third-party liability to:

Sharp Health Plan
 Attn: Third Party Liability
 8520 Tech Way, Suite 200
 San Diego, CA 92123
 Fax: 1-619-740-8571

Member Costs and Out-of-Pocket Maximum

Copayments, coinsurance, and deductibles are fees paid by the member to the provider for covered benefits at the time the service is received. Sharp Health Plan members may only be charged for applicable copayments, coinsurance and deductibles indicated on the member's identification card, through Sharp Connect and/or as verified with Customer Care.

A member's financial responsibility will vary based on the member's benefit plan. A copayment may be a flat amount (e.g., \$15.00 copayment for an office visit) or a percentage of the contracted rate (e.g., 20% coinsurance for durable medical equipment).

Some benefit plans include a deductible. A deductible is the amount the member must pay each calendar year for certain Covered Benefits before Sharp Health Plan will start to pay for those covered benefits. The amounts the member is required to pay for the covered benefits subject to a deductible are based upon Sharp Health Plan's cost for the covered benefit. Once the member has met the yearly deductible, the member pays the applicable copayment for covered benefits and Sharp Health Plan pays the rest. The deductible starts over each year.

- There is a maximum total amount of copayments, coinsurance and deductibles members pay each year for covered benefits, excluding supplemental benefits. The annual out-of-pocket maximum amount is listed on the Health Plan Benefits and Coverage Matrix and is renewed at the beginning of each calendar year. Copayments and deductibles for supplemental benefits (e.g., chiropractic services) do not apply to the annual out-of-pocket maximum. If a member pays amounts for covered benefits that equal the individual out-of-pocket maximum, no further

copayments or deductibles are required for that member for covered benefits (excluding supplemental benefits) for the remainder of the year. Premium contributions will continue to be required.

- Once a member in a family satisfies the Individual out-of-pocket maximum, the remaining enrolled family members must continue to pay applicable copayments and deductibles until either (a) the sum of the copayments and deductibles paid by the family reaches the family out-of-pocket maximum or (b) each enrolled family member meets his/her individual out-of-pocket maximum, whichever occurs first.
- When the sum of the copayments and deductibles paid for all enrolled members equals the family out-of-pocket maximum, no further copayments or deductibles are required from any enrolled member of that family for the remainder of the calendar year.
- Only amounts that are applied to the Individual out-of-pocket maximum may be applied to the family out-of-pocket maximum. Any amount the member pays for covered benefits that would otherwise apply to the individual out-of-pocket maximum, but which exceeds the Individual out-of-pocket maximum will be refunded to the member and will not apply toward the family out-of-pocket Maximum. Individual members cannot contribute more than their individual out-of-pocket maximum amount to the family out-of-pocket maximum.
- Calculation of out-of-pocket maximums may be different for members enrolled in an HSA-compatible benefit plan.

The following payments do not apply to the out-of-pocket maximum. Members are required to continue to pay the payments listed below even if the annual out-of-pocket maximum has been reached.

- Payments for services or supplies that the Plan does not cover, e.g., excluded drugs, cosmetic surgery, and unauthorized non-emergency services.
- Copayments for supplemental benefits such as assisted reproductive technologies, chiropractic services, and hearing aids.

Sharp Health Plan will provide enrollees with their most up-to-date accrual balance toward their annual deductible and out-of-pocket maximum for every month in which benefits were used until the accrual balance equals the full deductible and/or out-of-pocket amount. The member will receive a confirmation letter to show proof to providers that no additional out-of-pocket costs are due for the calendar year.

Balance Billing

Sharp Health Plan members may only be charged for applicable copayments, coinsurance and deductibles as indicated on the member's identification card and/or as verified with Customer Care. Balance billing occurs when a member receives a bill from a provider for services that are covered by Sharp Health Plan. Under the Knox Keene Act of 1975, health plan enrollees are not liable to a

provider contracted with the Plan for any sums owed to the provider by the Plan. Plan providers are prohibited by state law from billing members for services covered by the Plan. For example, if Sharp Health Plan denies a claim for a covered benefit because the claim was submitted after the submission deadline, the provider may appeal the denial to the Plan, but may not bill the member for the services regardless of the outcome of the appeal.

The California Supreme Court, in the case of *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group, et al.*, issued a ruling in January of 2009 which makes it unlawful for providers to bill emergency-room patients for the difference between their billed charges and what the health plan has paid for the out-of-network care received by the health plan's member. Providers may contact the department identified in your EOB/Remittance Advice to submit a provider payment dispute relating to the claim in question.

Plan providers may not seek additional payment from Sharp Health Plan enrollees beyond those authorized in the Plan description. At no time should members be balanced billed for appropriately authorized covered benefits. For services that are not covered under the Plan, the member should be notified in advance that the service is not covered, and that the member will be responsible for payment in full for that service.

Sharp Health Plan has a systematic process to assist providers and members with balance billing questions. In most cases, members are informed that they are receiving a statement from providers while billing between the provider and Sharp Health Plan is in process.

Please help us ensure that balance billing is not initiated when Plan payment is expected. For assistance with specific member issues and claims status, providers may contact Sharp Health Plan at 1-858-499-8300, or toll-free at 1-800-359-2002, or email customer.service@sharp.com. We are available to assist you Monday through Friday from 8 a.m. to 6 p.m.

Bills for Prenatal Genetic Testing

The California State Genetic Diseases Branch is responsible for conducting prenatal genetic testing and newborn screening for all births in California. Unfortunately, the State does not collect information about the member's insurance when the tests are conducted. As a result, every woman who has the prenatal tests conducted receives bills from the State for the services.

These tests are Covered Benefits for Sharp Health Plan members. Providers should encourage members to forward the bills they receive to the Plan at the following address or Fax number, so the claims can be paid.

Sharp Health Plan
Attn: Claims Research
8520 Tech Way, Suite 200
San Diego, CA 92123
Fax: 858-636-2276

It is important that members not ignore the bills from the Genetic Diseases Branch. If they remain unpaid, the billed amounts will be deducted from any tax refund due to the member from the state.

Dispute Resolution

A provider dispute is a provider's written notice to Sharp Health Plan:

- Challenging, appealing, or requesting reconsideration of a claim that has been denied, adjusted, or contested; or
- Seeking resolution of a billing determination or other contract dispute; or
- Disputing a request for reimbursement of an overpayment of a claim.

Sharp Health Plan's Provider Dispute Resolution Form can be found on sharphealthplan.com/providers/forms-and-materials. Providers without Internet access can contact Customer Care at 1-858-499-8300, toll-free at 1-800-359-2002, or email customer.service@sharp.com to obtain a copy.

Provider disputes must be received by Sharp Health Plan within 365 days from Sharp Health Plan's action that led to the dispute (or the most recent action if there are multiple actions).

In the case of Sharp Health Plan's inaction, provider disputes must be received by Sharp Health Plan within 365 days after the Plan's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

Sharp Health Plan will issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute or the amended provider dispute. If the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, Sharp Health Plan will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five working days of the issuance of the written determination.

Sharp Health Plan has posted a notice of claim settlement practices and provider dispute resolution on sharphealthplan.com. Please review the notice in its entirety. It is intended to inform you of your rights, responsibilities, and related procedures as they relate to claim settlement practices and Provider disputes.

Claim Acknowledgement



(858) 499-8300 – 8520 Tech Way, Suite 200 - San Diego, CA 92123 - Fax (858) 499-8244

02/02/2001
471*12345_1234567_1_0

Anthony P. Treatment, M.D.
9900 Medical Dr. STE 100
San Diego, CA 92000

Claims Acknowledgement

This form acknowledges claims received within the last seven days by Sharp Health Plan. This acknowledgement only serves to notify you that the claim was received. It does not guarantee claim payment. For questions regarding this receipt, please call Sharp Health Plan. All clean claims for Sharp Health Plan Members will be processed in 45 working days (60 calendar days) of receipt. For all acknowledged claims, please allow 60 calendar days for processing before inquiring about claims status.

<i>Patient Name</i>	<i>Claim #</i>	<i>Account #</i>	<i>Date</i>	<i>Billed Amount</i>	<i>Received Date</i>
MEMBER, JACK	5123456	TRE0000123456	01/01/2001	\$720.00	01/20/2001

Remittance Advice Summary

Remittance Advice Summary

Page 1

Sort

TREATMENT M.D., ANTHONY P.
9900 MEDICAL DR STE 100
SAN DIEGO, CA 92000

SHARP HEALTH PLAN
8520 Tech Way
SUITE 100
SAN DIEGO, CA 92123
Tax ID # 33-0609888
Check # 1100157126

Run No: 271

Provider: ANTHONY P. TREATMENT, M.D.

From Date	To Date	Proc Code	Procedure Mod Description	Disa	Tot Cms	Amount Billed	Non Contracted	Contract Adjustment	Coinsured	Amount Allowed	Deduct Copay Coins	COB	Withhold	Net Payable
Patient Member, Jack														
			Member # 12345678X *01											
								Plan : Sharp Health Plan HMO MEDICAL PLANS						
										1100SPA				
01/15/2001	01/15/2001	99213	OV.EXP.PROB FOCSD.LOW	401.9		60.00	0.00	0.00	0.00	60.00	10.00	0.00	0.00	50.00
01/15/2001	01/15/2001	71020	XR.CHEST 2 VIEWS-PA	401.9		40.00	0.00	0.00	0.00	40.00	0.00	0.00	0.00	40.00
Claim 12345, Account #0009876 totals:						100.00	0.00	0.00	0.00	100.00	10.00	0.00	0.00	90.00
01/01/2001	01/05/2001	44950	APPENDECTOMY 315 CONTRACT ADJUSTMENT	541		900.00	0.00	180.00	0.00	720.00	0.00	0.00	0.00	720.00
Claim 12345, Account #0009876 totals:						900.00	0.00	180.00	0.00	720.00	0.00	0.00	0.00	720.00
Provider totals:				2		1000.00	0.00	180.00	0.00	720.00	0.00	0.00	0.00	610.00
Payable total:														610.00
Remittance total:				2		1000.00	0.00	180.00	0.00	720.00	0.00	0.00	0.00	610.00

Payable total:

Provider disputes for dates of service on or after January 1, 2004 must be submitted to Sharp Health Plan within 365 days of the date of this Remittance Advice. If the dispute is regarding a claim it must contain, at a minimum: provider name, provider identification number, provider contract information, date of service, clear identification of the disputed item, and a clear explanation of the basis upon which you believe the payment amount, request for reimbursement for overpayment of claim, contest, denial, adjust, or other action is incorrect. Dispute requests must be accompanied by the Provider Dispute Resolution.

If the dispute involves an enrollee, or group of enrollees, the name and identification number (s) of the enrollee, or enrollees, clear explanation of the disputed item, including the date of service, provider's position on the dispute. And an enrollee's written authorization for the provider to represent said enrollee(s). Multiple "like" claims disputed must be accompanied by the Multiple "Like" Claim Request form, available at www.SharpHealthPlan.com or by calling (858) 499-8300.

Please mail the dispute to: PROVIDER DISPUTE RESOLUTION DEPT
SHARP HEALTH PLAN
8520 Tech Way, Ste 100
SAN DIEGO, CA 92123

Remittance Advice Terms

Glossary of Remittance Advice Terms:



Abbreviation	Definition
From Date	The date services began
To Date	The last date services were provided
Proc Code	Procedure Code, code used to identify the procedure performed
Procedure Mod Description	Procedure Modifier Description, description of modifier used to further identify the procedure
Tot Clm	Total Claim, the total billed amount for the claim
Amount Billed	The amount billed for the claim line
Non Covered	The amount that is not covered for the claim line
Contract Adjustment	Payment adjustments made to the claim line
Capitated	Amount of billed charges applied to capitation payments
Amount Allowed	Allowed amount for the claim line
Deduct Copay Coins	Deduct Copay/Coinsurance, amount deducted from the Allowed Amount for the patient's applicable copayment
COB	Coordination of Benefits, amount deducted from the Allowed Amount that was paid by primary payer
Withhold	Any monies that are subject to being withheld by the Plan
Net Payable	Total payable amount for the claim line

Glossary

Term	Definition
<p>Active Labor</p>	<p>An Emergency Medical Condition that results in a labor at a time at which any of the following would occur:</p> <p>A woman experiences contraction (a woman experiencing contractions is presumed to be in true labor unless a provider or qualified individual certifies after a reasonable time of observation that the woman is in false labor).</p> <p>There is inadequate time to affect a safe transfer to another hospital prior to delivery; or</p> <p>A transfer may pose a threat to the health and safety of the patient or the unborn child.</p>
<p>Activities of Daily Living (ADLs)</p>	<p>The basic tasks of everyday life, such as eating, bathing, dressing, toileting, and transferring (e.g., moving from the bed to a chair).</p>
<p>Appeal</p>	<p>A written or oral expression requesting a re-evaluation of a specific determination made by the Plan or any of its authorized Subcontractors (Plan Medical Groups).</p> <p>The determination in question may be a denial or modification of a requested service. (It may also be called an adverse benefit determination.)</p>
<p>Authorization</p>	<p>Approval by the member’s Plan Medical Group (PMG) or the Plan for Covered Benefits. (An Authorization may also be called a pre-service claim.)</p>
<p>Authorized Representative</p>	<p>An individual designated by the member to receive Protected Health Information about the member for purposes of assisting with a claim, appeal, grievance, or other matter. The Authorized Representative must be designated by the member in writing on a form approved by Sharp Health Plan.</p>

Term	Definition
Chronic Condition	A medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure, or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration.
Coinsurance	The portion of the cost of a covered health care service, calculated as a percent (for example, 20%) that is the financial responsibility of the member. The member pays coinsurance plus any deductibles owed. For example, if the Plan's allowed amount for an office visit is \$100 and the member has met the deductible, the coinsurance payment of 20% would be \$20.
Copayment	A fee that a plan provider or its subcontractors may collect directly from a member, and which a member is required to pay, for a particular Covered Benefit at the time service is rendered.
Covered Benefits	Medically Necessary services and supplies that members are entitled to receive under an employer group or individual agreement, and which are described in the Member Handbook.
Deductible	The amount a member must pay in a calendar year under some plans for certain Covered Benefits before the Plan will start to pay for those Covered Benefits in that calendar year. Once the member has met either the family or individual yearly Deductible, the member pays the applicable Copayment or Coinsurance for Covered Benefits, and the Plan pays the rest.
Dependent	An enrollee's legally married spouse, domestic partner, or child (including an adopted child or stepchild), who meets the eligibility requirements set forth in the member Handbook, who is enrolled in the Plan, and for whom the Plan receives premiums.
Disposable Medical Supplies	Medical supplies that are consumable or expendable in nature and cannot withstand repeated use by more than one individual, such as bandages, elastic bandages, incontinence pads, and support hose and garments.

Term	Definition
Domestic Partner	<p>A person who has established a domestic partnership as described in Section 297 of the California Family Code by meeting all the following requirements.</p> <ol style="list-style-type: none"> 1. Both persons agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership. 2. Neither person is married or a member of another domestic partnership. 3. The two persons are not related by blood in a way that would prevent them from being married to each other in this state. 4. Both persons are at least 18 years of age. 5. Both persons are capable of consenting to the domestic partnership. 6. Either of the following: <ol style="list-style-type: none"> a. Both persons are members of the same sex. b. One or both persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. <p>Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both persons are over the age of 62.</p> 7. Neither person has previously filed a Declaration of Domestic Partnership with the Secretary of State pursuant to this division that has not been terminated under Section 299. 8. Both file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division. <p>If documented in the agreement with Sharp Health Plan, Domestic Partner also includes individuals who meet criteria 1–5 above and who sign an affidavit attesting to that fact.</p>

Term	Definition
Drug Formulary (Drug List)	The continuously updated list of drugs that are covered by the Plan. A Drug Formulary enhances quality of care by encouraging the use of those prescription medications that are demonstrated to be safe and effective and produce superior patient outcomes. The Drug Formulary consists of brand and generic drugs. Prescription drugs must be dispensed in generic form when one is available, provided that no medical contraindication exists. Brand-name drugs are charged a higher Copayment. Medications that are not listed on the Drug Formulary are not covered, unless Authorized by the Plan.
Durable Medical Equipment	Medical equipment appropriate for use in the home which is intended for repeated use; is generally not useful to a person in the absence of illness or injury, and primarily serves a medical purpose.
Emergency Medical Condition	A medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable lay person could reasonably expect the absence of immediate attention to result in placing the patient's health in jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
Emergency Services	Covered Benefits, including Emergency Services and Care, provided inside or outside the Service Area that are medically required on an immediate basis for treatment of an Emergency Medical Condition.

Term	Definition
Emergency Services and Care	<ol style="list-style-type: none"> 1. Medical screening, examination, and evaluation by a provider, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a provider, to determine if an Emergency Medical Condition or Active Labor exists and, if it does, the care, treatment, and surgery by a provider if necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and 2. An additional screening, examination, and evaluation by a provider, 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.
Employer	Any person, firm, proprietary or nonprofit corporation, partnership, or public agency that is actively engaged in business or service, which was not formed primarily for purposes of buying health care service plan contracts and in which a bona fide employer-employee relationship exists.
Health Plan Benefits and Coverage Matrix	A list of the most commonly used Covered Benefits and applicable Copayments for the specific benefit plan purchased by the Employer. Members receive a copy of the Health Plan Benefits and Coverage Matrix along with the Member Handbook. The Health Plan Benefits and Coverage Matrix may also be called the Summary of Benefits.
Maintenance Drugs	Medications that represent drugs necessary for members with chronic, potentially life-threatening illnesses that are used by the majority of members and that the P&T Committee determines can be supplied for up to a 90-day supply per fill.

Term	Definition
Medically Necessary	<p>A treatment or service necessary to protect life; to prevent illness or disability; to diagnose, treat, or control illness, disease, or injury; or to alleviate severe pain. The treatment or service should be:</p> <ol style="list-style-type: none"> 1. Based on generally accepted clinical evidence. 2. Consistent with recognized standards of practice. 3. Demonstrated to be safe and effective for the member's medical condition; and <p>Provided at the appropriate level of care and setting based on the member's medical condition.</p>
Member	<p>An individual, who has enrolled in the Plan under the provisions of an employer group or individual plan agreement and for whom the applicable premiums have been paid.</p>
Out-of-Area	<p>Services received while a member is outside the Service Area. Out-of-Area coverage includes Urgent or Emergent services for the sudden onset of symptoms of sufficient severity to require immediate medical attention to prevent serious deterioration of a member's health resulting from unforeseen illness or injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the member returns to the Service Area. Out-of-Area medical services will be covered to meet the member's immediate medical needs. Applicable follow-up for the Urgent or Emergent service must be Authorized by Sharp Health Plan and will be covered until it is prudent to transfer the member's care into the Plan's Service Area.</p>
Plan	<p>Sharp Health Plan.</p>
Plan Hospital	<p>An institution licensed by the State of California as an acute care hospital that provides certain Covered Benefits to members through an agreement with the Plan and that is included in the member's Plan Network.</p>

Term	Definition
Plan Medical Group (PMG)	A group of providers, organized as or contracted through a legal entity, that has met the Plan's criteria for participation, and has entered into an agreement with the Plan to provide and make available Professional Services and to provide or coordinate the provision of other Covered Benefits to members on an independent contractor basis, and that is included in the member's Plan Network.
Plan Pharmacy	Any pharmacy licensed by the State of California to provide outpatient prescription drug services to members through an agreement with the Plan. Plan Pharmacies are listed in the Provider Directory.
Plan Provider	Any Doctor of Medicine, osteopathy, podiatry, or dental surgery licensed by the State of California who has agreed to provide Professional Services to members, either through an agreement with the Plan or as a member of a PMG, and who is included in the member's Plan Network.
Plan Providers	The providers, hospitals, Skilled Nursing Facilities, home health agencies, pharmacies, medical transportation companies, laboratories, X-ray facilities, Durable Medical Equipment suppliers, and other licensed health care entities or professionals that are included in the member's Plan Network and which or who provide Covered Benefits to members through an agreement with the Plan or PMG.
Primary Care Provider (PCP)	A Plan Provider, possibly affiliated with a PMG, who is chosen by or for a member from the member's Plan Network; and who is primarily responsible for supervising, coordinating, and providing initial care to the member, maintaining the continuity of member's care, and providing or initiating referrals for Covered Benefits for the member. Primary Care Providers include general and family providers, internists, pediatricians, and qualified OB-GYNs who have the ability to deliver and accept the responsibility for delivering primary care services.
Professional Services	Professional diagnostic and treatment services which are listed in the Member Handbook and supplemental benefits brochures, if applicable, and are provided by Plan Providers and other health professionals.

Term	Definition
Protected Individual	Any adult covered by the subscriber's health care service plan or a minor who can consent to a health care service without the consent of a parent or legal guardian, pursuant to state or federal law. "Protected individual" does not include an individual that lacks the capacity to give informed consent for health care pursuant to Section 813 of the Probate Code.
Provider Directory	A listing of Plan-approved providers, hospitals, and other plan providers, which is updated periodically.
Qualified Health Professional	A primary care provider (PCP), or a specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to a particular illness, disease or condition, or conditions associated with the request for a second opinion

Term	Definition
<p>Serious Emotional Disturbance (SED)</p>	<p>One or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, to include Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder and other pervasive developmental disorders not otherwise specified (including Atypical Autism), in accordance with diagnostic and statistical manual for Mental Disorders–IV-Text revisions (July 2000), other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child’s age according to expected developmental norms. One or more of the following must also be true:</p> <ol style="list-style-type: none"> 1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and either of the following occur: <ol style="list-style-type: none"> a. The child is at risk of removal from the home or has already been removed from the home; or <p>The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year if not treated.</p> 2. The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder; or 3. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.
<p>Service Area</p>	<p>The geographic area in which Sharp Health Plan is licensed to provide health services, as approved by the California Department of Managed Health Care.</p>

Term	Definition
Sensitive Services	All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.
Severe Mental Illness	One or more of the following nine disorders in persons of any age: schizophrenia, schizoaffective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive- compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.
Skilled Nursing Facility (SNF)	A comprehensive free-standing rehabilitation facility or a specially designed unit within a hospital licensed by the state of California to provide skilled nursing care.
Subscriber	The individual enrolled in the Plan for whom the appropriate premiums have been received by Sharp Health Plan, and whose status, except for family dependency, is the basis for enrollment eligibility.

Term	Definition
Totally Disabled	<p>A member who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, and who is chiefly dependent upon the Subscriber for support and maintenance. The determination as to whether a member is Totally Disabled will be made based upon an objective review consistent with professionally recognized medical standards.</p> <p>Member requires these services, or the member is Out-of-Area and requires Urgent Care Services. Urgent Care Services means those services performed, inside or outside the Plan's Service Area, which are medically required within a short time frame, usually within twenty-four (24) hours, in order to prevent a serious deterioration of a member's health due to an illness or injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgently needed services include maternity services necessary to prevent serious deterioration of the health of the member or the member's fetus, based on the member's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the member returns to the Service Area.</p>
Utilization Management	<p>The evaluation of the appropriateness, medical need, and efficiency of health care services and facilities according to established criteria or guidelines and under the provisions of the applicable health benefits plan.</p>

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