Community Care Health Provider Operations Manual

Revised as of December 31, 2024

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Section I: Introduction and Overview

Resource Guide

Resource	Contact Information
Medical Claims	For claims with DOS prior to 1/1/2025 to: PO Box 45026 Fresno, CA 93718 PAYOR ID: 85729 1-855-343-2247 For claims with DOS on or after 1/1/2025 send to: PO Box 45016 Fresno, CA 93718 PAYOR ID: CCH 25 customerservice@communitycarehealth.org
	Call Customer Service at: (559) 724-4995
Behavioral Health Claims	Send Behavioral Health claims to: SimpleBehavioral PO Box 25159 Fresno, CA 93729-5159 Electronically through: OfficeAlly – Payor ID: HALCY Fax: (855) 486-1341 Questions Call: (855) 424-4457
Physical Medicine Claims	Send physical medicine claims to: SimpleMSK PO Box 25220 Fresno, CA 93729-5220 Electronically through: OfficeAlly – Payor ID: PM001 Fax: (855) 486-1343 Questions Call: (877) 519-8839

Customer Service	Community Care Health PO Box 45016 Fresno, CA 93718 customerservice@communitycarehealth.org Call Customer Service at: (559) 724-4995 Monday through Friday 8am to 5pm Customer Service Fax: (559) 603-7368
Eligibility Information	Community Care Health PO Box 45016 Fresno, CA 93718 www.communitycarehealth.org/for-providers Call Customer Service at: (559) 724-4995
Provider Directory	Call Customer Service at: (559) 724-4995 https://www.communitycarehealth.org/find-a-provider
Prior Authorization – Medical Services	Community Care Health PO Box 45016 Fresno, CA 93718 Call Customer Service at: (559) 724-4995 UM Fax: PRIMARY: (559) 724-4750 SECONDARY: (559) 724-4751
Prior Authorization - Behavioral Health Services (SimpleBehavioral)	All forms and direct submission available at halcyonbehavioral.com/providers Email: clinical@halcyonbehavioral.com Fax: (888) 304-1429 Call SimpleBehavioral at: (888) 425-4800
Prior Authorization – Physical Medicine Services (SimpleMSK)	All forms and direct submission available at physmetrics.com/providers Email: clinical@physmetrics.com Fax- 888-439-4819 Call SimpleMSK at: (877) 519-8839

Resource	Contact Information
Prior Authorization – Prescription Drugs (MedImpact)	https://www.communitycarehealth.org/for-providers/#pharm MedImpact Fax: (858) 790-7100 Call MedImpact at: (855) 873-8739
Provider Portal	https://www.communitycarehealth.org/for-providers/
Provider Contracts	Providerrelations@communitycarehealth.org

Community Care Health's Responsibilities

Community Care Health is committed to serving its Members[1] and Providers with the highest quality of service. Participating Providers have the right to expect the following:

- Respect
- Confidentiality
- Orientation and in-service training
- Information about changes in policies, procedures, and plan benefits
- Prompt responses to inquiries
- Accurate and timely claims processing
- Timely resolutions of disputes
- Accurate representation in Community Care Health directories and publications

Service Area

Service Area means the geographic area in which Community Care Health is licensed to arrange for the provision of health care services, as approved by the California Department of Managed Health Care. The Community Care Health Service Area includes certain ZIP codes in Fresno, Madera and Kings Counties, California. For more information about Community Care Health's Service Area, please visit our website or call Customer Service at (559) 724-4995.

Compliance Program

Community Care Health has a comprehensive commitment to compliance based on trust, integrity and accountability, which reflects how fundamental components of Community Care Health's business operations are conducted.

Community Care Health recognizes that its Providers are key 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

Community Care Health complies with applicable federal and state statutory, regulatory, and contractual requirements related to health plan operations. In accordance with state and federal regulations, Community Care Health has a plan to detect, correct, and prevent fraud, waste, and abuse.

[1] Capitalized terms not defined in this Provider Manual shall have the same meaning assigned to them in the Participating Provider Agreement.

Fraud, waste, and abuse are defined as:

- **Fraud** – Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud Community Care Health 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, Community Care Health or any health care benefit program.

- **Waste** – Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to Community Care Health 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 Community Care Health 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.

The purpose of Community Care Health’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 Community Care Health’s delivery systems.

Community Care Health monitors, investigates, and corrects possible fraud, waste, and abuse issues. Reporters of suspected fraud have the right to remain anonymous. If you suspect fraud, please call Community Care Health’s Anonymous Alert Line at: (888) 394-2301 or report online at: https://app.convercent.us/en-us/LandingPage/01772b54-f08e-ea11-a831-000d3afda485?_=1593614497696

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.

The Privacy Rule seeks to ensure that an individual’s Protected Health Information (PHI) is properly protected, while still allowing the flow of information needed to provide and promote high-quality health care. A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent inappropriate uses and disclosures of PHI. The following are examples of appropriate safeguards that Providers should have in place 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 in order 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 passcode.
- Limit access to keys and passcodes.
- Lock computer screens when away from your desk or work station.
- 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 a list of all persons and organizations with whom their PHI has been shared. For more detailed information regarding these regulations, go to the Department of Health and Human Services website at www.hhs.gov/ocr/privacy.

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

California Mental Health Parity Law

California's Mental Health Parity law requires every health care service plan that provides hospital, medical, or surgical coverage to provide coverage for the medically necessary treatment of mental health and substance use disorders (MH/SUD) listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or the Diagnostic and Statistical Manual of Mental Disorders. Among other requirements, plans may not limit benefits or coverage for MH/SUD to short-term or acute treatment.
MH/SUD benefits include, but are not limited to, outpatient services, inpatient hospital services, partial hospital services, and prescription drugs. The terms and conditions applied to these benefits must be applied equally to all benefits under the plan, including maximum annual and lifetime benefits, copayments and co-insurance, individual and family deductibles, and out-of-pocket maximums.

Maternal Mental Health

California law requires that a licensed health care practitioner who provides prenatal or postpartum 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 or during the postpartum period and includes, but is not limited to, postpartum depression. The law also requires that health plans develop a maternal mental health program designed to promote quality and cost-effective outcomes.

Community Care Health has a maternal mental health program designed to assist mothers (prenatal and postpartum) with understanding health care benefits, making appointments, and providing health plan and community resources. Community Care Health 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 Community Care Health network behavioral health provider. A referral for behavioral health is not required. In addition, providers can refer mothers to Community Care Health's case management program. A case management referral can be made by completing the Case Management Referral form found in the Forms section of the Community Care Health website, or by calling Customer Service. Community Care Health's maternal mental health program guidelines and criteria are available to providers upon request.

Autism Services

Community Care Health is responsible for arranging and providing coverage for medically necessary medical services, such as occupational, physical, or speech therapy, for all diagnoses including autism spectrum disorder. Community Care Health will cover behavioral health treatment, subject to any Prior Authorization requirements, including applied behavioral analysis (ABA) therapy and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Member, and that meet the criteria required by California law.

Section II: Community Care Health Benefits

Product Overview

Health Maintenance Organization (HMO)

An HMO is a plan that provides covered services through defined networks of physicians or provider groups from which Members choose a Primary Care Physician (PCP) and receive specialty physician care or access to hospitals and other facilities. In some instances, Members may select a PCP contracted directly with Community Care Health. HMO Members must obtain covered services through their PCP and providers contracting with Community Care Health. The PCP is responsible for coordinating and directing necessary care to the appropriate Participating Providers.

Exclusive Provider Organization (EPO)

An Exclusive Provider Organization (EPO) is a plan that provides covered services through a defined network of physicians or provider groups, hospitals and other facilities. Members in an EPO are not required to select a PCP or obtain a referral for routine specialty care. However, prior authorization is necessary for specialized care such as outpatient services, inpatient services, certain diagnostic tests etc.

High-Deductible Health Plan (HDHP)

An HDHP is a health 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

Community Care Health'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.

Wellness Services

Community Care Health believes 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. In order 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 provider newsletters and in the provider portal.

Acupuncture

Some Community Care Health 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 go to www.communitycarehealth.org and click on Find a Provider. Or Members can call SimpleMSK at (559) 400-6225.
- No referral from Community Care Health or the PCP is required.

Behavioral Health Services

Behavioral health services include both mental health and substance use disorder services. Members have direct access to Participating Providers for behavioral health services without obtaining a PCP referral. Access to behavioral health services are offered through Community Care Health's partnership with SimpleBehavioral. To find a behavioral health provider, please direct Members to the Community Care Health website at https://www.communitycarehealth.org, click on Find a Provider. Or Members can call SimpleBehavioral at (855) 425-4800.

Dental Services – Pediatric

Community Care Health Members under the age of 19 may have coverage for pediatric dental services as part of the Small Group Essential Health Benefits (EHB). Community Care Health has partnered with Delta Dental of California to provide access to dental services for children. Members enrolled in dental coverage can call (888) 335-8227 or go to www1.deltadentalins.com, Find a Dentist, to find a dentist.

Dental Benefits – Delta Dental of California

Community Care Health Members may have access to dental services through their plan. Community Care Health offers dental coverage through its partnership with Delta Dental of California. Members enrolled in supplemental dental coverage can call (888) 335-8227 or go to www1.deltadentalins.com, Find a Dentist, to find a dentist.

Vision Services – Pediatric

Community Care Health Members under the age of 19 may have coverage for pediatric vision services as part of the Small Group Essential Health Benefits (EHB). Community Care Health has partnered with DeltaVision to provide access to pediatric vision services.

For a complete benefit description and to find a DeltaVision doctor, Members can visit www.vsp.com or call (800) 877-7195.

Vision Services Plan – DeltaVision

Community Care Health offers comprehensive vision coverage through its partnership with DeltaVision. All services are coordinated through DeltaVision. Members enrolled in supplemental vision services can visit www.vsp.com or call (800) 877-7195 for more information.

Specialty Pharmacy Services Covered under the Pharmacy Benefit

Community Care Health covers outpatient drugs, supplies, equipment and supplements through its pharmacy benefit manager MedImpact. Coverage is subject to the Member's benefit plan and Community Care Health's formulary guidelines. Medically Necessary drugs can be obtained at a Participating Pharmacy or through MedImpact's mail-order or Specialty Pharmacy service.

To find Participating Pharmacies in the area:

- Visit the Community Care Health website at www.communitycarehealth.org. Click on Find a Provider, Find a Pharmacy.
- Call MedImpact Customer Service at (855) 873-8739.
- Call Community Care Health Customer Service at (559) 724-4995.

Provider Resources

Community Care Health's Web-Based Provider Portal

Community Care Health's web-based provider portal is designed to provide quick and easy access to the information you need to ensure the best possible service to our Members. While this information is as accurate as possible, it does not take the place of any contract your office or organization may have with Community Care Health.

The provider portal provides a 24/7 centralized location for forms, resources, and tools you need to care for our Members, such as:

- Member eligibility verification
- Benefits/evidence of coverage (EOC) information
- Medical prior authorization forms
- Policies, operations manuals and guides
- News and alerts

You can also:

- Request pharmacy prior authorization
- Update your provider directory information

For assistance registering for the provider portal, please contact Customer Service at (559) 724-4995. To ensure compliance with HIPAA security standards, each user must have a unique user ID.

Section III: Member Eligibility

Eligibility Verification

Participating Providers are responsible for verifying eligibility each time a Member schedules an appointment and before medical services are provided, unless it is an emergency.

Because events leading to ineligibility can occur at any time, providers are encouraged to verify eligibility on the day services are to be rendered. Specialists should always verify Member eligibility on the day of the appointment. Primary Care Physicians (PCPs) 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 Community Care Health.

All Members are issued a health plan identification card, which should be presented each time services are requested. Community Care Health Identification Cards may include the following information:

- Member Name
- Member ID Number
- Date of Birth (DOB)
- Coverage Effective Date
- Group Name
- Group Number
- Primary Care Physician (PCP)
- PCP Telephone/After Hours Number
- Participating IPA/Medical Group (if applicable)
- Deductible
- Copayments/Coinsurance
- Medical Claims Mailing Address
- Customer Service toll-free number

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 Community Care Health. A new identification card is issued each time a Member changes PCP, but Members may forget to present the most recent card when accessing services. Therefore, it is important to verify eligibility for each visit.

Providers can verify Member eligibility through any of the following methods:

1. Online via the 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 the provider portal, go to www.communitycarehealth.org.

   If you are not currently set up for this easy-to-use and secure online resource, please contact Community Care Health's Customer Service at (559) 724-4995.

2. Community Care Health’s Customer Service at (559) 724-4995 allows Participating Providers to verify Member eligibility status, PCP assignment (if applicable) and copays/coinsurance for most commonly used services.

3. If a Member insists that they are enrolled in Community Care Health, but you are not able to confirm eligibility, please call Customer Service at (559) 724-4995.

Section IV: Member Services

Customer Service

Community Care Health's Customer Service Department assists both Members and Providers with information about any of the following:

- Eligibility
- Benefits
- PCP assignment
- Hospital information
- Status of medical referrals and authorizations
- Premium billing questions
- Community resources and support groups
- Grievances and appeals and provider disputes
- ID card replacements
- Value-added services

The Customer Service Department has knowledgeable, helpful representatives available Monday through Friday from 8:00am to 5:00pm at (559) 724-4995 or by email at https://customerservice@communitycarehealth.org.

Primary Care Physician (PCP) Assignment and Selection

HMO (Health Maintenance Organization):

Community Care Health HMO Members select a PCP to manage their medical needs. Individual family Members may choose the same or different PCPs in the following practice areas:

- Internal medicine, family practice, pediatrics, OB/GYN, and general practice. OB/GYNs are eligible PCPs so long as they meet the Community Care Health eligibility criteria for all specialists seeking PCP status. This means assuming the responsibility for providing initial and primary care to Members, maintaining the continuity of Members' care, and initiating referrals for specialist care. It also means providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues. OB/GYNs who are interested in becoming a PCP should contact Customer Service at (559) 724-4995.
- Members who select a PCP affiliated with a community clinic are assigned to the clinic, not an individual physician within the clinic.
- A Member, who is also a physician, may not select themselves as their PCP.

In the event that a Member does not select a PCP at enrollment, Community Care Health will assign a PCP based on the following factors:

- The existence of established relationships and family linkages
- The Member's residence or work place

- The Member's language preference
- The Member's age

Members are notified of a Community Care Health-assigned PCP and of the right to contact Customer Service if they want to select a different PCP.

EPO (Exclusive Provider Organization)

Community Care Health EPO members DO NOT need to select a primary care physician (PCP) and can self-refer for routine specialty care.

Hospital Admitting Privileges or Coverage Requirements

To ensure continuity of care for patients, Primary Care Physicians (PCPs) must meet one of the following requirements:

- Admitting privileges: PCPs must have hospital admitting privileges at a participating network hospital to directly oversee inpatient care.
- Designated Covering Provider: If a PCP does not have admitting privileges, they must identify or designate a covering provider who will manage their patients' care during hospitalization.

This requirement helps ensures timely access to hospital care and compliance with regulatory standards. All providers are responsible for maintaining up to date documentation of their admitting privileges or coverage arrangements.

Member Grievances

Providers may occasionally receive Grievances directly from Community Care Health Members. A Grievance is any expression of dissatisfaction with an aspect of the Member's health care and/or the delivery of care. Grievances received by Community Care Health may include complaints about the quality of health care services rendered or appeals of service denials. Members (or their designees) may call Customer Service or submit their Grievance in writing, via email or fax:

Community Care Health
PO Box 45016
Fresno, CA 93718
Toll-free: (559) 724-4995

If the Member prefers, he/she can complete the Grievance Form available on Community Care Health's website https://www.communitycarehealth.org/grievance-form/. Participating Providers are required to make Community Care Health Grievance Forms and a description of the grievance process available to Members upon request. Providers may also download a copy of the current form in English or Spanish from Community Care Health's website or by calling Customer Service at (559) 724-4995. Community Care Health encourages all Members to discuss questions and concerns with their PCP or other Participating Providers involved in their care.

Community Care Health 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, Community Care Health will provide a response within 72 hours. In most cases, Participating Providers involved in the Member's care will be contacted by Community Care Health 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 Community Care Health to resolve a Grievance will be provided to the Member upon request.

Community Care Health uses responses from Providers to identify opportunities to educate Members regarding realistic expectations of access, office wait times, appropriate patient–physician and patient–office staff interaction, etc. The responses also highlight opportunities for Community Care Health to work more closely with Providers on interactions that are perceived to be problematic by Community Care Health Members and to work together to improve processes.

Independent Medical Review (IMR)

If a Member's requested care is denied, delayed or modified, 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 Community Care Health who will review the information provided and make an independent determination. If the IMR specialist determines the service should be approved, Community Care Health 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 Community Care Health 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 physician 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 Community Care Health than the proposed therapy.

3. Either (a) the Member's physician, who is a Participating 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 physician (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 Community Care Health 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 Community Care Health's determination that the therapy is experimental or investigational for the Member's condition.

If a Member could qualify for IMR under this section, Community Care Health 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 physician will be asked to submit the documentation described in paragraph 3 above. An expedited review will occur if the physician 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 a health care services has been improperly denied, modified, or delayed by Community Care Health or its UM delegate. This is called a "disputed health care service." A "disputed health care service" is any health care service eligible for coverage that has been denied, modified, or delayed, in whole or in part, because the service is not Medically Necessary.

Community Care Health 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 of the following conditions:

1. The Participating 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 Participating 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 Community Care Health or a UM delegate, 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 Community Care Health and Community Care Health'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. In extraordinary and compelling cases, the DMHC may waive the requirement that the Member exhaust Community Care Health's grievance process.

Section V: Provision of Professional Services

Participating Provider Responsibilities

Community Care Health expects its Participating Providers to do the following:

- 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 interest.
- Maintain quality standards for all health care services.
- Provide all services in a culturally competent manner.
- Ensure that offices are physically accessible to patients with disabilities, and have adequate parking, restroom facilities, seating and a well-lit waiting area.
- Ensure office areas where care is provided are kept clean and orderly at all times.
- Maintain open physician-patient communication regarding appropriate treatment alternatives or when recommending a procedure. The physician recommendation does not guarantee coverage, as the service may require prior authorization.
- Effectively communicate with Members regarding their health care needs.
- Encourage Members to be active in decisions about their own treatment.
- Be accessible to Members, including emergency access via telephone as described in the Timely Access to Care standards section, below.
- As appropriate, notify Members when Telehealth services are available, how to schedule a Telehealth visit and if there is 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 Community Care Health and to make Grievance Forms available to Members upon request. (Refer to Section IV: Member Services – Member Grievances).
- Maintain licensures and other applicable credentials as required by law and Community Care Health'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 Community Care Health's Medical Director or designee in the review and supervision of the quality of care administered to 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 Community Care Health Members as requested by Community Care Health or Community Care Health's designee.
- Actively participate in Community Care Health'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 Community Care Health within five 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 Community Care Health's annual or bi-annual request for affirmative updates to your information, or risk deletion from the Provider Directory.
- Comply with this Provider Manual, the terms of your Agreement, and state/federal laws.

Role of the Primary Care Physician (PCP)

Primary Care Physicians (PCP) are responsible for providing certain basic health care services to 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 medications. Members may 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 injuries, and follow-up care for ongoing medical problems. In addition, the PCP manages all of 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:

- Providing the Member's primary health care services.
- Providing coverage 24 hours a day, 7 days a week. 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 Community Care Health's Service Area.
- Referring Members to a participating specialist when specialized care is indicated. Please see Section VI Utilization Management, Exhibit A, for a copy of the Community Care Health Referral Form or via Referral Form.
- Managing behavioral health issues within scope of a PCP. For those Members whose requirements are outside the scope of a PCP, assist Members with obtaining Behavioral Health care services. Members may also self-refer for certain Behavioral Health services. If further assistance is needed, refer the Member to Community Care Health Customer Service.
- Requesting Authorization for, services, procedures, and medications as required by Community Care Health.
- Reviewing and incorporating the specialist's documentation into the Member's primary medical record.
- Using contracted network laboratories and radiology services.
- Notifying Members of test results and documenting the notification in the medical record within 72 hours of receipt and acknowledgement of the results.

On-Call Physician Coverage

The PCP shall provide coverage for Community Care Health Members 24 hours a day, 7 days a week and shall make coverage arrangements with another Participating Physician (preferably one who is also contracted with Community Care Health) in the event of the provider's absence. A PCP contracted directly with Community Care Health shall notify Community Care Health in advance, or as soon as is reasonably possible, of the use of a non-participating physician in a coverage arrangement.

It is the responsibility of the PCP to ensure that the covering physician will comply with Community Care Health's peer review procedures and accept the fee from Community Care Health as payment in full for services delivered to the Member (except applicable Copayments). Capitated Providers must make arrangements directly with the covering physician for payment for all covered services provided to Community Care Health Members. Covering physicians must not bill Community Care Health Members for covered services.

Role of the Specialty and Ancillary Provider

For *HMO* members, 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 should refer the Member to the appropriate Participating Provider.

The specialty provider will provide treatment based on the referral initiated by the PCP. The referral can be received by the specialist via phone, email or a referral form sent by the PCP. Please see section VI Utilization Management, Exhibit A, for a copy of the Community Care Health Referral Form or via Referral Form.

For *HMO and EPO* members, any subsequent specialty visits or additional specialized care, such as certain lab tests, imaging services or therapy, might require a new referral or prior authorization. Please see the Referral and Authorization Processes Section on page 34. A list of services for which Community Care Health requires Prior Authorization can be found at www.communitycarehealth.org/for-providers. If you have questions regarding the Prior Authorization process, or do not see a specific procedure or service on the list, please contact Customer Service at (559) 724-4995.

Services must be performed at a contracted facility with appropriate authorization if required. The specialist is responsible for contacting Community Care Health 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 also responsible for sharing records with the Member's PCP.

Notification of Provider Terminations

Primary Care Physicians (PCPs)

PCPs contracted directly with Community Care Health should send written termination notifications to Community Care Health as required by their contract. Terminations will take effect on the last day of the month whenever possible. PCPs affiliated with a contracted Provider Group should send their termination notification to the group. Members in a current course of treatment will receive instructions for continuity of care.

Specialty and Ancillary Provider

Specialty and Ancillary providers contracted directly with Community Care Health should

send written termination notifications to Community Care Health as required by their contract. Members in a current course of treatment will receive instructions for continuity of care.

Americans with Disabilities Act

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 information on the ADA's requirements, visit www.ada.gov

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:

- Placing the Member's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part

Emergency Services are those covered services, including services provided inside or outside the Service Area, that are medically required on an immediate basis for treatment of an Emergency Medical Condition.

Medical Record Standards

Community Care Health expects Participating Providers to appropriately document Member encounters in their medical records according to the following standards:

1. All medical record entities must be legible and should establish the stated diagnosis including history and physical findings.
2. The therapies noted should be current therapies.
3. Drug allergies and idiosyncratic medical problems are conspicuously noted.
4. Pathology, laboratory and other diagnostic and screening reports are included.
5. The health professional responsible for each entry is identifiable and each entry is dated.
6. Consultation and progress notes are included.
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 any advance directives is in the chart.
10. Two patient identifiers are on each page of the medical record.

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:
    a. Home health nursing reports
    b. Specialty physician 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

Confidentiality and Availability of Medical Records

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

Provider Information Updates

To keep Provider Directories current, Community Care Health 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 or 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
- Specialty or board certification status changes
- Changes in languages spoken, non-English, by provider or in-office staff
- Change in practice Federal Tax Identification Number (TIN)

- Change in Participating Provider's panel status
- Change in practice name or ownership

Notice of any of the above-mentioned changes and the applicable effective date must be submitted to the affiliated provider group or, if contracted directly, by utilizing the Update Form located on Community Care Health's website https://www.communitycarehealth.org/find-a-provider on "Notice of Discrepancy" tab.

Tax Identification Number (TIN) Changes

TIN changes must be submitted in writing on a federal W-9 form (available at the IRS website, http://www.irs.gov/. Federal guidelines require Community Care Health to have this form before any payments can be made using the new TIN. In some instances, a new agreement between Community Care Health and the Participating Provider may be necessary.

Provider's Panel Status

PCPs may close their panels to new Members by providing five business days advance notice. Notice should be sent to Community Care Health's Network Management Department at: The closed panel will be noted in the next printing of the Provider Directory and the next scheduled update of the on-line directory. The PCP shall notify Community Care Health in writing within five business days when he/she elects to reopen the panel to new Members. If a Participating Provider is contacted by an enrollee or potential enrollee seeking to become a new patient and the Participating Provider is not accepting new patients, the Participating Provider or his/her staff member shall direct the enrollee or potential enrollee to both Community Care Health for additional assistance in finding a provider with an open panel and to the Department of Managed Health Care (DMHC) to report any inaccuracy with Community Care Health's directory.

Provider's Response to Directory Verification Inquiries

Community Care Health will contact Participating Providers annually to validate provider information listed in Community Care Health's directory. Providers must attest within thirty (30) business days of the original request, even if there are no changes, or risk deletion from the next edition of the Provider Directory. Failure to respond to the request may result in delay in payment. Community Care Health will notify Providers within ten days prior to deletion from the directory, but will revoke the action if the Participating Provider responds within the ten-day notification period.

Credentialing Program

Credentialing and re-credentialing files are processed by Community Care Health or its credentialing vendor. Final credentialing approval is coordinated through Community Care Health's Credentialing Committee, under the guidance of the Chief Medical Officer. Community Care Health retains the right to approve, suspend, and terminate Participating Providers.

Credentialing

Community Care Health credentials Participating Providers. Providers must meet Community Care Health's criteria for acceptance and are required to maintain compliance with all standards as a condition for continued participation. There may be instances where Community Care Health will delegate credentialing to those entities that meet or exceed Community Care Health's credentialing standards (see Delegated Credentialing/Re-Credentialing, below).

To begin the credentialing process, providers are instructed to complete and sign an application through the credentialing vendor web portal, ensuring all requested data elements are included. Community Care Health or its credentialing vendor will primary source verify, at a minimum, the

following:

- Licensure to practice
- DEA certificate
- Education and training
- Board certification
- Work history
- Malpractice history (NPDB)
- License sanctions (NPDB)
- OIG sanction check
- Current malpractice coverage

Providers must also sign a statement 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

In certain instances CCH may request:

- An 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
- A signed release granting Community Care Health 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

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.

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. Community Care Health's delegate 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, Community Care Health or its credentialing vendor will notify the Provider of the discrepancy via certified letter within 30 calendar days of receipt of the 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. Community Care Health 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 re-credentialing application, upon request.

Community Care Health or its credentialing vendor will respond to requests in writing within 7 business days after the receipt of the request. The response will 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 Credentialing Committee for review and approval. Providers are notified in writing of the Credentialing Committee's decision within 60 business days. A summary of the Credentialing Committee activities is presented to the Board of

Directors on a quarterly and annual basis.

No applicant is automatically entitled to participate in Community Care Health's provider network solely by virtue of their participation with a contracted provider group or professional organization, their board certification or their staff membership or privileges at a particular health facility or practice setting.

Standards and Guidelines

At a minimum, the following requirements must be met for Community Care Health to consider acceptance of the applicant for participation in its provider network:

- Acceptable compliance with general guidelines
- A participation agreement
- The applicant has not been rejected or terminated by Community Care Health within the previous 12 months
- No felony, misdemeanor convictions or evidence of committing other act involving moral turpitude, dishonesty, fraud, deceit, or misrepresentation
- Unrestricted license to practice in California

Delegated Credentialing/Re-Credentialing

Community Care Health may delegate credentialing/re-credentialing to certain provider groups or vendors after determining that the provider group's or vendor's policy and procedures meets Community Care Health's standards. When delegated, Community Care Health monitors and oversees the delegate to ensure compliance with the terms of the delegation agreement. Delegation oversight may include reporting, annual review of credentialing policies and procedures, annual delegation audit and corrective action, where appropriate.

Credentialing Appeals Process

Community Care Health's appeal process allows for adverse credentialing decisions to be discussed and for any errors to be corrected. This process ensures Participating Providers will be treated fairly and uniformly.

Re-Credentialing

Recredentialing for participating providers is conducted at least every three years. The credentialing department will send reminder notices approximately six months prior to the credentialing expiration date to ensure providers log in and update their information in the credentialing vendors portal. Providers are required complete the necessary forms and provide updated information through the portal. The credentialing process may take 45 to 90 days, depending on the timely submission of a completed application. To maintain active status, providers must submit all required information at least three months before the credentialing expiration date. Providers who fail to respond within the designated timeframe will be considered non-responders and may face termination from the Community Care Health network.

Notifications to Authorities and Participating Provider's Appeal Rights

In the event that, through a formal peer review process, an adverse action is taken against a Participating Provider, Community Care Health will report such adverse action to the Medical Board of California (MBC) and the National Practitioner Data Bank (NPDB) in accordance with Community Care Health's policies and procedures, as well as applicable state and federal law.

Community Care Health will also report health care related civil judgments and other adjudicated actions or decisions against network health care practitioners, providers or suppliers to the NPDB, in accordance with Community Care Health's policies and procedures, as well as applicable state and federal law. Community Care Health 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 Community Care Health'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 priority for Community Care Health. Participating Providers are required to provide a sufficient number of available appointments and adequate telephone capabilities to meet the needs of the Members served by that office. Provider locations must be accessible to Members during posted hours of business. Participating 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.

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

Community Care Health maintains a sufficient network of providers and facilities throughout its Service Area to ensure timely and geographic accessibility in compliance with California law and the following access standards:

Provider to Enrollee Ratios:

- Full-time Primary Care Physician (PCP) to Member Ratio (based on physician total patient load): 1:2,000

    - Full-time Physician (PCPs plus Specialists) to Member Ratio:

1:1,200 Geographic Distribution (Drive Time/Distance) Standards:

- PCP – Members have a residence or workplace within 15 miles or 30 minutes of a contracting PCP.

- Hospitals – Members have a residence or workplace within 15 miles or 30 minutes of a contracting hospital and, if separate from such hospital, a contracting or plan-operated provider of all emergency health care services.

- Ancillary Services - Ancillary laboratory, pharmacy and similar services and goods dispensed by order or prescription of the PCP are available from Participating Providers at locations (where enrollees are personally served) within a reasonable distance from the PCP.

Timely Access to Care

Participating Providers shall offer appointments to Members within the following standards:

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 physician (Psychiatrist)	10 business days
Non-physician mental health care 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

Exceptions to appointment wait times

Participating Providers may extend the wait time for an appointment if the Participating Provider has determined and noted in the Member's record that a longer wait time will not be detrimental to the Member's health.

Participating Providers may also schedule appointments in advance for preventative 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, and exceed the listed wait times.

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

At scheduled appointments, Community Care Health provides free interpreter services for Members whose primary language is not English. Please call Community Care Health at (559) 724-4995 to arrange for timely language assistance services for Members.

Concerns about timely referral to an appropriate provider

If a Member is unable to obtain a timely referral to an appropriate provider, the Participating Provider or Member may contact Customer Service (559) 724-4995 for assistance.

Standards for Office Wait Times

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

After-Hours Telephone Access for Primary Care Physicians and Behavioral Health Practitioners

Community Care Health requires PCPs and Behavioral Health practitioners or their designees to be available so that assigned Members have access to urgent and emergency care 24 hours per day, 7 days per week. Participating Providers must maintain 24 hour, 7 day per week telephone access capability to provide immediate response to emergency inquiries by Members. Either the PCP or their designated on-call provider must return non-emergent calls, upon enrollee request, within 30 minutes.

CCH requires physicians to provide or arrange for the provision of 24/7 telephone triage or screening services. CCH requires telephone triage or screening services be provided by an authorized medical professional in a timely manner appropriate for the enrollee's condition, not to exceed 30 minutes. The member must be informed of the following.

- The wait time for a return call from the Participating 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, to deliver urgent or emergency care.

Emergency Instructions

Every Member who 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 physician 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 physician, 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.

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 at any time. Calls must be returned by a psychiatrist or qualified behavioral health care professional within 30 minutes.

Missed Appointments

Missed appointments are those where a Member does not arrive for a scheduled medical appointment, either with or without notice from the Member. Missed appointments shall be documented in the Member's medical record, with provisions for a case-by-case review of Members with repeated failed appointments.

Some Participating Providers have established a missed appointment fee for their patients. Community Care Health reserves the right to review and approve such policies. Participating Providers shall demonstrate that Members were notified in advance regarding missed appointment fees and shall waive such fees under extenuating circumstances. Community Care Health does not reimburse Participating Providers for missed appointment fees.

Provider-Initiated Termination of Provider/Patient Relationship

Rarely, a Participating Provider encounters a Member who is disruptive or excessively difficult. Participating 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. Any terminations are subject to Community Care Health's approval.

Culturally and Linguistically Appropriate Services

California law requires health plans to establish a Language Assistance Program (LAP) for Members with Limited English Proficiency (LEP). Under this law, Participating Provider are required to cooperate and comply with Community Care Health's LAP by facilitating Member access LAP services. Community Care Health provides the following language assistance services at no cost to the Member:

1. Access to Interpreters: Participating Providers may request interpreters for Members whose primary language is other than English by calling Community Care Health at (559) 724-4995.

2. 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 Members that they may request such translated materials by calling Community Care Health at (559) 724-4995.

3. Notices Available from the Department of Managed Health Care: Informational notices explaining how Members may contact Community Care Health, file a complaint with Community Care Health, 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 www.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. In order to ensure that all LEP Members receive appropriate access to covered services, Participating Providers are expected to comply with federal and state requirements regarding cultural and linguistic services.

Following the tips below will help Providers and their staff 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 Members 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 Community Care Health to request translated documents at no cost to the Member and to register their preferred languages with Community Care Health.
- Provide periodic training to office staff on cultural competency and use of interpreters.
- Call Customer Service at (559) 724-4995 if you need assistance providing language assistance services (interpretation, translated documents, etc.) for Members.

For additional information or resources about Community Care Health's Language Assistance Program, contact (559) 724-4995 or visit the "Language Assistance" link on the Provider tab of Community Care Health's website.

Section VI: Utilization Management

Utilization Management Program

Community Care Health's Utilization Management (UM) Program evaluates whether 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 with appropriate discharge planning. Community Care Health may delegate UM activities to qualified entities that meet specific regulatory requirements.

All UM decision-making is based solely on the appropriateness of care and existence of coverage. Neither Community Care Health nor its UM delegates may 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.

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

Referral and Authorization Process

Referrals:

HMO:

For HMO members, PCPs act as managers of their patients' health and are responsible for ensuring that Members in need of medical care beyond their scope of practice are referred to appropriate specialist providers.

Members may self-refer to the following in-network specialists (no referral from the Member's PCP is necessary): Dermatologists, most Behavioral Health and Substance Abuse professional providers (SimpleBehavioral), Allergists, Chiropractors, and OB/GYNs. A PCP referral is required to access all other specialists.

The PCP is responsible for referring the Member to the appropriate specialist by initiating a referral request to the specialist. This can occur via phone, email or by completing a referral form. Please see section VI Utilization Management, Exhibit A, for a copy of the Community Care Health Referral Form or via Referral Form. Any subsequent visits or additional specialized care, such as certain lab tests, imaging services or therapy, might require a new referral or prior authorization.

EPO:

For EPO members, a referral is not necessary as a primary care physician is not required. Member can self-refer to in-network specialists.

For both HMO and EPO there may be cases where the Member's condition will qualify for a standing referral to a specialist or specialty care center. This includes referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinate the Member's health care. Standing referrals require prior authorization from CCH and will be made pursuant to a treatment plan approved by CCH in consultation with the PCP, the specialist or specialty care center, if any, and the Member, if a treatment plan is deemed necessary to describe the course of the care. Services must be Medically Necessary and provided by Participating Providers unless approved in advance by CCH.

Prior Authorization for HMO and EPO

Prior Authorization is the process of evaluating medical services prior to the provision of services in order to determine Medical Necessity, appropriateness, and benefit coverage. Services requiring Prior Authorization should not be scheduled until a provider receives approval from Community Care Health. Community Care Health reserves the right to deny payment for authorized services if it is determined that inaccurate information was provided to support the authorization request.

A list of services for which Community Care Health requires Prior Authorization can be found at www.communitycarehealth.org/for-providers --> 2022 Provider Toolkit

Requests for Prior Authorization must be submitted using the Prior Authorization Form via fax to Community Care Health at: (559) 724-4750 (Primary) or (559) 724-4751 (Secondary) and be accompanied by all pertinent medical records and supporting documents to avoid unnecessary delays. Medical information, including but not limited to the information listed below, should accompany all Prior Authorization requests, as appropriate. This information should also be provided to the rendering provider to ensure that he/she 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 physicians
- Information on referrals pending for other providers

If you have questions regarding the Prior Authorization process, please contact Customer Service at (559) 724-4995.

Experimental/investigational services are not a Covered Service. Providers may submit a completed Prior Authorization request to Community Care Health to determine whether a requested service is considered experimental or investigational.

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.

Exhibit A Community Care Health HMO Referral Form

HMO REFERRAL FORM

Date of Referral

Patient Information:

CCH Member ID# ____ DOB

Name ____

Address ____

Phone Number _______________________________________

Email Address (optional)___________________________________

Referring Physician Information:

Name ______________________

Specialty____________________

Practice_____________________

Address ____________________

Phone Number _______________

Email Address

Physician/Provider Member is being referred to:

Name ___________________________________

Specialty/Service ____________________________

Primary Diagnosis and Reason for Referral:

Form prepared by:

Print Name Signature Date Phone

Utilization Management

Community Care Health may use a range of approved clinical criteria, guidelines, and reference tools to assist in the review of medical necessity including, but not limited to, the following:

- Evidence of Coverage
- MCG Guidelines
- Recognized Standards of Care from National Professional Organizations

Contact Information

- Community Care Health UM staff is available 8:00am to 5:00pm Monday through Friday to answer questions from Providers regarding utilization management issues.
- After hours, Providers may call (855) 873-8739 for Urgent prescription drug requests (available 24 hours a day, 7 days a week).
- Community Care Health or UM delegates will identify themselves by name, title and organization name when making inbound or outbound calls about UM issues.

Prior Authorization Review Time Lines

Community Care Health and its UM delegates are required to provide prompt and timely decisions on Prior Authorization requests appropriate to the Member's condition. 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 PCP.

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 request. All letters of denial or modification include an explanation of the reason for denial or modification, the clinical guidelines used to reach the decision, as well as a description on how to file an appeal. For questions regarding the status of a Prior Authorization request, contact Community Care Health at (559) 724-4995.

Concurrent Hospitalization Review

Inpatient stays are reviewed to determine the appropriate level of care. Telephonic and/or on-site chart reviews are conducted at all contracted 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 Community Care Health. 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 a continued stay, the nurse reviewer will consult

with the Member's attending physician, physician advisors, or other appropriate hospital staff to obtain additional information.

In the event that a Member is admitted to a facility outside Community Care Health's Service Area, Community Care Health's UM department will work with the out-of-area Provider and (as applicable) the Member's Provider Group to determine when the Member can safely be transferred back into the Service Area and to coordinate the transfer. The UM department 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 Community Care Health 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 Community Care Health or its UM delegate 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 Community Care Health was not notified before or during the provided service. Cases for retrospective review are often identified upon receipt of a claim for a service ~~for~~ that had required prior authorization. Cases may also be identified through requests for retrospective authorization from out-of-network or out-of-area Providers.

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. Following the stabilization of an Emergency Medical Condition, the treating Provider may determine that a member requires additional Medically Necessary Hospital Services. Post-stabilization services in these cases, do not require Prior Authorization.

Denial of Services

A denial may occur at any time during the review process: prospective, concurrent, or retrospective. Only a physician may issue a denial for reasons of Medical Necessity. Nurse reviewers or designated UM Department staff may issue denials for other reasons, such as lack of benefit coverage or Member ineligibility. Providers requiring additional information on denials may contact Community Care Health or the appropriate UM delegate to discuss the case. Notification of a denial to the requesting provider will include a clearly defined reason for denial, the criteria utilized in the decision-making process, a statement indicating that the reviewing physician is available to discuss any UM denial, and a direct phone number to the physician reviewer who adjudicated the case.

Second Medical Opinions

When requested by the member or the Participating Provider, a second medical or surgical opinion may be covered by Community Care Health after the first opinion 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:

Second Medical Opinion
Reasons for a second opinion to be authorized include, but are not limited to, the following:

- If the member questions the reasonableness or necessity of recommended surgical procedures;
- If the member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition;
- If 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 requests an additional diagnosis;
- If the treatment plan in progress is not improving the medical condition of the member within an appropriate period of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment; or
- If 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 following steps must be followed to request a second opinion:

1. Prior authorization is required for second medical opinions. CCH's Chief Medical Officer or designee is responsible for approving or denying all requests for a second medical opinion.
2. A request for a second medical opinion will be approved or denied in a timely fashion appropriate for the nature of the member's condition.
    a. For circumstances other than an imminent or serious threat to health, a second medical opinion request will be approved or denied within five business days after the request is received by CCH.
    b. When there is an imminent or serious threat to health, a decision about the second opinion will be made within 72 hours after receipt of the request by CCH (or in a timely fashion appropriate for the nature of the member's condition, not to exceed 72 hours, whenever possible). An imminent and serious threat includes the potential loss of life, limb or other major bodily function, or where a lack of timeliness would be detrimental to the ability to regain maximum function.
3. Members may request a second medical opinion at any level of care:
    a. If the member is requesting a second medical opinion about care received from their PCP, the second medical opinion will be provided by an appropriately qualified health care professional of the member's choice within the same physician group. If the PCP is independently contracted with CCH, the member may request a second opinion from any appropriately qualified health care professional in the CCH network.
    b. If the request is for a second medical opinion about care received from a specialist, the second medical opinion will be provided by any health care professional of the member's choice from any physician group or individual physician within the CCH participating provider network of the same or equivalent specialty. However, if there is no participating provider within the network who is an appropriately qualified health care professional, then the member may request and CCH will arrange for the second medical opinion to be provided by an appropriately qualified health care professional who is not in the CCH network.

4. If CCH approves a request for a second opinion, the member will be responsible only for the same cost-sharing required by the member's benefit plan for similar referrals to participating providers, whether the provider is in CCH's network or outside CCH's network.

5. In approving a second opinion either inside or outside of the CCH provider network, CCH will take into account the ability of the member to travel to the provider.

6. The second medical opinion will be documented in a consultation report prepared by the second opinion provider, which report will be made available to the member and their treating participating provider. The report will include any recommended procedures or tests that the provider giving the second opinion believes are appropriate. If this second medical opinion includes a recommendation for a particular treatment, diagnostic test or service covered by CCH – and the recommendation is determined to be medically necessary by CCH – the treatment, diagnostic test or service will be provided or arranged by CCH.

7. The fact that an appropriately qualified health care professional gives a second medical opinion and recommends a particular treatment, diagnostic test or service does not necessarily mean that the recommended action is medically necessary or a covered service.

8. If the member's request for a second medical opinion is denied, CCH will notify the member in writing and provide the reasons for the denial and their right to file a grievance. If the member obtains a second medical opinion without prior authorization from CCH, the member will be financially responsible for the cost of the opinion.

Case Management Program

Members can have multiple diseases or other issues, which makes their care more complex. The case management team is focused on the whole person and their needs. It is a more holistic approach that also considers the members' needs outside of direct Health Care and includes access to care and the member's perception of the treatment they are receiving. The case management process involves case management nurses working collaboratively with members, providers, and potentially social workers to develop care plans and monitor outcomes. The case management team keeps an open line of communication with providers and advocates for members in order to achieve the best possible care for the member. Support patients and their families when changing care settings.

The Case Manager can assist the member with a variety of needs, such as preventative care, coordination of care, discussing medications and side effects, understanding their health issues and how to treat them, and encouraging them to join programs to improve their health as suggested by providers.

Members have access to a social worker and case management as part of their care. The process involves the social worker assessing and identifying the psychosocial needs of the member and the member's family. Psychosocial needs are a combination of mental health, emotional, spiritual, or behavioral needs, concerns or aspects of the member. Additionally, assessing social determinants of health and social risk factors when providing care: financial, language and literacy skills, housing, food security, access to health services, and social support. A holistic approach and a person-centered approach are both used to support the member in a comprehensive way.

The social worker provides multiple services to meet the member's specific needs. When appropriate the members are provided with coordination of care, education, counseling, support with coping and adjusting with illness, advocacy, monitoring/evaluating progress in care, addressing existing/new barriers to care, addressing social determinants of health, implementing tangible goals, evaluate

options and services required to meet the member's individual care needs, and accessing the necessary care and treatment resources in the community.

The social worker works collaboratively with other social workers, nurse case managers, other disciplines, and other organizations. The goal of the social worker is to help members meet basic and complex needs, provide guidance, information, promote health, improve quality of life, and address barriers to access to healthcare.

Referral to the Case Management Program can be made by, but not limited to, the following:

- Primary Care Physician (PCP)
- Specialist
- Hospital Case Manager/Discharge Planner
- Hospital Staff
- CCH Staff
- Member

The member's participation in the Case Management Program is voluntary.

Section VII: Pharmacy Benefit Services

Formulary

Community Care Health maintains a prescription drug formulary designed to support the achievement of positive patient outcomes through the selection of high-quality, cost-effective pharmaceuticals. The formulary includes drugs that are identified as prescription drug benefits in the Member's Evidence of Coverage (EOC). Members and Providers can access drug coverage information on the Community Care Health website. Updated formularies are posted to the website regularly.

Community Care Health covers drugs listed on the formulary and prescribed by licensed Participating Providers operating within the scope of their practice. As the prescribing physician, Participating Providers are essential to the appropriate use of pharmaceuticals. This includes:

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

To determine if a drug is covered or if UM edits apply to a drug, go to: https://www.communitycarehealth.org/for-providers/#pharm.

Pharmacy Benefits Manager (PBM)

MedImpact is Community Care Health's PBM. MedImpact is delegated to review Community Care Health's pharmacy prior authorization and exception requests. MedImpact Customer Service is available 24 hours a day, 7 days a week at: (855) 873-8739.

Section VIII: Quality Improvement

Quality Improvement Program

The purpose of the Quality Improvement (QI) Program is to promote organization-wide commitment to quality of care and services through ongoing performance improvement activities identifying opportunities for improvement, implement change and reevaluate actions taken.

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 Community Care Health 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 Community Care Health;
- Promote Provider participation in the quality improvement process and assure compliance with Community Care Health standards;
- Implement and evaluate Community Care Health's annual quality metrics;
- 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 Provider Groups and vendors are in alignment with Community Care Health, regulatory, and accreditation standards; and
- Promote Provider and Member satisfaction.

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.

Participation in the QI Program

Participation in QI Program activities is required for all Participating Providers. Participation may include providing medical records for various studies, responding to requests for corrective action when the QI Program identifies Provider-specific deficiencies or opportunities for improvement, and/or reviewing and providing feedback on potential new and/or ongoing QI activities through Community Care Health's Quality Improvement Oversight Committee (QIOC).

Section IX: Claims

Claims

Community Care Health seeks to ensure Participating Providers' claims and payments are processed accurately and in a timely manner, and that there is a process for resolving claims disputes as required by applicable law and regulations. The guidelines in this section of the Provider Manual can help Providers ensure their claims are submitted correctly. Providers who are contracted with Community Care Health through an affiliated Provider Group must follow the requirements outlined by the Provider Group when billing for services that are the responsibility of the Provider Group.

Claims Address

Providers contracted directly with Community Care Health should send claims for medical services to:

PO Box 45016
Fresno, CA 93718
Payer ID: CCH25

Claims for Behavioral Health Services should be sent to:

Electronically through:

OfficeAlly - Payor ID: HALCY

Fax: 855.486.1341

Mail: SimpleBehavioral ATTN: Claims P.O. Box 25159 Fresno, CA 93729-5159

For behavioral health claims questions, please call SimpleBehavioral at: (855) 424.4457

Claims for Physical Medicine Services should be sent to:

Electronically through:

OfficeAlly - Payor ID: PM001

Fax: 855.486.1343

Mail: SimpleMSK ATTN: Claims P.O. Box 25220 Fresno, CA 93729-5220

For physical medicine claims questions, please call SimpleMSK at: (877) 519-8839

Claims for services provided to Members assigned to entities delegated for claims processing should be sent directly to the entity.

Claim Submission Requirements

The following is a list of claim timeliness requirements, claims supplemental information, and claims documentation for Participating Providers submitting claims to Community Care Health.

- Participating Providers must submit claims according to the terms of their agreement

with Community Care Health. 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 (institutional Providers). Forms should be completed legibly in black ink with standard fonts on forms printed in red “dropout” ink.
- 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 Community Care Health 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 are encouraged to submit 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.

Claim Receipt Verification and Claim Status Inquiries

For verification of claim receipt or claim status inquiries:

- Community Care Health will verify the date of claim receipt within two working days of receipt of an electronic claim and within 15 working days of receipt of a hard copy claim.
- Claim status is provided via an Explanation of Benefits (EOB) that is included with payments.
- Providers can confirm claim receipt and claim status by calling Customer Service at (559) 724 4995. In order 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.

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 rejected as duplicates. Providers who feel their claim was processed incorrectly should contact Customer Service at (559)724-4995 for an explanation, or send in an adjustment request with a copy of the claim to the following address:

Balance Billing

Community Care Health 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 Service. Balance billing occurs when a Member receives a bill for amounts in excess of the applicable copayment, coinsurance and/or deductible for covered services. By law, health plan enrollees are not liable to a Provider contracted with Community Care Health for any sums owed to the Provider by Community Care Health. Participating Providers are prohibited by law from billing Members for services covered by Community Care Health. For example, if Community Care Health denies a claim for a covered service because the claim was submitted after the submission deadline, the Provider may appeal the denial to Community Care Health, but may not bill the Member for the services regardless of the outcome of the appeal.

Furthermore, it unlawful for physicians 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 submit a payment dispute to the health plan relating to the claim in question.

For services that are not covered under the Member's benefit agreement, the Member must be notified in advance in writing that the service is not covered and that the Member will be responsible for payment in full for that service.

For assistance with specific Member issues and claims status, Providers may contact Community Care Health at (559) 724-4995.

Dispute Resolution

A Provider dispute is a Provider's written notice to Community Care Health:

- 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.

Community Care Health's Provider Dispute Resolution Form is available by contacting Customer Service at (559) 724-4995 to obtain a copy.

Provider disputes must be received by Community Care Health within 365 days from Community Care Health's action that led to the dispute (or the most recent action if there are multiple actions). In the case of Community Care Health's inaction, Provider disputes must be received by Community Care Health within 365 days after Community Care Health's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

Community Care Health 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, Community Care Health 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.