2022

CCIPA PROVIDER MANUAL

CommunityCare IPA

Table of Contents

Welcome

Welcome to the Community Care IPA, provider manual. This provider manual is a tool and reference guide that allows you and your staff to find important information such as how to process claims and prior authorizations. This manual also includes important contact information and websites, essential to your day to day operations. Find operational standards, policies, and other online tools, including an up-to-date copy of this manual, on our management company website at: www.medpointmanagement.com.

EASILY FIND INFORMATION IN THIS PDF MANUAL USING THE FOLLOWING STEPS:

1. CTRL + F.
2. Type in the key word.
3. Press Enter.

Community Care IPA has a designated team of experts working to serve you through its management company MedPOINT Management (MPM).

Periodically, you will receive materials, delivered via fax, mail, or hand delivered from our Field Representatives. Please add these materials to your manual.

If you have questions about the information or material in this manual, or about our policies, please email: CCIPA_ProviderServices@medpointmanagement.com

Important Information About the Use of This Manual

If there is a conflict beween your Agreement and this provider manual, use this manual unless your Agreement states you should use it, instead. If there is a conflict beetween your Agreement, this manual and applicable federal and state statuses and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. Community Care IPA reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This manual will be amended as policies change.

Please visit Community Care IPA website at: communitycareipa.com for more information

Quick Reference Guide

Need to contact us? This reference guide provides you with quick access to a variety of resources.
Dial: 866-423-0060. For English Press 1, For Spanish Press 2, select Option 1 for Provider access then make your department selection below.

Provider Network Operations

Phone: 866-423-0060, Option 5
CCIPA_ProviderServices@medpointmanagement.com
Provider Network Operations is responsible for the oversight of all its contracted providers. Our responsibilities include education and training for your staff, updating facility data, and resolution of provider issues and complaints.
Provider Services is available 9 a.m. – 5 p.m., weekdays Pacific Time (PT) except major holidays.

MedPOINTManagement.com

Visit the MPM webpage for Provider Resources and access to the MPM Web Portal. Access the Provider Portal 24 hours a day to check eligibility, submit authorizations, and manage claims.

If you do not have an account, please visit: portal.medpointmanagement.com/sign-in
and click 'Request an Account.'

For technical questions and to resolve issues with the portal, please contact IT at
866-423-0060, Option 6.

Eligibility

Phone: 866-423-0060, Option 1
Verify Eligibility through the MPM Web Portal. The MPM Eligibility is updated on a weekly, bi-monthly or monthly basis, depending on the Health Plan file availability. To obtain real-time eligibility information, check directly on the Health Plan website.

Referrals and Authorizations

Phone: 866-423-0060, Option 2
Providers are encouraged to use the MPM web portal to request authorizations and look up other information. Once the authorization is completed, a print screen is available for posting in patient charts. Specialist notes and other pertinent information is also attached to the web profile.

Claims Inquiry

Phone: 866-423-0060, Option 3
Claims history and status can be viewed through the MPM Web Portal. Providers are encouraged to submit claims electronically through Office Ally, our preferred method, or make special arrangements to use another clearinghouse. Providers can also upload documents as needed by utilizing the MPM Web Portal.

Claims Submission Electronic

Office Ally: Payer ID: MPM48
ClaimRemedi: Payer ID: MPM48
Gateway/Trizetto: Payer ID: MPM48
Change Healthcare: Payer ID: CCI01

To set up an account with Office Ally, contact them at 866-575-4120 or visit: cms.officeally.com/Register/Register.aspx

Provider Dispute Resolution

Phone: 866-423-0060 Option 3
portal.medpointmanagement.com/sign-in
For appeals or requests for reconsideration of a claim that has been denied, adjusted, or contested, please mail the Provider Dispute Resolution to the mailing address below.

For more information and to obtain the PDR form, visit the Provider Resources tab at:
MedPOINTManagement.com.

Please mail Provider Dispute to:
Community Care IPA, Inc.
Attn: PDRs
P.O. Box 7020-04
Tarzana, CA 91357

Credentialing

Phone: 866-423-0060, Option 4
Our Credentialing team, in conjuntion with the Quality Management team, facilitates and monitors the Provider credentials verification process. This includes initial credentialing and recredentialing every 3 years. CAQH is strong recommended.

Quality Management

qualitymeasures@medpointmanagement.com
For HEDIS training and information related to quality management, email the Quality Management team.

Contracting

Phone: 866-423-0060, Option 5
CCIPA_ProviderServices@medpointmanagement.com
Please contact the Contracting Team at MedPOINT Management for all contracting inquiries.

Compliance Hotline

Phone: 866-423-0060, x1531
ComplianceConcerns@medpointmanagement.com

Please mail Compliance concerns to:
Community Care IPA, Inc.
Attn: Compliance Officer
P.O. Box 7020-04
Tarzana, CA 91357

Section 1: Introduction

Through our management company, MedPOINT Management, Community Care IPA (CCIPA) provides comprehensive management services to Health Providers and FQHC's on a personalized approach. Community Care IPA provides services to managed care lives in the Central Valley, Imperial, and San Diego counties.

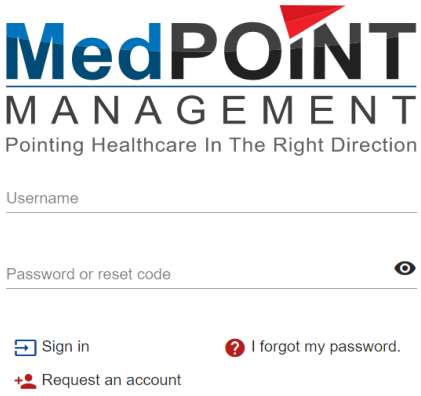
How to Join Our Network

For instructions on joining the Community Care IPA provider network, contact MedPOINT Management at: LOI@medpointmanagement.com.

SECURE PROVIDER WEB PORTAL

MedPOINT Management's (MPM) Provider Web Portal is a secure centralized location that allows providers to accomplish a number of tasks 24 hours a day; minimizing additional paperwork and telephone calls. It can help you save time, improve efficiency and reduce errors caused by conventional claims submission practices.

To access the MPM Provider Web Portal, visit MedPOINTManagement.com and click on the red Provider Portal Login button on the upper right hand corner. You will be directed to the login page by clicking on the MPM Provider Web Portal link:



The secure MPM Provider Web Portal allows you to:

- Check Eligibility status
- Access Eligibility Reports
- View patient's gap in care information
- Check claim submission status
- Submit Authorization requests and check status
- Upload and attach consult notes
- Inquire and communicate directly with MPM staff regarding Claims, Auths, or Eligibility
- Receive Alerts from MPM

PROVIDER NETWORK OPERATIONS

Provider Network Operations is responsible for all business related to the Community Care IPA network. It ensures that the Provider Network is operating smoothly and efficiently. Provider Services works closely with all departments to assist you and your members with questions and concerns.

The Provider Network Operations team should be contacted for demographic updates such as:

- New billing or service location addresses
- TIN or business name changes
- Adding a provider to a group
- Adding an individual provider
- Provider and group terminations

For processing, please email the appropriate distribution group below:

- Demographic updates: DemographicsUpdates@medpointmanagement.com
- Termination Notifications: Contracts_Amendments@medpointmanagement.com
- TIN/Business Changes: Contracts_Amendments@medpointmanagement.com
- Adding a new provider: LOI@medpointmanagement.com

Section 2: Network and Affiliates

CONTRACTED HEALTH PLANS

Community Care IPA provides managed care services in the Central Valley, (Madera County, Kings County, Tulare County) Imperial, and San Diego counties. Here is a list of contracted Health Plans, by line of business along with contact information.

SERVICE AREA	MEDI-CAL	MEDICARE ADVANTAGE	MEDI-MEDI	COVERED CALIFORNIA	CAL MEDICONNECT
CENTRAL VALLEY COUNTIES (Madera County, Kings County, Tulare County)					
Anthem Blue Cross	✓	✓			
Brand New Day		✓	✓		
IMPERIAL COUNTY					
Brand New Day		✓	✓		
California Health & Wellness	✓				
Health Net	✓	✓	✓		
Molina	✓	✓	✓	✓	
SAN DIEGO COUNTY					
Aetna Better Health of CA	✓				
Blue Shield of California		✓			
Blue Shield Promise Health Plan	✓		✓		✓
Brand New Day		✓	✓		
Health Net	✓	✓	✓		
Molina	✓	✓	✓	✓	

HEALTH PLAN CONTACT INFORMATION

AFFILIATED HOSPITALS

We have provider networks around major hospitals throughout the counties we serve in California ensuring the best care for our members.

The following is a list all Community Care IPA affiliated hospitals, by service area and Health Plan contract status by line of business. Be sure to coordinate care with providers privileged at hospitals contracted with members' Health Plan and product.

HEALTH PLAN CONTRACTED HOSPITALS

CENTRAL VALLEY COUNTIES Madera County, Kings County, Tulare County	
	MEDI-CAL
Community Care IPA	Anthem Blue Cross Blue CrossMedi-Cal
CORE HOSPITALS	
Adventist Health Hanford	**Y**
Kaweah Delta Medical Center	**Y**
Madera Community Hospital	**Y**
Sierra View Medical Center	**Y**
Valley Children's Hospitals	**Y**

Y- Contracted

N- Not Contracted

Kings County only *

Madera County only **

Tulare County only ***

Note: San Diego County Hospitals are used in Emergency cases

HEALTH PLAN CONTRACTED HOSPITALS - IMPERIAL COUNTY												
Community Care IPA	MEDI-CAL			MEDICARE			COVERED CALIFORNIA	MEDI-MEDI			CAL MEDICONNECT	
	California Health & Wellness Medi-Cal	Health Net Medi-Cal	Molina Medi-Cal	Brand New Day Medicare	Health Net Medicare	Molilna Medicare	Molina Covered California	Brand New Day Medi-Medi	Health Net Medi- Medi	Molina Medi-Medi	Health Net Cal Mediconnect	Molina Cal Mediconnect
CORE HOSPITALS												
El Centro Regional Medical Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Pioneers Memorial Hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Y- Contracted
N- Not Contracted

Note: San Diego County Hospitals are used in Emergency cases

HEALTH PLAN CONTRACTED HOSPITALS - SAN DIEGO COUNTY																
Community Care IPA	MEDI-CAL				MEDICARE				COVERED CALIFORNIA	MEDI-MEDI				CAL MEDICONNECT		
	Aetna Better Health of CA Medi-Cal	Blue Shield Promise Health Plan	Health Net Medi-Cal	Molina Medi-Cal	Blue Shield of California Medicare	Brand New Day Medicare	Health Net Medicare	Molina Medicare	Molina Covered California	Blue Shield Promise Health Plan Medi-Medi	BrandNewDay Medi-Medi	Health Net Medi-Medi	Molina Medi-Medi	Blue Shield Promise Health Plan	Health Net CMC	Molina CMC
CORE HOSPITALS																
Alvarado Hospital	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y	N	Y
Palomar Medical Center-Escondido	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y	N	Y
Paradise Valley Hospital	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y	N	Y
Palomar Medical Center Poway	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y	N	Y
Scripps Green Hospital	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
Scripps Memorial Hospital Encinitas	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Scripps Memorial Hospital La Jolla	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Scripps Mercy Chula Vista	N	Y	Y	N	Y	Y	Y	N	N	Y	Y	Y	N	Y	Y	N
Scripps Mercy Hospital San Diego	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
Sharp Chula Vista Medical Center	Y	Y	N	Y	N	N	Y	Y	Y	Y	N	Y	Y	Y	N	Y
Sharp Coronado Hospital	Y	Y	N	Y	N	N	Y	Y	N	Y	N	Y	Y	Y	N	Y
Sharp Grossmont Hospital	Y	Y	N	Y	N	N	Y	Y	Y	Y	N	Y	Y	Y	N	Y
Sharp Mary Birch Hospital for Women & Newborns	N	Y	N	Y	N	N	Y	N	Y	Y	N	Y	Y	Y	N	Y
Sharp Memorial Hospital	Y	Y	N	Y	N	N	Y	Y	Y	Y	N	Y	Y	Y	N	Y
Sharp Mesa Vista	N	N	N	N	N	N	Y	N	N	N	N	Y	N	N	N	N
Tri City Medical Center	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y

Y- Contracted
N- Not Contracted

Section 2: Network and Affiliates

HOSPITALISTS

CCIPA is contracted with Hospitalists that supervise care from admission through discharge at COMMUNITY CARE, IPA affiliated hospitals.

THE CONTRACTED HOSPITALISTS WILL BE RESPONSIBLE FOR THE FOLLOWING

- All urgent and emergent admissions
- Provision of internal medicine, pulmonary disease and critical care medical services to all hospitalized adult patients
- Newborn Care
- Medical coordination and inpatient utilization management for surgical patients
- Provide consultation on complicated Surgical and Obstetric cases
- Coordination of all ancillary services related to the inpatient episode of care inclusive of durable medical equipment, home health and infusion services, etc.
- Coordination, in conjunction with the discharge planner, of discharge planning needs with the patient and the patient's family
- Feedback to the Primary Care Physician, as required, inclusive of a discharge summary within 24 hours of discharge
- Coordination of transfer of out-of-network patients to an in-network hospital
- MPM Inpatient Team can be reached during regular business hours, Monday – Friday, 9 am – 5 pm at 866-423-0060 ext. 1449
- MPM On-Call Nurses are available after hours, Monday – Friday, 5 pm to 9 am and on weekends and holidays, 24/7 at 866-423-0060

For a listing of contracted Hospitalists by facility, email Provider Services at:
ccipa_providerservices@medpointmanagement.com

Section 2: Network and Affiliates

PHARMACY INFORMATION

For a listing of participating pharmacies, along with corresponding Formulary Information, please reference applicable Health Plan website and seacrch for terms such as 'Pharmacy':

- Aetna Better Health of California
  www.aetnabetterhealth.com/california/providers/pharmacy.html
- Anthem Blue Cross
  www.anthem.com/ca
- Blue Shield of California
  www.blueshieldca.com
- Blue Shield Promise Health Plan
  Pharmacy Listing
- Brand New Day
  bndhmo.com
- California Health & Wellness
  www.cahealthwellness.com/providers/pharmacy.html
- Health Net
  www.healthnet.com
- Molina
  www.molinahealthcare.com

Section 2: Network and Affiliates

CONTRACTED LABORATORIES

All Community Care IPA members must be referred to either LabCorp or Quest Diagnostics, depending on the County. Please refer to the following to determine which contracted lab to refer members.

CENTRAL VALLEY COUNTIES

Online appointment scheduling is available at: www.labcorp.com.
Members may also call 855-277-8669. An appointment is not required for service but may reduce the wait time for members. For Patient Service Center locations and driving directions, visit: www.labcorp.com or call Customer Service at 888-522-2677.

Please note: Lab costs related to members referred to non-contracted providers are subject to deduction from cap or future claims payments.

Where to refer Central Valley Members:

	Anthem Blue Cross	Brand New Day	HealthNet
DME	ExpressRX	Any Plan contracted vendor	Any Plan contracted vendor
Medical Supplies	ExpressRX	ExpressRx	ExpressRX

IMPERIAL AND SAN DIEGO COUNTY

Online appointment scheduling is available at: www.questdiagnostics.com.

You may also call 888-277-8772. Appointments are not required for service but may reduce the wait time for members. For assistance in find Patient Service locations and driving directions, visit: www.questdiagnostics.com or call Customer Service at 866-697-8378. Lab work does not require prior authorization (except genetic testing). If you are not presently doing business with either of the Labs, contact them at the Customer Service numbers provided above to obtain requistion forms, etc.

DURABLE MEDICAL EQUIPMENT (DME)

Effective November 1, 2019 all Durable Medical Equipment (DME) and Medical Supplies services are capitated to ExpressRX for Tulare, Madare and Kings. This does not effect DME and Medical Supply Services rendered to members in San Diego and Imperial.

Section 2: Network and Affiliates

URGENT CARE FACILITIES

PROVIDER NAME	ADDRESS	TELEPHONE & FAX NUMBER	HOURS OF OPERATION
24 HOUR URGENT CARE OF THE DESERT	82013 DR CARREON BLVD # G, INDIO, CA 92201	PHONE: (760) 775-9500 FAX: (760) 775-9567	Mon-Fri: 7:00AM-10:00PM Sat-Sun: 9:00AM-6:00PM
CONTEMPORARY MEDICINE	231 W MAIN ST FL 2, EL CAJON, CA 92020	PHONE: (619) 631-7300 FAX: (619) 631-7334	Mon-Fri: 8:30AM-1:00PM Sat-Sun: CLOSED
EAST COUNTY URGENT CARE INDUSTRIAL & MED	1625 E MAIN ST # 100, EL CAJON, CA 92021	PHONE: (619) 442-9896 FAX: (619) 442-2245	Mon-Fri: 8:00AM-7:00PM Sat-Sun: 9:00AM-4:00PM
KAWEAH DELTA URGENT CARE	1633 S COURT ST, VISALIA, CA 93277	PHONE: (559) 624-6090 FAX: N/A	Mon-Fri: 8:00AM-4:30PM Sat-Sun: CLOSED
KAWEAH DELTA URGENT CARE	3600 W FLAGSTAFF AVE, VISALIA, CA 93291	PHONE: (559) 624-6090 FAX: N/A	Mon-Fri: 8:00AM-5:00PM Sat-Sun: 8:00AM-5:00PM
SOUTH BAY URGENT CARE I INC	1628 PALM AVE, SAN DIEGO, CA 92154	PHONE: (619) 591-9999 FAX: (619) 941-2078	Mon-Fri: 9:00AM-2:00PM Sat-Sun: 10:00AM-6:00PM
TULARE URGENT CARE	1581 HILLMAN ST, TULARE, CA 93274	PHONE: (559) 892-0646 FAX: (559) 329-5034	Mon-Fri: 9:00AM-9:00PM Sat-Sun: 9:00AM-9:00PM
TULARE URGENT CARE	810 N CHERRY ST, TULARE, CA 93274	PHONE: (559) 376-2744 FAX: (559) 329-5034	Mon-Fri: 9:00AM-9:00PM Sat-Sun: 9:00AM-9:00PM
TYSON MEDICAL INC	420 SUNFLOWER CT, BRAWLEY, CA 92227	PHONE: (760) 592-4351 FAX: (760) 970-4285	Mon-Fri: 8:00AM-5:00PM Sat-Sun: CLOSED

Visit www.medpointmanagement.com for the most up to date urgent care information.

Section 2: Network and Affiliates

EMERGENCY ROOM – PATIENT EDUCATION TOOL

ATTENTION

SIGNS TO GET TO THE ER IN A HURRY

Emergency services are those health care services provided to evaluate and treat medical conditions where urgent medical care is required. An emergency medical condition can consist of one or more of the following symptoms:

- Difficulty breathing, shortness of breath
- Chest pain/pressure
- Seizures (convulsions)
- Fainting, trouble talking, dizziness
- Changes in vision
- Confusion
- Uncontrolled bleeding
- Severe persistent vomiting or diarrhea
- Coughing up or vomiting blood
- Suicidal feelings
- Unusual abdominal pain
- Suspected broken bones
- Eye pressure
- Asthma attack
- Possible ingestions of poison, or medicine overdose

When should I call the Doctor for advice?

Always! For example, conditions such as, fevers over 102°, abdominal pain, headaches, heartburn, indigestion, constipation, hemorrhoids, back pain. If you call your doctor's office after working hours, you may ask to speak with the doctor on call.

What should I do if my doctor's office can't help me?
Contact your Health Plan's 24-hour nurse advice line.

Please call 911 if your condition is life threatening.

Section 2: Network and Affiliates

EMERGENCY ROOM – PATIENT EDUCATION TOOL

ATENCIÓN

¡¡¡INDICACIONES PARA IR DE PRISA A UNA SALA DE EMERGENCIA!!!

Los servicios de emergencia son los servicios de salud prestados para evaluar y tratar condiciones médicas donde atención médica de urgencia se requiere. Una condición médica de emergencia puede consistir de uno o varios de los siguientes síntomas:

- Dificultad en la respiración ó falta de aire
- Dolor en el pecho ó presión
- Convulsiones
- Desmayo, dificultad en el habla, maréos
- Cambios en la visión
- Confusión
- Sangrar incontrolable
- Vómito ó diarrea severo
- Toser ó vomitar con sangre
- Deseos de suicidio
- Dolor de abdomen inusual
- Sospecha de huesos rotos
- Presión en los ojos
- Ataque de asma
- Ingestión de veneno ó sobredosis de medicina

¿CUÁNDO DEBO PEDIR CONSEJO A MI DOCTOR?

¡Siempre! Para condiciones, por ejemplo, fiebres que pasan de 102°, dolores de estómago, dolores de cabeza, acidez estomacal, indigestión, estreñimiento, hemorroides, dolor de espalda. Si llama después de las horas de trabajo a la oficina de su doctor, puede preguntar por el doctor que atiende las llamadas a esas horas.

¿QUÉ DEBO HACER SI LLAMO A LA OFICINA DE MI DOCTOR Y NO ME PUEDEN AYUDAR?

Puede llamar a su a seguranza y pedir consejo con enfermeras que están disponibles las 24 horas del día.

Si su condición es potencialmente mortal, por favor llame al 911.

Section 3: Utilization Management

MedPOINT's Utilization Management (UM) Department encompasses three main areas: outpatient review, inpatient review and case management. Overall, the utilization management program is designed to ensure consistent care delivery by encouraging high quality of care in the most appropriate setting from our highly qualified provider network.

VERIFYING MEMBER ELIGIBILITY

It is the provider's responsibility to confirm the member's eligibility at the time of service. When a Community Care IPA patient arrives for an appointment, please verify eligibility. Eligibility verification can be accomplished by doing the following:

1. Request the patient's Health Plan identification card.
2. Run eligibility on the Health Plan portal to verify status.
3. If the Health Plan or MPM portals cannot verify eligibility and the member still states that he/she is eligible, please call the MedPOINT Management Eligibility Department at 866-423-0060, Option 1

The following steps should be followed whether the patient has his/her identification card or not.

1. Check Health Plan eligibility portal as instructed above.
2. Contact the Health Plan. If the member is still not identified, providers should contact the Health Plan before services are rendered. If the Health Plan is unable to verify eligibility, please do not turn away patient from medically necessary services.

HEALTH PLAN WEBSITE AND INTERACTIVE VOICE RESPONSE (IVR)

Eligibility should be confirmed directly through the Health Plan. Please be advised that Health Plan direct eligibility information will be the most current. Health Plans prioritize their online portals for eligibility verification, however, for most Plans an Interactive Voice Response (IVR) automated phone system is also in place. Before calling into the IVR line, please have the following information on hand:

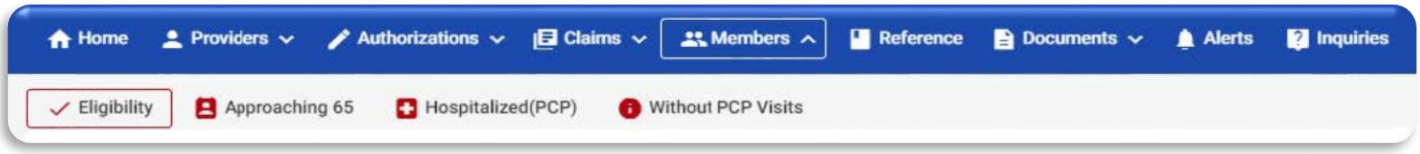
- Tax Identification Number
- National Provider Identifier
- Provider Fax Number (for call to fax IVR)
- Member Identification Number
- Member Date of Birth

HEALTH PLAN	IVR
Aetna Better Health of California	800-624-0756
Anthem Blue Cross	800-677-6669
Blue Shield of California	800-424-6521
Blue Shield Promise Health Plan	800-605-2556
Brand New Day	866-255-4795
California Health & Wellness	877-658-0305
Health Net	877-857-0701
Molina	800-357-0172

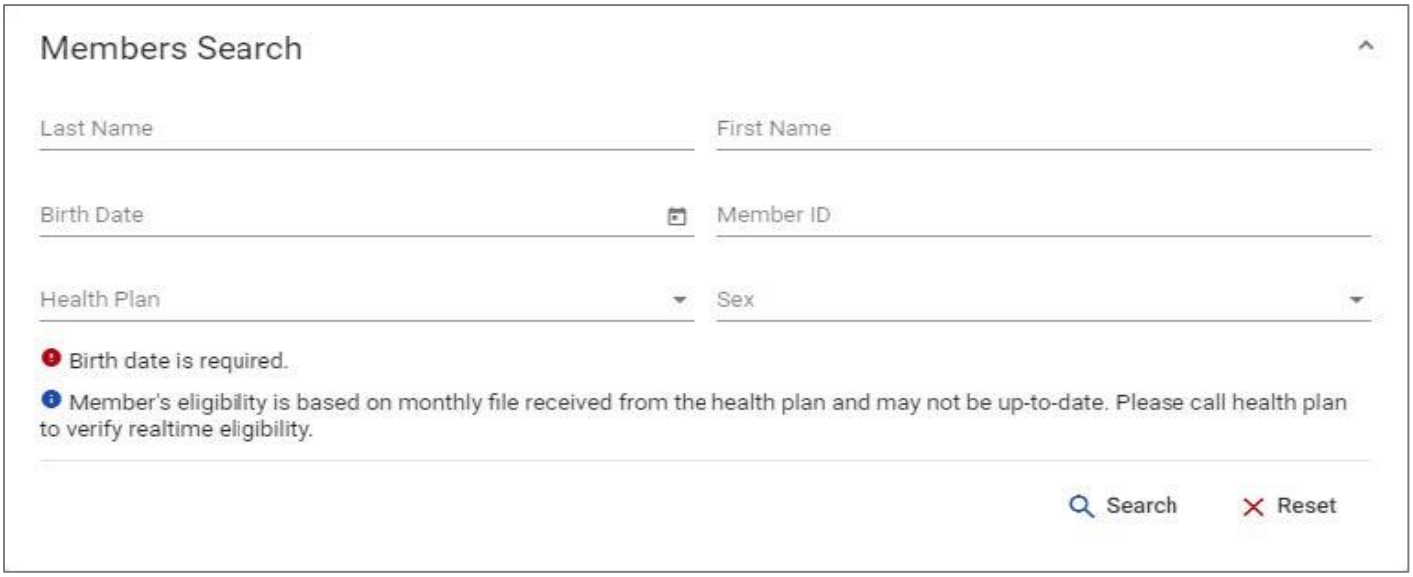
VERIFIYING ELIGIBILITY VIA THE WEB PORTAL

The web portal allows you to search for Eligibility record(s) in the system. The MPM Eligibility is updated on a weekly, bi-monthly or monthly basis, depending on the Health Plan file availability. Use Health Plan portal for most up to date information.

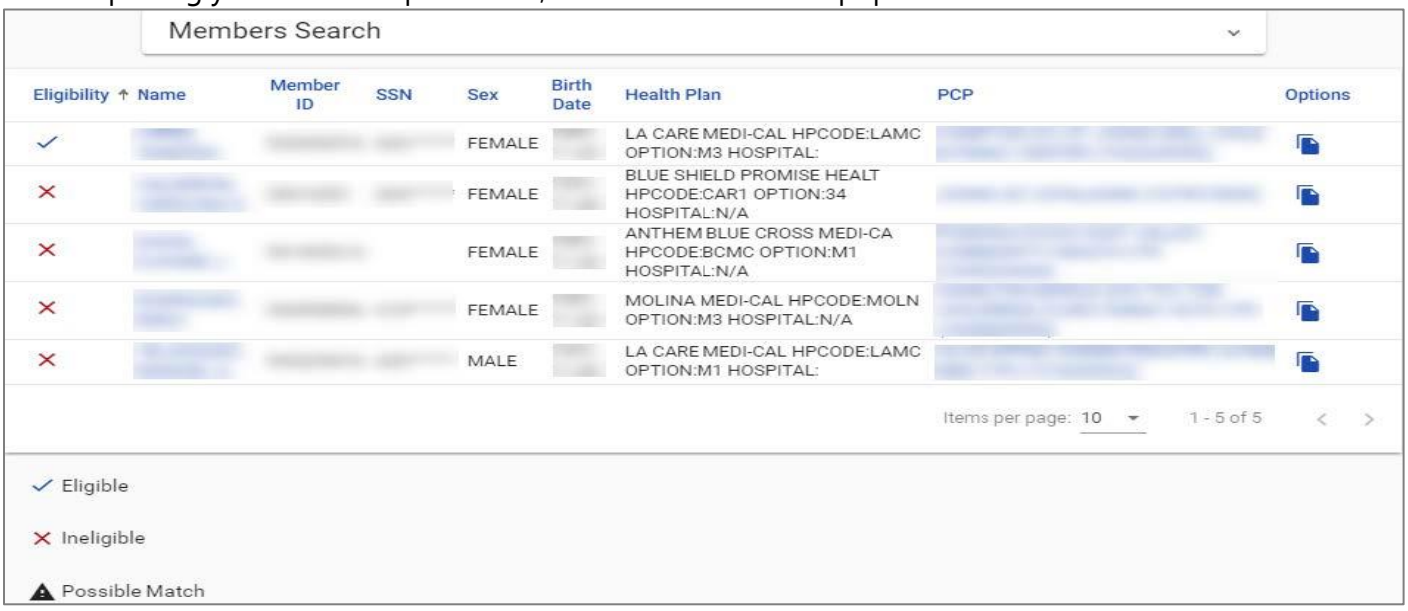
To access the Eligibility search feature, go to the Main Menu, click on Members then Eligibility:



The Member Search screen will appear. Search for the Member's first name, last name and DOB. The DOB is a required HIPAA field when searching for a Member through the web portal.



After inputting your search requirements, the search results will populate.



When the system returns the Member record, you will have a clear visual indication whether the Member is Eligible, Possible Match or Ineligible. By clicking on the Member Name, you will pull up the Member Detail Page.

Member Information:	Fields contain the Member's information. Such as: name, member ID, sub-relation, DOB, Health Plan, additional info, and address.
PCP Information:	Fields contain PCP information. Such as: Name, provider ID, specialty, phone numbers (office and fax), and effective date.
Benefit Information:	Fields contain the Member's benefit information. Such as option, co-pay, effective date, and termination date.
Attachments	View all the attachments associated with this member, i.e., medical records, consult notes, etc.

From the Member Details page you could also perform the following tasks:

- Copy member's information to Authorization
- Inquire about the member
- Print or save as PDF the Member Detail page

System Requirements:

To get the best experience out of the Web Portal you'll need:

Windows:

- Windows 7, Windows 8, Windows 8.1, Windows 10 or later
- An Intel Pentium 4 processor or later that's SSE2 capable
- Mac
- OS X Yosemite 10.10 or later Linux
- 64-bit Ubuntu 14.04+, Debian 8+, openSUSE
- 13.3+, or Fedora Linux 24+
- An Intel Pentium 4 processor or later that's SSE2 capable

To view PDF's directly from your browser, please have the latest version of Google Chrome or Windows Edge installed in your computer.

REFERRAL AND PRIOR AUTHORIZATION GUIDELINES

The following procedures are to be followed when submitting a request for prior authorization from Community Care IPA.

1. Submit all authorization requests via the Community Care IPA/MPM Portal at: portal.medpointmanagement.com/sign-in. Always provide clear and concise notes stating the medically necessary/clinical reason for the referral.
2. All authorization requests are to be submitted under the actual referring provider, even if referring provider, even if referring provider is a physician extender. In this way, we will have data to better track and trend referral patterns and care delivery.
3. Refer members to a contracted provider or facility. There is a current participating provider roster to choose from or if you have any questions about a provider's participation, feel free to contact the Provider Services Department at MedPOINT Management.
4. Referral to non-contracted/out of network providers cannot be submitted to UM as an Urgent referral. Place in note that this is a non-contracted provider and needs immediate attention.
5. Upon approval or denial of authorizations, alerts will be sent to the Provider via the MPM Web Portal. Authorizations generally expire ninety (90) days after the date of the assignment and will be documented on the authorizations. Unused authorizations may be extended for a maximum of thirty (30) days. After this extended period, unused authorizations must be resubmitted with current progress notes to be approved for a new authorization.
6. The requesting provider must file a copy of the approval or denial letter printed from MPM in the member's chart.
7. The Utilization Management Committee will review all redirected referrals or denials. If in disagreement with a redirect or denial, access to the Utilization Management or the Medical Director is available to discuss any concerns regarding the decision and/or alternate treatment options.
8. For appeals process and procedures, please refer to the Provider Dispute Resolution section.
9. Do not provide the member with a copy of an authorization that is in requested status. An approved routine referral will be mailed to the patient within seven (7) day
10. PCP must have a way of tracking both Specialty Referrals and missed appointments, avoiding care fragmentation. Consult notes and follow up must be documented.
11. Standing Referral: If you have a member who requires continuing Specialty care over a prolonged period or specialist coordination of primary care, please contact the UM Department for a Standing Referral. The Standing Referral eliminates the need to return to the PCP on a repeated basis when Specialty care is required on an on-going basis. PCP continues to coordinate all medically necessary covered diagnostic, preventive and treatment services.
12. Utilization Management: Decisions are made based on nationally recognized objective standards, criteria and guidelines based on sound medical evidence. Providers may contact MedPOINT Management for copies of all policies and procedures as well as Clinical Criteria used in the decision-making process. Providers are encouraged to discuss UM decisions with our Physician Reviewers. Contact 866-423-0060 x 1779 to have a Medical Director answer your questions. No physician reviewer receives financial incentives to limit, restrict or deny services.

CLINICAL PROTOCOLS AND GUIDELINES

The following outlines the clinical protocols that are to be followed when submitting a request for prior authorization from Community Care IPA.

1. The IPA has Clinical Protocols for all common specialties and these protocols include:
2. Clinical indications for a specialty referral
   - Recommended records needed with a referral submission
   - The IPA has clinical protocols and guidelines that pertain to our PCP's scope of care for both adults and children. These clinical protocols are posted on our website: www.medpointmanagement.com/provider-resources and titled, "Scope of PCP Care for Adults" or "Scope of PCP Care for Pediatrics".
3. The IPA generally uses industry standard guidelines to assess requests for specialty care and Providers can find the criteria for common diagnoses and treatments on the MPM website.

There are three (3) levels of priority when submitting a request for referral:

Type of Request	Description	Decision TAT
URGENT	Urgent requests are for emergent referrals. The patient cannot wait for an appointment and may suffer loss of life or limb within 24 hours if not treated. Requests that do not meet this criterion will be downgraded to routine.	24 to 72 hours See SUBMITTING AUTHORIZATIONS VIA THE WEB PORTAL for instructions on submitting urgent requests. Please call the Utilization Management department at 866-423-0060 ext. 1449 (Inpatient) or ext. 1579 (Outpatient) to follow up on urgent requests.
ROUTINE 	Routine requests are for non-urgent/non emergent referrals. The patient can wait for the appointment. Do not make an appointment for the member without an approved prior authorization.	Five (5) working days
RETROSPECTIVE 	Retrospective (Retro) refers to a process that occurs after a treatment has been completed or when a discharge from services has been accomplished.	See the RESTROSPECTIVE REVIEW POLICY for complete details. Submit Retro Authorization Requests via the MPM Portal as Routine and enter "Retro Authorization Request" in Notes.

RETROSPECTIVE REVIEW POLICY

Purpose: The Utilization Management Committee, Medical Director or physician designee conducts retrospective review of cases, which were not previously authorized and of claims, which require authorization for payment. A senior physician has substantial involvement in the retrospective review process. The process also includes tracking and trending and analysis of utilization statistics.

Policy: The Utilization Management Committee or its designee will retrospectively review and make authorization determinations on all cases, which require authorizations.

1. Qualified health professionals assess the clinical information used to support UM decisions and appropriately apply to all requests for service.
2. Relevant clinical information will be obtained, and the treating physician will be consulted as appropriate. Approved practice guidelines and criteria will be appropriately applied to all requests for service.
3. All determinations will be clearly documented and made available to providers.
4. Complex cases will be evaluated by the Medical Director/Utilization Management Committee, Board-certified physicians from appropriate specialty areas also will assist in making determinations of medical appropriateness for retrospective authorizations.
5. Case management and revenue recovery cases will be submitted to the appropriate staff for follow-up.
6. Approved requests will be paid according to the specific services authorized.
7. Determinations for the denial of requests based on medical appropriateness will be made only by licensed physicians.
8. Retrospective service denials are followed by notification to the providers of the determination.
9. Denials for requested services will include a clearly documented letter to the provider explaining the reason for the denial, suggesting an alternative treatment plan, and informing them of CCIPA's and the member 's Health Plan appeals process within five days of receipt.
10. Utilization statistics will be tracked, trended and analyzed by the UM Committee and reports will be presented to the Board of Directors at least on a quarterly basis.
11. Retrospective review decisions are made according to Regulatory Standards and Health Plan Policies.
12. Within thirty (30) calendar days in accordance with Health and Safety Code 1367.01, or any future amendments thereto.
13. Notification will take place within the thirty (30) calendar day timeframe. Providers will be notified in writing with two (2) working days of the decision.
14. **Utilization Management decisions** are made based on nationally recognized objective standards, criteria and guidelines that are based on sound medical evidence. Providers may contact MedPOINT Management for copies of all policies and procedures as well as Clinical Criteria used in the decision-making process. Providers are encouraged to discuss UM decisions with our Physician Reviewers. Please contact 866-423-0060 x 1779 to have a Medical Director answer your questions. No physician reviewer receives financial incentives to limit, restrict or deny service.

Making a Referral?

Before your patient leaves, discuss

Turnaround Time

Explain the time it will take for patients to receive the referral, as well as how they will receive it.

Specialist Information

If you know the Specialist the patient will see, provide the contact information (name & phone), reason for referral, and referral authorization number if available.

If you do NOT know the Specialist the patients will see, provide the contact information (name & phone), reason for referral, and referral authorization number, if available.

Setting an Appointment

Set your patient's expectations regarding how long it may take to get a specialist appointment. Explain that some specialists' schedules are busier than others and getting an appointment may take up to two (2) weeks.

Setting an Appointment

Let patients know they can contact you if they do not receive the referral or if they are not able to schedule an appointment with the specialist.

Best Practice: For urgent or critical referral, offer to contact the Specialist's office and assist the patient with scheduling the appointment.

COMMON ERRORS AND SOLUTIONS

⚠ **Error**-Authorizations left "Unassigned" without documentation of requested provider.
Solution- Document the full name, address and phone number of the provider in the notes. Please do not choose any provider and then ask to change the provider in the notes. Please use unassigned.

⚠ **Error**- Incorrect Place of service (i.e. Using Office - POS 11 for an Ambulatory or Inpatient request)
Solution- Select the correct place of service on the authorization request form. The default on MPM is Office POS 11, but if you are requesting a procedure that is performed at an Ambulatory Surgical Center, Outpatient or Inpatient Facility you need to select the correct place of service as well as the facility.

⚠ **Error**- Entering the incorrect rendering provider (i.e. assigning the hospital instead of the surgeon).
Solution- Use the provider who will render the service.

⚠ **Error**- Duplicate authorizations.
Solution- Always review the member's authorization history before entering a new request.

⚠ **Error**- Requesting to change provider on an approved authorization.
Solution- We cannot change a provider on an approved authorization. A new request is required.

⚠ **Error**- Entering surgeries and office visit follow ups on the same authorization.
Solution- Submit separate authorizations for office visits and outpatient procedures. In office procedures may be submitted on the same authorization. Please note: Most major surgeries include follow-up visits within 90 days.

⚠ **Error**-No clinical information documented or documenting "see fax".
Solution- Please document the basic medical indication for the request. If you need to submit additional consult notes or radiology reports, please scan and attach to the request in the MPM Portal.

⚠ **Error**-Submitting a new visit code when a follow up visit is appropriate or vice versa.
Solution- Please check the member history to make sure a consult has not been requested previously or vice versa.

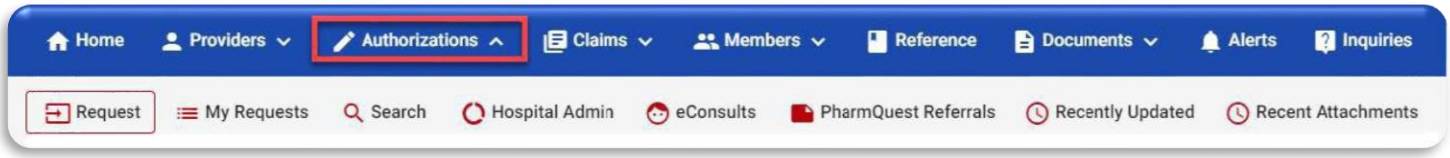
⚠ **Error**-Submitting a new request in response to a deferred request.
Solution- Do not enter a new request. Scan and attach the information to the original request.

⚠ **Error**- Submitting comments with additional information on a denied request.
Solution- Once an authorization request has been denied that request cannot be changed. If the request was denied due to a lack of medical information, you may resubmit a new request with the additional clinical information. If it was denied due to no medical necessity or no coverage and your provider has questions, contact your Provider Liaison to assist in getting in contact with a Medical Director. Otherwise, the member must appeal the decision with the Health Plan. The denial reason is always stated in the notes.

SUBMITTING AUTHORIZATIONS VIA THE WEB PORTAL

The Authorizations tab is where you can request an Authorization, view your requests, search Authorizations, and view Authorization related reports.

Please note: all authorization requests are to be submitted using the Actual Referring Provider, even if referring provider is a physician extender (i.e. Nurse Practitioner or Physician Assistant). All providers, regardless of specialty, are visible on our portal. However, authorization requests should not be submitted using the Health Center as the referring provider. In this way, we will have data to better track and trend referral patterns and care delivery.



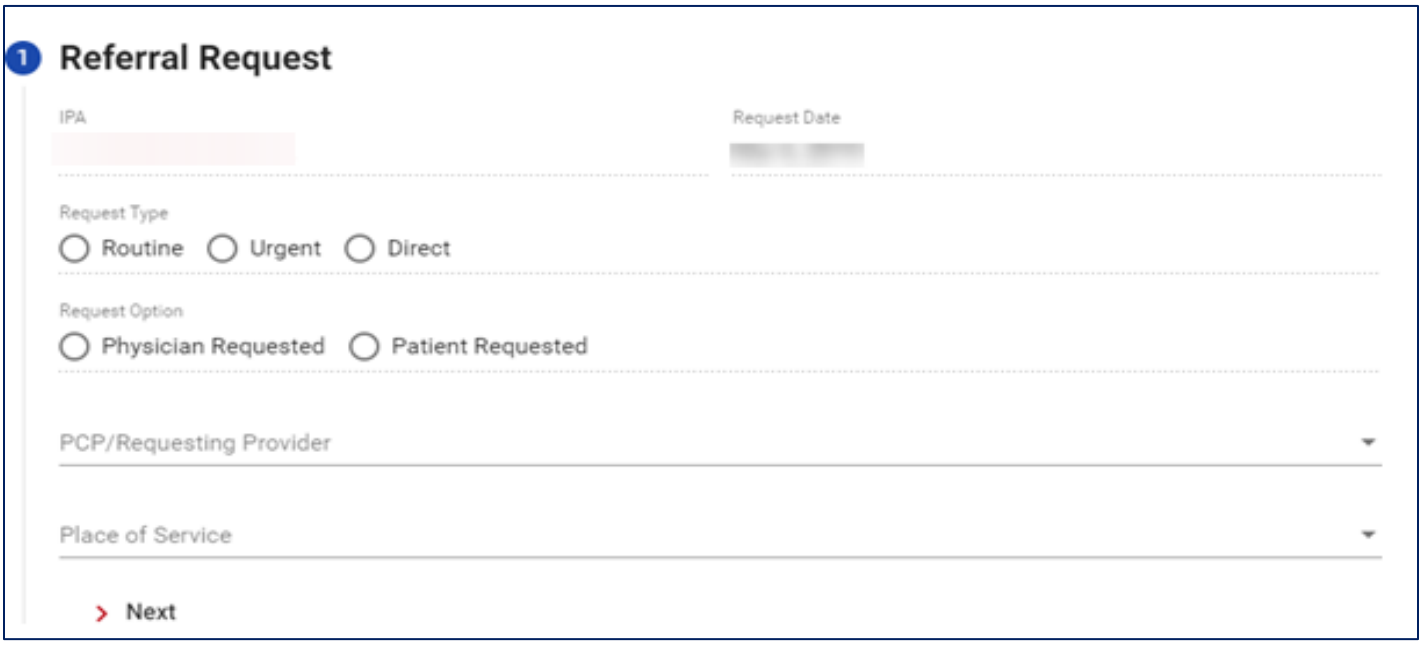
Note: For Inpatient & Outpatient Pre-Certification Authorization, we require 2 authorizations for pre-certification of inpatient/outpatient surgeries.

- One for the facility component
- One for the professional component

This is due to the services are being billed/paid by two separate entities. The hospital will also require their own approvals to identify services being rendered with each admission.

A) Request
The Request tab is where you can submit a Referral Request.

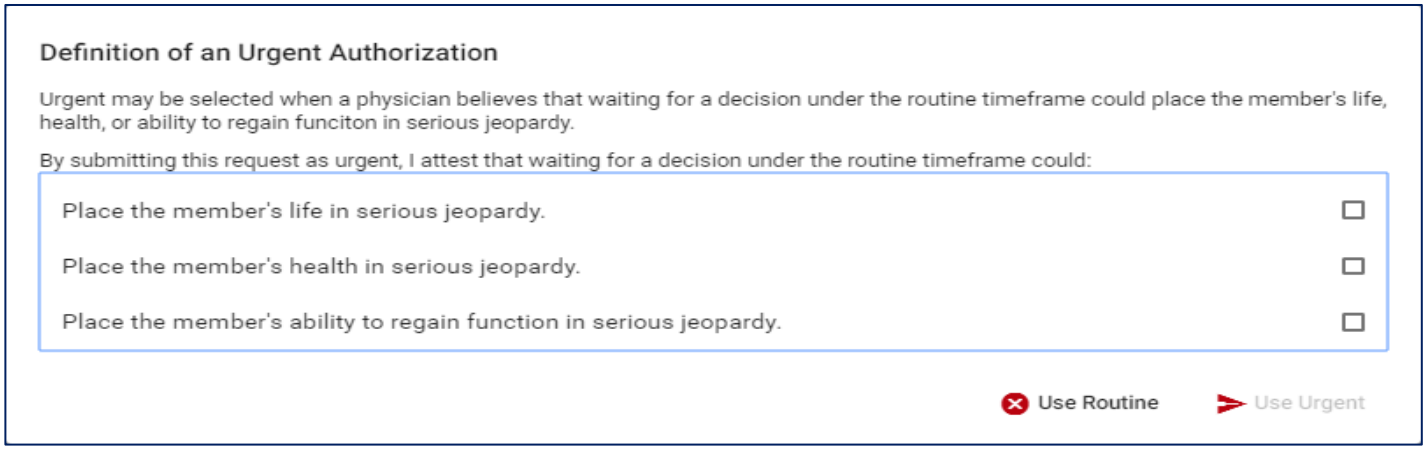
Step 1) Referral Request



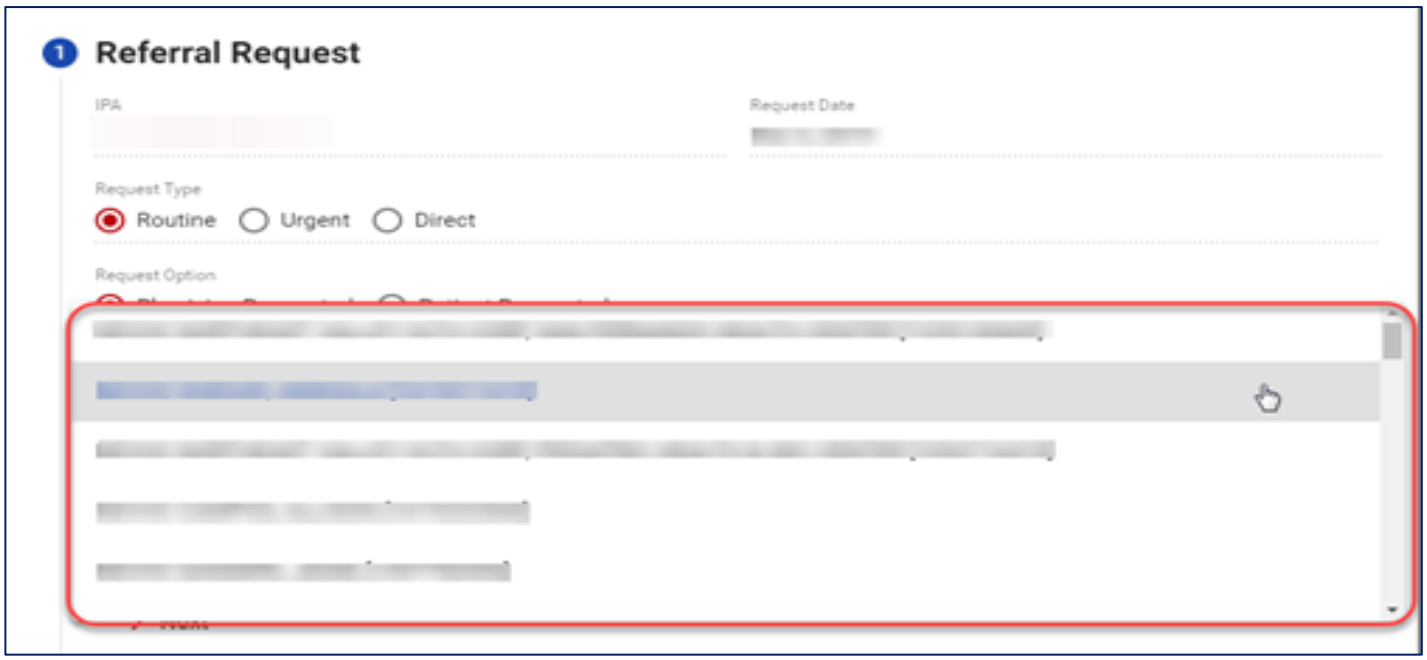
In this section, your selected IPA and request date are automatically filled in. Request Type: The timeliness of the request types per line of business is as follows:

Note: When selecting Urgent Requests, a prompt will pop up to identify why the request meets the regulatory definition of an urgent request.

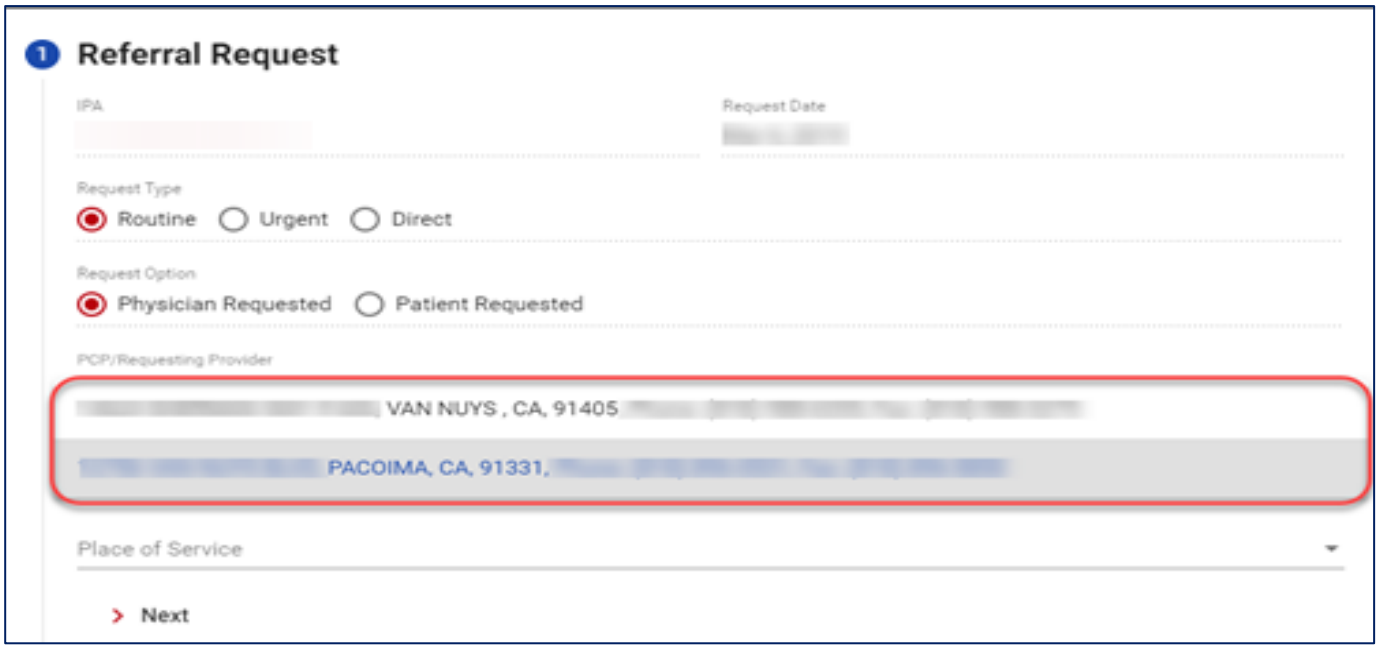
✓ Check all boxes that apply



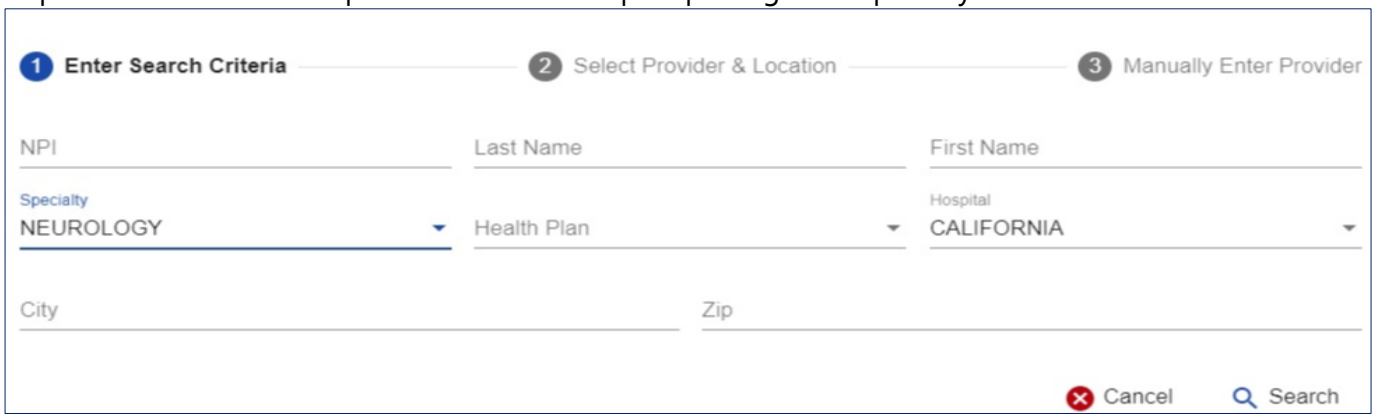
Request Option: Physician Requested or Patient Requested. PCP/Requesting Provider: Clicking on the drop down will provide you with a list of all Provider within your network.

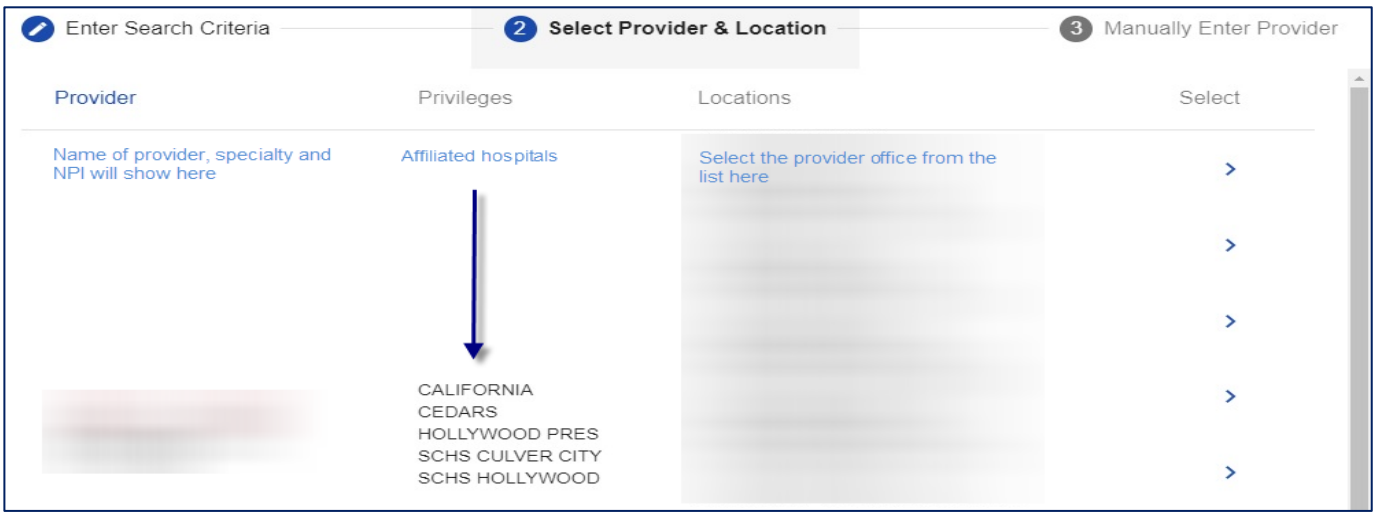


After selecting a PCP/Requesting Provider, an additional line will appear asking for the provider location. If the provider has multiple office locations, both will appear. Place of Service: A drop down of all the available place of services will be available. You can type the code or description to populate the POS in the field.



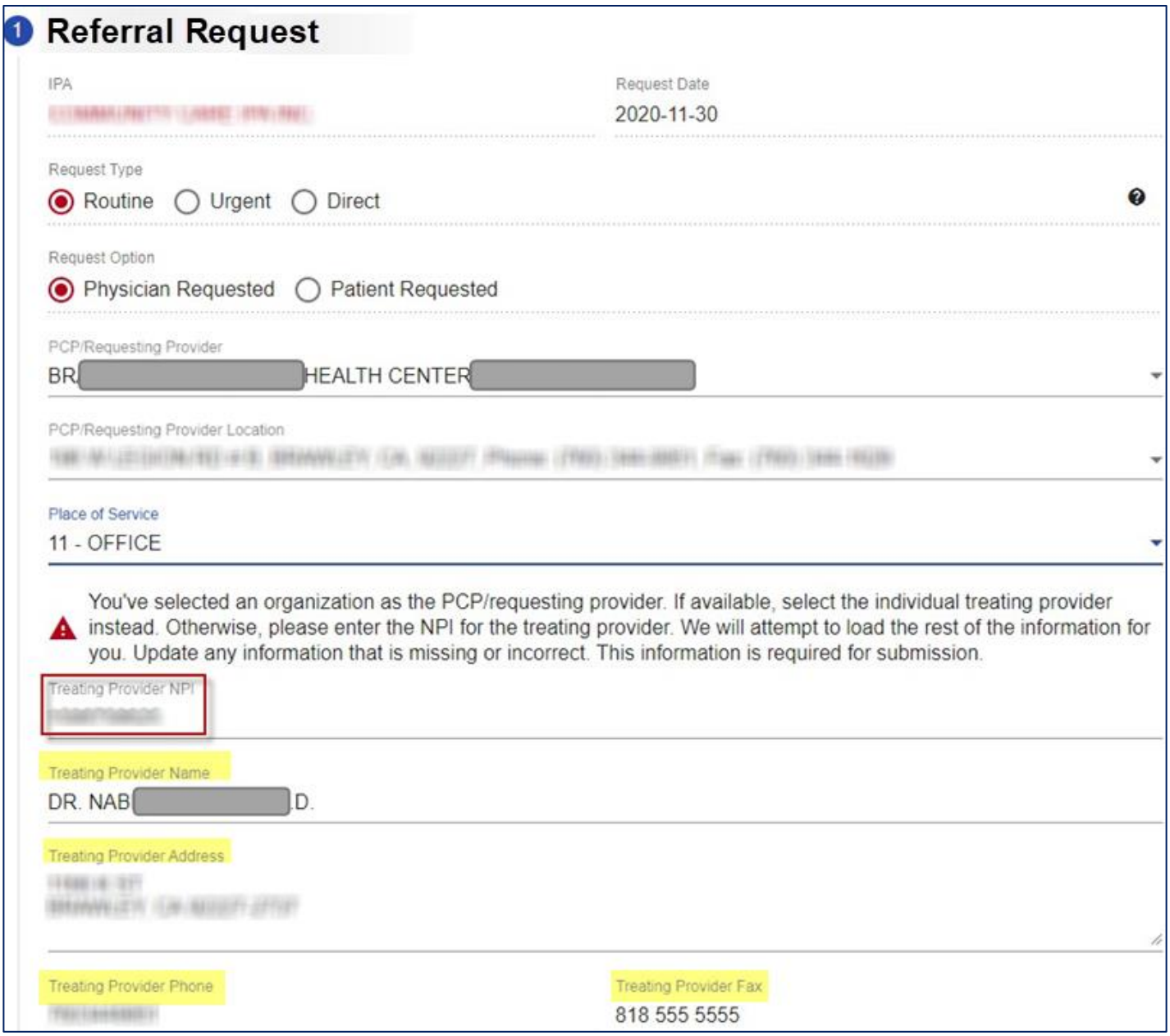
*A provider can also be requested based on hospital privilege and specialty





Treating Provider

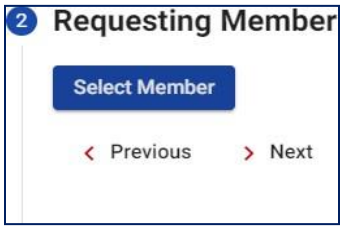
When a user selects an Organization as the PCP/requesting provider, a new field called Treating Provider will appear on the screen. The user will be required to enter the Treating provider information by entering the NPI number. Once the NPI is filled in, the provider's information will be populated in the other fields. Any information that is not auto populated can be enter by free text.



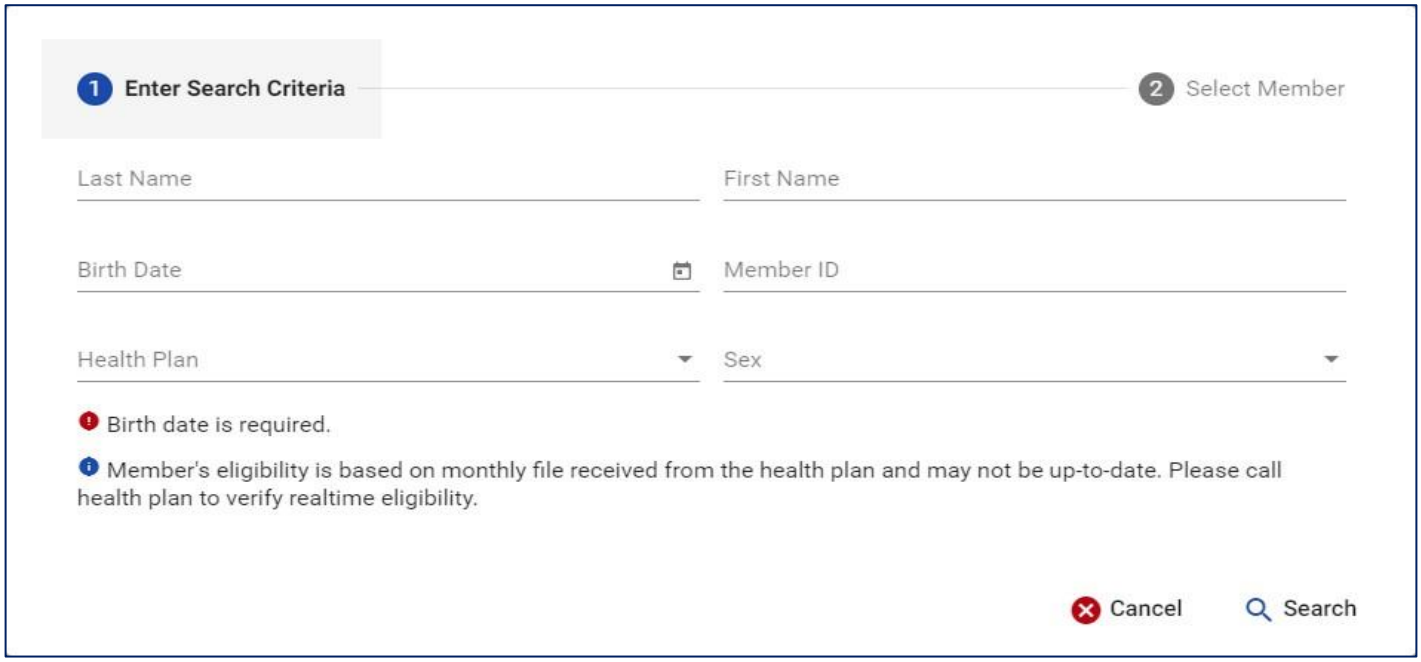
Click on next, or Step 2 to proceed.

Step 2) Requesting Member

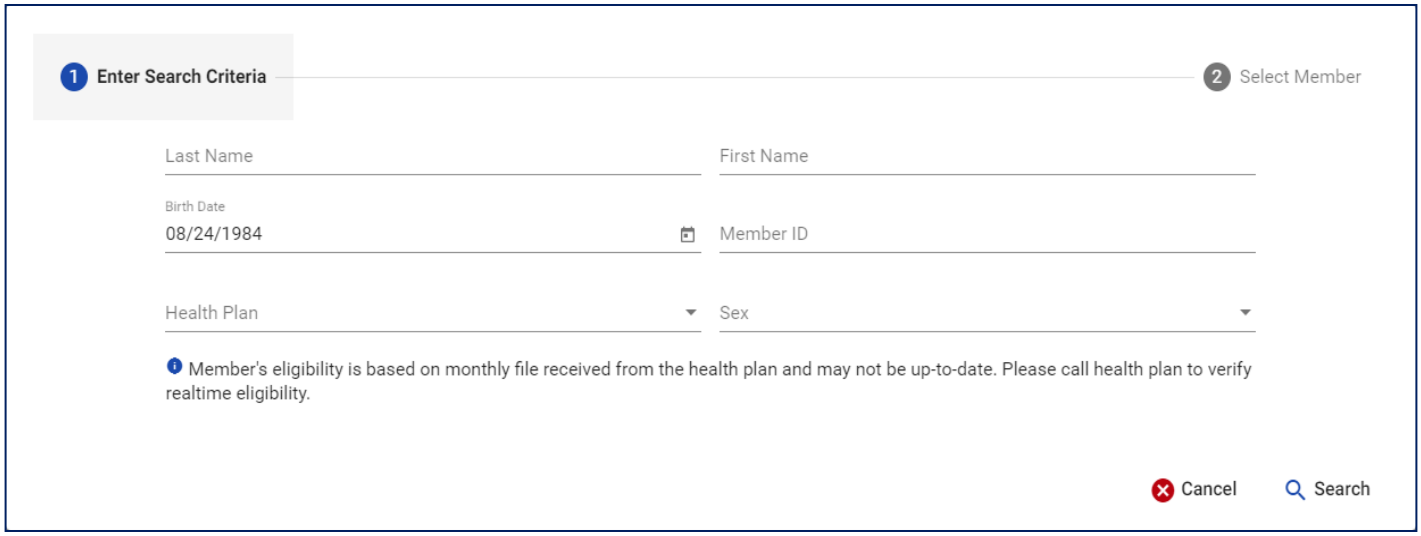
In this section, select the Member in which the Referral is for.



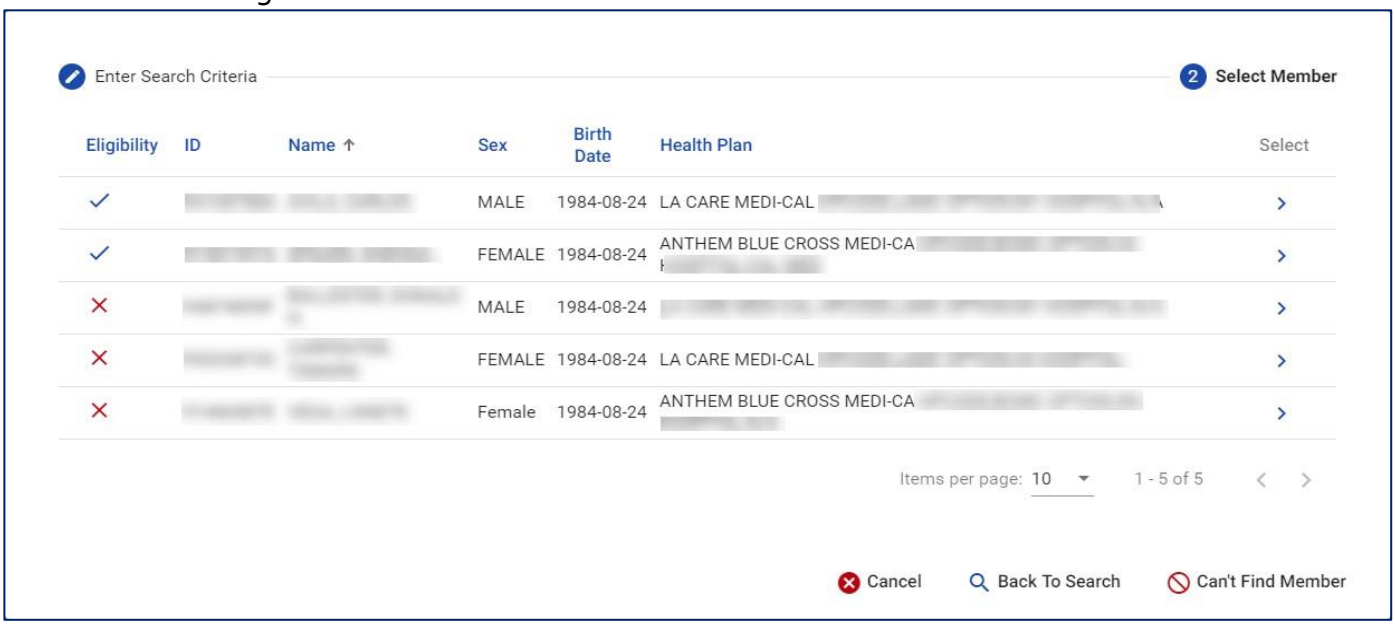
Click on Select Member to populate the member search window.



Enter the member's information. The birth date is the minimum requirement to search for a member.



All of the members who fit within the search criteria will populate. A check mark under Eligibility will appear if the member is eligible.



Click on the arrow under Select to add the member to the Authorization request.

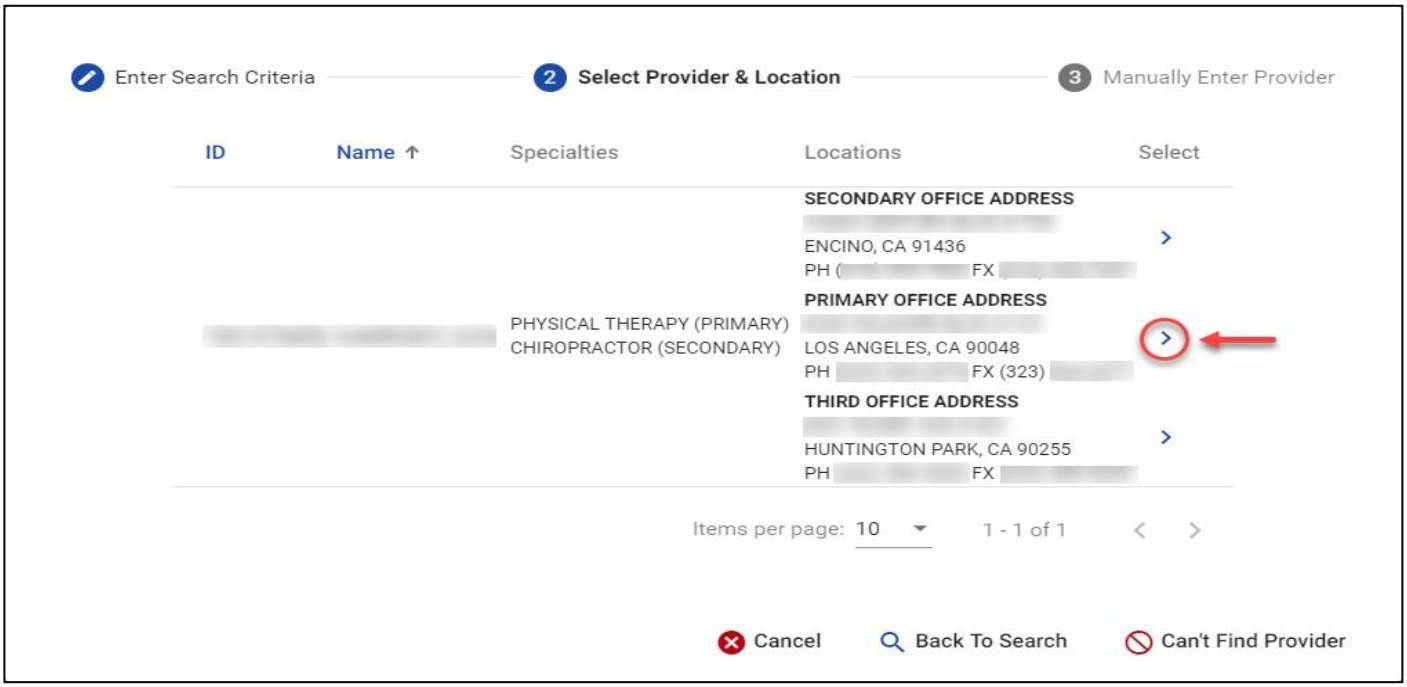
Click on Next, or Step 3 to proceed.

Step 3) Requested Provider

Select the Requested Provider in this section.

Click on Select Provider to pull up the Provider search window.

Enter the information for the Provider and click on the search icon. If a provider has multiple addresses, all of them will appear. Click on the icon to select the desired location to continue.

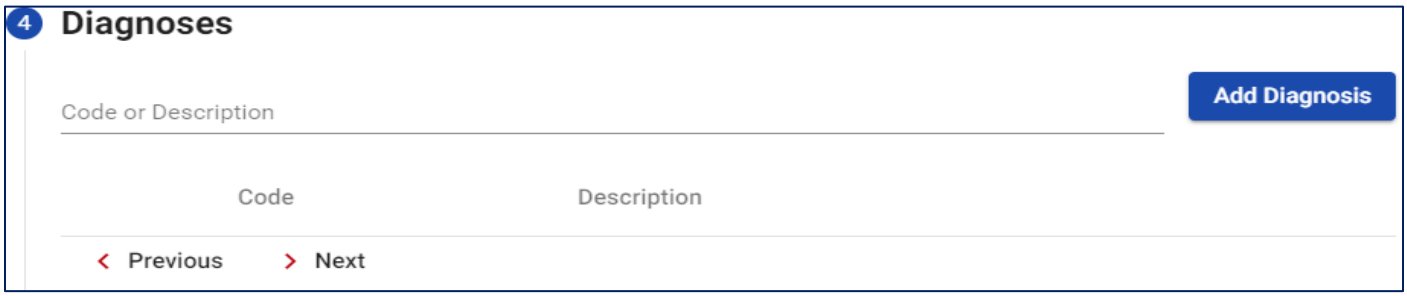


The Provider's information will now appear under Step 3

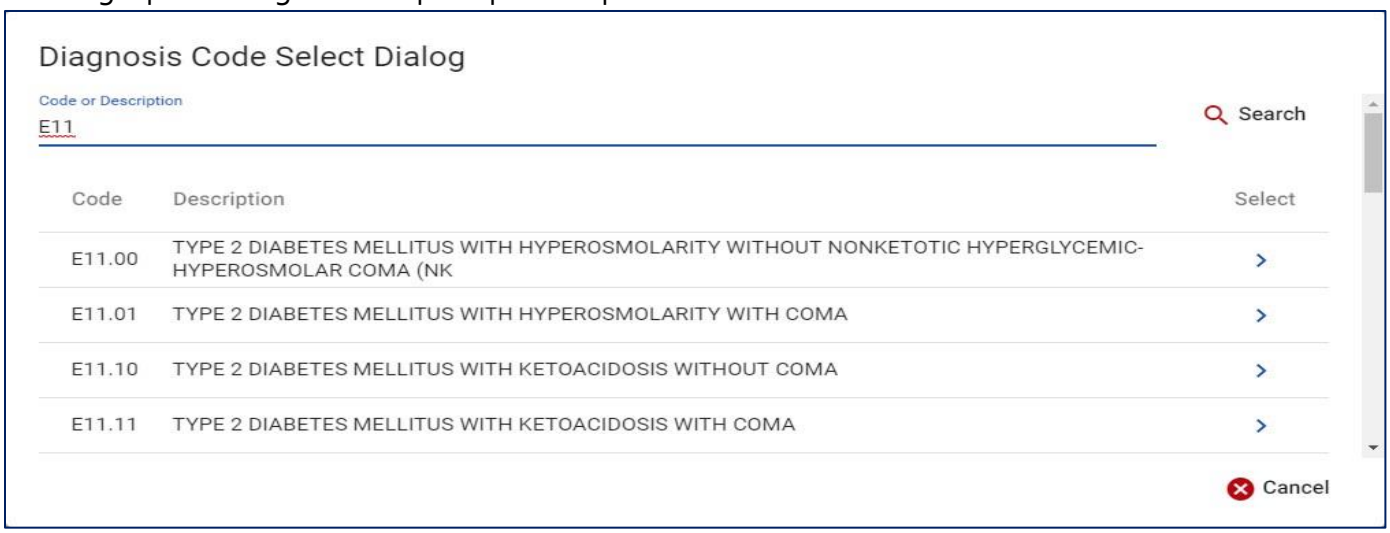
Click on next, or step 4 to proceed.

Step 4) Diagnoses

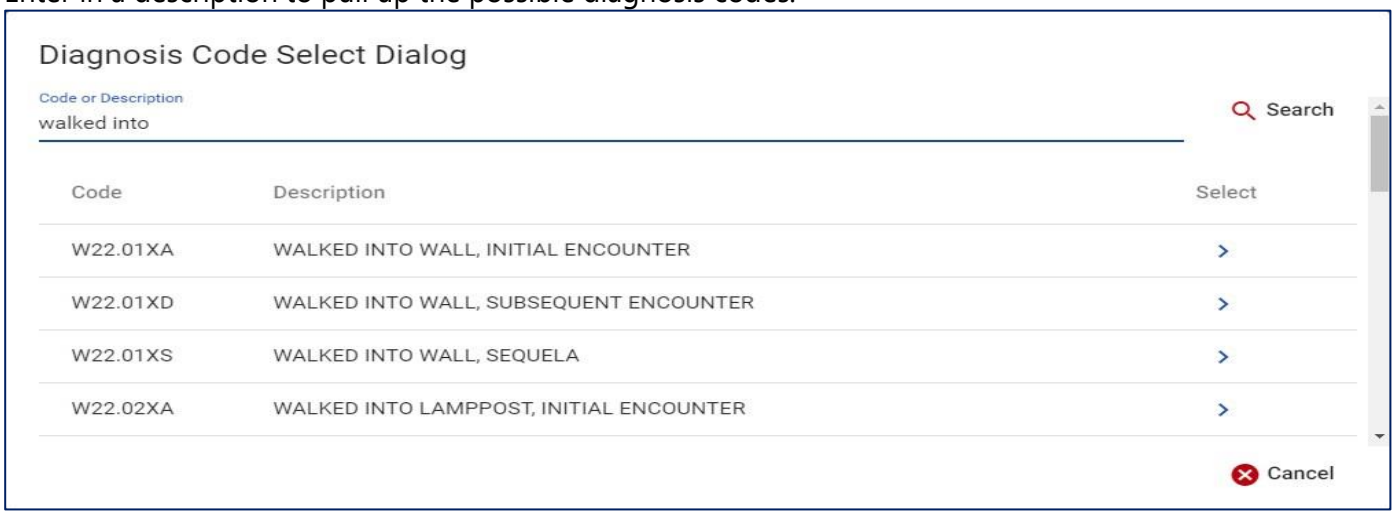
Enter the diagnosis code(s) in this section.



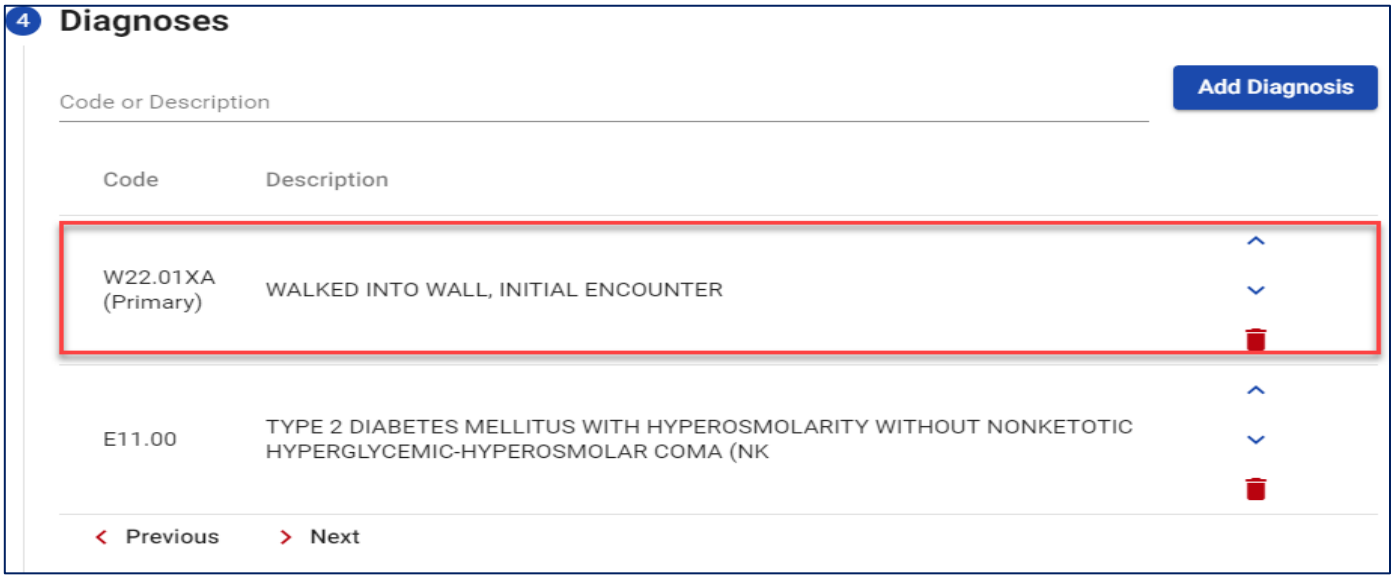
Entering a partial diagnosis will pull up all the possible matches.



Enter in a description to pull up the possible diagnosis codes.



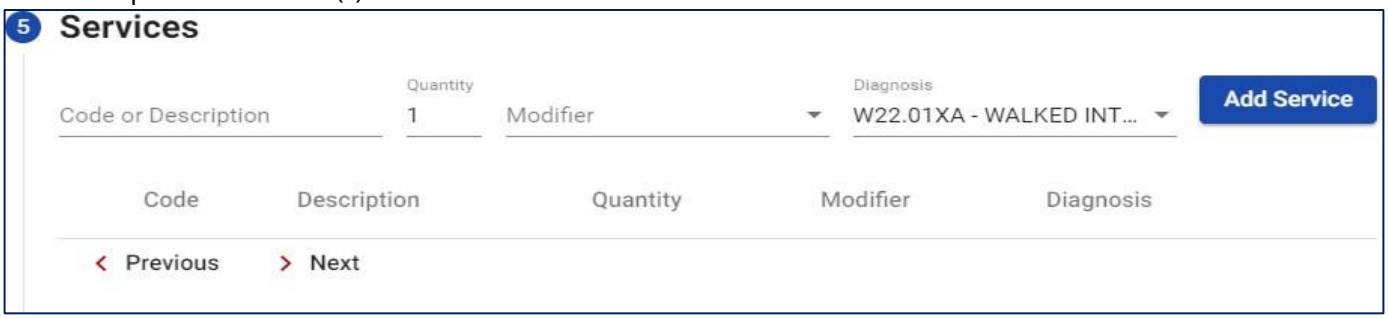
Once the codes are selected, they will appear on the Authorization Request page. Click on the up and down arrows to move the diagnosis codes in sequence; primary, secondary, etc.



Once the diagnosis code(s) are entered, **click on Next or Step 5 to continue.**

Step 5) Services

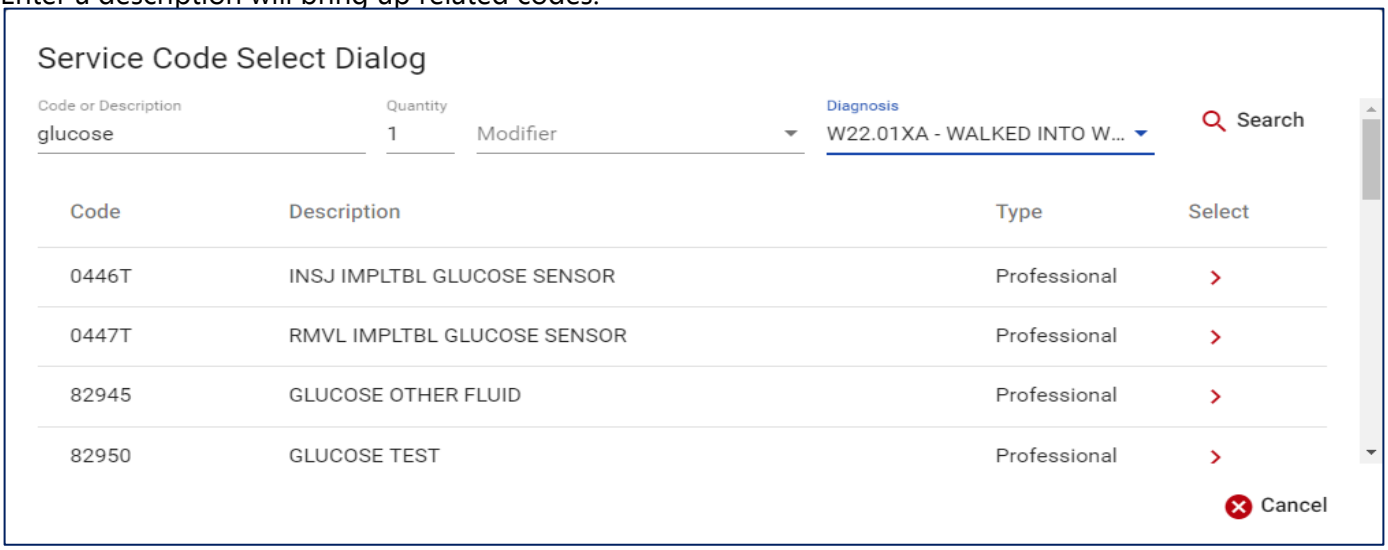
Enter the procedure code(s) in this section.



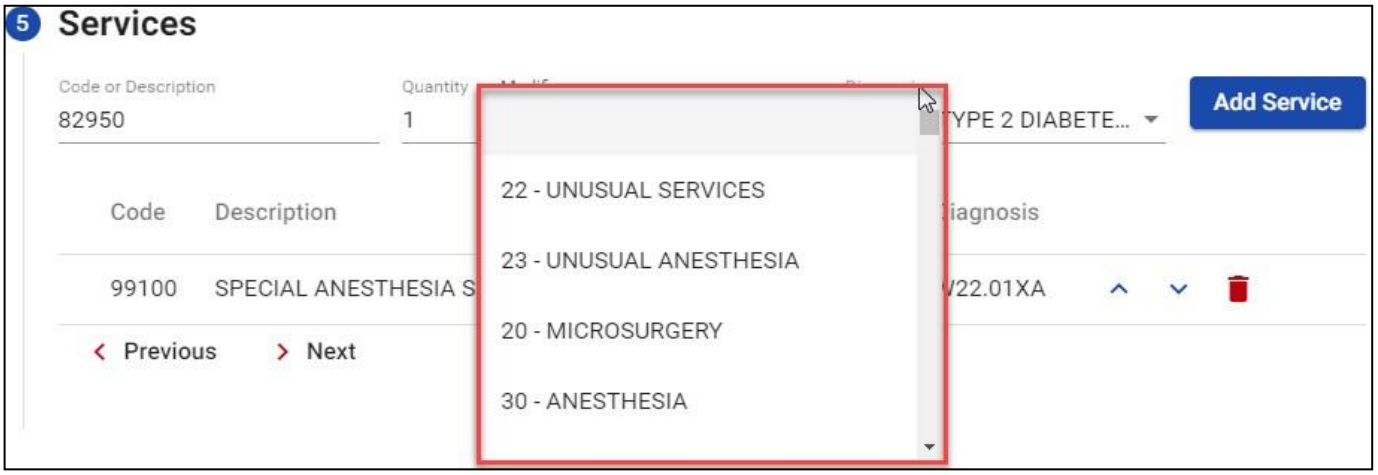
Code or Description: Enter in the procedure code.

Entering in a partial code or description will bring up the search window.

Enter a description will bring up related codes.

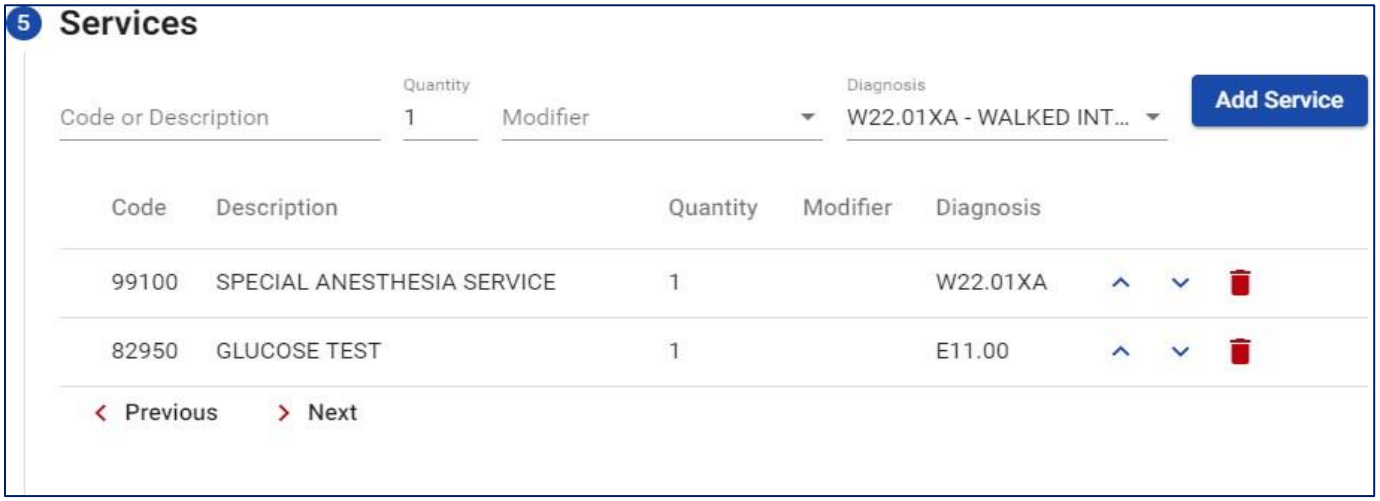


Select a modifier from the drop down (if applicable).



Select which diagnosis the procedure will be tied to.

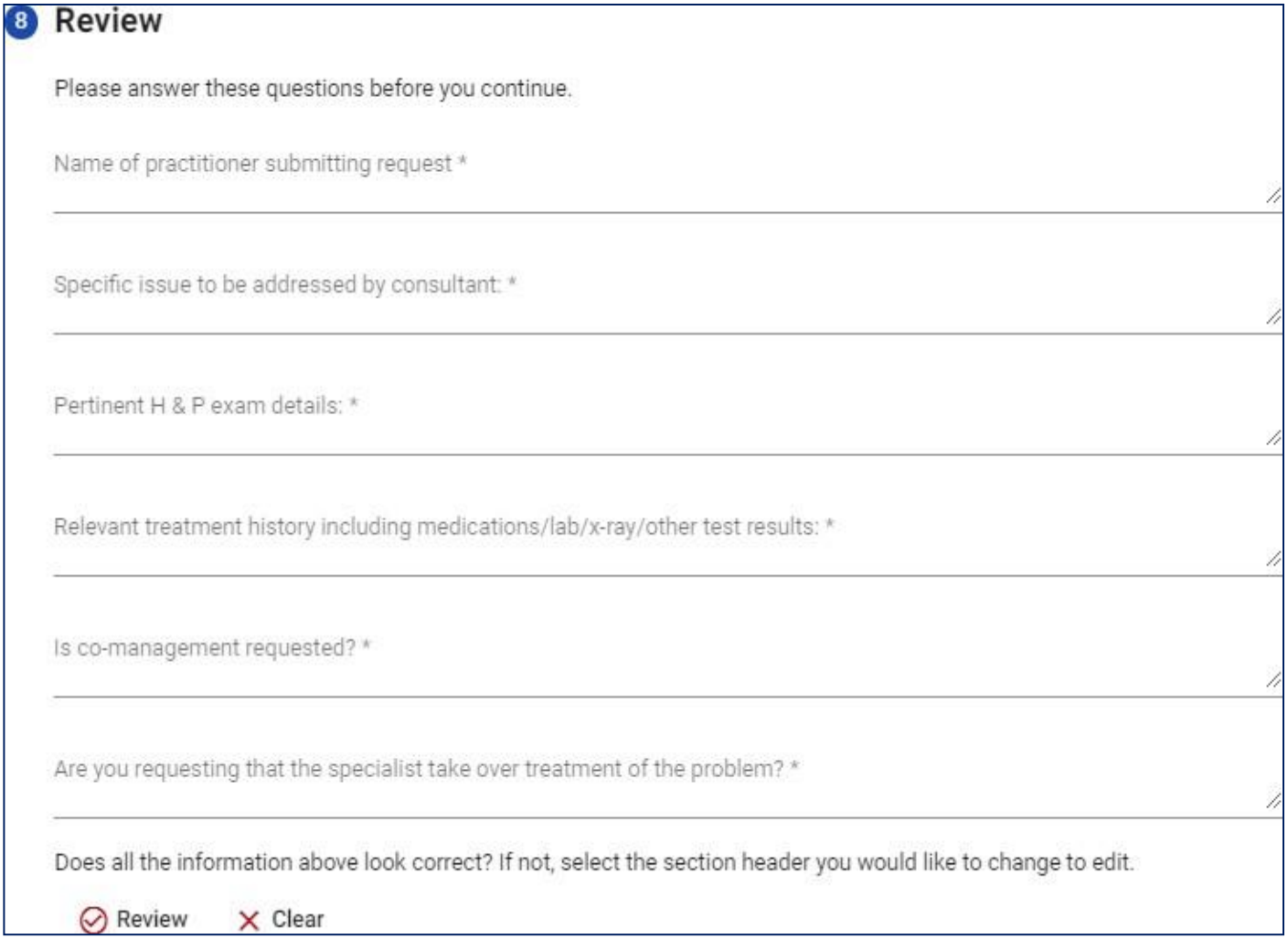
Click on Add Service to add the code to the Authorization request.



Referral Clinical Questions

Certain consultation CPT codes require additional information. Using these following codes (99201-99205 or 99243-99245) will prompt you to answer five (5) clinical questions. You must answer these questions in detail. This information is helpful for the Requested Provider to diagnose and treat the Member when he/she comes to the office. Your answers will print on the Authorization letter that is faxed to the Requested Provider.

If any of the above service codes are entered, the referral clinical questions will populate in the review section (see Step 8).



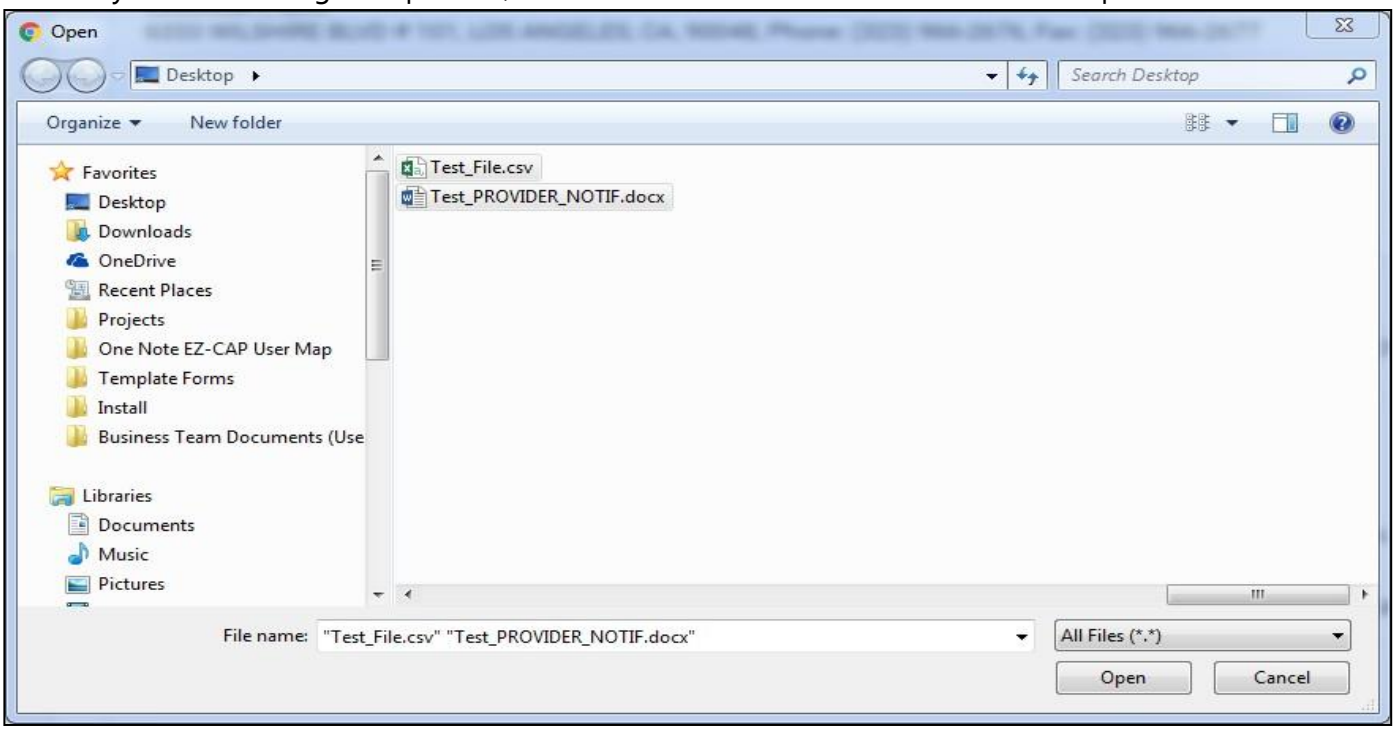
Click on next, or step 6 to proceed.

Step 6) Attachments

Add any supporting documents to the Authorization request.

Click on Select File(s) to select files to upload. Select the files to be uploaded.

Note: If you are selecting multiple files, hold Ctrl and click on each individual file to upload.

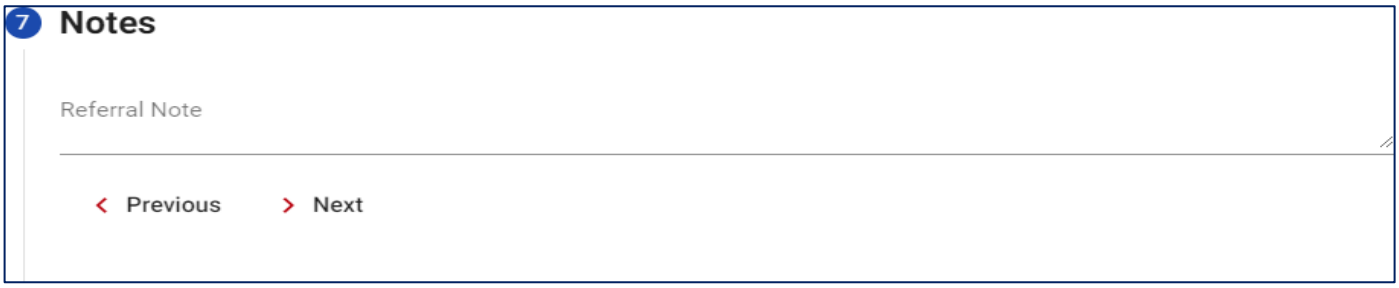


Click on Open.

Click on next, or step 7 to proceed.

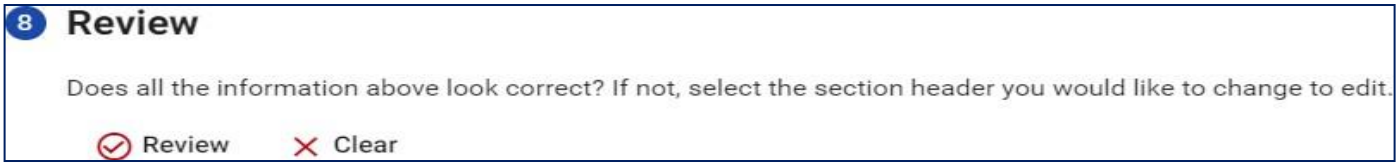
Step 7) Notes

Enter in any notes regarding the referral in this section.



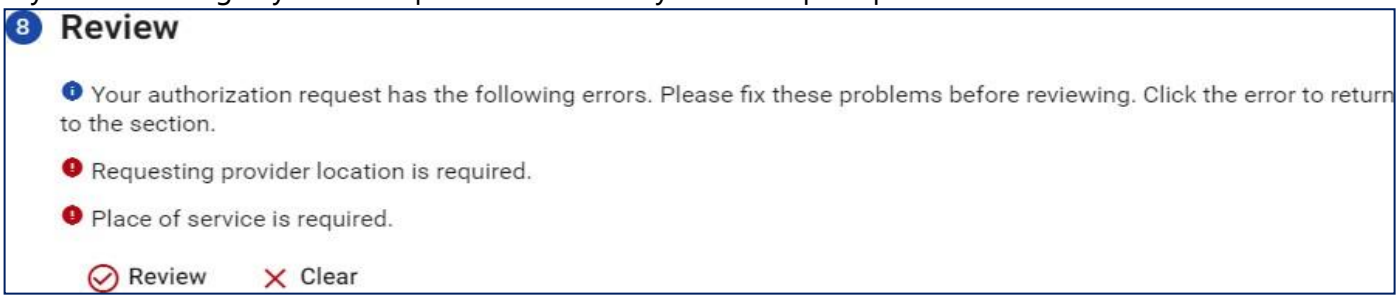
Click on next, or step 8 to proceed.

Step 8) Review



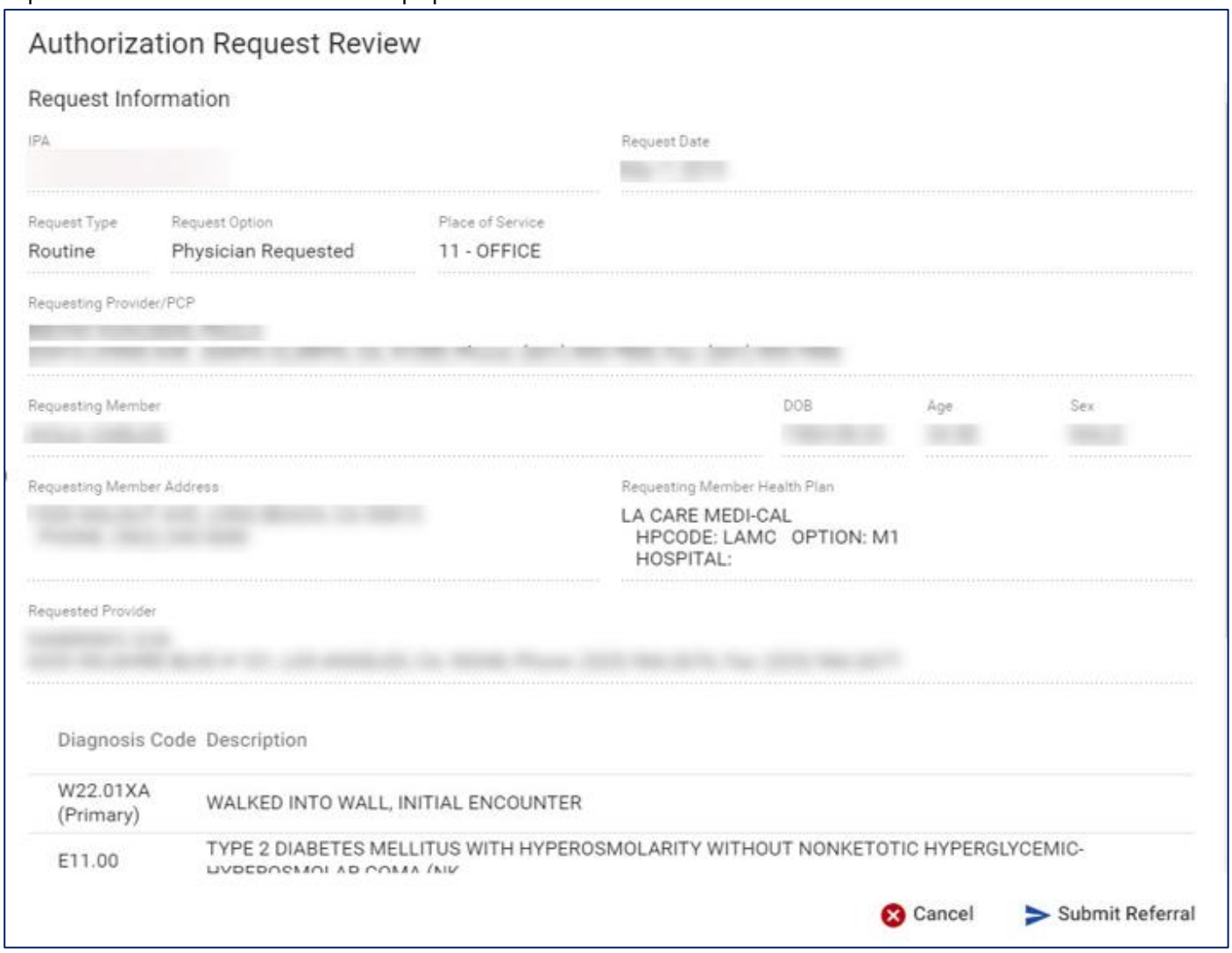
Review the Authorization request, and if no changes need to be made click on Review.

If you are missing any of the required information you will be prompted.



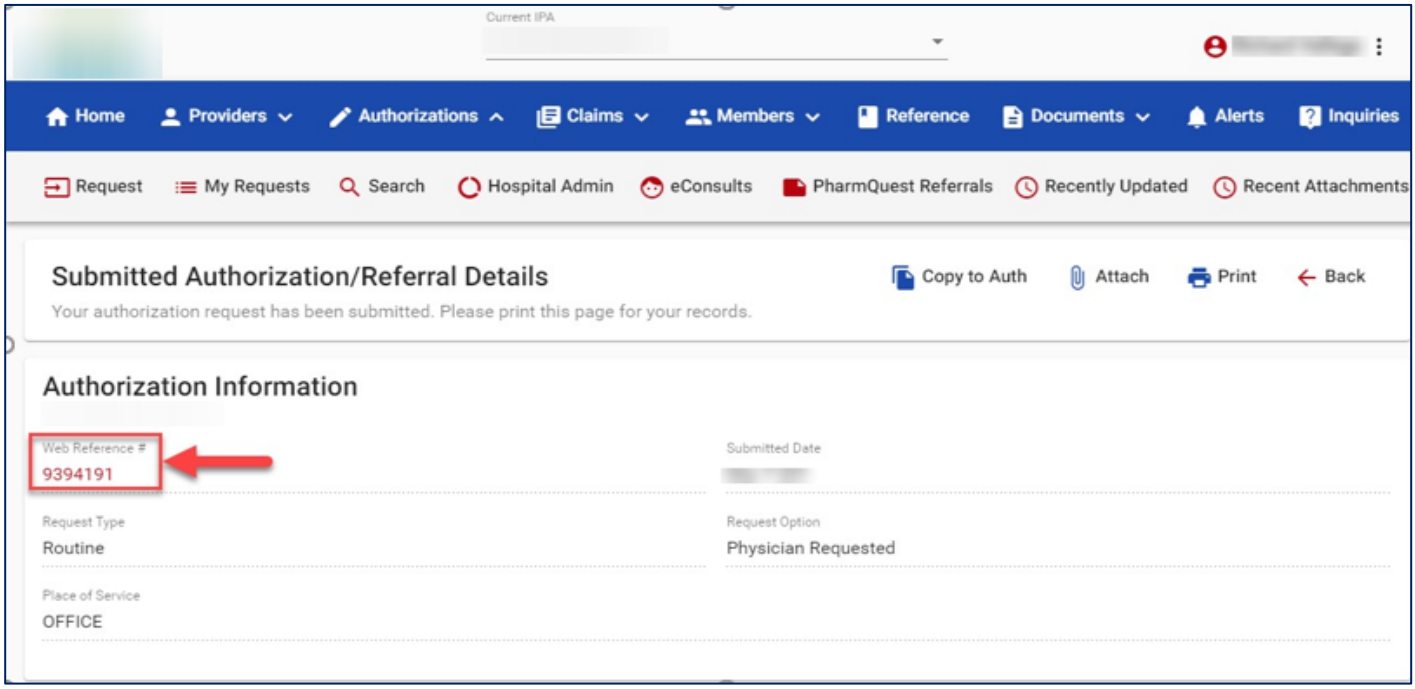
Make any necessary corrections and click on Review.

A preview of the Authorization will populate.



Review the Authorization and if no changes need to be made click on Submit Referral .

Once completed, you will be redirected to a new page stating the authorization has been submitted with a Web Reference number. The Web Reference number will become an Authorization number once the Referral goes through the system and is ready for MPM to review.



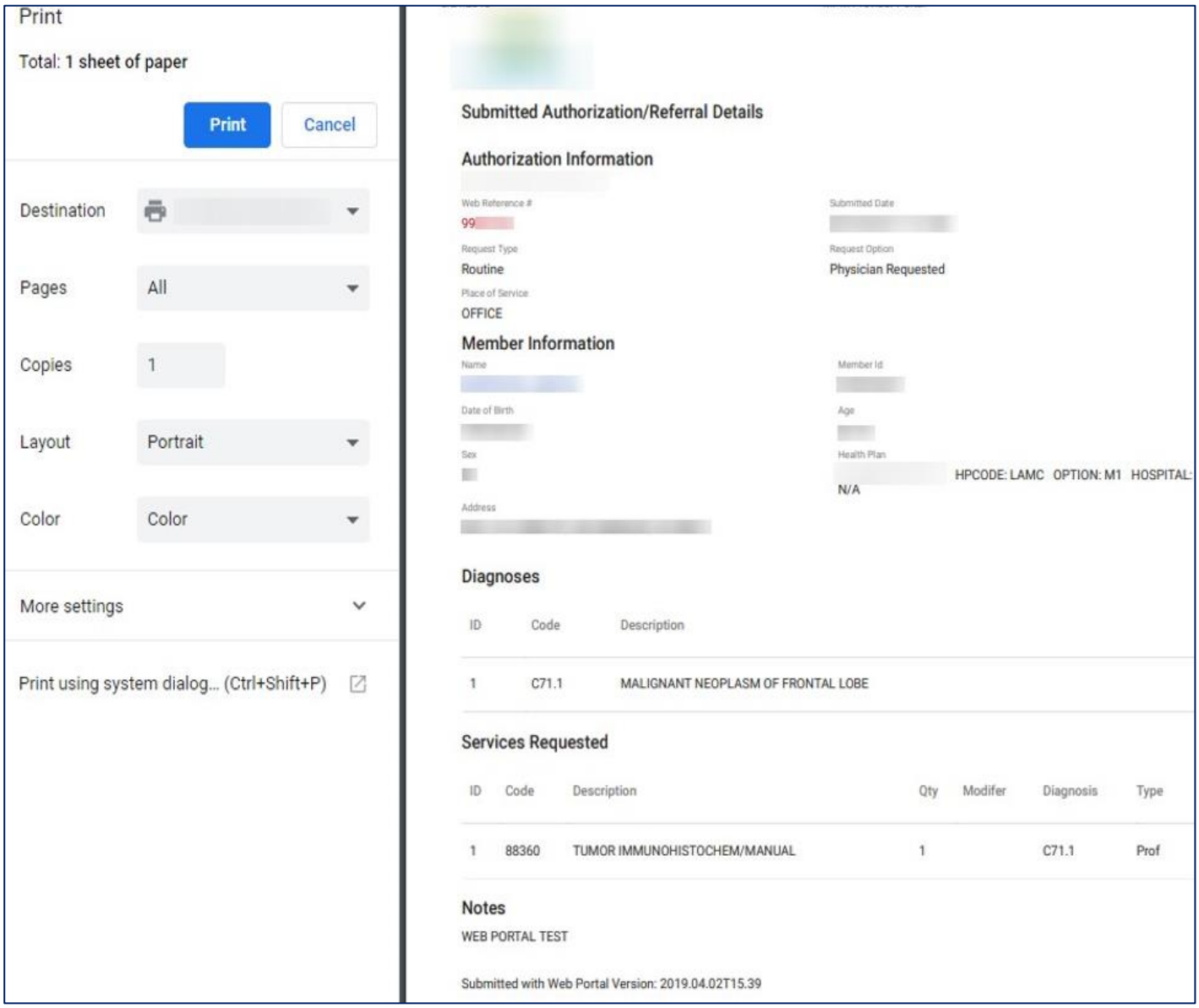
Copy to Authorization: When you click on Copy to Authorization, the member information copies over to the Authorization Request page so you wouldn't need to re-enter that information.

Attach: Attach any supporting documents that may have been left out in the initial Authorization request.

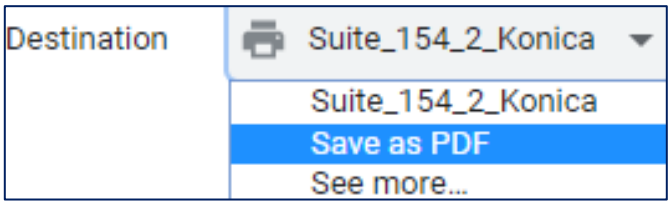
Inquire: Send an inquiry to MPM's UM department regarding the referral.

Print: Print or save the request as a PDF file.

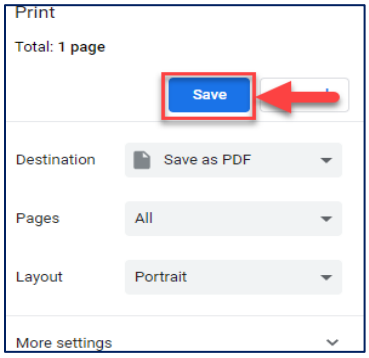
Clicking on the Print icon will open the print preview page.



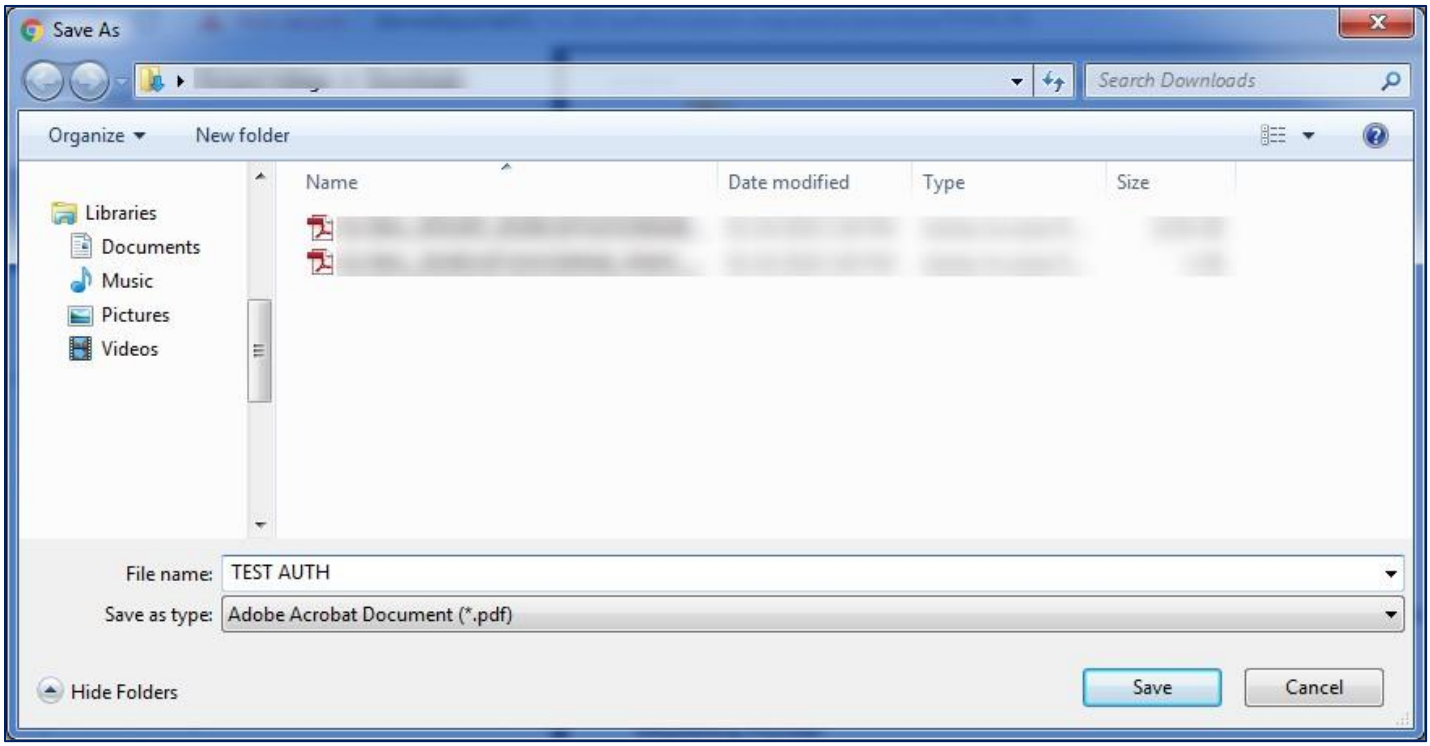
To save the file to PDF, click on the Destination drop down and select "Save as PDF"



Click on Save to choose where to save the PDF.



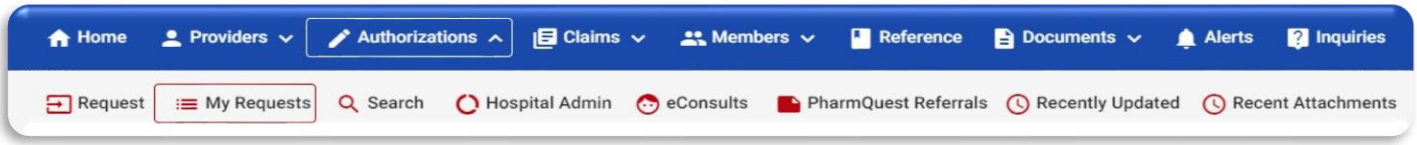
Select a destination to save the PDF.



Click Save to save the PDF.

B) My Requests

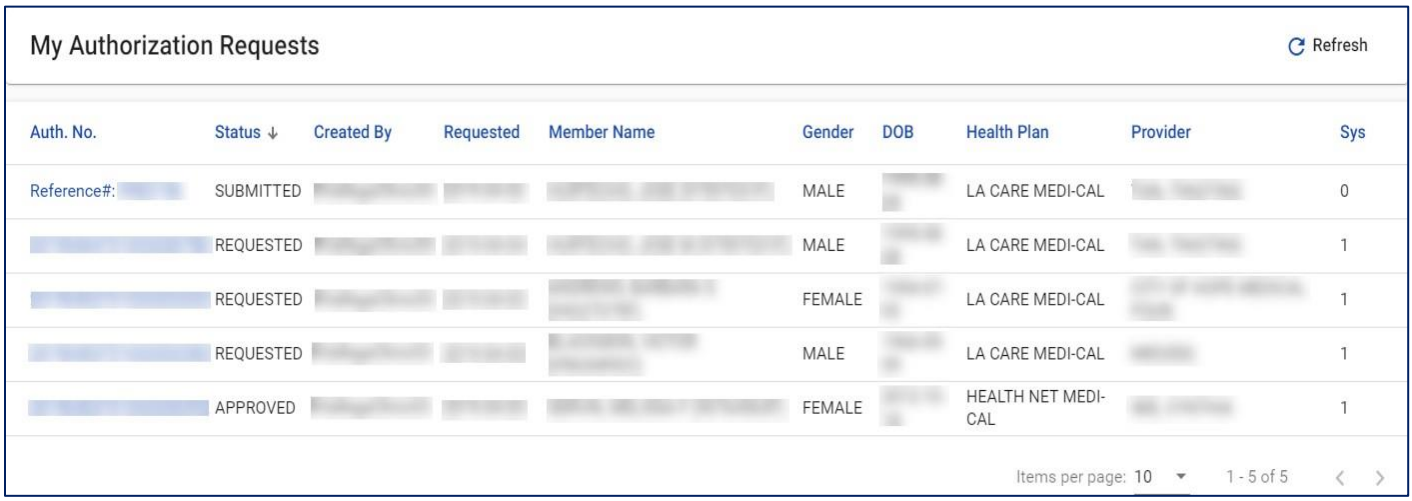
The My Requests section allows you to view all of Authorizations submitted by you in the past 30 days. This allows you to gain the benefits of:



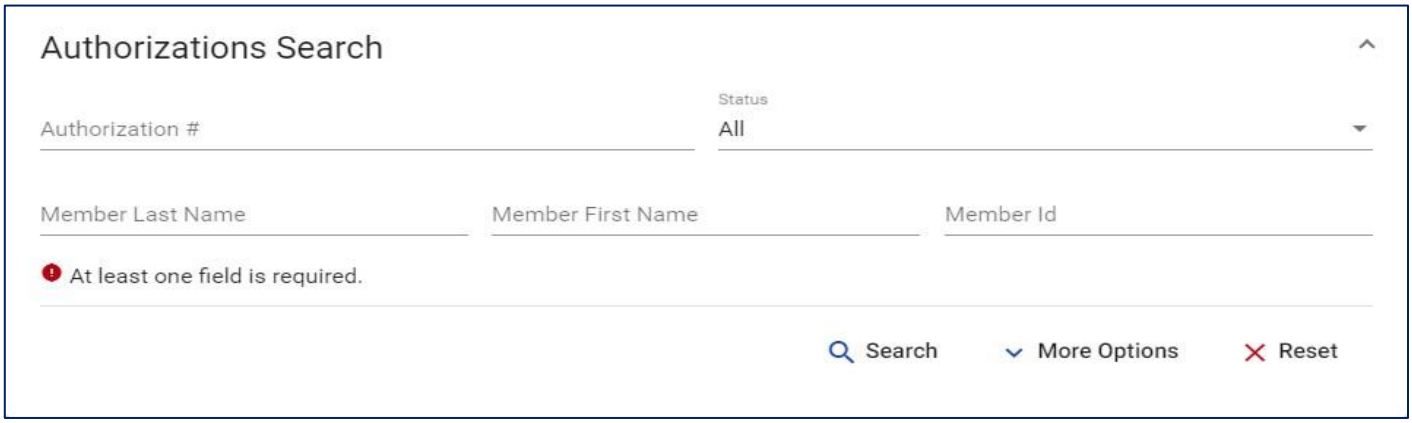
- Verifying if the Authorization submission was successful
- Ability to view the status of the Authorization
- Provides a centralized location to view all your Authorizations without, having to search

C) Authorization Search

You can search for Authorizations by using the following fields:

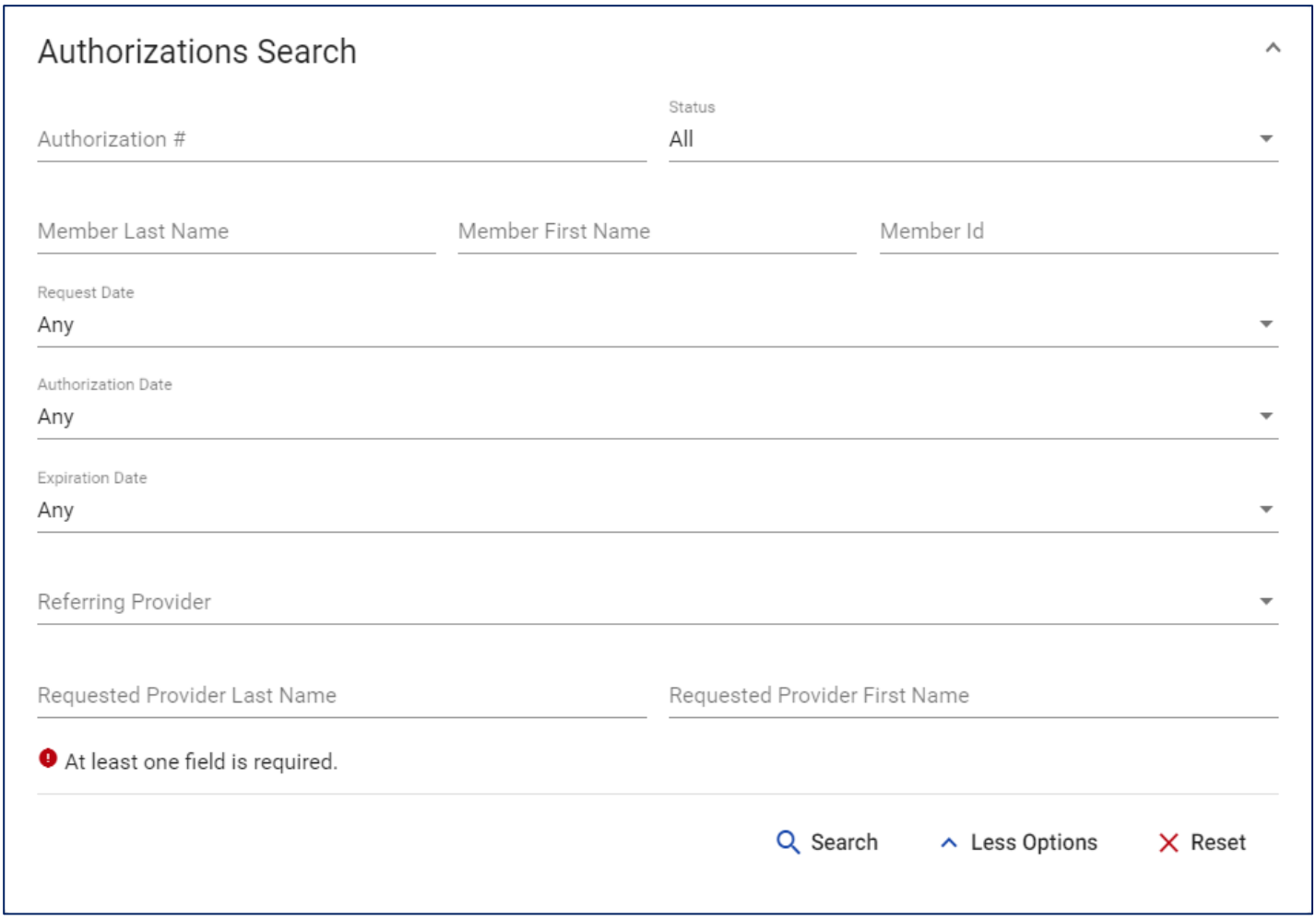


- Authorization Number
- Status
- Member Last Name
- Member First Name
- Member ID



If you would like more fields available to narrow down your search even further, click on More Options. This will allow you advanced search options by:

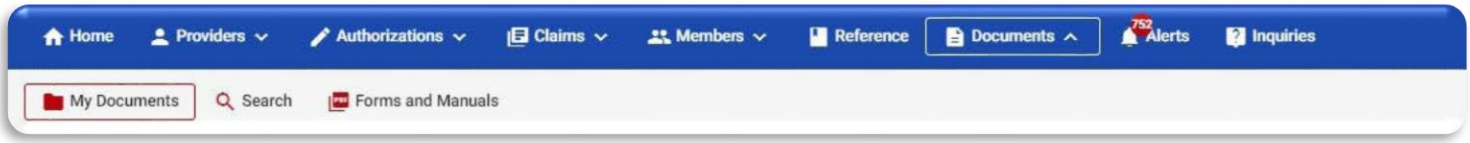
- Request Date
- Authorization Date
- Expiration Date
- Referring Provider
- Requested Provider Last Name
- Requested Provider First Name



ACCESSING REPORTS

The My Documents section of the MPM Web Portal consists of documents with critical information for your office/health center. This section of the web portal is not accessible to all levels of users. Ideal users who should have access to this menu are finance staff, health center/office administrators or any user with an Admin role. Access to this area requires special permission. For first time users, visit: portal.medpointmanagement.com/sign-in and click on 'Request an Account'.

PCP reports are available on the MPM Web Portal. The documents found in the My Documents section include:



PCP Reports

- Assessment Forms – Patient health assessment documents
- CAP Payment Summary Reports – Capitation Explanation of Benefits report
- EOP Reports-Capitated Services – Explanation of Payment reports for capitated services
- Eligibility Reports – List of full Eligibility reports with a breakdown of three types
- Current Eligibility – List of all currently enrolled members from the previous month
- Recently Termed Members – List of members termed in the previous month
- New Members – List of new members in the previous month
- Member CAP Reports – Member level reports displayed in a summary list of capitations paid by member for current, previous, adjusted and net cap amounts
- Misc. Reports – List of other documents useful to the health center. This could be the Healthcare Quality Patient Assessment form or any other pertinent documents for the health center.
- Monthly Reports – View monthly reports associated to your log-in

Register for PAYSPAN

It's: Easy, Free, Quick, Convenient, and Efficient!

- Please visit www.payspanhealth.com and register using your unique registration code
- You may also request your registration code(s) at: www.payspanhealth.com/requestRegCode OR
- Contact Payspan via e-mail to request your Payspan registration codes at: Providersupport@Payspanhealth.com. The registration code will be sent to you within 24 – 48 hours.

Fee-for-Service (FFS) Reports are available via Payspan

As our contracted provider, you will be able to obtain via Payspan for the following:

- Electronic Remittance Advice (ERA)
- Electronic Data Interchange (EDI) or 835 files
- Electronic Explanation of Benefits/Payments (EOB/EOP)

Section 3: Utilization Management

LINKED AND CARVED OUT SERVICES

For a comprehensive list of linked and carved out services, visit: www.dhcs.ca.gov

Medi-Cal: Members are eligible to receive treatments to prevent, modify or alleviate severe and chronic pain from a medical condition.

Aetna Better Health: IPA contracted provider

Anthem Blue Cross: Members may self-refer by calling American Specialty HealthPlan ASH at (800) 972-4226.

Blue Shield of California: Members may self-refer by calling American Specialty HealthPlan ASH at (800) 972-4226.

Blue Shield Promise Health Plan: Medi-Cal and Cal MediConnect - IPA contracted provider.

Brand New Day: Members may self-refer by calling American Specialty HealthPlan ASH at (800) 972-4226.

California Health & Wellness: Services will be provided by the Health Plan. Contact (877) 658-0305 for Member Services.

Health Net: Medi-Cal – Members may self-refer by calling American Specialty HealthPlan ASH at (800) 972-4226. Medicare - IPA contracted provider.

Molina: Medi-Cal and Covered CA – Members may self-refer by calling American Specialty HealthPlan ASH at (800) 972-4226. Medicare and Cal MediConnect – Not a covered benefit.

CHIROPRACTIC

Medi-Cal: Members are eligible to receive treatments of the spine by means of manual manipulation.

Aetna Better Health: IPA contracted provider

Anthem Blue Cross: Services will be provided by the Health Plan. Contact (800) 407-4627 for Anthem Blue Cross Member Services.

Blue Shield of California: IPA contracted provider.

Blue Shield Promise Health Plan: IPA contracted provider.

Brand New Day: IPA contracted provider.

California Health & Wellness: IPA contracted provider.

Health Net: IPA contracted provider.

Molina: Medi-Cal, Medicare, Cal MediConnect – IPA contracted provider. Covered CA – Services will be provided by the Health Plan. Contact (888) 665-4621 for Molina Member Services.

VISION SERVICES

Medi-Cal: Members are eligible to receive vision care services, including the provision of examinations and eyewear at the same location. Members may obtain, as a covered benefit, one pair of prescription glasses every two years. Additional services and lenses are to be provided based on medical necessity. For all other products check benefits via member's Health Plan.

Aetna Better Health: Vision Services will be provided by the Health Plan. Contact (855) 772-9076 for Member Services.

Anthem Blue Cross: Vision Services will be provided by Vision Service Plan (VSP). Members may self-refer by calling VSP at (800) 877-7195.

Blue Shield of California: Vision Services will be provided by Vision Service Plan (VSP). Members may self-refer by calling VSP at (800) 877-7195.

Blue Shield Promise Health Plan: Medi-Cal – IPA contracted provider. Cal MediConnect - Vision Services will be provided by Vision Service Plan (VSP). Members may self-refer by calling VSP at (800) 877-7195.

Brand New Day: Services will be provided by Medical Eye Services (MES). Members may self-refer calling (833) 240-7289 option 2.
California Health & Wellness: Not covered benefit.
Health Net: Medi-Cal: Not covered benefit. Medicare - Vision Services to be provided by Envolve Vision. Members may self- refer for this benefit under the Health Plan by calling (800) 334-3937.
Molina Medical Centers: Vision Services to be provided by March Vision Care Group. Members may self-refer by calling (844) 336-2724.

DENTAL SERVICES

Primary Care Physicians are to conduct primary care dental screenings, including inspection of teeth and gums for any signs of infection, abnormalities, malocclusion, inflammation of gums, plaque deposits, cavities or missing teeth. They are to facilitate and document appropriate and timely referrals to dental providers participating in Denti-Cal or Health Plan Dental Plan.

As part of the CHDP health assessment, children are to be referred to a Denti-Cal or Health Plan Dental Plan dentist if they have not been seen by a dentist within the prior 6 months. It is recommended that all members greater than age three see a dentist annually.

HIV and AIDS

The treatment and management of members with HIV and AIDs is complex and should not be undertaken by physicians without clinical expertise in this area.

Children and adolescents with HIV will receive HIV related services through California Children's Services (CCS). Adults will receive HIV related services through an IPA contracted specialist.

CALIFORNIA CHILDREN'S SERVICES (CCS)

CCS eligible conditions are reimbursed directly through the CCS program.

EARLY INTERVENTION

Members who are children in need of early intervention services are to be referred to an Early Start Program in California. These include children with an established condition leading to developmental delay, those in whom a significant developmental delay is suspected, or those whose early health history places them at risk for delay. Infants and children with the following conditions have a potential for being at risk for developmental disabilities and requiring Early Start Program services include those with: HIV\AIDS, cancer, blindness, hearing impairments, retardation, heart conditions, epilepsy, juvenile diabetes, cleft palate, lung disorders (such as asthma and cystic fibrosis), downs syndrome, physical handicaps due to extensive orthopedic problems, neurological impairments, spinal cord injuries, and sickle cell anemia.

ARRANGEMENTS FOR REFERRAL

Parents may self-refer their children for an evaluation and determination of eligibility for Early Start Program Services. Plan partners and their providers are to furnish procedures for referral to parents in order to facilitate easy and timely access to Early Start Program Services.

WIC NUTRITIONAL SERVICES

Members who are pregnant, breast-feeding, postpartum, or infants and children, should be assessed for eligibility and need for Women, Infants and Children (WIC) Nutritional Services and, if appropriate, referred to the local health department WIC Program.

COMPREHENSIVE PERINATAL SERVICES PROGRAM

Comprehensive Perinatal Services Program (CPSP) provides enhanced perinatal services, nutrition, psychosocial and health education for Medi-Cal pregnant women from conception through 60 days postpartum.
Please view the Health & Human Services Agency website for San Diego County and Central Valley counties at the below link for more information on CPSP.
San Diego County:
www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/comprehensive_perinatal_services_program.html
Central Valley Counties:
www.co.fresno.ca.us/departments/public-health/public-health-nursing/comprehensive-perinatal-services-program-cpsp

PERINATAL RESIDENTIAL DRUG ABUSE SERVICES

Perinatal Residential Drug Abuse Services include intake, assessment, admission physical examinations and laboratory tests, diagnosis, medical direction, individual and group counseling services, education on alcohol and other drug problems, parenting, education, urine drug screens, medication services, collateral services, and crisis intervention services. Does not include room and board and must be provided by a licensed residential facility with 6 or more adult beds.

DAY CARE HABILITATIVE SERVICES

Day Care Habilitative Services provided only to pregnant and postpartum women and EPSDT- eligible beneficiaries and include intake, assessment, diagnosis, evaluation, admission, physical examinations, treatment planning, individual and group counseling, urine drug screens, medication services, collateral services, and crisis intervention. Naltrexone Treatment Services (for Opiate addiction): include intake, assessment, diagnosis, evaluation, admission, physical examinations, treatment planning, individual and group counseling, urine drug screens, medication services, collateral services, and crisis Intervention services. Fee-for-service Medi-Cal covers outpatient heroin detoxification services.

ALCOHOL AND DRUG TREATMENT SERVICES

Specific alcohol and drug treatment services are carved out and covered through Short-Doyle Drug Medi-Cal (D/MC) and fee-for-service Medi-Cal.

SABIRT (DRUG SCREENING, ASSESMENT, BRIEF INTERVENTIONS & REFFERAL TO TREATMENT

Under the Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) benefit, the American Academy of Pediatrics (AAP) suggests preventive screening services regarding tobacco, alcohol, and drug use should begin at age 11.

The United States Preventative Services Task Force (USPSTF) also recommends, for adults 18 years or older, including pregnant women, preventive screenings for unhealthy alcohol use. Screening includes, but is not limited to, asking questions about unhealthy drug use in adults ages 18 years or older. Screening will assist in determining accurate and effective diagnosis and care.

For extensive information on SABIRT, please visit the link below:
www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-014.pdf

COLLECTING SOCIAL DETERMINANTS OF HEALTH DATA (SDOH)

Population Health Management (PHM) has taken initiative with Cal AIM to identify and manage member risk and necessity of services by taking a holistic approach through whole person care an inclusion of Social Determinants of Health Data SDOH.

DHCS recognizes that consistent and reliable collection of SDOH data is vital to the success of Cal Aim's PHM initiative. To advance improvements, DHCS is providing guidance on collecting SDOH data to:

- Assess member health and social risks to ensure proper care and program enrollment
- Assist DHCS in evaluating population health statewide through the analysis of SDOH

For further information, visit the below link to a memo found on DHCS site:
www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-009.pdf

SHORT DOYLE DRUG MEDI-CAL (SD/MC)

SD/MC covers the services listed and described below:

Outpatient Methadone Maintenance: includes intake, evaluation, assessment and diagnosis, treatment planning, medical supervision, urine drug screening, physician and nursing services related to drug abuse, individual and group counseling, admission physical examinations and laboratory tests, medication services, collateral services (face to face sessions with significant persons in the life of a client, focusing on the treatment needs of the client in terms of supporting the achievement of the client's treatment goals), crisis intervention, and the provision of methadone as prescribed by physician to alleviate the symptoms of withdrawal from narcotics.

OUTPATIENT DRUG FREE TREATMENT SERVICES

Services include intake physical examinations, intake, evaluation, assessment and diagnosis, medical supervision, medication services, urine drug screens, treatment and discharge planning, crisis intervention, collateral services, group counseling, and individual counseling.

REGIONAL CENTERS

Regional Centers are private, non-profit corporations under contract with California Department of Developmental Services (DDS). Their purpose is to enable people with developmental disabilities to lead as independent and productive lives as possible, to protect the legal rights of people with developmental disabilities and their families, and to reduce the incidence of developmental disabilities.

Regional Centers are not responsible for provision of direct medical or health care services, but do provide overall case management for their clients, assuring health, developmental, social, and educational services throughout the lifetime of members who have a developmental disability. This includes diagnostic services, counseling, client, and family support, including family respite, and intervention and rehabilitation programs.

To be eligible, a person must have developmental disability before the age of 18, which includes mental retardation or similar conditions, cerebral palsy, epilepsy, and autism.

Preventive services may also be provided to anyone determined to be at high risk of parenting a child with a developmental disability, and at the request of the parent or guardian, to any infant at high risk of becoming developmentally disabled.

There are no financial eligibility requirements for Regional Center services, however, parents are required to pay based on a sliding fee scale for out-of-home placement for children under age 18. Families are responsible for primary medical and health care for their children as well as those services normally provided to a child without

disabilities. All persons receiving services must be California residents and must apply to the Regional Center for the area in which they reside.
Referrals from the PCP are directed to the intake coordinator at the regional center and must include the reason for referral, complete history and physical examination, including developmental screens, the results of developmental assessments and psychological evaluations, and diagnostic tests.
A list of Regional Centers and other relevant information is available upon request or see the following website: www.dds.ca.gov.

LINKED AND CARVED OUT SERVICES

SPECIALTY MENTAL HEALTH SERVICES

Primary Care Physicians are responsible for providing mental health services that are within the primary care scope of practice (including prescribing related medications). Outpatient specialty mental health services are provided directly by the Department of Mental Health through the Mental Health Plan of the county. The Mental Health Plan will provide Short-Doyle outpatient services, which are restricted to conditions meeting severe and persistent medical necessity criteria specified by the state. Fee-for- service Medi-Cal specialty mental health providers will provide outpatient services outside the scope of the primary care physician that do not meet Short- Doyle medical necessity criteria. Inpatient specialty mental health services are provided through the county's Department of Mental Health's contract facilities.

All outpatient and inpatient specialty mental health services are provided through the Department of Mental Health of the county through contract providers and facilities as well as directly (for Short Doyle services).

A comprehensive list of Mental Health Providers can be access via Web at: www.dmh.co.la.ca.us Search under: "Administration", then click on "Fee- For- Service Network Providers".

BEHAVIORAL HEALTH PROGRAM ACCESS

Telephone #: (800) 854-7771

Department of Developmental Services Home and Community Based waiver program. This Home and Community-Based Services (HCBS) Waiver Program is administered by the State Department of Developmental Services (DDS) through local Regional Centers and provides community-based services for a limited number of developmentally disabled Medi-Cal beneficiaries who live in the community but are at risk for institutional placement.

Members who fall four to six months below age appropriate parameters (on a case-by-case basis) and those with the conditions listed below are to receive HCBS Waiver Program eligibility evaluation.

- Mental Retardation
- Cerebral Palsy
- Seizures
- Autism or similar conditions

HCBS Waiver Program services include home health aide services, respite care, rehabilitation services, skilled nursing, adult day health care, and personal care and other non-medical services. Referral: Providers do not directly make HCBS Waiver referrals. When indicated by clinical evaluation or requested by a member or the member's family, physicians, IPAs, Medical Groups, assist the member by providing information on California Department of Developmental Services (DDS) Regional Center contacts and potential services.

ACUPUNCTURE SERVICES

Health Plan	Commercial	Medicare	Medi-Cal	Cal MediConnect	Covered CA
Aetna Better Health (San Diego)	N/A	N/A	Authorization Required – CCIPA	N/A	N/A
Anthem Blue Cross (Central Valley)	N/A	N/A	American Specialty Health Plan (ASH) (800) 972-4226	N/A	N/A
Blue Shield of California (San Diego)	N/A	American Specialty Health Plan (ASH) (800) 678-9133	N/A	N/A	N/A
Blue Shield Promise Health Plan (San Diego)	N/A	N/A	Authorization Required – CCIPA	Authorization Required – CCIPA	N/A
Brand New Day (All)	N/A	American Specialty Health Plan (ASH) (800) 678-9133	N/A	N/A	N/A
California Health & Wellness (Imperial)	N/A	N/A	Contact Plan Member Services (877) 658-0305	N/A	N/A
Health Net (All)	N/A	Authorization Required – CCIPA	American Specialty Health Plan (ASH) (800) 972-4226	N/A	N/A
Molina	N/A	Not Covered Benefit	Imperial and San Diego American Specialty Health Plan (ASH) (800) 972-4226	Not Covered Benefit	Imperial and San Diego American Specialty Health Plan (ASH) (800) 972-4226

Please Note: Providers must have contract with ASH to render services

BEHAVIORAL HEALTH SERVICES

Health Plan	Commercial	Medicare	Medi-Cal	Cal MediConnect	Covered CA
Aetna Better Health (San Diego)	N/A	N/A	Contact Plan Member Services (855) 772-9076	N/A	N/A
Anthem Blue Cross (Central Valley)	N/A	N/A	Contact Plan Member Services (800) 407-4627	N/A	N/A
Blue Shield of California (San Diego)	N/A	Authorization required – CCIPA	N/A	N/A	N/A
Blue Shield Promise Health Plan (San Diego)	N/A	N/A	Beacon Health (855) 321-2211	Beacon Health (855) 321-2211	N/A
Brand New Day (All)	N/A	Authorization required – CCIPA	N/A	N/A	N/A
California Health & Wellness (Imperial)	N/A	N/A	Contact Mental Health Services (MHS) (877) 658-0305	N/A	N/A
Health Net (All)	N/A	Contact Managed Health Network MHN (800) 646-5610	Not Covered Benefit	N/A	N/A
Molina	N/A	Imperial and San Diego Contact Plan Member Services (888) 665-4621	Imperial and San Diego Contact Plan Member Services (888) 665-4621	Imperial and San Diego Contact Plan Member Services (888) 665-4621	Imperial and San Diego Contact Plan Member Services (888) 665-4621

Please Note: Providers must have contract with Beacon/Plan Network to render services

CHIROPRACTOR SERVICES

Health Plan	Commercial	Medicare	Medi-Cal	Cal MediConnect	Covered CA
Aetna Better Health (San Diego)	N/A	N/A	Authorization Required – CCIPA	N/A	N/A
Anthem Blue Cross (Central Valley)	N/A	N/A	Contact Plan Member Services (800) 407-4627	N/A	N/A
Blue Shield of California (San Diego)	N/A	Authorization Required – CCIPA	N/A	N/A	N/A
Blue Shield Promise Health Plan (San Diego)	N/A	N/A	Authorization Required – CCIPA	Authorization Required – CCIPA	N/A
Brand New Day (All)	N/A	Authorization Required – CCIPA	N/A	N/A	N/A
California Health & Wellness (Imperial)	N/A	N/A	Authorization Required – CCIPA	N/A	N/A
Health Net (All)	N/A	Authorization Required – CCIPA	Authorization Required – CCIPA	N/A	N/A
Molina	N/A	Authorization Required – CCIPA	Authorization Required – CCIPA	Authorization Required – CCIPA	Imperial and San Diego Contact Plan Member Services (888) 665-4621

Please Note: Providers must have contract with ASH to render services

VISION SERVICES

Health Plan	Commercial	Medicare	Medi-Cal	Cal MediConnect	Covered CA
Aetna Better Health (San Diego)	N/A	N/A	Contact Plan Member Services (855) 772-9076	N/A	N/A
Anthem Blue Cross (Central Valley)	N/A	N/A	VSP (844) 239-7644	N/A	N/A
Blue Shield of California (San Diego)	N/A	VSP (800) 877-7195	N/A	N/A	N/A
Blue Shield Promise Health Plan (San Diego)	N/A	N/A	Authorization Required – CCIPA	VSP (800) 877-7195	N/A
Brand New Day (All)	N/A	MES (833) 240-7289	N/A	N/A	N/A
California Health & Wellness (Imperial)	N/A	N/A	Not Covered Benefit	N/A	N/A
Health Net (All)	N/A	Envolve Vision (800) 334-3937	Not Covered Benefit	N/A	N/A
Molina	N/A	March Vision Care (844) 336-2724	March Vision Care (844) 336-2724	March Vision Care (844) 336-2724	March Vision Care (888) 493-4070

Please Note: Providers must have contract with VSP/EyeMed Vision Care/Envolve Vision/March Vision Care/Plan Network to render services

Section 3: Utilization Management

LINKED AND CARVED OUT SERVICES

LANGUAGE ASSISTANCE PROGRAMS

Contracted Health Plans are required to provide access to cost-free, qualified language assistance programs (LAPs) for members with limited English proficiency (LEP), or with hearing or speech impairments, through the Health Plan's designated Cultural and Linguistic Program. Health Plans can provide this service by telephonic interpreting services, face-to-face interpreters, or both. For hearing or speech impaired members, the teletypewriter (TTY) phone system is available through all Health Plans. Additionally, Health Plans are required to provide or translate vital written materials into a language and/or format that is understood by each member.

When coordinating LAP services for a member appointment, telephonic language or communication assistance should be prioritized in order to avoid delay in care. This service should be used when a member is being seen for a standard consultation or is already in the office for an appointment. Face-to-face, in-person interpretation services should be reserved for conveying complex medical information, or if the member requests an onsite translator. Adequate prior notice must be made with the Health Plan in order to arrange a face-to- face interpreter for a member appointment. Remember to document a LEP member's preferred language in the medical record as well as his or her refusal or acceptance of LAP services. Avoid using the member's friends or family members as interpreters unless the member has been offered and denies LAP services.

Before calling the Health Plan's language assistance line, gather the following details:

- Member name
- Member ID
- Member date of birth
- Language being requested
- Date, time, and duration of appointment
- Location of appointment (face-to-face services)
- Provider specialty and/or treatment
- Other special instructions

Available languages for each Health Plan will vary in accordance with the Plan's required Threshold Languages set by the Department of Health Care Services (DHCS).

Threshold Languages are established by determining the primary languages spoken by at least 3,000 LEP members or 5% of LEP membership population (whichever is lower) associated with a given Health Plan.

Section 3: Utilization Management

LINKED AND CARVED OUT SERVICES

LANGUAGE ASSISTANCE PROGRAMS

HEALTH PLAN	PRODUCT LINE	PHONE NUMBER	HOURS	LANGUAGES	FACE-TO-FACE PRIOR NOTICE
Aetna Better Health of California	All	1-800-385-4104 TTY: 711	24/7	Spanish, Korean, Chinese (Mandarin), another threshold available on request	Unavailable
Anthem Blue Cross	All	Business hours: 1-800-407-4627 After hours: 1-800-224-0336 TTY: 1-888-757-6034 TTY: 1-800-794-1099	24/7	Spanish, Chinese (Traditional), Vietnamese, Tagalog, Korean	3 days
Brand New Day	All	1-866-255-4795 TTY: 1-866-321-5955	24/7	Spanish, Vietnamese, Korean, Khmer, another threshold available on request	10 days
Blue Shield Promise Health Plan	Medi-Cal	1-800-605-2556	24/7	Spanish, Chinese, (Cantonese & Mandarin), Arabic, Armenian, Khmer, Korean, Farsi, Tagalog, Vietnamese, Russian	7 days
	Commercial Duals	1-800-544-0088 1-855-905-3825			
	After Hours	1-877-904-8195 Access #828201			
	TTY (All)	1-888-877-5379			

Section 3: Utilization Management

LINKED AND CARVED OUT SERVICES

LANGUAGE ASSISTANCE PROGRAMS

HEALTH PLAN	PRODUCT LINE	PHONE NUMBER	HOURS	LANGUAGES	FACE-TO-FACE PRIOR NOTICE
California Health & Wellness	All	1-877-658-0305	Mon-Fri 8:00am-5:00pm	Spanish, Chinese (Traditional), another threshold available on request	Unavailable
Health Net	Medi-Cal	1-800-675-6110	24/7	150+ languages	5 days
	Medicare	1-800-929-9224	Mon-Fri 8:00am-5:00pm		
	Covered CA	Business hours: 1-888-926-2164 After hours: 1-800-546-4570	24/7		
	TTY (All)	711	24/7		
Molina	Medi-Cal	1-888-665-4621	Mon-Fri 7:00am-7:00pm	Spanish, Chinese (Cantonese & Mandarin), Arabic, Armenian, Khmer, Korean, Farsi, Tagalog, Vietnamese, Russian	5 days
	Medicare	1-800-665-0898	Mon-Fri 8:00am-8:00pm		
	Covered CA	1-888-858-2150	Mon-Fri 8:00am-6:00pm		
	Duals	1-855-665-4627	Mon-Fri 8:00am-8:00pm		
	TTY (All)	711	24/7		

Section 3: Utilization Management

EXPANDED MENTAL HEALTH BENEFIT

Effective January 1, 2014, Medi-Cal managed care is now responsible for providing Medi-Cal members with the following mental health benefits:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring medication treatment
- Outpatient laboratory, medications, supplies and supplements (supplements may include vitamins that are not specifically excluded in the Medi-Cal formulary and that are scientifically proven effective in the treatment of mental health disorders, although none are currently indicated for this purpose)
- Psychiatric consultation

PCP RESPONSIBILITY

PCPs are required to continue to ensure mental health and substance abuse screening of all members. Members with positive screening results should be treated by the PCP within the PCP's scope of practice.

SPECIALTY MENTAL HEALTH SERVICES (SMHS)

There has been no change in specialty mental health services. These services will continue to be provided by the county's Department of Mental Health (DMH).

For more details and referrals to DMH please visit: www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx
Services provided by the County Department of Mental Health:

- Inpatient services
- Residential services
- Outpatient services

To be eligible for services, beneficiaries must meet three criteria:

- SMHS included diagnosis
- Significant functional impairment or probability of significant deterioration
- Condition would be responsive to mental health services and not physical healthcare treatments

Section 3: Utilization Management

MEDI-CAL SMHS INCLUDED DIAGNOSES	
• Pervasive Developmental Disorders except Autism Spectrum Disorder • Attention Deficit/Hyperactivity Disorders • Feeding & Eating Disorders of Infancy or Early Childhood • Elimination Disorders • Other Disorders of Infancy, Childhood or Adolescence • Schizophrenia & other Psychotic Disorders • Mood Disorders • Anxiety Disorders • Somatic Symptom & Related Disorders	• Factitious Disorders • Dissociative Disorders • Paraphilic Disorders • Gender Dysphoria • Eating Disorders • Disruptive, Impulse-control Disorders and Conduct Disorders • Adjustment Disorders • Personality Disorders excluding Anti-Social Personality Disorders • Medication - Included Movement Disorders

MEDI-CAL SMHS		
OUTPATIENT SERVICES	**INPATIENT SERVICES**	**RESIDENTIAL SERVICES**
• Mental Health Services (assessment, plan development, therapy, rehabilitation and collateral) • Medication Support Services • Day Treatment Intensive • Day rehabilitation • Crisis Intervention & Stabilization • Targeted Case Management	• Acute psychiatric inpatient hospital services • Psychiatric inpatient hospital professional services • Psychiatric Health facility services	• Adult residential treatment • Crisis residential treatment

EXPANDED MENTAL HEALTH BENEFITS FOR MILD TO MODERATELY IMPAIRED INDIVIDUALS WHOSE NEEDS FALL OUTSIDE THE PCP'S SCOPE OF PRACTICE ARE PROVIDED THROUGH THE HEALTH PLANS BEHAVIORAL HEALTH NETWORKS

MENTAL HEALTH NETWORK CONTACTS BY PLAN		
HEALTH PLAN	**CONTRACT NAME**	**PHONE**
ANTHEM BLUE CROSS	Direct Behavioral Health Network	(888) 831-2246 Option 1
BLUE SHIELD PROMISE HEALTH PLAN	Beacon Health Strategies	(855) 765-9701
HEALTH NET	MHN	(888) 426-0030
MOLINA	Direct Behavioral Health Network	(844) 557-8434

Section 3: Utilization Management

TRANSITION OF CARE PROCESS FOR POST DISCHARGE PATIENTS

NOTIFICATION OF ADMISSION

CCIPA/MedPOINT TOC (Transition of Care) staff will send a PCP Admit notification list via email or fax to Designated Primary Provider (DPP) individual. Notification includes members/patients with recent admissions from hospitals or skilled nursing facilities.
** This process should apply to all the Primary Provider Offices

NOTIFICATION OF DISCHARGE

Managed Care Patients who are hospitalized within or out of network facilities should be scheduled by the DPP individual for PCP post discharge follow up within 3-7 days from discharge date.

ADMISSION AND DISCHARGE PROCESS

- The hospitals (admitting) notify CCIPA of the admissions via fax or phone
- CCIPA generates a tracking number in EZ-Cap
- PCP notification report is generated the next day and sent to the DPP individual via fax or email
- CCIPA/MPM Inpatient UM Nurses follow the member's review in-house to determine daily acute care medical necessity and facilitate discharge to a lower level
- CCIPA/MPM discharge planners also take care of the discharge needs i.e. Home Health, DME and any specialty consults/follow up visits ordered by the hospitalist/attending MD.
- CCIPA/MPM TOC Coordinator emails/faxes/calls PCP to notify of discharged members.
- CCIPA/MPM TOC Coordinator emails/faxes/calls the DPP individual (preferably while in-house) to schedule the appointment dates.

OBTAINING PCP APPOINTMENTS CAN BE MADE BY PHONE

Email: A list of discharged members and demographic information is sent via secured email to the DPP individual and is emailed back to the TOC Coordinator within 2 business days with appointment information
Fax: A list of discharged members and demographic information is sent via fax to DPP individual and is faxed back to the TOC Coordinator within 2 business days with the appointment information
Phone Call: TOC Coordinator calls the DPP individual (preferably while still in-house) to schedule appointments of discharged members by the PCP/provider.

**Available Medical Records/TOC Packets are sent 1-2 days prior to the scheduled visit
**TOC Coordinators notify the members (preferably while still in-house) of the scheduled PCP visit
**DPP individual and/or staff member from PCP office confirms/reminds members of the scheduled visit.

Section 3: Utilization Management

CASE MANAGEMENT

Case Management employs a team-based model formed by many health care professionals- to deliver quality care and help individuals gain access to needed medical, social and educational services. Widely accepted as a compass to optimize health performance by enhancing patient experience, improving population health, reducing costs and improving the continuum between health care providers and patients. The overall goal of case management is to help members regain optimum health or improve functional capability by ensuring efficient communication and coordination between the member and their medical network.
MedPOINT Management's Case Management team is made up of nurses, care coordinators, social workers and other healthcare professionals. Together, the team configures ways to help members and the member's health care providers better manage the member's health. It is a multidisciplinary approach to ensure integration of service. The process involves comprehensive assessments of the member's condition(s), determination of available benefits and resources, development and implementation of patient prioritized goals: what is important to the patient and for the patient, monitoring and follow up.

Who can submit referrals?

- Primary Care Physicians
- Members
- Health Plans
- Medical Directors
- Hospitals
- Others

Process

- Patient Identification
- Utilization review
- Member contact/ Patient Agreement
- Individualized Care Plan Development
- Assessment and Problem/ Opportunity Identification
- Care Plan Implementation and Coordination with ICT
- Re-evaluation of Care Plan, monitor and Follow-up

For more details about our services, please call the Case Management Department at 866-423-0060 ext. 1834, Monday through Friday from 8:00 a.m. to 5:00 p.m. Fax: (818) 444-1203. Referrals may be submitted via fax or e-mail. E-mail: cm_notification@medpointmanagement.com

Section 4: Provider Standards & Policies

TIMELY ACCESS TO CARE STANDARDS

The Department of Managed Healthcare (DMHC) and the Department of Healthcare Services (DHCS) require you to complete appointment requests within these timelines. These standards guarantee that patients have timely acccess to care.

Please review these standards with all staff and audit your own office for compliance. Ensure that hours and days of operation are consistent with what you have reported. If there are changes, please notify us.

TIMELY ACCESS TO CARE REQUIREMENTS

- Distance: Access to a Primary Care provider or hospital must be provided within a 15 mile radius from where the member lives, or 30 miles from where they work.
- Availability: Health Plans should provide members telephone services 24/7.
- Interpreter: Services must be coordinated with scheduled appointments for Health Care to ensure interpreter services are available at the time of the appointment

For more information please visit:
Department of Managed Healthcare (DMHC) California Department of Managed Health Care or contact the DMHC Help Center at: 888-466-2219 or www.HealthHelpca.gov.

Urgent Care

- Prior Authorization not required by the Health Plan: Wait Time**:** 2 days
- Prior Authorization required by the Health Plan: Wait Time: 4 days
- Services that do require prior authorization: Wait Time**:** 4 days

Non Urgent Appointments

- Primary Care Physician, Regular/Routine: Wait Time**:** 10 business days, (Speciality Care Physician) 15 business days
- Preventive Care: Wait Time**:** 30 calendar days
- Mental Health Appointment (non-physician): Wait Time**:** 10 business days**,** (ancillary provider) 15 business days
- Other services to diagnose or treat a health condition have a wait time of, 15 business days

Follow-Up Care

- Mental Health / Substance Use Disorder Follow-up Appointment (non-physician): Wait Time: 10 business days from prior appointment (effective July 1, 2022)

AFTER HOURS ACCESS REQUIREMENTS

After Hours Access audits are routinely conducted to ensure that physician offices have appropriate after-hours telephone recordings that direct patients to an emergency room or urgent care facility to access immediate care.
An on-call phone number or nurs's line must be provided during the message.
Primary Care Physicians are to be available by telephone 24 hours per day, 7 days per week within 30 minutes of member call.
An effective telephone service after normal business hours provides for callers to reach a live voice within 30 seconds. All calls must be returned within 30 minutes to meet DMHC Access Requirements.
One of the following scripts, on the next page, may be used by your office or medical group as an example for ensuring members have access to timely medical care after normal business hours.

AFTER HOURS SAMPLE SCRIPT

CALLS ANSWERED BY A LIVE VOICE (e.g. answering service or centralized triage):
If the caller believes the situation is an emergency or urgent in nature, advise the caller to call 911 immediately or proceed to the nearest Urgent Care Center or Emergency Room.
If the member indicates a need to speak with a physician, facilitate the contact by:

a. Putting the caller on hold momentarily and then connecting the caller to the on-call physician or providing a pager number and advising them to call back if they have not heard from the physician within one hour.
b. Get the member's number and advise a physician will call them back within the 30 Minutes.
c. If a member indicates a need for interpreter services, facilitate the contactby accessing interpreter services.

CALLS ANSWERED BY AN ANSWERING MACHINE

If this is an emergency, please call 911 immediately.
Hello, you have reached (Name of Doctor/Office/Medical Group). If you wish to speak to the physician on-call:

a. Please hold and you will be connected to (Dr. Name).
b. You may reach the on-call doctor directly by calling (give number).
c. Please call (give number). The doctor will be paged, and you may expect a return call within 30 minutes. If you do not hear from the doctor within 30 minutes, please go to the nearest Emergency Room. Our Urgent Care Center is located at (give or phone or address)

Note: The same Standard of Access and Availability is met by physicians providing "on call" coverage for provider panel members.

ACCESS TO RECORDS

Providers must provide access to any medical, financial or administrative records related to services provided to Community Care IPA members. Maintain these records for at least 10 years.
Providers must establish policies that safeguard privacy and maintain accurate medical records that abide by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information.

ADMINISTRATION OF HEALTH ASSESSMENTS

An Initial Health Assessment (IHA) must be provided to all members 18 months or older within one hundred twenty (120) days of enrollment and within sixty (60) days of enrollment for members under age 18 months. This consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA). Follow the Staying Healthy Assessment (SHA) Periodicity Schedule. The SHA policy letter, forms, and provider training materials are found here: dhcs.ca.gov.

Providers may not deny, limit, or condition the coverage or furnishing of benefits to individuals on the basis of any factor that is related to health status including, but not limited to, the following: medical condition including mental as well as physical illness, claims experience, receipt of health care, medical history, generic information, evidence of insurability including conditions arising out of acts of domestic violence, or disability. Providers further may not differentiate or discriminate against any member as a result of his/her race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for health services, status as a litigant, status as a Medicare or Medi-Cal beneficiary, sexual orientation, or any basis prohibited by law.

Initial Health Assessment (IHA) Components and Requirements

PCPs are responsible for reviewing each member's IHA in combination with:

- Medical history, conditions, problems, medical/testing results, and member concerns.
- Social history, including member's demographic data, personal circumstances, family composition, member resources, and social support.
- Local demographic and epidemiologic factors that influence risk status.

The IHA consists of:

A. Comprehensive History – must be sufficiently comprehensive to assess and diagnose acute and chronic conditions including:

- History of present illness
- Past medical history
- Prior major illnesses and injuries
- Prior operations
- Prior hospitalizations
- Current medications
- Allergies
- Age appropriate immunization status
- Age appropriate feeding and dietary status

- Social history
- Marital status and living arrangements
- Current employment
- Occupational history
- Use of alcohol, drugs and tobacco
- Level of education
- Sexual history
- Any other relevant social factors
- Review of organ systems

B. Preventive services

- Asymptomatic healthy adults – must adhere to the current edition of the Guide to Clinical Preventive Services of the U.S. Preventive Services Task Force (USPSTF), specifically USPSTF "A" and "B" recommendations for providing preventive screening, testing and counseling services. Document status of current recommended services.
  Members younger than 21 years of age – provide preventive services by the most recent American Academy of Pediatrics age specific guidelines and periodicity schedule.
- Perinatal services for pregnant members must be provided according to the most current standards of guidelines of the American College of Obstetrics and Gynecology (ACOG). A DHCS
- approved comprehensive risk assessment tool must be used for all pregnant members. This must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. Risks identified must be followed up and documented in the medical record.

C. Comprehensive Physical and Mental Status exam must be sufficient to assess and diagnose acute and chronic conditions.

D. Diagnoses and Plan of Care – the plan of care must include all follow up activities

E. Individual Health Education Behavioral Assessment (IHEBA)

- IHEBA requirement – administer an age specific
- IHEBA as part of the IHA. Assessment tools used to complete the IHEBA must be approved by the Medi-Cal Managed Care Division (MMCD) prior to use
- Exceptions for transferring members – the IHEBA requirement for members transferring from an outside group may be met if the medical record indicates in the IHEBA tool or a behavioral risk assessment has been completed within the last 12 months.

The age specific and age appropriate behavioral risk assessment should cover:

- Diet and weight issues
- Dental care
- Domestic violence
- Drugs and alcohol
- Exercise and sun exposure
- Medical care from other sources
- Mental health
- Pregnancy
- Birth control
- STIs/STDs
- Sexuality
- Safety prevention
- Tobacco use and exposure

Who Can Perform the IHA?

- The member's PCP of record
- Perinatal Care Providers
- Primary Care Providers
- Non-Physician Mid-Level Practitioners

Staying Healthy Assessment (SHA) Periodicity Schedule

Members must complete a SHA in accordance with the following guidelines and time frames listed. Document a member's refusal to complete the SHA on the appropriate age-specific form and keep in their records.

New members must complete the SHA within 120 days of the effective date of enrollment. The effective date of enrollment is the first day of the month following notification by the Medi-Cal Eligibility Data System (MEDS) that a member is eligible to receive services.

Current members who have not completed an updated SHA must complete it during the next preventive care office visit, according to the SHA periodicity table.

Pediatric members – members 0 –17 years of age must complete the SHA during the first scheduled preventive care office visit upon reaching a new SHA age group. PCPs must review the SHA annually with the patient (parent/guardian or adolescent) in the intervening years before the patient reaches the next age group. Adolescents (12–17 years) should complete the SHA without parental/guardian assistance beginning at 12 years of age, or at the earliest age possible. This helps to get accurate responses to sensitive questions. You should determine the most appropriate age, based on discussion with the parent/guardian and the family's ethnic/cultural background.

Adult and senior members – There are no designated age ranges for the adult and senior assessments. It is intended for use by ages 18 to 55 years. The age at which the PCP should begin administering the senior assessment to a member should be based on the patient's health and medical status, and not exclusively on age. The adult or senior assessment must be re-administered every three to five years, at a minimum. You must review previously completed SHA questionnaires with the patient every year, except years when the assessment is re-administered.

Although not required, SHA annual administration is highly recommended for the adolescent and senior groups because behavioral risk factors change frequently during these years.

SHA DOCUMENTATION BY PCP

Periodicity Table:	Periodicity	Administer	Administer/Re-administer		Review
DHCS Form Number	**Age Groups**	**Within 120 days of Enrollment**	**1st Scheduled Exam** (after entering new age group)	**Every 3-5 years**	**Annually** (intervening years)
DHCS 7098 A	0-6 Months	✓	✓		
DHCS 7098 B	7-12 Months	✓	✓		
DHCS 7098 C	1-2 Years	✓	✓		✓
DHCS 7098 D	3-4 Years	✓	✓		✓
DHCS 7098 E	5-8 Years	✓	✓		✓
DHCS 7098 F	9-11 Years	✓	✓		✓
DHCS 7098 G	12-17 Years	✓	✓		✓
DHCS 7098 H	Adult	✓		✓	✓
DHCS 7098 I	Senior	✓		✓	✓

A. Sign print your name, and date the "Clinic Use Only" section of a newly administered SHA to verify you reviewed and discussed it with the member.
B. Document specific behavioral-risk topics and patient counseling, referral, anticipatory guidance, and follow-up provided, by checking the appropriate boxes in the "Clinical Use Only" section.
C. Sign print your name, and date the "SHA Annual Review" section of the questionnaire to document that an annual review was completed and discussed with the member.
D. If a member refuses the service:

- Enter the member's name (or person completing the form), date of birth, and date of refusal in the header section of the questionnaire.
- Check the box "SHA Declined by Patient."
- Sign, print your name, and date the "Clinic Use Only" section of the SHA.
- Keep the SHA refusal in the member's medical record.

Section 5: Encounter Data, Claims and Billing

CLAIMS AND ENCOUNTER DATA SUBMISSIONS

Claims and/or encounter data submission is required to ensure services are provided in compliance with state guidelines. We encourage you to submit claims and encounters directly to MedPOINT Management via a contracted clearinghouse. Office Ally is our preferred clearinghouse.

Office Ally

Payer ID: MPM 48
www.Officeally.com
866-575-4120

Claimremedi

Payer ID: MPM48
www.claimremedi.com
800-763-8484

Trizetto/Gateway

Payer ID: MPM48
www.trizetto.com
800-556-2231

Change Healthcare

Payer ID: CCI01
www.changehealthcare.com
888-870-4751

ENCOUNTER DATA REQUIREMENTS

All encounter information must be received by the 15th of the following month from the date of service. Health Plans require MedPOINT to submit this information by the 30th of the month. MedPOINT will decipher specialty services from your encounter data. The specialty services will be paid sixty (60) days after the date received. Submit all services on a "per patient, per visit" basis, not as a monthly summary.

The CMS-1500 is the required format for encounter submission and superbills. Each submission must be in this HIPAA compliant format or the submission will be rejected.

The use of current, applicable CPT/HCPCS Codes and other applicable codes are needed for Payor to determine services provided and accuracy of payment on each encounter for services rendered to each member.

The following information, in a typed or system generated format, must be included:

1. Insured's I.D. # (Box 1a)
2. Patient's Name (Box 2)
3. Patients Birth Date (Box 3)
4. Sex (Box 3)
5. Patient's Address (Box 5)
6. Claim Codes (by NUCC) (Box 10d)
7. Prior Authorization Number (Box 23)
8. Date(s) of service (Box 24 A)
9. Place of service (Box 24 B)
10. Procedures, Services or Supplies (Box 24 D)
11. Rendering Provider ID# (Box 24 J)
12. Rendering Provider NPI (Box 24 J)
13. Federal Tax I.D. Number "TIN" (Box 25)
14. Signature of Physician or Supplier (Box 31)
15. Service Facility Location Information (Box 32)
16. Service Facility Location NPI Number (Box 32a)
17. Billing Provider Info and PH # (Box 33)
18. Billing Provider NPI (Box 33a)

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM (CHDP) ENCOUNTERS

Some Health Plans require CHDP encounters to be submitted to both the IPA and the Health Plan to qualify. The CMS-1500 form is used for paper submissions.
Please note, the PM 160 form has been phased out and is no longer used for services provided on or after July 1, 2017. However, Anthem Blue Cross requires the PM 160 form in conjunction with the CMS 1500. Anthem Blue Cross pays claims without the PM160 but require the form to capture HEDIS and other data.

CHDP HEALTH PLAN SUBMISSION GUIDELINES

Aetna Better Health of CA

- Submit CMS 1500 to IPA
- CHDP is IPA risk

Anthem Blue Cross

- Submit CMS 1500 to IPA
- CHDP is IPA risk

Blue Shield Promise Health Plan

- Submit CMS 1500 to IPA
- CHDP is IPA risk included in capitation

California Health & Wellness

- Submit CMS 1500 to IPA
- CHDP is IPA risk

Health Net

- Submit CMS 1500 to IPA
- CHDP is IPA risk

Molina

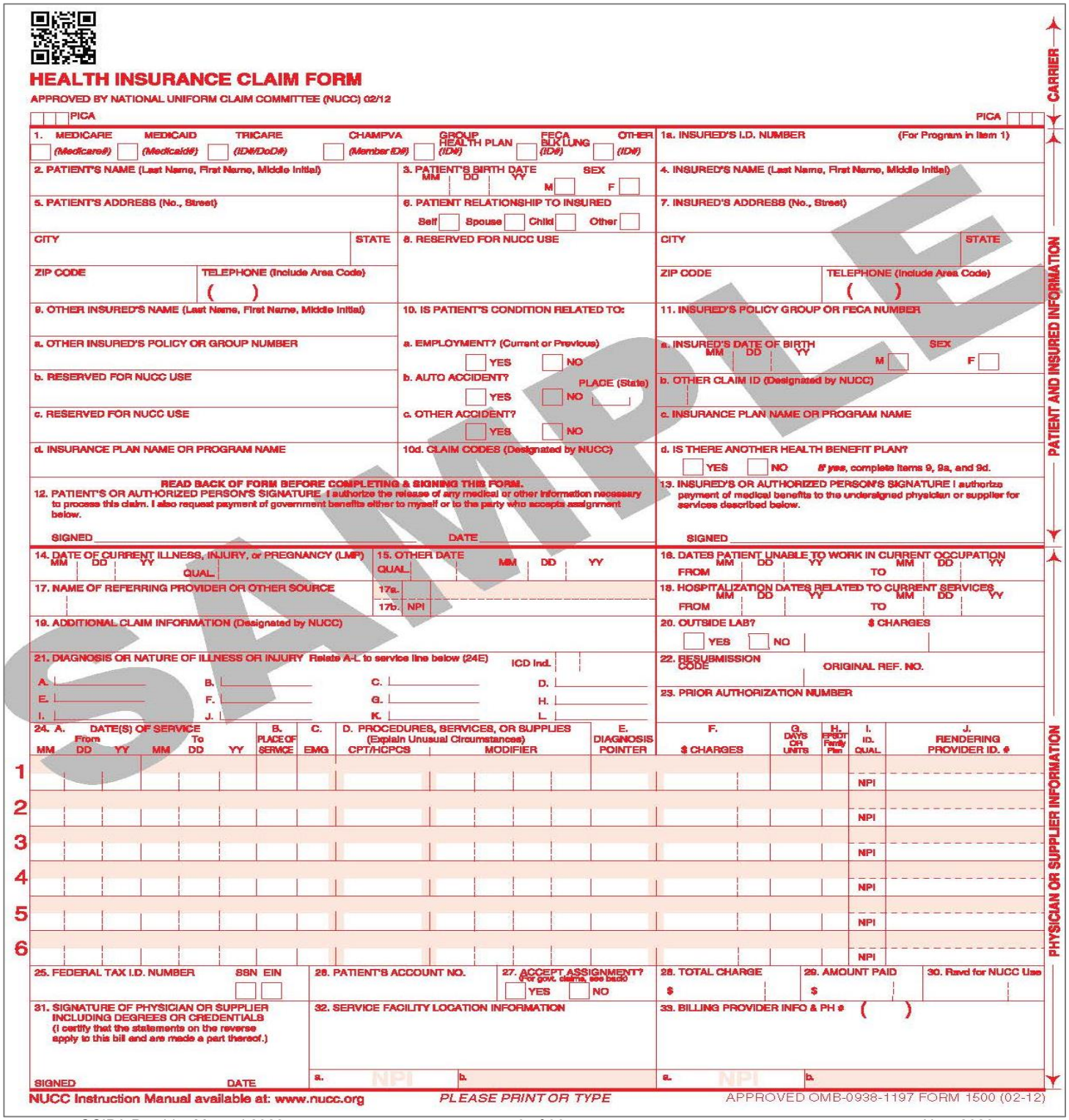
- Submit CMS 1500 to IPA
- CHDP is IPA risk

CMS 1500 SAMPLE FORM

The National Uniform Claim Committee (NUCC) has developed a 1500 reference Instruction Manual detailing how to complete the claim form. The current version is available by visiting www.NUCC.org and clicking on the '1500 Claim Form' tab, then '1500 Instructions'.

CLAIMS TIMELINESS

Contracted providers will have 90 days from the date of service to submit claims. Non-contracted providers will have 180 calendar days from date of service to submit claims.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

COMPLETE CLAIMS

Claims are to be filed on CMS-1500, UB 04 or any other format approved by IPA. Reports are required for all Anesthesia, Surgical and Emergency Room services. Copy of Invoice is required for all injectables, immunizations, medications or supplies billed under a Miscellaneous CPT Code.

CLAIM RECEIPT VERIFICATION

For verification of claim receipt, access the MPM Web Portal. You can also contact us at: 866-423-0060, Option 3.

CLAIM REJECTION

If a claim is rejected during Office Ally or the payer's scrubbing process, your claims will be sent to Claim Fix. There claims can be easily repaired and re-submitted once you have made all necessary corrections. Please click here Office Ally Claim Fix Instructions for more information.

NATIONAL DRUG CODES (NDC)

Health Plans are requiring the presence of National Drug Codes (NDC) on encounter submission. NDCs provide full transparency for physician administered drugs (PAD). PAD is any covered drug provided or administered to a patient which is billed by a provider other than a pharmacy. This includes any method of administration and is not limited to injectable drugs.

MedPOINT Management requires an NDC on all claims that include drugs covered by medical benefits. Claims for a PAD submitted without NDC numbers will be denied and/or returned and require resubmission. Paper claims submitted without proper NDC codes will be denied back to the providers on the EOB with applicable instruction on how to rebill with the NDC.

For a listing of the Healthcare Common Procedure Coding System (HCPCS) codes which require an NDC code, please go to: portal.medpointmanagement.com/sign-in.

PROVIDER DISPUTE RESOLUTION (PDR)

DISPUTE RESOLUTION PROCESS

A contracted Provider Dispute is a provider's written notice to IPA and/or the member's applicable Health Plan challenging, appealing, or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted, contested, seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered), or disputing a request for reimbursement of an overpayment of a claim.

Each contracted Provider Dispute must contain, at a minimum, the following information: provider's name, provider's identification number, provider's contact information, and:

1. If the contracted Provider Dispute concerns a claim or a request for reimbursement of an overpayment of a claim from IPA to a contracted provider, the following must be provided: a clear identification of the disputed item, the Date of Service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment, or other action is incorrect.
2. If the contracted Provider Dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue.
3. If the contracted Provider Dispute involves an member or group of members, the name and identification number(s) of the member or members, a clear explanation of the disputed item, including the Date of Service and provider's position on the dispute, and an member's written authorization for provider to represent said members.

DISPUTE RESOLUTION SUBMISSION

Provider Disputes submitted must include the information listed in Section 1 above, for each contracted Provider Dispute. All contracted Provider Disputes must be mailed to:

Community Care IPA, Inc.
Attn: Provider Dispute Resolutions
P.O. Box 7020-04
Tarzana, CA 91357

TIME PERIOD FOR SUBMISSION

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

Provider Disputes that do not include all required information may be returned to the submitter for completion. An amended contracted Provider Dispute which includes the missing information may be submitted within thirty (30) working days of your receipt of a returned Provider Dispute.

ACKNOWLEDGMENT OF PROVIDER DISPUTE

All incoming disputes will be acknowledged upon receipt of the dispute regardless of whether the dispute is complete within 15 working days of receipt. A letter of acknowledgement will be sent to the provider.

PROVIDER DISPUTE INQUIRIES

All inquiries regarding the status of a contracted Provider Dispute or about filing a contracted Provider Dispute must be directed to the Provider Dispute department by calling
866-423-0060, Option 3.

INSTRUCTIONS FOR FILING SUBSTANTIALLY SIMILAR CONTRACTED PROVIDER DISPUTES

Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:

1. Sort Provider Disputes by similar issue
2. Provide cover sheet for each batch
3. Number each cover sheet
4. Provide a cover letter for the entire submission describing each provider dispute with references to the numbered cover sheets

TIME PERIOD FOR RESOLUTION AND WRITTEN DETERMINATION OF CONTRACTED PROVIDER DISPUTE

IPA will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) Working Days after the Date of Receipt of the contracted Provider Dispute or the amended contracted Provider Dispute.

PAST DUE PAYMENTS

If the contracted Provider Dispute or amended contracted Provider Dispute involves a claim and is determined in whole or in part in favor of the provider, IPA will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) working days of the issuance of the written determination.

CLAIM OVERPAYMENTS

Notice of Overpayment of a Claim: If IPA determines that it has overpaid a claim, IPA will notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the Date of Service(s) and a clear explanation of the basis upon which IPA believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

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

No Contest: If the provider does not contest IPA's notice of overpayment of a claim, the provider must reimburse IPA within thirty (30) working days of the provider's receipt of the notice of overpayment of a claim.

Offsets to Payments: IPA may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when; (I) the provider fails to reimburse IPA within the time frame set forth above, and (ii) IPA's contract with the provider specifically authorizes IPA to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions.

In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, IPA will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

DISPUTES FOR RETROSPECTIVE CLAIMS

IPA will follow Health Plan guidelines for hearing appeals. In all cases of denials, IPA will explicitly describe process of appeal rights for retrospective medical necessity and claims denials. IPA may be delegated to handle First Level Appeal; exact mechanism will be noted on letter, depending on Health Plan.
For Medicare Members: Under Part C (Medicare Advantage) rules, once a service has been rendered without obtaining prior authorization, it is post-service even if we have not received a claim. Post-services, you may be required to submit a claim for payment.

BILLING GUIDELINES

CO-PAYMENTS, CO-INSURANCE, AND DEDUCTIBLES

Providers may only bill and collect the member's applicable co-payments, co-insurance and deductibles which are specifically permitted in the member's Health Plan contract. A member's co-pay for an office visit can often be found on the member's Health Plan card or via th plan website. The provider shall bill and collect all charges from a member for non-covered services provided to the member. Non-Covered Services are defined as follows:

1. NOT authorized but requested by patients, regardless of authorization.
2. NOT a covered benefit as determined by member's benefit plan.

Before a non-covered service is performed, the provider should require the member to sign an acknowledgement of financial responsibility form. The form details the non-covered services for which the patient will be financially responsible.

NO BILLING OF PATIENTS

According to the Knox-Keene Health Care Service Plan Act of 1975. No bills or statements of any kind shall be sent to Plan members, except for copayment amounts, unauthorized services, or non-covered benefits. Members are responsbile only for co-payment amounts and services determined as exclusions and limitations to the Health Plan explanation of benefits.

PAYSPAN

As our contracted provider, you will receive a free innovative web-based solution for Electronic Funds Transfer (EFT), Electronic Remittance Advice (ERA), and other services via Payspan. Payspan offers payment automation services that improve administrative efficiency, meet regulatory requirements, and allow providers to manage their reimbursements.

BENEFITS

- Payment Transactions Consolidated
- Electronic Platform for Payment
- Payment Collection Simplified

SERVICES

- Electronic Funds Transfer (EFT) Payments
- Electronic Remittance Advice (ERA) / Electronic Data Interchange (EDI)/835 files
- Electronic Explanation of Benefits / Payments (EOB/EOP)

Register for PAYSPAN

It's: Easy, Free, Quick, Convenient, and Efficient!

- Please visit www.payspanhealth.com and register using your unique registration code
- You may also request your registration code(s) at: www.payspanhealth.com/requestRegCode OR
- Contact Payspan via e-mail to request your Payspan registration codes at: Providersupport@Payspanhealth.com. The registration code will be sent to you within 24 – 48 hours.

Fee-for-Service (FFS) Reports are available via Payspan:

As our contracted provider, you will be able to obtain the following:

- Electronic Remittance Advice (ERA)
- Electronic Data Interchange (EDI) or 835 files
- Electronic Explanation of Benefits/Payments (EOB/EOP)

TIMELY CHECK CASHING PROCESS

In conjunction with the IPA's check cashing policy and monitoring of timely check cashing by the Health Plans and regulatory agencies, all checks are to be cashed within 14 days of receipt.

Section 6: Quality Management

QUALITY MANAGEMENT PROGRAM

MedPOINT has a comprehensive and integrated Quality Management (QM) Program. It is designed to monitor and evaluate quality, appropriateness and outcome of care and services along with the processes by which they are delivered to IPA members objectively and systematically.
Specific activities in the QM program include but are not limited to the following areas:

- Development of clinical practice guidelines
- Provider accessibility and availability
- Provider and member satisfaction
- Under- and over-utilization
- Adverse outcomes/ sentinel events
- Grievance resolution
- Access and clinical studies
- Department call center management
- Population health, including HEDIS® and STARs measure improvement

MEDICARE FIVE STAR QUALITY RATING

What is a Five Star Plan Rating?
Medicare uses information from member satisfaction surveys, plan and healthcare providers to give overall performance star ratings to Medicare Health Plans. These ratings help you compare plans based on quality and performance. A plan can get a rating from one to five stars. A five star rating is considered excellent.

Five Star Quality Measures

- Staying healthy:
  Includes how often members got various screening tests, vaccines, and other check-ups that help them stay healthy
- Managing chronic (long-term) conditions: Includes how often members with different conditions got certain tests and treatments that help them manage their conditions
- Ratings of Health Plan responsiveness and care: Includes ratings of member satisfaction with the plan
- Health Plan member complaints and appeals: Includes how often members filed a complaint against the plan
- Health Plan telephone customer service: Includes how well the plan handles calls from members

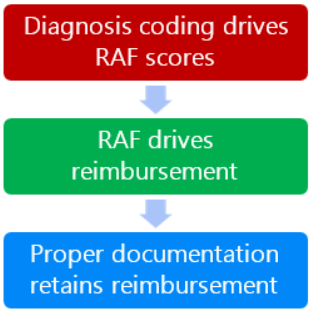
How to Achieve a Five star Rating

- Provider education and support
- Correct billing
- EHR template updates
- Check MPM clinical alert dashboard
- Submission of encounter with all documented diagnosis

What are Hierarchical Condition Categories (HCC)?
HCC is a category of medical conditions that map to a corresponding group of ICD-10 diagnosis codes.

What is Risk Adjustment Factor (RAF)?

- Payment methodology used by Medicare Advantage Health Plan to adjust Health Plan payments
- Based on member health status and demographic characteristics
- HCC
- Documentation:



Components for Success

- Specific diagnostic coding to include chief complaint and all co- morbidities
- Status codes (V-codes)
- Documentation of underlying disease
- Documentation of manifestation of disease
- Specific coding regarding stages of disease (i.e. chronic kidney disease codes)
- Compliance to CMS documentation requirements

PROPER CODING VERSUS NO CODING

All conditions coded appropriately		Some conditions coded – low level of specificity		No conditions coded	
76 year old female	0.457	76 year old female	0.457	76 year old female	0.457
Medicaid eligible	0.179	Medicaid eligible	0.179	Medicaid eligible	0.179
Diabetes w/vascular complications 250.70 (HCC 15)	0.508	Diabetes w/o complications 250.00 (HCC 19)	0.162	No diabetes coded	X
Vascular disease w/complications 445.89 (HCC 104)	0.610	Vascular disease w/o complications 443.9 (HCC 105)	0.316	No vascular disease coded	X
CHF 428.0 (HCC 80)	0.410	CHF not coded	X	CHF not coded	X
Disease Interaction (DM + CHF)	0.154	No Disease Interaction	X	No Disease Interaction	X
Total RAF	2.27	Total RAF	1.066	Total RAF	0.588
PMPM Payment	$2,157	PMPM Payment	$1,013	PMPM Payment	$558
Annual Payment	$25,295	Annual Payment	$12,160	Annual Payment	$6,707

To schedule training related to HEDIS and HCC, email: qualitymeasures@medpointmanagement.com

CULTURAL COMPETENCY PROGRAM

Serving members requires supporting their cultural and lingustic needs while meeting Affordable Care Act Section 1557 Language Assistance Requirements.

If your patient needs an interpreter, please schedule services by contacting the Health Plan. Find Health Plan contact information in Section 2.

Who is responsible for arranging interprester services?
The provider conducting the consultation or treatment plan is to scheudle interpreter services.

How far in advance should I call the Health Plan to arrange interpreter services?
For a phone interpreter, call at least 1 hour before the patient's appointment. For a face-to face interpreter, please contact the Health Plan for guidelines on prior notice.

What information will the Health Plan require in order to arrange interpreter services?

- Patient's name
- ID number
- Date of Birth
- Requested Language
- Time of the appointment
- Type of medical services

Incentives for Clinics/Health Centers - ANNUAL WELLNESS VISITS (AWV)			
Health Plan	**LOB**	**Program**	**Details**
Blue Shield Promise Health Plan	Medicare, Cal MediConnect	In Office Assessment (IOA) Provider Incentive Program 2021	Please contact your provider field representative regarding incentive information.
Brand NewDay	Medicare	STARs Annual Wellness Exam (AWE)	$200 per AWE form received and complete by 6/30/21. $150 per AWE form received and complete after 6/30/21 to 12/31/21. For more details, contact: provider_services@universalcare.com. (Members receive $50 for completed annual exam.)
Health Net	Medicare	Annual Wellness Program	$100 incentive for each comprehensive health assessment performed at a qualifying visit (CPT codes G0438/G0439/G0402/99396/99397). Besides the encounter submission, the corresponding medical chart must alsobe available to earn the incentive.
Molina	Medicare, Medi-Medi, Cal Medi-Connect (CMC), Covered CA	2021 Annual Exam Program	Annual wellness exam forms submitted 01/01/2021 – 12/31/21:For select members with Medicare/Medi-Medi/CMC: $125 – per complete detailed EMR, $50 Bonus if received by 07/30/2021. For select members with Covered California: $125 – per complete detailed EMR, $50 Bonus if received by 08/31/2021. Email completed forms to: AEProgramSubmissions@MolinaHealthcare.com or assigned HCLA Coder for review. For assistance with obtaining or completing forms, email: klitzsey@medpointmanagement.com or your HCLA coder. Video telehealth visits are acceptable. For more details, contact: Alicia Chatterley | Associate, Risk Adjustment(801) 858-0400 x171085 or Alicia.Chatterley@molinahealthcare.com

Incentives for Clinics/Health Centers - PROGRAMS			
Health Plan	**LOB**	**Program**	**Details**
All Medi-Cal Health Plans	Medi-Cal	Value Based Payment (VBP) Program 2021 (Prop 56)	The Prop 56 VBP Program is for eligible providers (not FQHCs). The Governor's Budget proposed a VBP through Medi-Cal managed care Health Plans (MCPs) thatprovides incentive payments to providers for meeting specific measures aimed atimproving care for certain high-cost or high-need populations. These risk-based incentive payments will be targeted at physicians that meet specific metrics targeting areas such as behavioral health integration, chronic disease management, prenatal/post-partum care and early childhood prevention. www.dhcs.ca.gov/provgovpart/Prop-56/Pages/Prop56-Programs-Value-Based-Payment.aspx The Prop 56 rates are confirmed for FY (Fiscal Year) 2019-2021 and will be paid atthe same rates used for State Fiscal Year (SFY) 2018-2019. Please see details, measures and payments here: www.cahealthwellness.com/newsroom/prop-56-rates-for-sfy-2019- 2021.html. FQHCs are eligible for developmental www.dhcs.ca.gov/provgovpart/Prop-56/Pages/Prop56-Screenings-Developmental.aspx and trauma www.dhcs.ca.gov/provgovpart/Pages/TraumaCare.aspx screening payments only. Specific questions regarding this program should be directed to each respectiveHealth Plan.
Blue Shield Promise Health Plan	Medi-Cal	Patient Centered Medical Home(PCMH) Certification 2021	Please contact your provider field representative regarding incentive information.

Incentives for Clinics/Health Centers - PROGRAMS			
Health Plan	**LOB**	**Program**	**Details**
HealthNet	Medi-Cal	Clinic HEDIS Improvement Program (C-HIP) 2021 - FQHCs	This financial incentive program for FQHC/RHC/IHS providers recognizes efforts tomaintain open primary care provider panels, submit accurate and timely encounters and demonstrates HEDIS improvement. Incentive is from encounters and pharmacy data and rewards are based on NCQA national average performance level. 2021 HEDIS measures included: AMM Acute, AMM Cont., BCS, CBP, CCS, CDC-A1c<9, CDC A1c Test, CHL, CIS10, IMA2, Prenatal, Postpartum, W30, WCV, WCC. Payment is max $3.40 PMPM (per member per month) including meeting MPL (minimum performance level) and improvement. Providers with measures that meet the incentive criteria for 2021 (based on 2019 performance) will receive a payment advance early in 2021 (30% of the calculated incentive amount). *C-HIP is offered to clinics in all 31 counties statewide with active W-9 on file.* For more details, please contact: HEDIS@healthnet.com.
HealthNet	Medi-Cal	HEDIS Improvement Program (HIP) 2021 – PCPs	The HIP Program rewards PCP's efforts to improve quality in the following HEDIS measures through encounter data: CIS 10 ($200), PPC Postpartum ($75) and Prenatal ($75), AMM acute ($100) and continuation ($100), BCS ($75), CCS ($75), IMA-2 ($50), CBP ($50), CDC A1c <9 ($50) , CHL ($25), CDC A1c Test ($12.50), WCC BMI ($5), WCC Nutrition ($5), WCC Physical Activity ($5), W30 ($75), WCV ($25). Minimum of 50 members required. For more information, please contact: HEDIS@healthnet.com.

Incentives for Clinics/Health Centers – PROGRAMS (continued)			
Molina	Medi-Cal	Achieving Equity in Care Program (AECAP) 2021	The goals of the program are to: 1) achieve or exceed the target thresholds for selected preventive and chroniccare measures per region, and 2) to reduce targeted health disparities by 3%. The program entails a five-prongapproach which includes: 1. Improve data collection 2. Data analysis 3. Member engagement 4. Provider support 5. Pilot innovations Adjustments to MY 2020 final payments will be increased for eligible providers. For further details, contact (888) 562-5442.
Molina	Medi-Cal	HEDIS PCP P4P (Pay-for-Performance) Bonus Program 2021	The PCP P4P Program is effective as of 1/1/21 and requires a minimum of 200Medi-Cal members to qualify for Cervical Cancer Screening (CCS) and A1c <8 performance bonus. No minimum on other measures below. <u>P4P Bonus measures include:</u> San Diego (SD) County: CCS ($25), CDC A1c<8 ($100), Prenatal Notification Form ($75 per form),CIS 10 ($100 for all immunizations completed). • 2021 Top Provider in each of the following measure receives $5,000 in 2nd reporting period (500 members minimum): CCS, CDC A1c<8 and CIS 10. FQHCs and Rural Health Centers in SD, IM and IE are no longer eligible forthis program but may have health center specific programs.
Molina	Medi-Cal	HEDIS P4P Program (Pay-for-Performance) for FQHC/RHCs 2021 Applies to FQHCs outside of LA County only	Molina Update 5-20-20 states that goals were reduced, and payment was allowed even if the 50th percentile was not met. The member growth component has been removed. PMPM payment was changed to $3.00 PMPM. Minimum of 500 Molina Medi-Cal members needed. To qualify for any payment, all goals for "NCQA 2020 Threshold" for each measure must be met. This will trigger a $3.00 PMPM payment. Additional payment is then based on how many of the stretch goals are met and if the Member Satisfaction component is met. Payments will be paid annually after final HEDIS rates are announced. 2021 measures include BCS, CBP, CCS, CHL, CIS-10, CDC>9%, IMA-2, PPC Prenatal, PPC Postpartum, WCC-BMI, WCC-N, WCC-PA, W30A (0-15 mos.), W30B (15-30 mos.), WCV, CDF (Clinical Depression Screening and Follow-Up) and Lead Screening in Children. For questions, please email: MHCQuality@MolinaHealthCare.com. Please refer to JTF notice dated 1/31/2020. MCAS measures are listed here: www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEAS.aspx.

Incentives for MEMBERS			
Health Plan	**LOB**	**Program**	**Details**
Anthem Blue Cross	Medi-Cal	Healthy Rewards Program 2021	Incentives are given based on claims data and loaded into the member's Healthy Rewards account for the following HEDIS measures and services: $25: WCV age 3-21, CIS10, IMA2, CHL, CDC A1c, Prenatal $50: BCS, CCS, Postpartum $40 ($10 each): High blood pressure medication refill, ADHD medication management, Antidepressant medication management $80 ($10/8 visits): W30
Brand New Day	Medicare	Rewards Plus Program 2021	Gift cards for completing preventive screening: $50 for Annual Wellness Exam, (2) $10 for Health Risk Assessment, (3) $10 for annual exercise plan, (4) $25 for mammogram, (5) $25 for colonoscopy or $10 for stool test, (6) $25 for diabetic members who have A1c, eye exam and nephropathy, and (7) $25 for weight management program for members with a BMI greater than 30. Rewards are loaded on a Rewards Plus Card to use at selected retailers for health related and personal care items. Call 866-255-4795 for questions.
Health Net	Medi-Cal	Medi-Cal Reward Cards Program	Members receives information from Novu Health vendor by print communication, email and online. Member attests to completion of screening and gift cards are mailed by Health Net. Rewards include: $25 for Adolescent Well Care, $10 x 6 for Well Child in first 15 months of life, $25 for Asthma Medication Ratio and $15 for Flu. For questions, email: HEDIS@healthnet.com.
Health Net	Medi-Cal Medicare	Point-of-Care Reward Card Program	Select health centers receive $20 gift cards for the measures below and give them to the member after the visit is completed at the clinic. A log of cards distributed to members is required. Measures: Flu Vaccine, Mammography, Bone Mineral Density, HRA or Personal Wellness Assessment (SNPs only), Colorectal Cancer Screening, CDC Eye, CDC A1c and Annual Wellness Visit. *Health Centers who use this program will opt out of the Novu incentives and mailings above for 2020.*

Section 7: Compliance

FRAUD, WASTE, ABUSE

Community Care IPA's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection, and investigation of false and abusive acts. Examples of fraud, waste, and abuse are: billing for procedures not performed and physician kick-backs for referrals. For additional information on fraud, waste and abuse, please refer to the Provider Resources – Mandatory Health Plan Trainings on the MPM Web Portal.

REPORTING

We must report Medi-Cal suspected fraud or abuse within ten (10) days. Thirty (30) days for Medicare. Please refer potential compliance issues to the Compliance department withing 24 hours of notification or identification.

EXCLUSION CHECKS

Community Care IPA is required by its contracted Health Plans to ensure that our providers screen their practitioners, employees, contractors, volunteers, board members, referring physicians/practitioners and any other individual working on the behalf or closely with the providers. The screening is performed prior to hiring or contracting then monthly thereafter

For more information or access to the publicly accessible excluded party online databases, please see the following links:

- Health and Human Services- Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE) at: HHS OIG Exclusions List
- General Services Administration (GSA) System for Award Management at: SAM.gov | Home

VOLUNTARY STERILIZATION

You must comply with the procedures below prior to obtaining an authorization and performing a sterilization service. A completed Consent Form (PM330) must be submitted with claims for all sterilization procedures. Claims submitted without the PM330 will not be processed for payment. The PM330 form is available for download from:

Microsoft Word - PM 330 _1-99_ Eng-SP.doc (ca.gov)

Voluntary sterilization consent requires:

- The member to be at least 21 years of age at the time consent is signed
- The recipient to be mentally competent
- It to be voluntary and obtained without duress
- 30 days, but not more than 180 days, to pass between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery
- At least 72 hours must have passed since the recipient gave informed consent for the sterilization if the recipient is to be sterilized at the time of a premature delivery or emergency abdominal surgery
- The informed consent must be given at least 30 days before the expected date of delivery in the case of premature delivery

- The person securing the informed consent and the care provider performing the sterilization procedure are required to sign and date the consent form
- Copy of the signed Federal Consent Form must be submitted by each provider involved with the hospitalization and/or the sterilization procedure
- Providers must indicate in the record that the recipients already receive the sterilization booklet
- That sterilization consents may not be obtained when an eligible recipient:
    - is in labor or childbirth
    - is seeking to obtain or obtaining an abortion
    - is under the influence of alcohol or other substance that affect that recipient's state of awareness

ACCESS TO CARE SURVEYS

Community Care IPA conducts quarterly Access to Care compliance audits by telephone to assess appointment availability and after hours ccess to healthcare providers as required by DHCS, DMHC, CMS and NCQA. Appointment Availability calls will be made during the Provider's normal operating hours. After Hours calls will be conducted during early mornings, evenings, weekends and holidays to meet the requrement for 24/7 coverage.

Respondents who refuse to participate in the survey will be scored as noncompliant. You will find Timely Access and Availability Standards in Section 4.

REFERRAL, MISSED APPOINTMENT AND ABNORMAL TEST RESULTS TRACKING LOG

Primary Care Providers must have a way of tracking both Specialty Referral and Missed Appointments. All Health Plans audit for this documentation. The goal is to track and support patients when they obtain services outside the PCP practice, and to ensure safe and timely referrals or transitions.

Tracking Log of Speciality Referrals must include the following:

- Date of Referral
- Reason for referral and clearly documented in the medical record
- Date of appointment
- Confirmation that patient went to appointment
- Copy of Speciality visit notes
- Documentation in the Patient's record of review of visit and recommendations

Tracking Log of all Missed Appointments must include the following:

- Date of Missed Appointment
- Outreach efforts/Follow up contacts-minimum two (2) calls, and if not response written request
- Evidence documented in medical record

Tracking Log of all Abnormal test results must include the following:

- Date Received
- Evidence of review and action taken on abnormal results
- Documenation in the Patient's record of review of the abnormal results and recommendations

Suggestion: If it is not captured in your Electronic Health Record (EHR), create a stamp for medical record, example below:

- No action required
- Abnormal Results
  - Labs
  - X-rays
  - Other
- Discussed recommendation with patient

MEMBER RIGHTS & RESPONSIBILITIES

PURPOSE

To ensure members receive quality care delivered in a professional manner with respect for the Member and their rights. Additionally, to ensure members are informed of their rights and ensure the protection of member rights during healthcare delivery.

POLICY

It is the policy of the IPA/medical group to demonstrate a commitment to treating members with dignity and in a manner that respects their rights. This policy will be distributed to all contracted practitioners, reviewed annually, and revised as necessary.

The designated IPA/medical group member has the right to:

- Exercise these rights without regard to gender, sexual orientation, or cultural, economic, educational, or religious background
- Be provided with comprehensible information about our medical group, services, providers, and healthcare service delivery process. This information includes instructions about how to obtain care with various providers and varied facilities (e.g., primary care, specialty care, behavioral health services, and hospital services). Additionally, information will be included about how to obtain services outside of the IPA system or service area
- Be informed of emergent and non-emergent benefit coverage and cost of care and receive an explanation of the member's financial obligations, as appropriate, prior to incurring the expense (including co-payments, deductibles, and co-insurance)
- Be provided with instructions in accordance with prudent layperson standards and address the needs of non-English speaking members with information about how to obtain care after normal office hours and how to obtain emergency care, including when to directly access emergency care or use 911 services.
- To have access to family planning services, Federally Qualified Health Centers, American Indian Health Service Programs, sexually transmitted disease services, and Emergency Services outside the Contractor's Network pursuant to the federal law
- To access Minor Consent Services
- Examine and receive an explanation of bills generated for services delivered to the member
- Be provided with information on how to submit a claim for covered services
- Be informed of the name and qualifications of the physician who has primary responsibility for coordinating the member's care; and be informed of the names, qualifications, and specialties of other physicians and non-physicians who are involved in the member's care
- Have 24-hour access to the member's primary care physician (or covering physician)
- Receive complete information about the diagnosis, proposed course of treatment or procedure, alternate courses of treatment or non-treatment, the clinical risks involved in each, and prospects for recovery in terms that are understandable to the member, so that the member may give informed consent or refuse that course of treatment
- Candidly discuss appropriate or medically necessary treatment options for the member's condition, regardless of cost or benefit coverage
- Receive confidential treatment of all member information and records used for any purpose
- Actively participate in decisions regarding the member's health care and treatment to the extent permitted by law. This includes the right to refuse any procedure or treatment. If the recommended procedure or treatment is refused, an explanation will be given addressing the effect that this will have on the Member's health

- To formulate advance directives
- Be treated with respect and dignity
- Receive considerate and respectful care with full consideration of the member's privacy
- Be informed of applicable rules in the various health care settings regarding member conduct
- Express opinions or concerns about our medical group of the care provided and offer recommendations for change in the healthcare delivery process by contacting the member Services Department

- Be informed on how to express a complaint, grievance, and appeal, including having knowledge of the entire process
- To request a State Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible
- To have access to, and where legally appropriate, receive copies of, amend, or correct their Medical Record
- Be informed of the termination of a primary care provider or practice site and receive assistance in selecting a new primary care provider or site in this situation
- Change primary care physicians by contacting the Health Plan member Services Department
- Be provided with information on how we evaluate with Health Plans, new technology for inclusion as a covered benefit
- Receive reasonable continuity of care and be given timely and sensible responses to questions and requests made for service, care, and payment (including complaints and appeals)
- Be informed of continuing health care requirements following office visits, treatments, procedures, and hospitalizations
- Have all member rights apply to the person who has the legal responsibility to make health care decisions for the member
- To make available and/or assist Limited English Proficiency (LEP) members access to their contracted Health Plan interpreter services, or when requested, at any scheduled or unscheduled visits at provider offices, including ancillary providers, specialty service providers, diagnostic testing facilities, and urgent care at no cost to the member
- To receive written member informing materials in alternative formats (including Braille, large size print, and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with W & I Code Section 14182 (b) (12)
- Right to make recommendations regarding member rights and responsibility policies
- Request enrollment in or to decline or disenroll from case management and/or disease management programs
- For any member denial, the member will be able to contact the Medical Group and request a copy of the criteria used to make the decision on a denial that the group has made

The member has the responsibility to:

- Be familiar with the benefits and exclusions of the member's Health Plan coverage
- Provide the member's health care provider with complete and accurate information which is necessary for the care of the member (to the fullest extent possible)
- Be on time for all appointments and notify the provider's office as far in advance as possible for appointment cancellation or rescheduling
- Report changes in the member's condition according to provider instructions
- Inform providers of the member's inability to understand the information given to him/her

- Carry out the treatment plan which has been developed and agreed upon by the health care provider and the member
- Contact the member's primary care physician (or covering physician) for any care which is needed after that physician's normal office hours
- Treat the health care providers and staff with respect
- Obtain an authorized referral from the member's primary care physician for a visit to a specialist and/or to receive specialty care
- Be familiar and comply with the IPA/medical group health care service delivery system regarding access to routine, urgent, and emergent care
- Contact the member Services Department or the member's Health Plan member Services Department regarding questions and assistance
- Respect the rights, property, and environment of all physician and medical group providers, staff, and other members
- Have all these responsibilities apply to the person who has the legal responsibility to make health care decisions for the member
- Make recommendations regarding our member rights and responsibilities

Important notes for our members and providers:

- We do not reward or offer incentives to employees or associates to encourage inappropriate under-utilization of services. We are committed to providing quality care to our members, and therefore:
- Utilization Management decision-making is based only on the appropriateness of care and service and the existence of coverage
- We do not specifically reward practitioners or other individuals for issuing denials of coverage or service care
- Financial incentives for utilization management decision-makers do not encourage decisions that result in underutilization

MEDI-CAL MEMBER RIGHTS

A. Member's right to a State Fair Hearing, how to obtain a Hearing, and representation rules at a hearing.

B. Member's right to file grievances and appeals and their requirements and timeframes for filing.

C. Availability of assistance in filing.

D. Toll-free numbers to file oral grievances and appeals.

E. Member's right to request continuation of benefits during an appeal or State Fair Hearing.

Please Note: The Member ID card includes the Health Plan Member Services phone number listed where all complaints (grievances or appeals) may be filed.

GLOSSARY

ACA	Patient Protection and Affordable Care Act
ACO	Accountable Care Organization
ALOS	Average Length of Stay
AMA	American Medical Association
AMCRA	American Managed Care and Review Association
APT	Admissions Per Thousand
ASO	Administrative Services Only
ASR	Age/Sex/Rate
AUR	Ambulatory Utilization Review
AWP	Average Wholesale Price
Cal AIM	California Advancing and Innovating Medi-Cal
CAP	Capitation or Corrective Action Plan
CAPG	California Association of Physicians Group
CDHS	California Department of Health Services
CDPH	California Department of Public Health
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHIP	Children's Health Insurance Program
CHP	Competitive Health Plan
CIN	Clinically Integrated Network
CMP	Competitive Medical Plan
CMS	Centers for Medicare and Medicaid Services
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985
CPCA	California Primary Care Association
CPT	(Physician's) Current Procedural Terminology
CQI	Continuous Quality Improvement
DHCS	Department of Health Care Services
DME	Durable Medical Equipment
DMHC	Department of Managed Health Care
DOS	Date of Service
DPT	Days Per Thousand
DRG	Diagnosis Related Group
DX	Diagnosis Code
EAP	Employee Assistance Program

GLOSSARY

ECM	Enhanced Care Management
EOB	Explanation of Benefits
EOM	End of Month
EPO	Exclusive Provider Organization
ER	Emergency Room
ERISA	Employee Retirement Income Security Act of 1974
FFS	Fee for Service
FMTB	Federal Means Tested Benefit
FQHC	Federally Qualified Health Center
GHAA	Group Health Association of America
HCC	Hierarchical Condition Category
HCCN	Health Center Controlled Network
HCFA	Health Care Financing Administration
HCPCS	HCFA Common Procedural Coding System
HEIDIS	Health Plan Employer Data and Information Set
HHS	(Department) Health and Human Services
HMO	Health Maintenance Organization
HRA	Health Risk Assessment
IBNR	Incurred but not Reported
ICD-10-CM	International Classification of Diseases, 9th ed. (Clinical Modification)
IHA	Initial Health Assessment
ILOS	In Lieu of Services
IPA	Independent Physician Association
JCAHO	Joint Commission of Accredited Hospitals
LOS	Length of Stay
LPR	Legal Permanent Resident
MAC	Maximum Allowable Cost

GLOSSARY

MCE	Medi-Cal Expansion
MCR	Modified Community Rating
MD	Medical Doctor
MESH	Medical Staff Hospital Joint Venture
MH/CD	Mental Health/Chemical Dependency
MPM	MedPOINT Management
NCQA	National Committee on Quality Assurance
NON-PAR	Non-Participating Provider
NPN	Non-Participation not Approved
OOA	Out of Area
OOPS	Out of Pocket Expenses
P&T	Pharmacy and Therapeutics Committee
PAC	Pre-Admission Certification
PAR	Participation Provider
PC	Public Charge
PCP	Primary Care Physician
PCPM	Per Contact per Month
PCR	Physician Contingency Reserve
PEC	Pre-existing Condition
PMG	Primary Medical Group
PMPM	Per member per month
PMPY	Per member per year
POS	Point of Sale or Point of Service
PPACA	Patient Protection and Affordable Care Act
PPO	Preferred Provider Organization
PRO	Professional (or peer) review Organization
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act
PSRO	Professional Standards Review Organization
QA	Quality Assurance
QM	Quality Management
QMB	Qualified Medicare Beneficiary
R&C	Reasonable and Customary

GLOSSARY

RAF	Risk Adjustment Factor
RBRVS	Resource Based Relative Value Scale
RFP	Request for Proposal
RPI	Registered Provisional Immigrant
SIC	Standard Industry Code
SNAP	Supplemental Nutrition Assistance Program
SPD	Seniors and People with Disabilities
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TPA	Third Party Administrator
U&C	Usual and Customary
UCR	Usual Customary and Reasonable
UM	Utilization Management
UR	Utilization Review
UR/QA	Utilization Review/Quality Assurance
YTD	Year to Date

MANAGED CARE DEFINITIONS

For a comprehensive list of up-to-date Managed Care Definitions, please visit the helpful links below:

Link to DHMC Useful Terms:

Useful Terms (ca.gov)

Link to DHS Managed Care Definitions PDF:

Managed Care Definitions