2023

HCLA PROVIDER MANUAL

Health Care LA, IPA

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Welcome

Welcome to Health Care LA, 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 keyword.
3. Press Enter.

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

Periodically, you will receive materials 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: HCLA_ProviderServices@medpointmanagement.com

Important Information About the Use of This Manual

If there is a conflict between your Agreement and this provider manual, use this manual unless your Agreement states you should use it, instead. If there is a conflict between your Agreement, this manual, and applicable federal and state statuses and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. Health Care LA, IPA (HCLA) 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 Health Care LA, IPA website at: healthcarela.org for more information.

For questions, or to follow up on a previously submitted application, please contact HCLA's Executive Director, Iris Weil at: iweil@healthcarela.org.

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 and Spanish Press 2, select Option 1 for Provider access then select your department below.

Provider Network Operations

Phone: 866-423-0060, Option 5
HCLA_ProviderServices@medpointmanagement.com
Provider Network Operations is responsible for the oversight of all its contracted providers. Our responsibilities include educating and training your staff, updating facility data, and resolving provider issues and complaints.

Referrals and Authorizations

Phone: 866-423-0060, Option 2
Providers are encouraged to use the MPM Provider 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 are also attached to the web profile.
Provider Network Operations is available 9 a.m. – 5 p.m. weekdays Pacific Time (PT) except for major holidays.

MedPOINTManagement.com

Visit the MPM webpage for Provider Resources and access the MPM Provider 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:

MPM Provider Web Portal 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 Provider 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.

Claims Inquiry

Phone: 866-423-0060, Option 3
Claims history and status can be viewed through the MPM Provider 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 Provider Web Portal.

Claims Submission Electronic

Office Ally
Payer ID: MPM06
To set up an account with Office Ally, contact them at 866-575-4120 or visit: Office Ally Registration

Provider Dispute Resolution

Phone: 866-423-0060, Option 3

For appeals or requests for reconsideration of the 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:

Health Care, LA IPA

Attn: PDRs

P.O. Box 570590 Tarzana, CA 91357

Credentialing

Phone: 866-423-0060, Option 4

Our Credentialing team, in conjunction with the Quality Management team, facilitates and monitors the Provider credentials verification process. This includes initial credentialing and recredentialing every 3 years.

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

HCLA_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:

Health Care LA, IPA

Attn: Compliance Officer

P.O. Box 570590 Tarzana, CA 91357

Section 1: Introduction

Through our management company, MedPOINT Management, Health Care LA, IPA (HCLA) provides comprehensive management services to a network of Federally Qualified Health Centers (FQHCs) and Community Health Centers (CHCs) on a personalized approach. Health Care LA, IPA provides services to managed care lives in Los Angeles County.

How to Join Our Network

For instructions on joining the Health Care LA, 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 several 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 in 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 the 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, Authorizations, or Eligibility
- Receive Alerts from MPM

PROVIDER NETWORK OPERATIONS

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

Contact the Provider Network Operations team 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 demographic changes, please email the appropriate distribution group below:

Requested Update	PCP	Specialty/Ancillary
Adding a New Provider	PNOApplication@medpointmanagement.com HCLA_ProviderServices@medpointmanagement.com	LOI@medpointmanagement.com HCLA_ProviderServices@medpointmanagement.com
Demographic Updates	HCLA_ProviderServices@medpointmanagement.com DemographicsUpdates@medpointmanagement.com	HCLA_ProviderServices@medpointmanagement.com DemographicsUpdates@medpointmanagement.com
TIN/Business Changes	Contracts_Amendments@medpointmanagement.com HCLA_ProviderServices@medpointmanagement.com	Contracts_Amendments@medpointmanagement.com HCLA_ProviderServices@medpointmanagement.com
Terminations	HCLA_ProviderServices@medpointmanagement.com	Contracts_Amendments@medpointmanagement.com HCLA_ProviderServices@medpointmanagement.com

Section 2: Network and Affiliates

CONTRACTED HEALTH PLANS

Health Care LA, IPA provides primary care services comprised of Community Clinics and FQHCs in Los Angeles County. Here is a list of contracted Health Plans, by line of business, along with contact information.

HEALTH PLANS	MEDI- CAL	MEDICARE	MEDI- MEDI	COVERED CALIFORNIA	EAE D-SNP	COMMERCIAL	POS
Alignment Health Plan*		✓	✓				
Anthem Blue Cross*	✓	✓	✓	✓		✓	✓
Blue Shield of California*		✓				✓	✓
Blue Shield of California Promise Health Plan*	✓		✓		✓		
Brand New Day*		✓	✓				
Cigna*						✓	✓
Health Net**	✓**	✓*	✓*	✓**	✓*	✓*	✓*
L. A. Care Health Plan*	✓			✓	✓		
Molina Healthcare**	✓	✓		✓	✓		

*Enrollment assigned at Individual Provider Level **Enrollment assigned at the Health Center and Site Level

HEALTH PLAN CONTACT INFORMATION		
Alignment Health Plan	844-361-4712	www.alignmenthealthplan.com
Anthem Blue Cross	800-331-1476	www.anthem.com
Blue Shield of California	800-541-6652	www.blueshieldca.com
Blue Shield of California Promise Health Plan	855-699-5557 Medi-Cal 855-905-3825 EAE D-SNP	www.blueshieldca.com/promise
Brand New Day	866-255-4795	www.bndhmo.com
Cigna	800-997-1654	www.cigna.com
Health Net	800-929-9224	www.healthnet.com
L.A. Care Health Plan	866-522-2736	www.lacare.org
Molina Healthcare	855-322-4075	www.molinahealthcare.com

CONTRACTED HEALTH PLANS

FULL RISK CONTRACTS VS. SHARED RISK CONTRACTS	
Dual/Full Risk Plan	Both the hospital and the IPA are capitated. The hospital and IPA share any savings remaining in the hospital capitation pool. Deficits are carried forward. ▪ Anthem Blue Cross (California Hospital POD only) ▪ Health Net (Medi-Cal)
IPA Risk	The IPA is capitated by the health plan for professional medical services. There is no Hospital Savings Pool established ❖ Molina Healthcare
Shared Risk	Under this model, the IPA is capitated for professional medical services. The Health Plan is financially responsible for the hospital services. There is a Hospital Savings Pool established between the Health Plan and the IPA. The IPA receives a portion of the savings remaining in the pool on an annual basis. Deficits are carried over to the next year. All other Plans (see Health Plan Affiliates)

FAQ – WHAT HOSPITAL CAN I REFER MY PATIENTS TO?	
Dual/Full Risk Plan	(Anthem Blue Cross, Health Net, Medi-Cal) Any hospitalization or out-patient surgical procedure must be directed to capitated hospital* ❖ California Hospital ❖ Valley Presbyterian Capitated Hospital is based on PCP/Health Center Hospital POD linkage. *It is best to refer patients to a specialist with privileges at members assigned capitated hospital
IPA Risk	Any hospital contracted with Health Plan (see Health Plan contracted hospital matrix)* *It is best to refer patients to a specialist with privileges at a health plan contracted hospital

HEALTH PLAN AFFILIATIONS

NAME OF HMO	TYPE OF CONTRACT
Alignment Health Plan: Shared Risk Contract, Enrollees can go to any Alignment Health Plan contracted and HCLA Affiliated Hospital	HMO: Medicare
Anthem Blue Cross: Dual/Full Risk for California Hospital POD. POD LINKAGE IS BASED ON GEOGRAPHIC LOCATION OF PCP. IPA Risk Contract all other areas, Enrollees can go to any Anthem Blue Cross contracted and HCLA Affiliated Hospital	HMO: Medi-Cal, Medicare, Covered California, Commercial and POS
Blue Shield of California: Shared Risk Contract, Enrollees can go to any Blue Shield contracted and HCLA Affiliated Hospital	HMO: Commercial, Medicare and POS
Blue Shield of California Promise Health Plan: (formerly Care 1st) Shared Risk Contract, Enrollees can go to any Blue Shield Promise Health Plan contracted and HCLA-affiliated Hospital	HMO: EAE D-SNP, Medi-Cal, and Medi-Medi
Brand New Day: Shared Risk Contract, Enrollees can go to any Brand New Day contracted and HCLA Affiliated Hospital	HMO: Medicare and Medi-Medi
Cigna: Shared Risk Contract, Enrollees can go to any Cigna contracted and HCLA affiliated Hospital	HMO: Commercial and POS

HEALTH PLAN AFFILIATIONS

NAME OF HMO	TYPE OF CONTRACT
Health Net: **Commercial, Covered California, Medicare, Medi-Medi & EAE D-SNP:** Shared Risk Contract, Enrollees can go to any Health Net contracted and HCLA Affiliated Hospital **Medi-Cal:** Full Risk contract. Hospital is capitated for Health Net Medi-Cal Enrollees. Members must be referred to **California Hospital, or Valley Presbyterian Hospital.** HOSPITAL LINKAGE IS BASED ON GEOGRAPHIC LOCATION OF THE PCP. A Shared Risk Contract is in place for service areas with no Capitated Hospital Partner.	HMO: Commercial, POS, Covered California, EAE D-SNP, Medi-Cal, Medicare, and Medi-Medi. **Medi-Cal Capitated Hospitals:** **California Hospital, and Valley Presbyterian** (Some Clinics are shared risk due to no geographically suited partner Hospital) See crosswalk.)
L.A. Care Health Plan: Shared Risk Contract, Enrollees can go to any L.A. Care Health Plan contracted and HCLA Affiliated Hospital	HMO: EAE D-SNP, Covered California and Medi- Cal
Molina Healthcare: IPA Risk Contract, Enrollees can go to any Molina Healthcare contracted and HCLA, IPA Affiliated Hospital.	HMO: EAE D-SNP, Covered California, Medi-Cal, and Medicare

AFFILIATED HOSPITALS

HOSPITAL AFFILIATIONS		
Alta Hospitals:	Hollywood Presbyterian Medical Center	• St. Joseph Medical Center
• Los Angeles Community	Martin Luther King Jr. Community Hospital	San Gabriel Valley Medical Center
• Norwalk Community	Memorial Care Health System:	Southern California Hospital
Centinela Hospital Medical Center	• Community Hospital of Long Beach	• Culver City (formerly Brotman Medical Center)
Emanate Health:	• Long Beach Memorial Medical Center	• Hollywood (formerly Hollywood Community)
• Foothill Presbyterian	• Miller Children's Hospital Long Beach	• Van Nuys
• Inter-community Campus	Olive View – limited scope of services	St. Francis Medical Center
• Queen of the Valley	Pomona Valley Hospital	**Valley Presbyterian Hospital ***
Dignity Health Hospitals:	Providence Health & Sciences:	White Memorial Medical Center
• **California Hospital Medical Center ***	• Holy Cross Medical Center	Legend:
• St. Mary Medical Center Long Beach	• Little Company of Mary	*** Full Risk Partners for Medi-Cal Enrollees**

Hospitals contracted with the IPA for ancillary services will show on the Specialty Provider Listing under the "Hospital" category. For outpatient surgeries and inpatient referrals, the Hospital must be contracted with the enrollee's Health Plan. This rule does not apply to ER referrals. Enrollees should be referred to closest ER when medically indicated.

Updated Provider Listings are available upon request. E-mail Provider Network Operations: HCLA_ProviderServices@medpointmanagement.com

AFFILIATED HOSPITAL LISTING BY HEALTH PLAN/PRODUCT LINE

	MEDI-CAL					MEDICARE					COMMERCIAL				COVERED CALIFORNIA			EAE D-SNP				
HEALTH CARE LA	ANTHEM BLUE CROSS	BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN	HEALTH NET	L A CARE	MOLINA HEALTHCARE	ALIGNMENT HEALTH	BLUE SHIELD	BRAND NEW DAY	HEALTH NET	MOLINA HEALTHCARE	ANTHEM BLUE CROSS	BLUE SHIELD	CIGNA	HEALTH NET	HEALTH NET	L A CARE	MOLINA HEALTHCARE	BLUE SHIELD PROMIS	HEALTH NET	L A CARE	MOLINA HEALTHCARE	IPA ANCILLARY AGREEMENT
CALIFORNIA HOSPITAL MEDICAL CENTER	Y-FR	Y-SR	Y-FR	Y-SR	N	Y-SR	N	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	N	N	Y-SR
CENTINELA HOSPITAL MEDICAL CENTER (PRIME)	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	Y-SR	N	N	N	N	N
EMANATE HEALTH - FOOTHILL PRESBYTERIAN	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR
EMANATE HEALTH - INTERCOMMUNITY	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR
EMANATE HEALTH - QUEEN OF THE VALLEY	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR
GLENDALE MEMORIAL HOSPITAL	Y-SR	Y-SR	N	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	N	N	Y-SR
HOLLYWOOD PRESBYTERIAN MEDICAL CENTER	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR
LONG BEACH MEMORIAL MEDICAL CENTER	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR
LOS ANGELES COMMUNITY HOSPITAL - LOS ANGELES (ALTA)	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	N	N	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	N	N	Y-SR	N
LOS ANGELES COMMUNITY HOSPITAL - NORWALK (ALTA)	N	Y-SR	N	Y-SR	Y-SR	N	N	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	N
MARTIN LUTHER KING, JR. COMMUNITY HOSPITAL	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	N
MEMORIAL HOSPITAL OF GARDENA (AVANTI)	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR
MILLER CHILDREN'S HOSPITAL	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	N	N	Y-SR	Y-SR	Y-SR	N	Y-SR	N	Y-SR	Y-SR	N	N	Y-SR	Y-SR	N
POMONA VALLEY HOSPITAL MEDICAL CENTER	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	N	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	N	N	N	N
PROVIDENCE HOLY CROSS MEDICAL CENTER	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	N
PROVIDENCE LITTLE COMPANY OF MARY (SAN PEDRO)	Y-SR	Y-SR	N	Y-SR	Y-SR	N	Y-SR	N	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	Y-SR	N	Y-SR	Y-SR	Y-SR
PROVIDENCE LITTLE COMPANY OF MARY (TORRANCE)	N	N	N	Y-SR	N	N	Y-SR	N	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	N	Y-SR	Y-SR	N	N
PROVIDENCE SAINT JOHN'S MEDICAL CENTER	N	N	Y-SR	Y-SR	N	N	Y-SR	N	N	N	Y-SR	Y-SR	Y-SR	N	N	Y-SR	N	N	N	Y-SR	N	N
PROVIDENCE SAINT JOSEPH MEDICAL CENTER	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	N	Y-SR	N	Y-SR	Y-SR	Y-SR
PROVIDENCE TARZANA MEDICAL CENTER	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	Y-SR	Y-SR	Y-SR
SAN GABRIEL VALLEY MEDICAL CENTER (AHMC)	N	Y-SR	N	Y-SR	N	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N
SOUTHERN CA HOSP AT CULVER CITY	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N
SOUTHERN CA HOSP AT HOLLYWOOD	N	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	N
ST FRANCIS MEDICAL CENTER	Y-FR	Y-SR	Y-FR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR
ST MARY MEDICAL CENTER	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	N	Y-SR	N	N	N
VALLEY PRESBYTERIAN HOSPITAL	Y-FR	Y-SR	Y-FR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	N	Y-SR
WHITE MEMORIAL MEDICAL CENTER	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N
LIMITED AFFILIATION																						
ADVENTIST HEALTH GLENDALE	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N
ALHAMBRA HOSPITAL (AHMC)	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	
ANTELOPE VALLEY HOSPITAL	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	N	N	N	Y-SR	Y-SR	N	N	Y-SR	N	Y-SR	N	Y-SR	N	
ADVENTIST HEALTH WHITE MEMORIAL - MONTEBELLO	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	N
COLLEGE MEDICAL CENTER- LONG BEACH	N	N	N	N	N	N	Y-SR	N	N	N	Y-SR	N	N	N	N	N	N	N	N	N	N	N
GARFIELD MEDICAL CENTER (AHMC)	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	N
GOOD SAMARITAN HOSPITAL (PRIME)	Y-SR	Y-SR	N	Y-SR	N	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	N	Y-SR	Y-SR	Y-SR	N	N
GREATER EL MONTE MEDICAL CENTER (AHMC)	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	N
HENRY MAYO NEWHALL	Y-SR	N	N	N	N	N	Y-SR	N	Y-SR	N	Y-SR	Y-SR	Y-SR	N	N	N	N	N	Y-SR	N	N	Y-SR
HUNTINGTON MEMORIAL HOSPITAL	Y-SR	N	N	Y-SR	N	N	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	N	N	Y-SR	N	N	N	Y-SR	N	N
METHODIST HOSPITAL	N	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	N	Y-SR	N	N	Y-SR	Y-SR	N	N	Y-SR	Y-SR	
MISSION COMMUNITY HOSPITAL	Y-SR	Y-SR	N	N	N	N	Y-SR	Y-SR	Y-SR	N	Y-SR	N	N	N	N	N	N	N	N	N	N	Y-SR
MONTEREY PARK HOSPITAL (AHMC)	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N
NORTHRIDGE HOSPITAL MEDICAL CENTER	Y-SR	Y-SR	N	Y-SR	N	Y-SR	N	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	N	N	Y-SR	N	Y-SR	N	Y-SR	N	N
OLIVE VIEW MEDICAL CENTER	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	N	Y-SR	Y-SR	N	N	N	N	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	
PALMDALE REGIONAL MEDICAL CENTER	N	N	Y-SR	Y-SR	Y-SR	Y-SR	N	N	N	Y-SR	N	Y-SR	Y-SR	N	N	Y-SR	N	N	N	Y-SR	N	
SHRINERS HOSPITALS FOR CHILDREN	N	N	N	N	N	N	N	N	N	N	N	N	Y-SR	N	N	N	N	N	N	N	N	N
UCLA MEDICAL CENTER RONALD REGAN	Y-SR	N	N	Y-SR	N	N	N	N	N	N	Y-SR	Y-SR	Y-SR	N	N	N	N	N	N	N	N	N
UCLA MEDICAL CENTER	N	N	N	N	N	N	Y-SR	N	N	N	Y-SR	Y-SR	Y-SR	N	N	N	N	N	N	N	N	N

HOSPITALISTS

HCLA is contracted with Hospitalists that supervise care from admission through discharge at HEALTH CARE LA, 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 – 9 am and Weekends and Holidays, 24 hours at 866-423-0060

For a listing of contracted Hospitalists by facility, email Provider Network Operations at: HCLA_ProviderServices@medpointmanagement.com.

PHARMACY INFORMATION

For a listing of participating pharmacies, along with corresponding Formulary Information, please reference applicable Health Plan Web site and search for key words such as 'Pharmacy':

- **Alignment Health Plan**
  www.alignmenthealthplan.com
- **Anthem Blue Cross**
  www.anthem.com/ca
- **Blue Shield of California**
  www.blueshieldca.com
- **Blue Shield of California Promise Health Plan**
  Promise home | Blue Shield of CA (blueshieldca.com)
- **Brand New Day**
  bndhmo.com
- **Cigna**
  www.cignaforhcp.com
- **Health Net**
  Health Net Pharmacy | Health Net
- **L.A. Care**
  lacare.org
- **Molina Healthcare**
  www.molinahealthcare.com

CONTRACTED ANCILLARY PROVIDERS

LABORATORY

ALL MEMBERS MUST BE REFERRED TO: **QUEST DIAGNOSTICS - (866) 697-8378**
Lab work does not require prior authorization (except genetic testing). If you are not presently doing business with Quest, contact them at the number above to obtain requisition forms, etc.

QUEST IS ALSO THE EXCLUSIVE CONTRACTED PROVIDER FOR BRCA GENE TESTING
Lab costs for services associated with patient referrals to non-contracted lab, i.e., labs other than Quest, without formal prior authorization from the IPA, will be deducted from PCP Capitation.

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

DURABLE MEDICAL EQUIPMENT (DME)
IPA financial responsibility varies by Health Plan. Authorization request may be redirected based on contractual relationships when Health Plan or Hospital is financially responsible for DME.

CONTRACTED RADIOLOGY
Outpatient Radiology to be referred to IPA participating free standing Radiology facilities. Do not refer to Hospital Radiology Department for basic x-ray, ultrasound, mammogram, CT, MRI or Pet Scans.

*Exception: California Hospital Women's Health Center for Mammography.

URGENT CARE FACILITIES

For an online listing of urgent care facilities, please visit: Urgent Care - MedPoint Management

PROVIDER NAME	ADDRESS	TELEPHONE & FAX NUMBER	HOURS OF OPERATION
A.N.D. INC. URGENT CARE	6426 COLDWATER CANYON AVE. NORTH HOLLYWOOD, CA 91606	PHONE: (818) 927-4112 FAX: (818) 308-6351	Mon–Fri: 10:00 AM – 6:00PM Sat: 10:00 AM – 4:30 PM
BAYSIDE MEDICAL CENTER	2301 W EL SEGUNDO BLVD. HAWTHORNE, CA 90250	PHONE: (323) 757-2118 FAX: (323) 757-7503	Mon–Fri: 7:00 AM – 7:00 PM
DUSK TO DAWN URGENT CARE (GARDENA)	1045 W REDONDO BEACH BLVD. #138 GARDENA, CA 90247	PHONE: (310) 323-2273 FAX: (310) 324-2203	Mon–Fri: 9:00 AM – 9:00 PM Sat–Sun: 9:00 AM – 2:00 PM
DUSK TO DAWN URGENT CARE (INGLEWOOD)	323 N PRAIRIE AVE. SUITE 434 INGLEWOOD, CA 90301	PHONE: (310) 673-2273 FAX: (310) 673-2203	Mon–Fri: 9:00 AM – 9:00 PM Sat–Sun: 9:00 AM – 2:00 PM
DUSK TO DAWN URGENT CARE (LONG BEACH)	701 E 28TH ST. #401 LONG BEACH, CA 90806	PHONE: (562) 426-2662 FAX: (562) 426-2665	Mon–Fri: 9:00 AM – 9:00 PM Sat–Sun: 9:00 AM – 2:00 PM
DUSK TO DAWN URGENT CARE (LYNWOOD)	3680 E IMPERIAL HWY. #410 LYNWOOD, CA 90262	PHONE: (310) 639-2220 FAX: (310) 639-2221	Mon–Fri: 9:00 AM – 9:00PM Sat–Sun: 9:00 AM – 2:00 PM
DUSK TO DAWN URGENT CARE (MONTEBELLO)	709 NEW MARK MALL MONTEBELLO, CA 90640	PHONE: (888) 372-5536 FAX: (310) 673-2203	Mon–Fri: 9:00 AM – 9:00 PM Sat–Sun: 9:00 AM – 2:00 PM
DUSK TO DAWN URGENT CARE (PARAMOUNT)	15745 PARAMOUNT BLVD PARAMOUNT, CA 91723	PHONE: (562) 808-2273 FAX: (562) 808-2203	Mon–Fri: 9:00 AM – 12:00 AM Sat–Sun: 9:00 AM – 6:00 PM
ELITE PROVIDER URGENT CARE NETWORK	201 S ALVARADO ST # 100 LOS ANGELES, CA 90057	PHONE: (213) 989-1900 FAX: (213) 989-1923	Mon–Fri: 1:00 PM – 10:00 PM Sat: 9:00 AM – 5:00 PM Sun: CLOSED
ENCINO URGENT CARE	20011 VENTURA BLVD # 1002 WOODLAND HILLS, CA 91364	PHONE: (818) 708-6163 FAX: (818) 340-5537	Mon–Fri: 9:00 AM – 6:00 PM Sat: 9:00 AM – 2:00 PM Sun: CLOSED
EXPRESS CARE (MAYFLOWER MED GROUP)	1433 N HOLLENBECK AVE # 200 COVINA, CA 91722	PHONE: (626) 331-2209 FAX: (626) 967-1410	Mon–Fri: 12:00 PM – 8:00 PM
GLENOAKS URGENT CARE MEDICAL GROUP	1100 W GLENOAKS BLVD. GLENDALE, CA 91202	PHONE: (818) 242-3333 FAX: (818) 546-1056	Mon–Fri: 9:00 AM – 8:00 PM Sat–Sun: 9:00 AM – 5:00 PM
HENRY MAYO NEWHALL HOSPITAL	23845 MCBEAN PKWY VALENCIA, CA 91355	PHONE: (661) 253-8773 FAX: (661) 253-8071	Mon-Sun: 10:00 AM – 10:00 PM
QUICK STOP URGENT CARE – LOS ANGELES	1455 N LA BREA AVE LOS ANGELES, CA 90028	PHONE: (323) 798-5158 FAX: (323) 798-4914	Mon–Fri: 9:00 AM – 9:00 PM Sat–Sun: 9:00 AM – 6:00 PM
QUICK STOP URGENT CARE - PASADENA	215 N ALLEN AVE PASADENA, CA 91106	PHONE: (323) 798-5158 FAX: (855) 806-1554	Mon–Fri: 9:00 AM – 9:00 PM Sat–Sun: 9:00 AM – 6:00 PM
RELIANT IMMEDIATE CARE MEDICAL GROUP – FRANCISCO	814 FRANCISCO ST #101 LOS ANGELES, CA 90017	PHONE: (310) 491-7070 FAX: (310) 491-7071	Mon-Fri: 7:00 AM – 1:30 AM Sat-Sun: 7:00 AM – 11:00 PM Wed. CLOSED
RELIANT IMMEDIATE CARE MEDICAL GROUP – MONTEBELLO	2300 W BEVERLY BLVD # 108 MONTEBELLO, CA, 90640	PHONE: (626) 467-0202 FAX: (310) 491-7076	Mon-Fri: 8:00 AM – 9:00 PM Sat-Sun: 10:00 AM – 5:00 PM
RELIANT IMMEDIATE CARE MEDICAL GROUP – PACIFIC	5900 PACIFIC BLVD HUNTINGTON PARK, CA, 90255	PHONE: (310) 491-7080 FAX: (310) 491-7081	Mon-Fri: 8:00 AM – 10:00 PM Sat-Sun: 10:00 AM – 5:00 PM

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
- Ingestions of poison, or medicine overdose

Please call 911 if your condition is life threating.

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. Click here for a list of nurse advice lines by health plan.

To obtain card stock supply, please contact Jenny Laporte via e-mail: JLaporte@medpointmanagement.com.

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
- Ingest the ión de veneno ó sobredosis de medicina

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

¿Cuándo debo llamar al médico para pedir consejo?
¡Siempre! Por ejemplo, condiciones tales como, fiebres superiores a 102°, dolor abdominal, dolores de cabeza, acidez estomacal, indigestión, estreñimiento, hemorroides, dolor de espalda. Si llama al consultorio de su médico después del horario de trabajo, puede pedir hablar con el médico de guardia.

¿Qué debo hacer si el consultorio de mi médico no puede ayudarme?
Comuníquese con la línea de asesoramiento de enfermería las 24 horas de su plan de salud. Haga clic aquí para obtener una lista de líneas de asesoramiento de enfermería por plan de salud.

To obtain card stock supply, please contact Jenny Laporte via e-mail: JLaporte@medpointmanagement.com.

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 Health Care LA, 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:

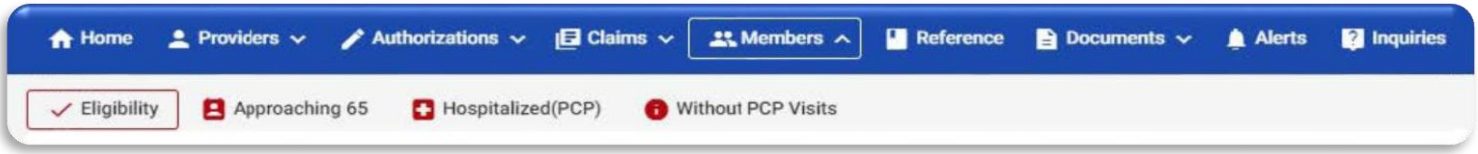
- Tax Identification Number
- National Provider Identifier
- Provider Fax Number (for call to fax IVR)
- Member Identification Number
- Member Date of Birth

Please refer to the list below for the Health Plan IVR Line:

HEALTH PLAN	IVR
Alignment Healthcare	888-517-2247
Anthem Blue Cross	800-677-6669
Blue Shield of California	800-424-6521
Blue Shield of California Promise Health Plan	800-605-2556
Brand New Day	866-255-4795
Cigna	800-882-5562
Health Net	877-857-0701
Health Net (Covered CA)	888-926-2164
L.A. Care Health Plan	866-522-2736
Molina Healthcare	800-357-0172

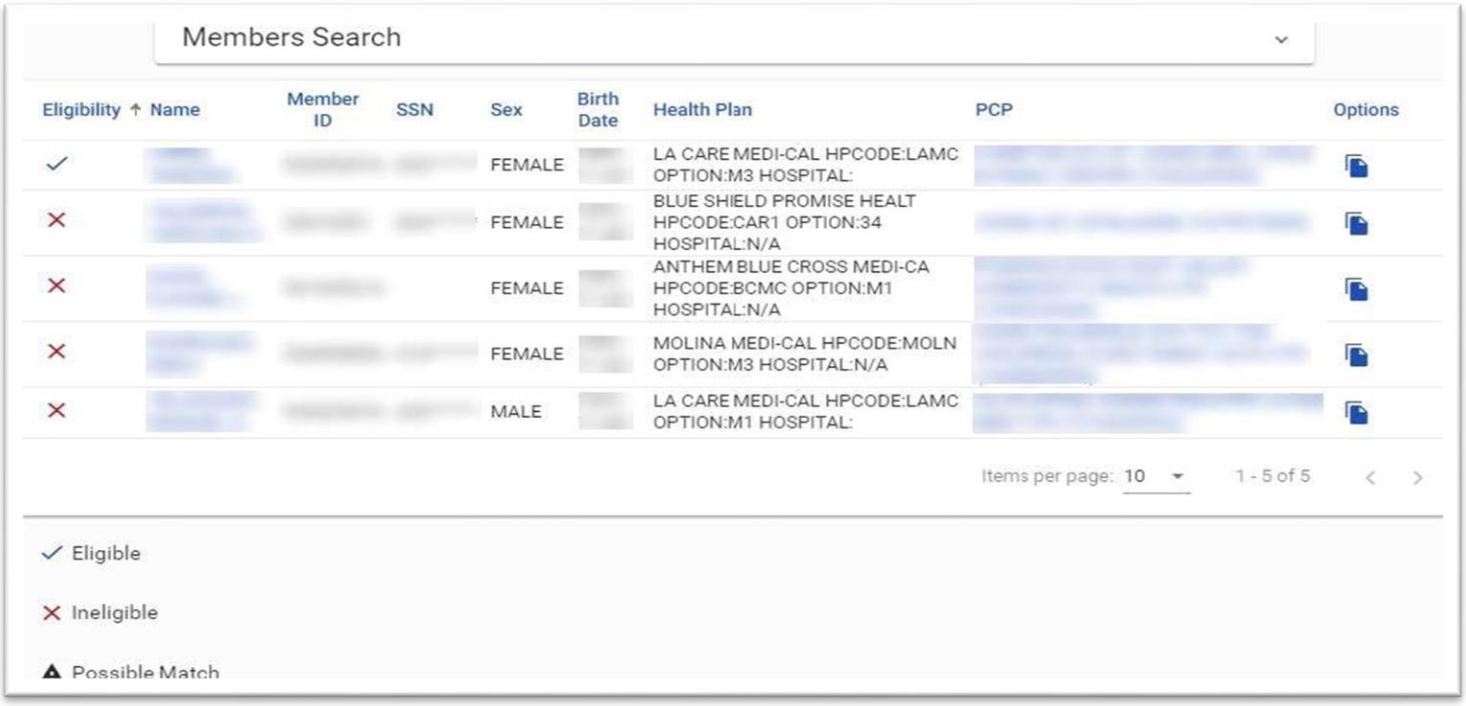
VERIFIYING ELIGIBILITY VIA THE WEB PORTAL

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 web 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 entering your search requirements, the results are populated.



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 will 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 referral or prior authorization from Health Care LA, IPA. As best practice, it is for important for providers to submit referrals and prior authorizations after a patient is examined and by the next business day.

1. Submit all authorization requests via the Health Care LA, IPA/MPM Portal at: MPM Provider Web Portal
   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 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 Network Operations 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 Provider Web Portal. Authorizations expire ninety 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) days.
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 of time 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 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 services.

CLINICAL GUIDELINES AND PROTOCOLS

The following outlines the clinical protocols and guidelines that are to be followed when submitting a request for prior authorization1. from Health Care LA, IPA.

1. The IPA has Clinical Protocols for all common specialties and these protocols include:
    a. Clinical indications for a specialty referral
    b. Recommended records needed with a referral submission

2. 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 MPM Provider Resources and titled, "Scope of PCP Care for Adults" or "Scope of PCP Care for Pediatrics".

3. The IPA 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.

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 HCLA'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 services.

LEVELS OF PRIORITY

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 Auth Requests via the MPM Portal as Routine and enter "Retro Auth Request" in Notes.

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.

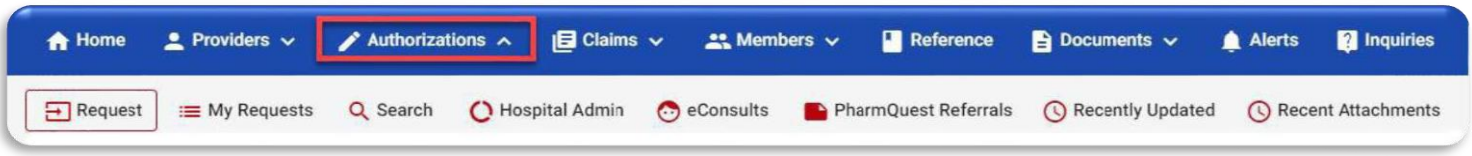
Error-Submitting a new request in response to a deferred request.
Solution- Do not enter a new request. Scan and attach the information to the original request.

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 contacting 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 Auth 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.



A) Request

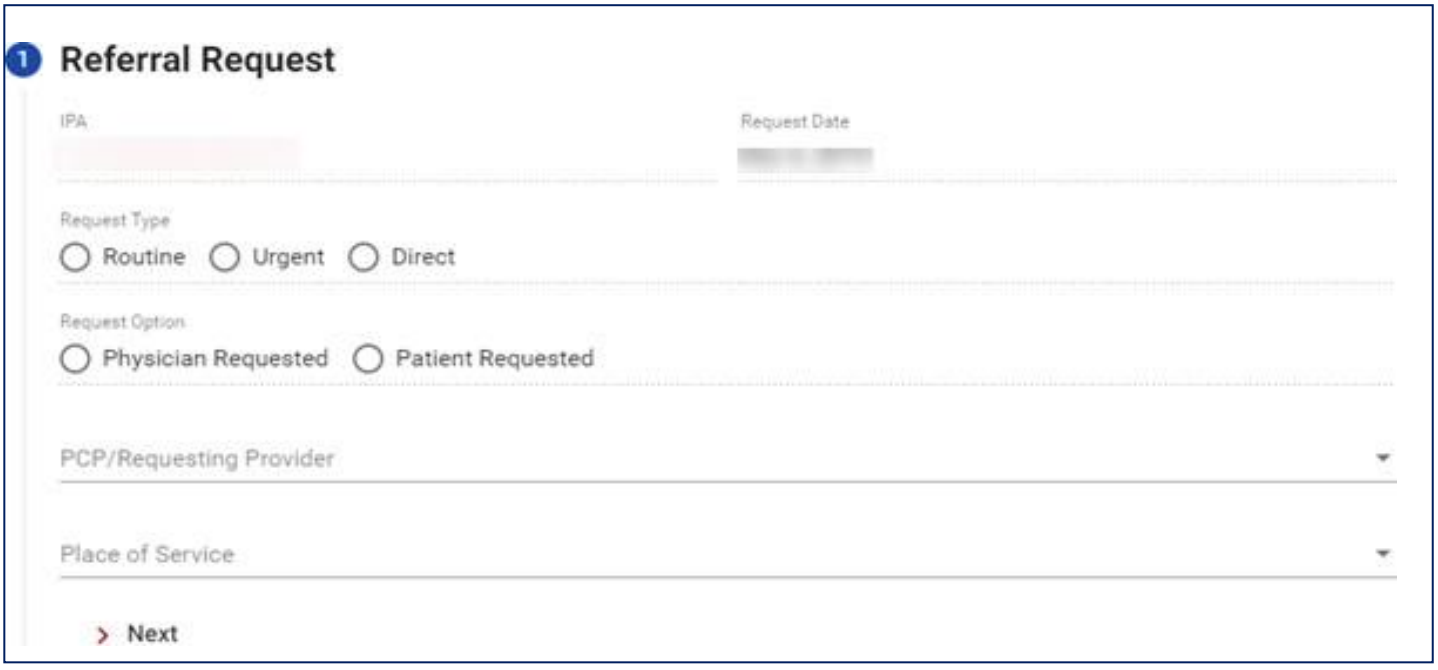
Note: For Inpatient & Outpatient Pre-Certification Authorization, we require two authorizations for pre-certification of inpatient/outpatient surgeries.

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

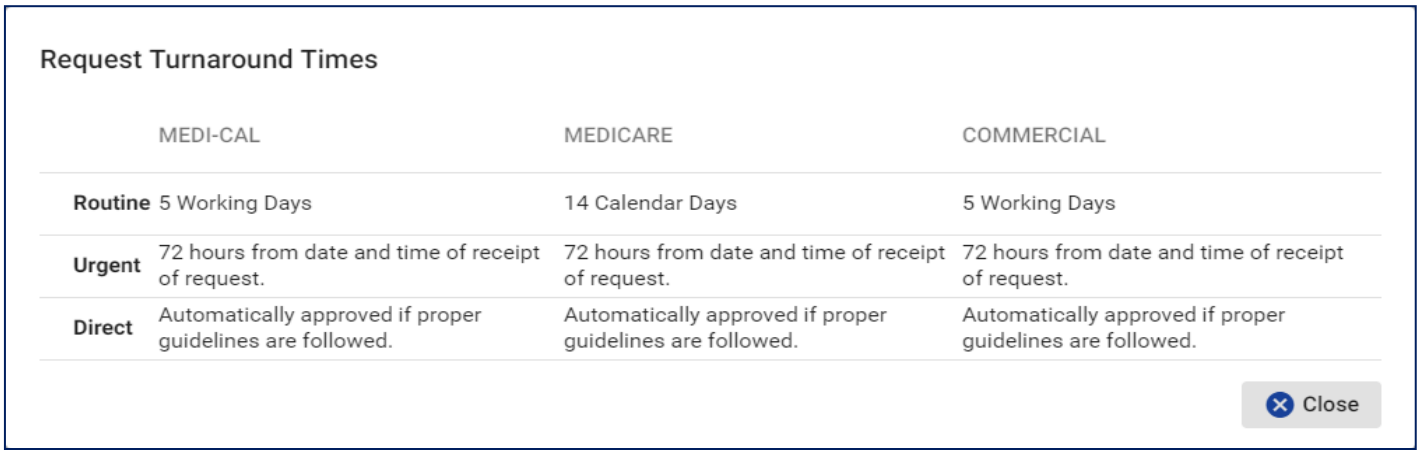
This is due to the services are being billed/paid by two separate entities. The hospital will also require their own approvals to identify services being rendered with each admission.

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:

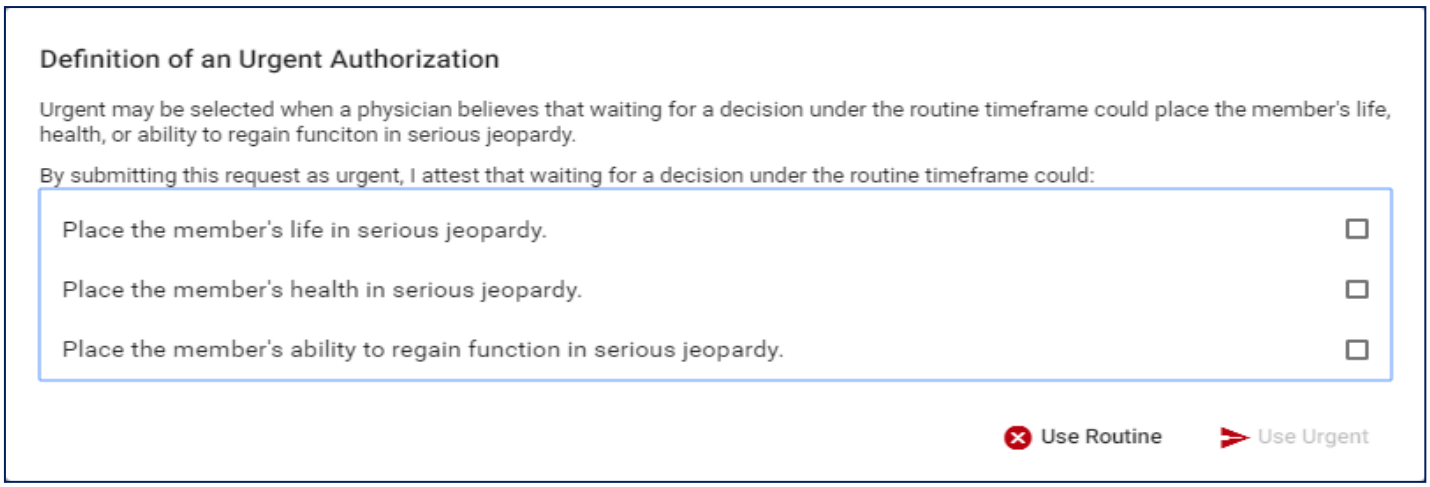


Request Turnaround Times

	MEDI-CAL	MEDICARE	COMMERCIAL
Routine	5 Working Days	14 Calendar Days	5 Working Days
Urgent	72 hours from date and time of receipt of request.	72 hours from date and time of receipt of request.	72 hours from date and time of receipt of request.
Direct	Automatically approved if proper guidelines are followed.	Automatically approved if proper guidelines are followed.	Automatically approved if proper guidelines are followed.

Close

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.



Definition of an Urgent Authorization

Urgent may be selected when a physician believes that waiting for a decision under the routine timeframe could place the member's life, health, or ability to regain funciton in serious jeopardy.

By submitting this request as urgent, I attest that waiting for a decision under the routine timeframe could:

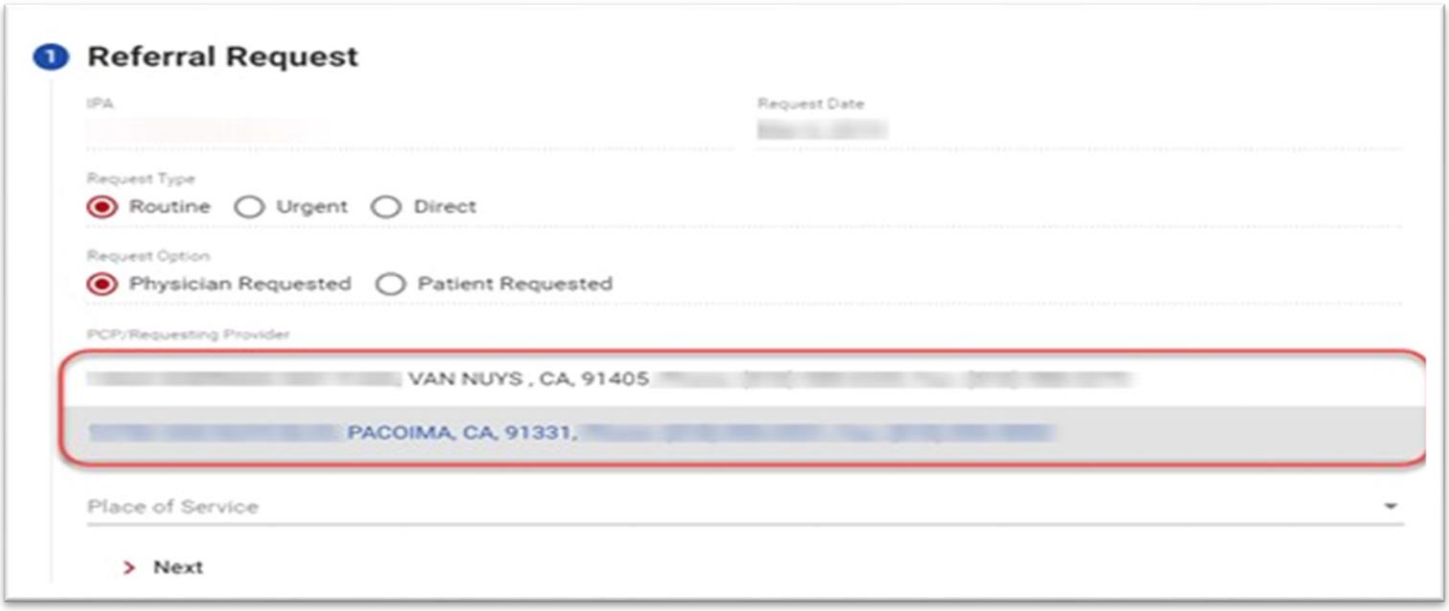
- Place the member's life in serious jeopardy. ☐
- Place the member's health in serious jeopardy. ☐
- Place the member's ability to regain function in serious jeopardy. ☐

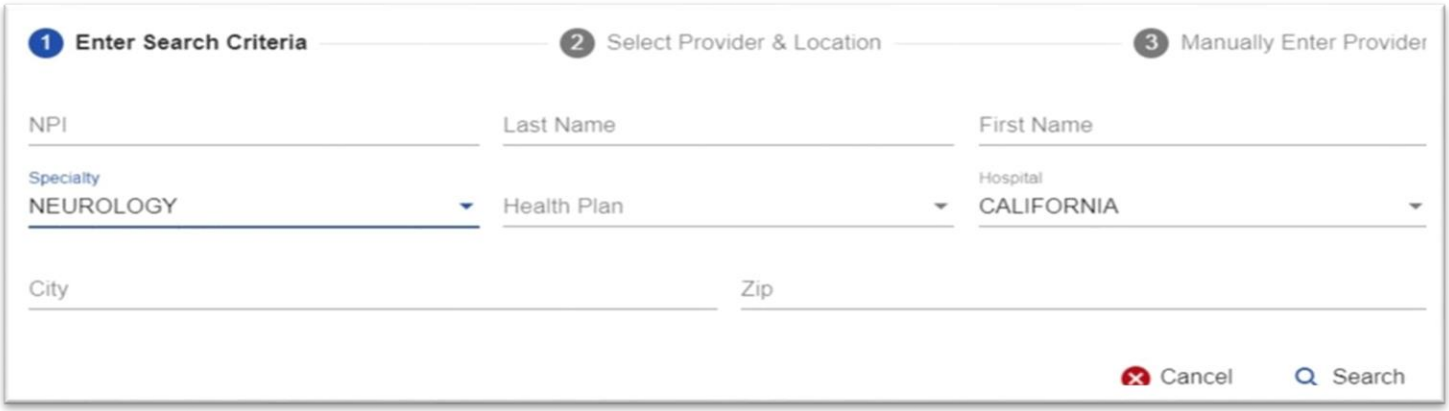
Use Routine Use Urgent

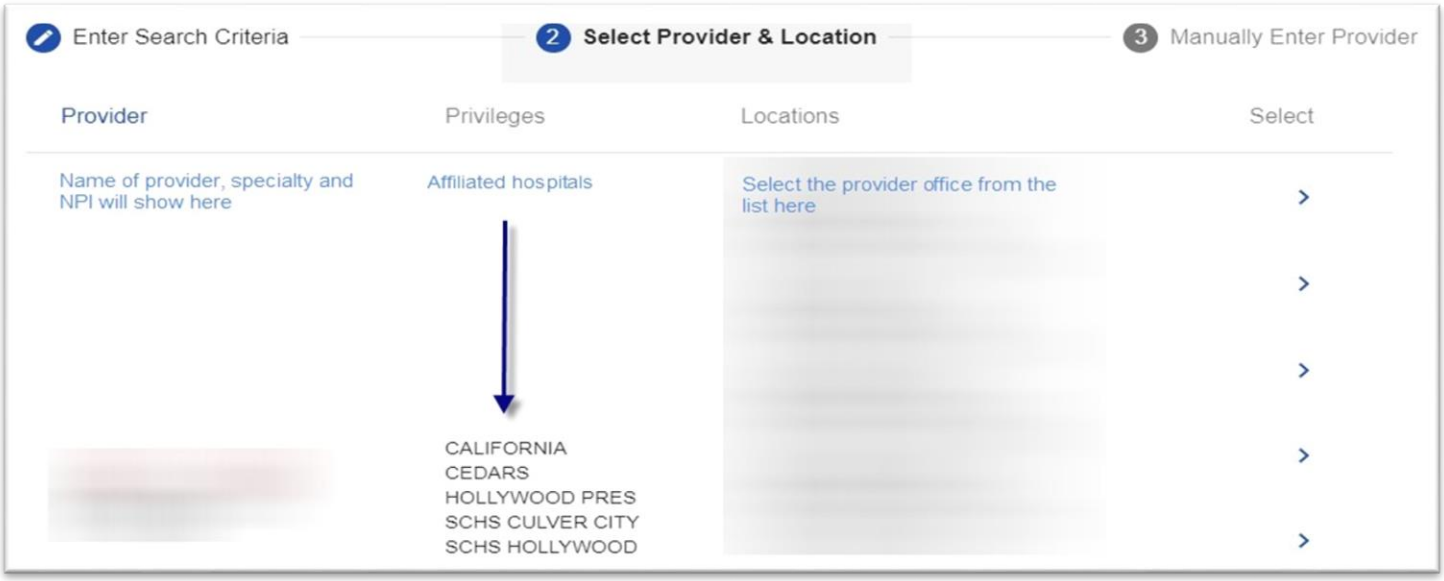
Request Option: Physician Requested or Patient Requested. PCP/Requesting Provider: Clicking on the drop down will provide you with a list of all Providers within your network.

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 of 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

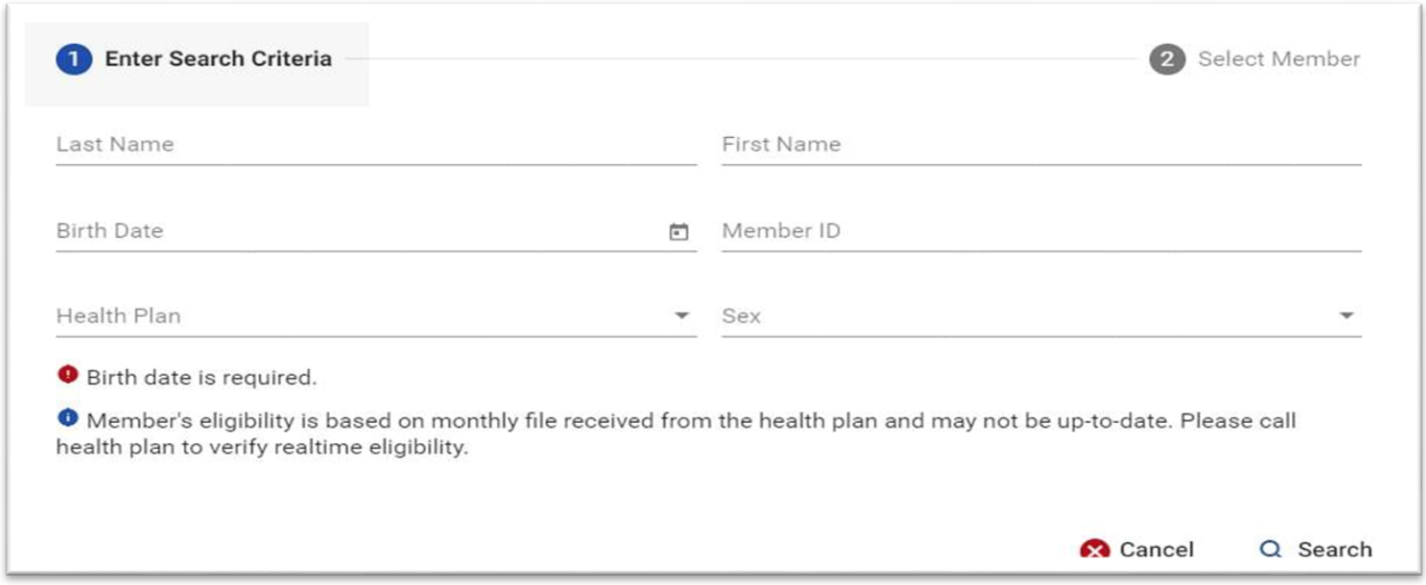
When a user selects an Organization as the PCP/requesting provider, a new field called Treating Provider will appear on the screen. The user will be required to enter the Treating provider information by entering the NPI number. Once the NPI is filled in, the provider's information will be populated 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.

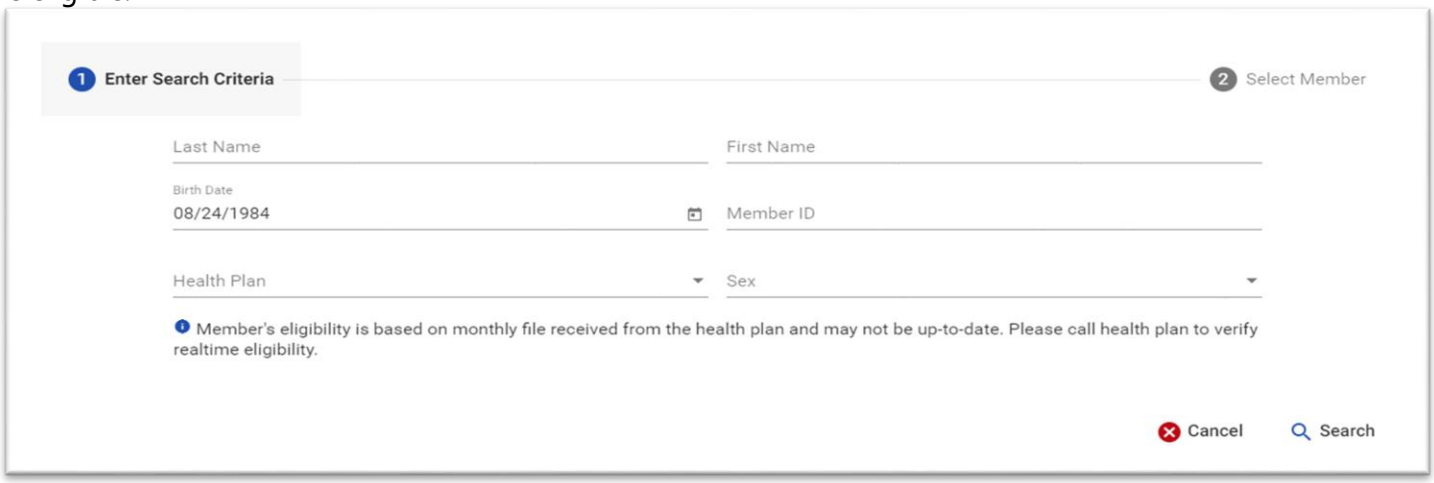
Step 2) Requesting Member

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.

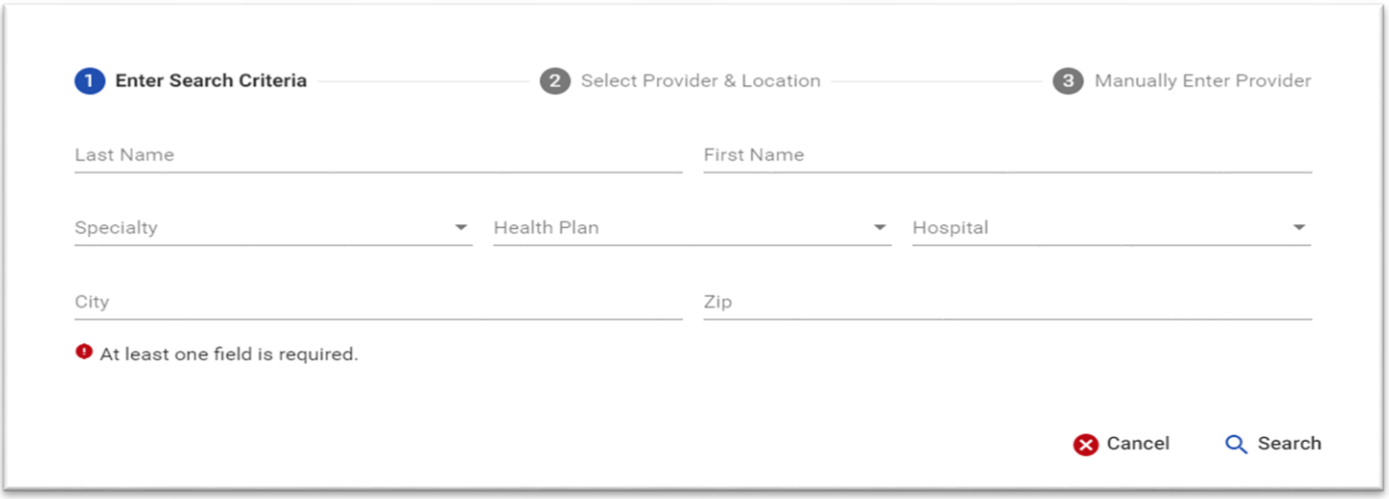


Click on the arrow under Select to add the member to the Authorization request.
Click on Next or Step 3 to proceed.

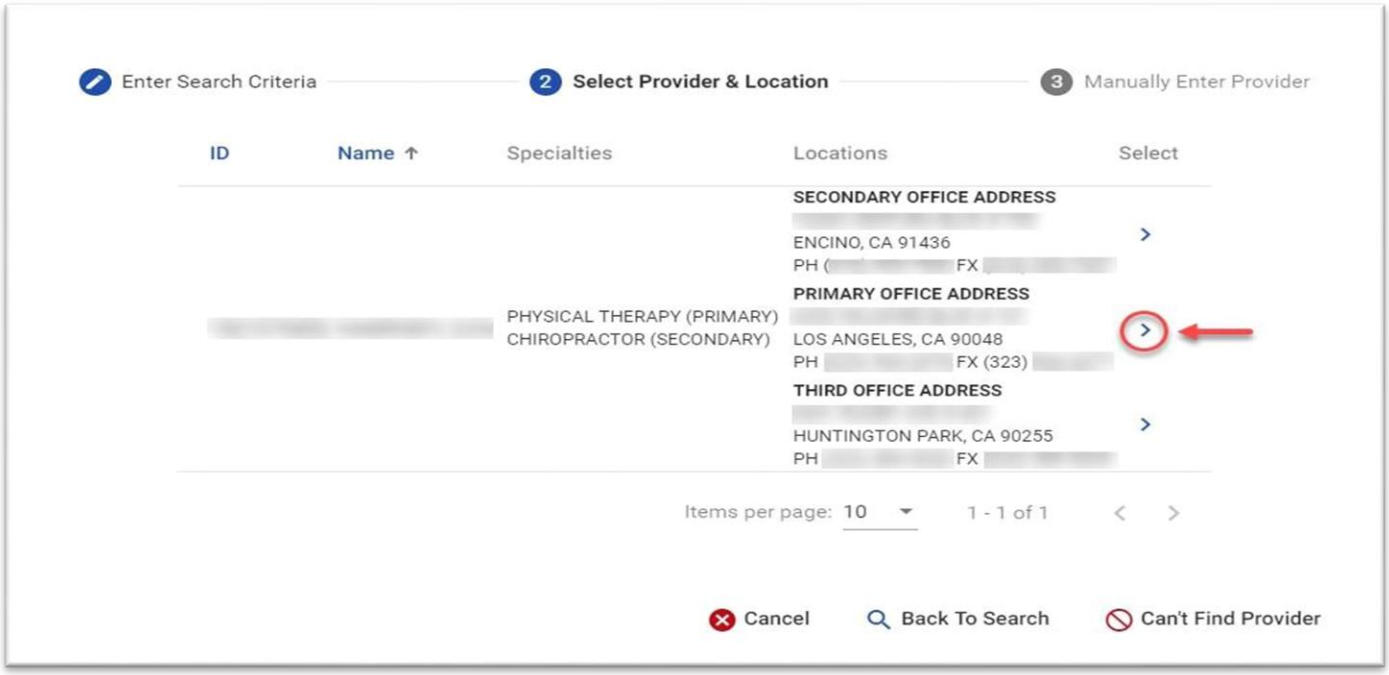
Step 3) Requested Provider

Select the Requested Provider in this section.

Click on 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.



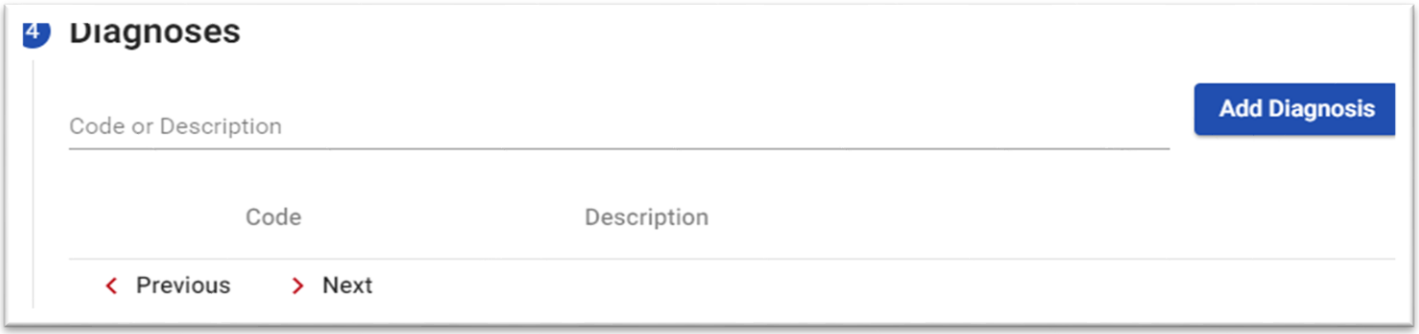
The Provider's information will now appear under Step 3.

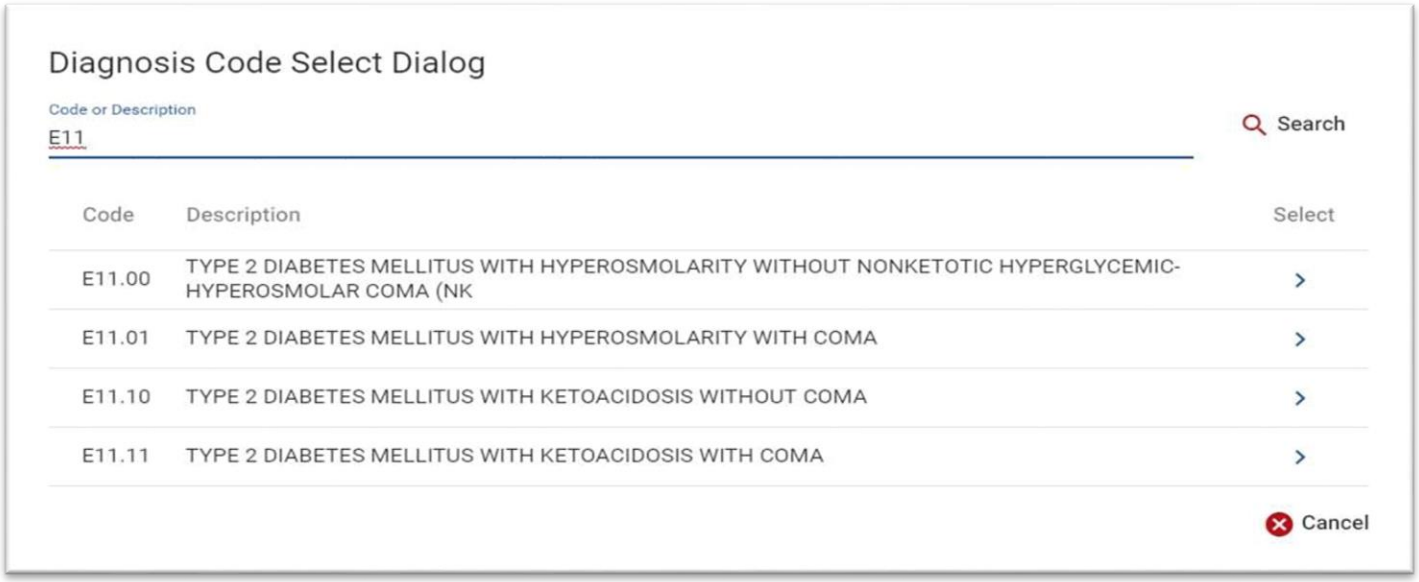
Click on Next or Step 4 to proceed.

Step 4) Diagnoses

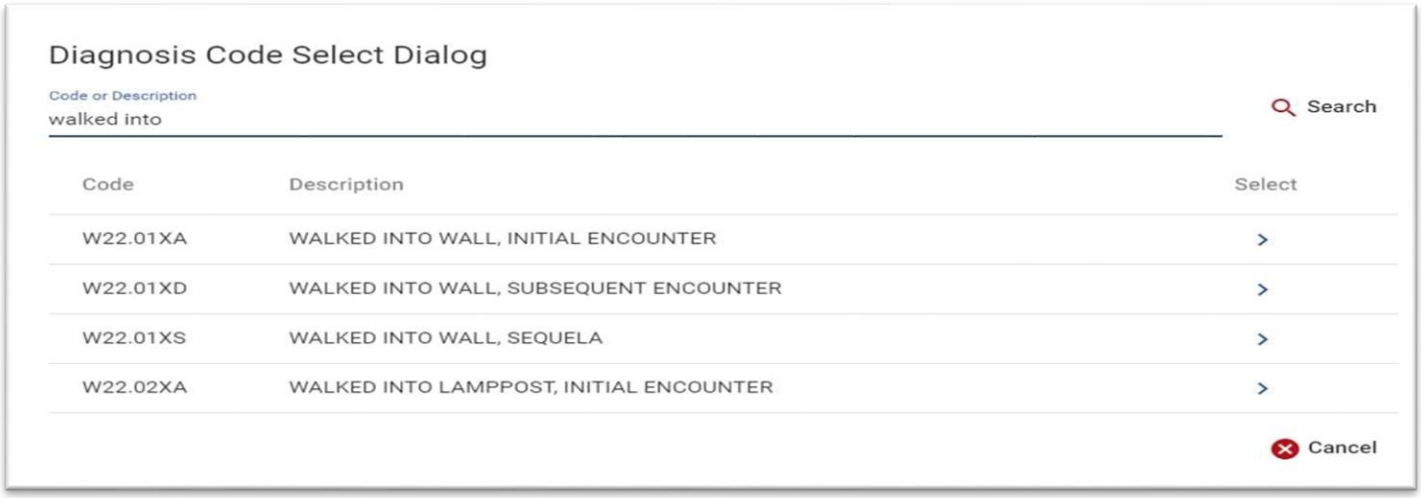
Enter the diagnosis code(s) in this section.

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

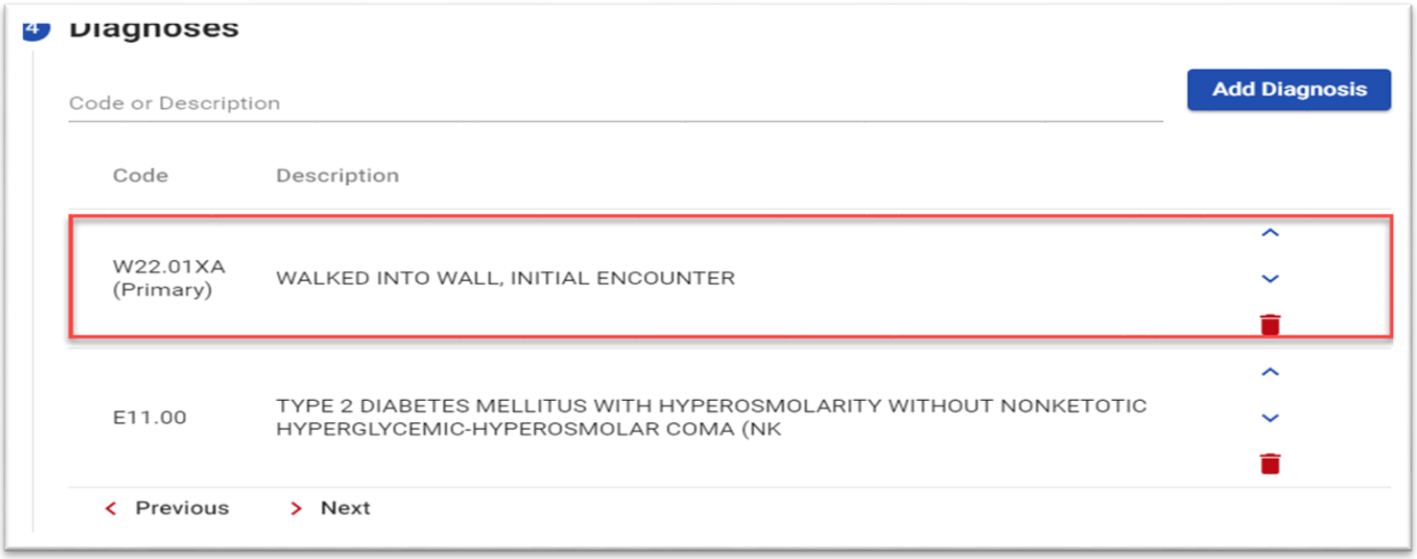




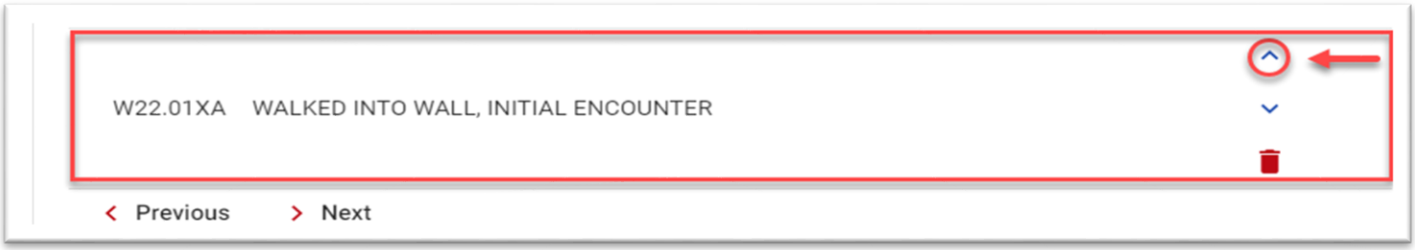
Enter in a description to pull up the possible diagnoses' codes.



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.

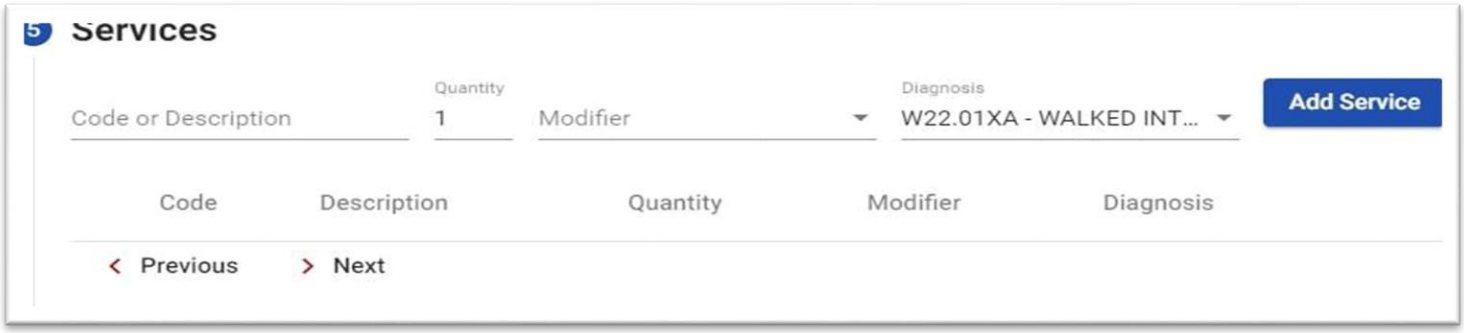


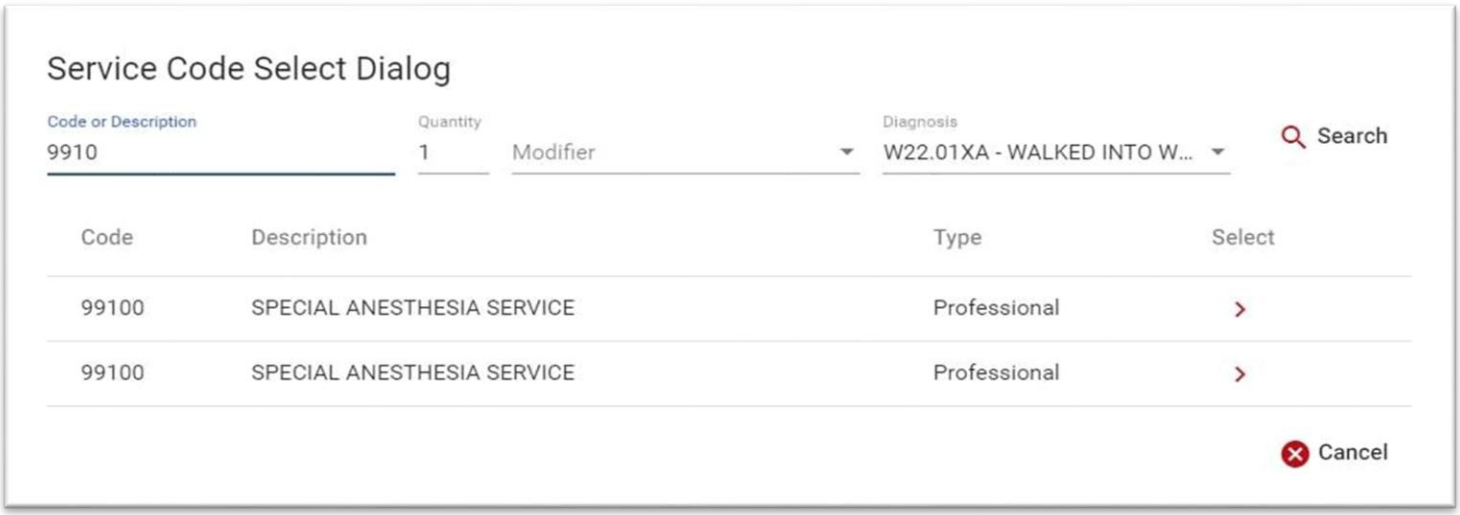
Once the diagnosis code(s) are entered, click on Next or Step 5 to continue.

Step 5) Services

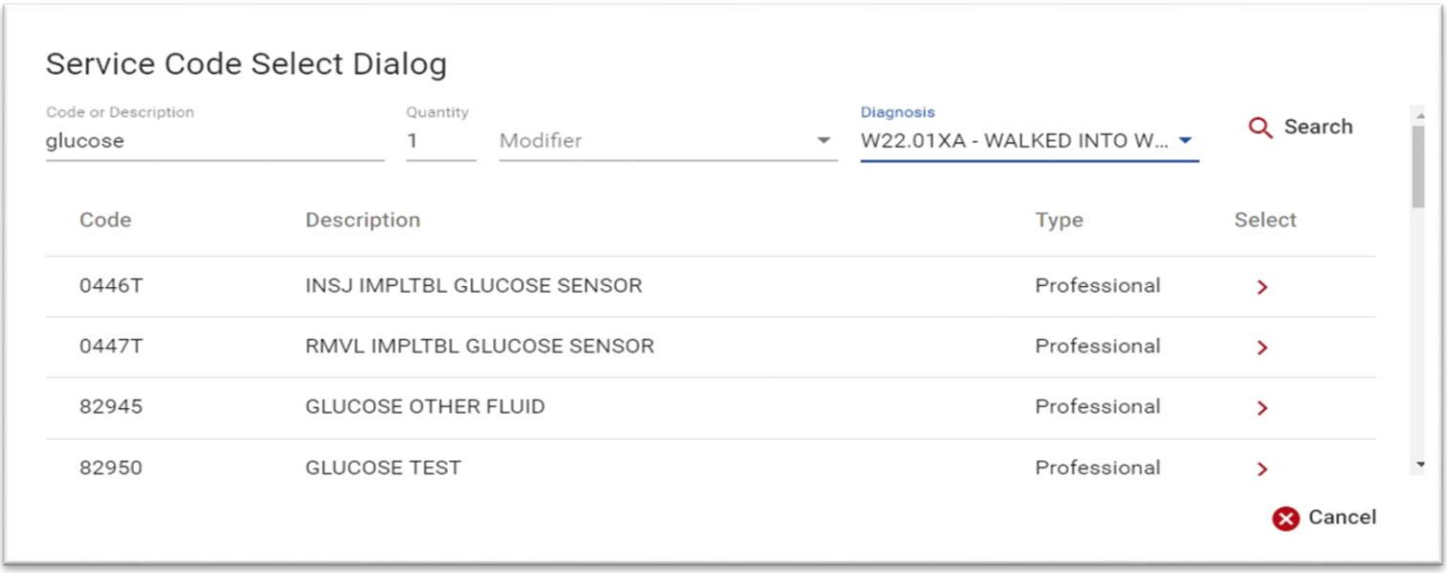
Enter the procedure code(s) in this section.

Code or Description: Enter the procedure code. Entering in a partial code or description will bring up the search window.



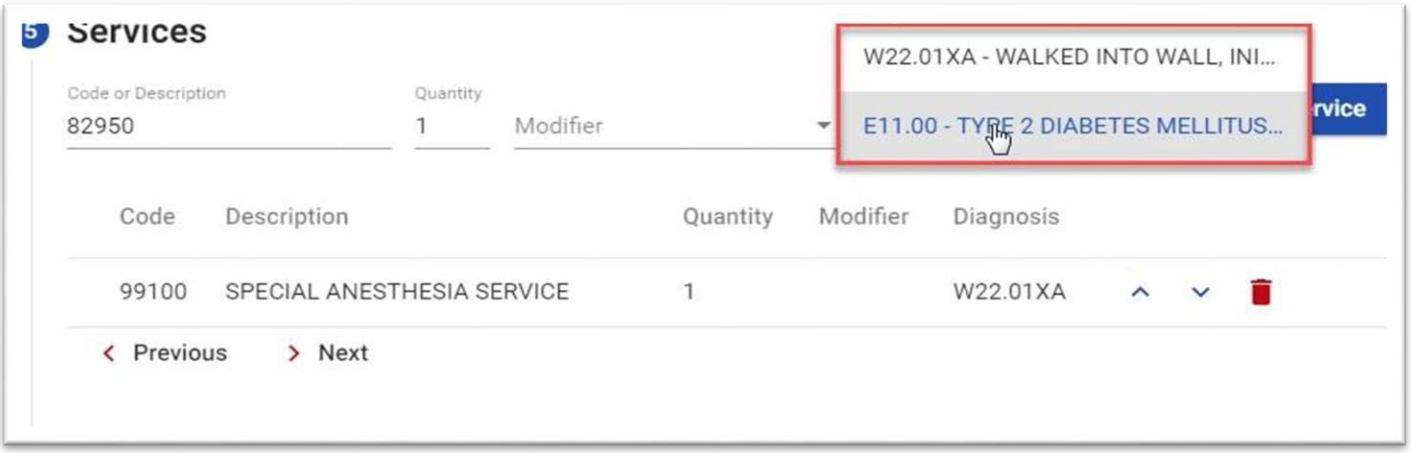


Enter a description that will bring up related codes.

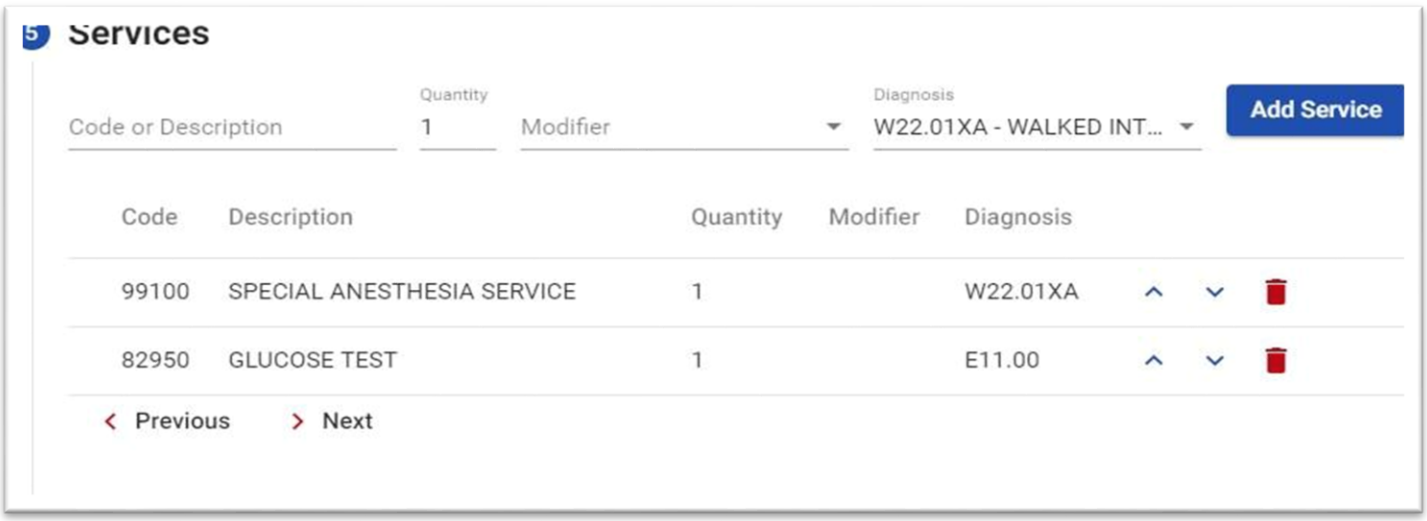


Select a modifier from the drop-down (if applicable).

Select which diagnosis the procedure will be tied to.



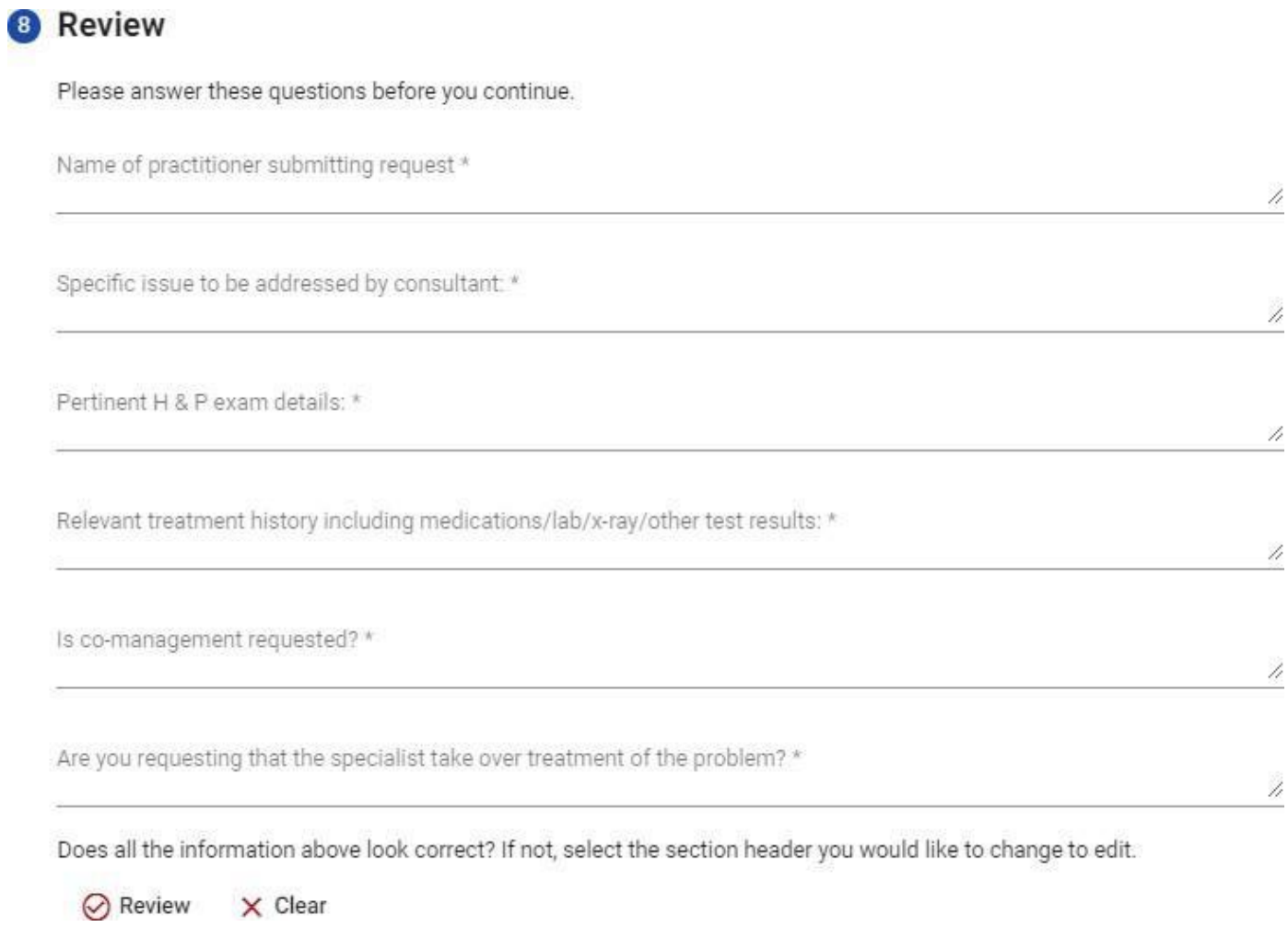
Click on **Add Service** to add the code to the Authorization request.



REFERRAL CLINICAL QUESTIONS

Certain consultation CPT codes require additional information. Using the 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).

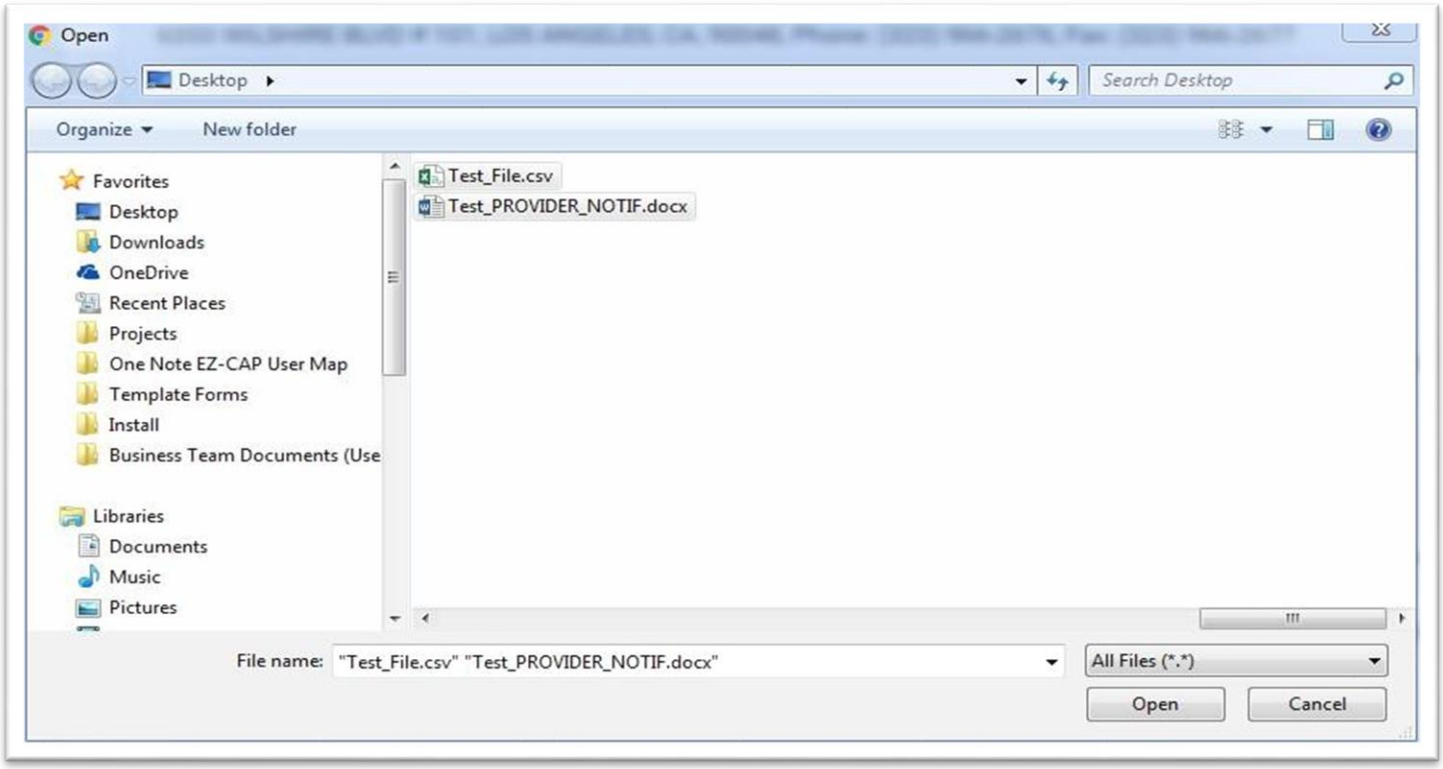
Click on Next or Step 6 to proceed.



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 file to upload.



Click on Open.

Click on Next or Step 7 to proceed.

Step 7) Notes

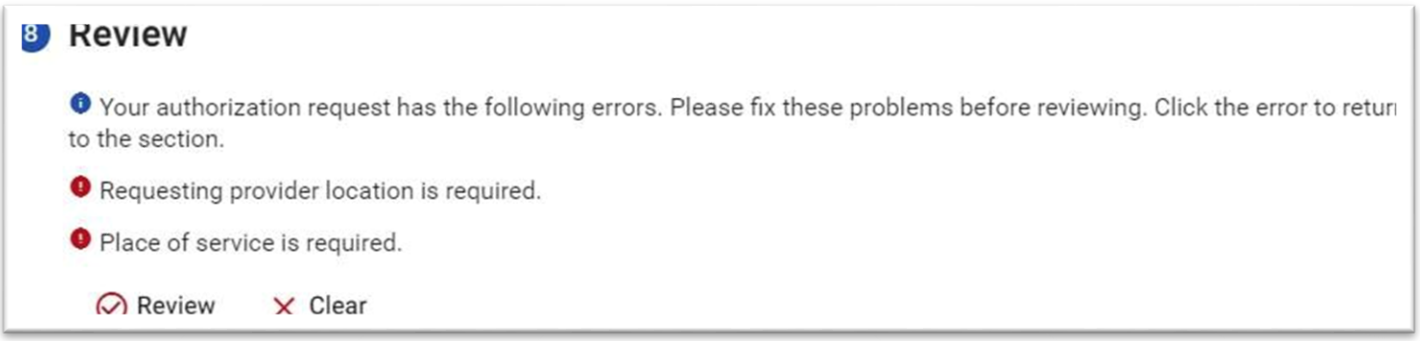
Enter any notes regarding the referral in this section.

Click on Next or Step 8 to proceed.

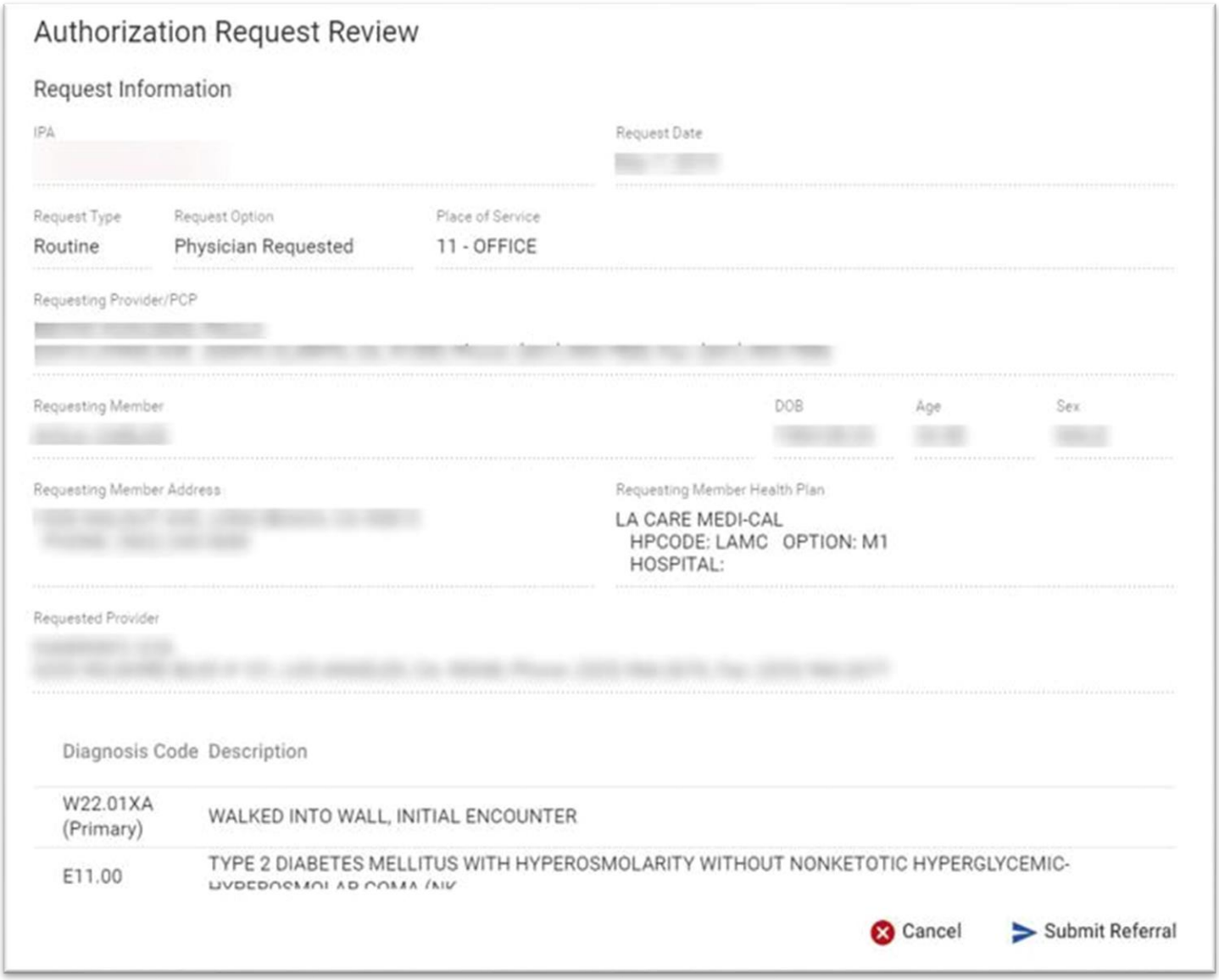
Step 8) Review

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

If you are missing any of the required information you will be prompted. Make any necessary corrections and click on Review.

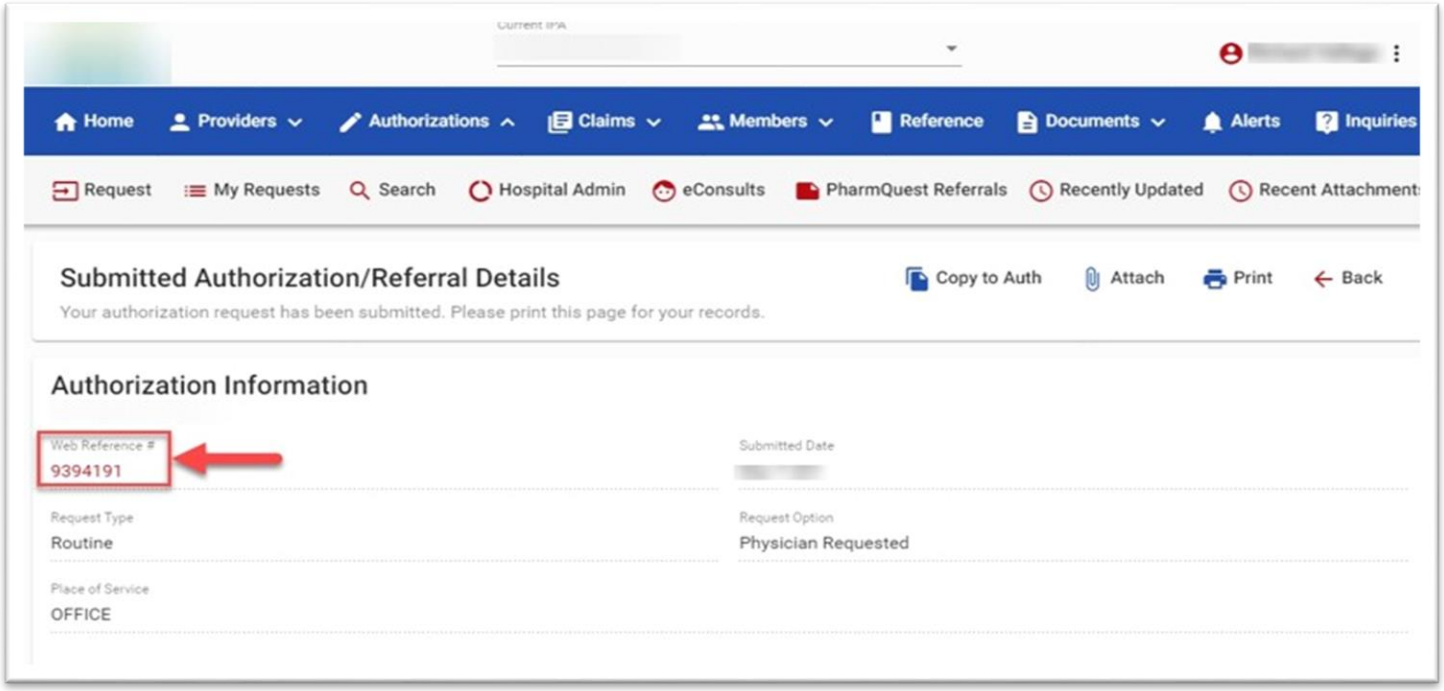


A preview of the Authorization will populate.



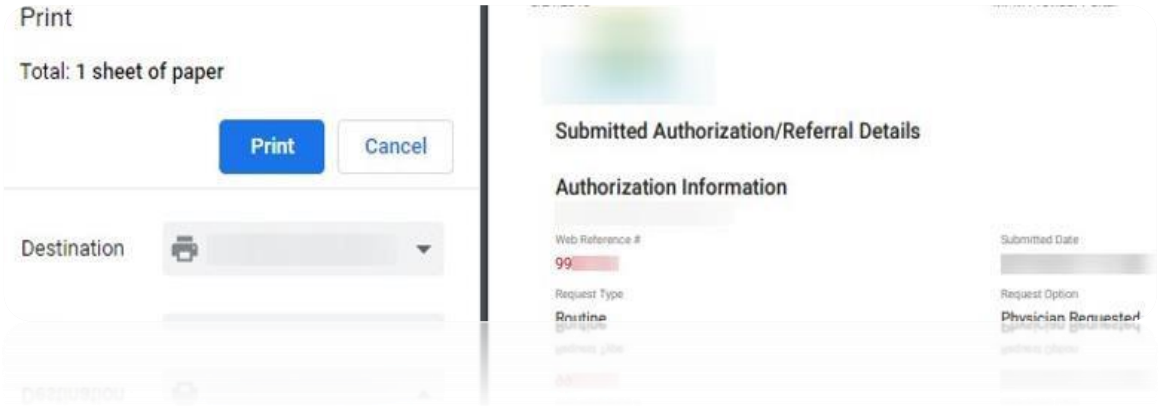
Review the Authorization, and if no changes need to be made, click on Submit Referral.

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.

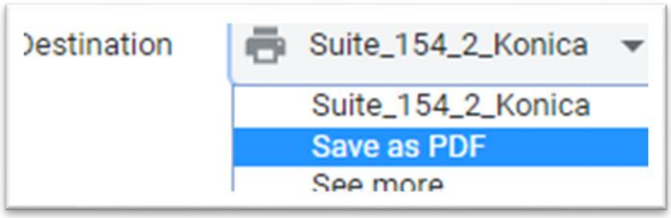


Copy to Authorization: When you click on Copy to Auth, the member information copies over to the Authorization Request page so you would not need to re-enter that information.
Attach: Attach any supporting documents that may have been left out in the initial Auth request
Inquire: Send an inquiry to MPM's UM department regarding the referral
Print: Print or save the request as a PDF file

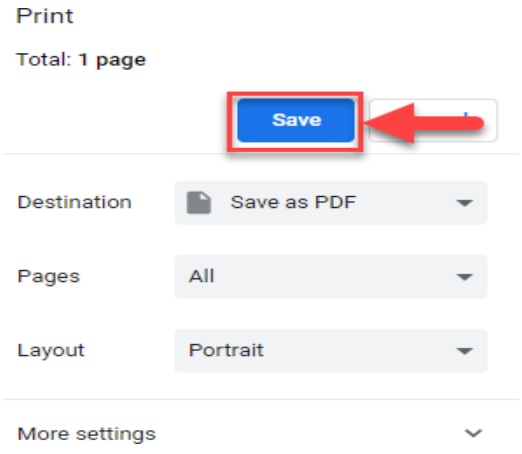
Clicking on print and the print review page will open up.

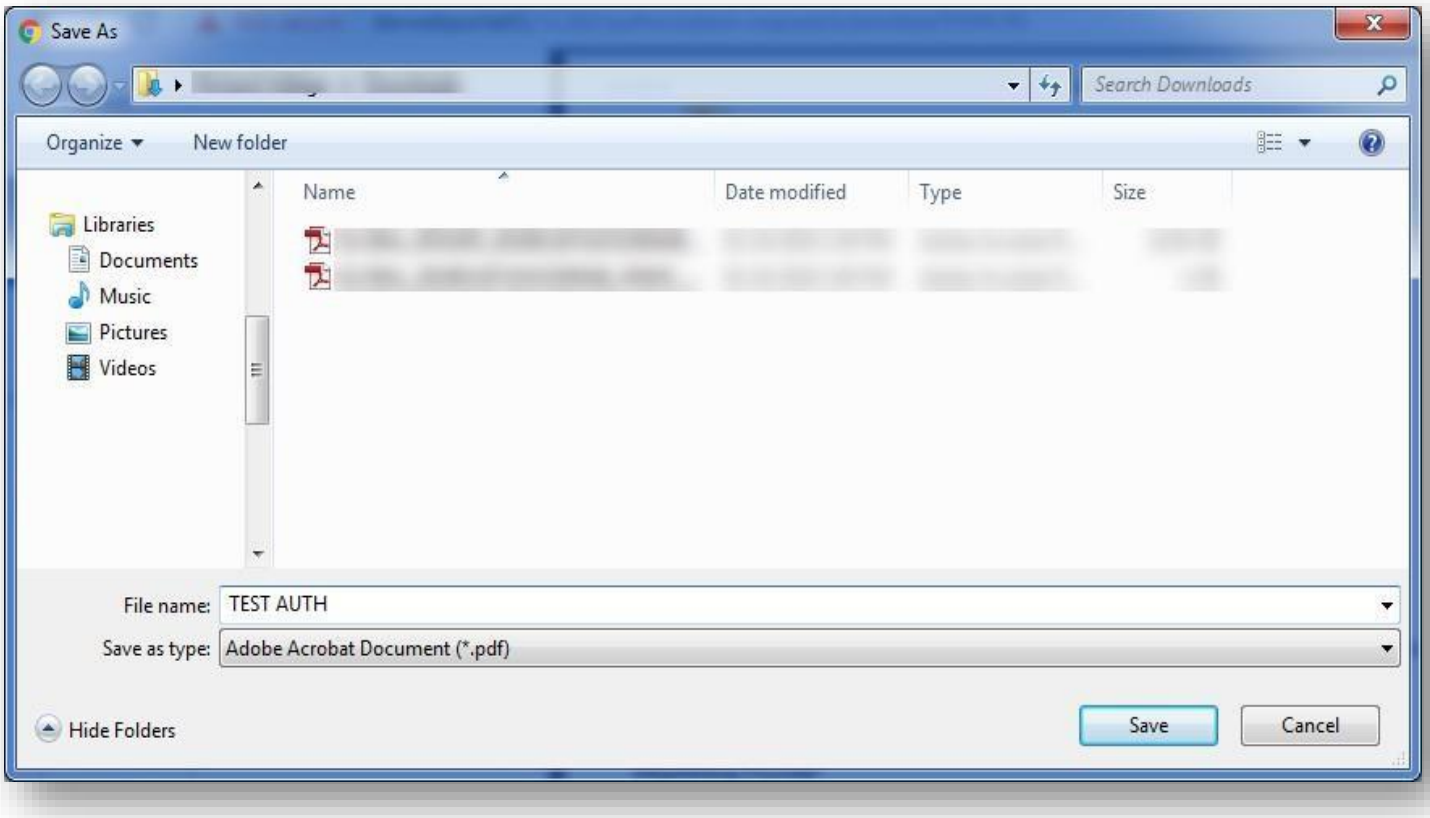


To save the file to PDF, click on the Destination drop down and select "Save as PDF."



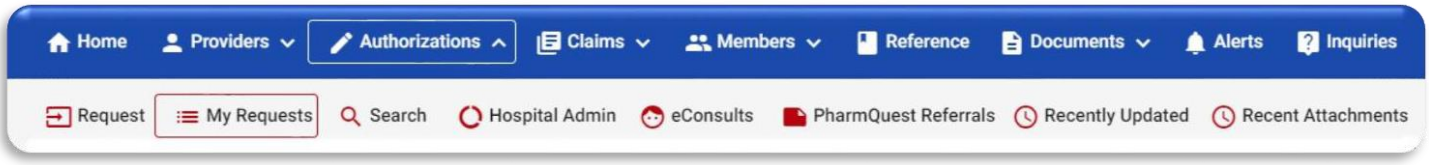
Click on Save to choose where to save the PDF.





Select a destination to save the PDF.
Click Save to save the PDF.

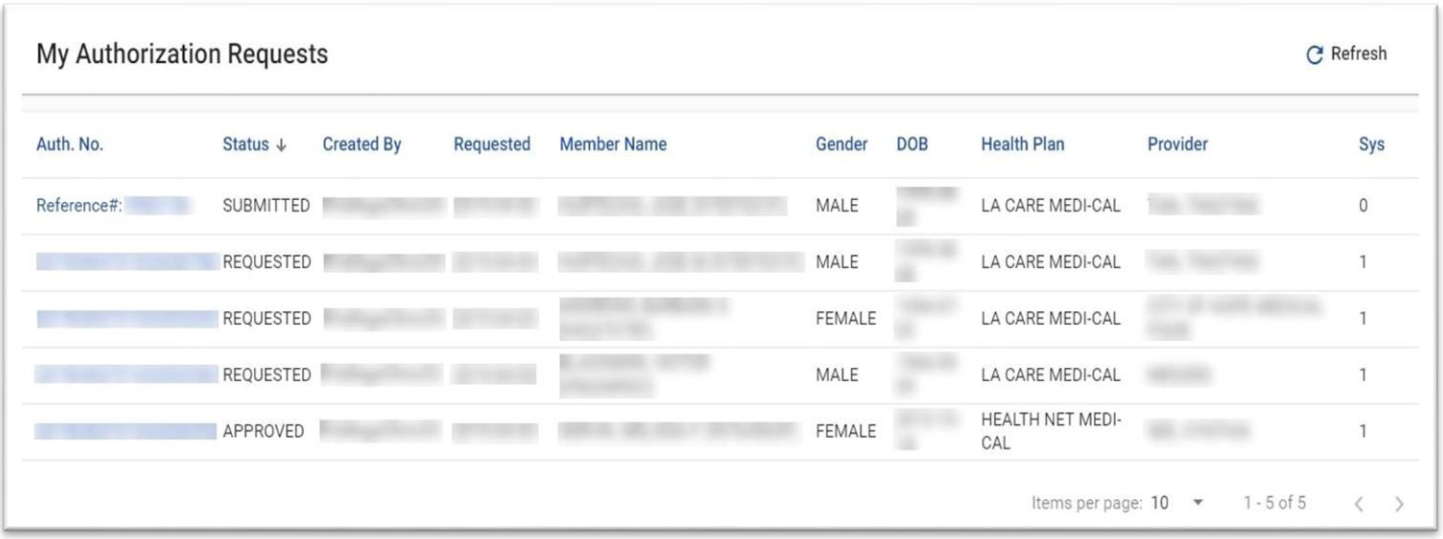
B) My Requests



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:

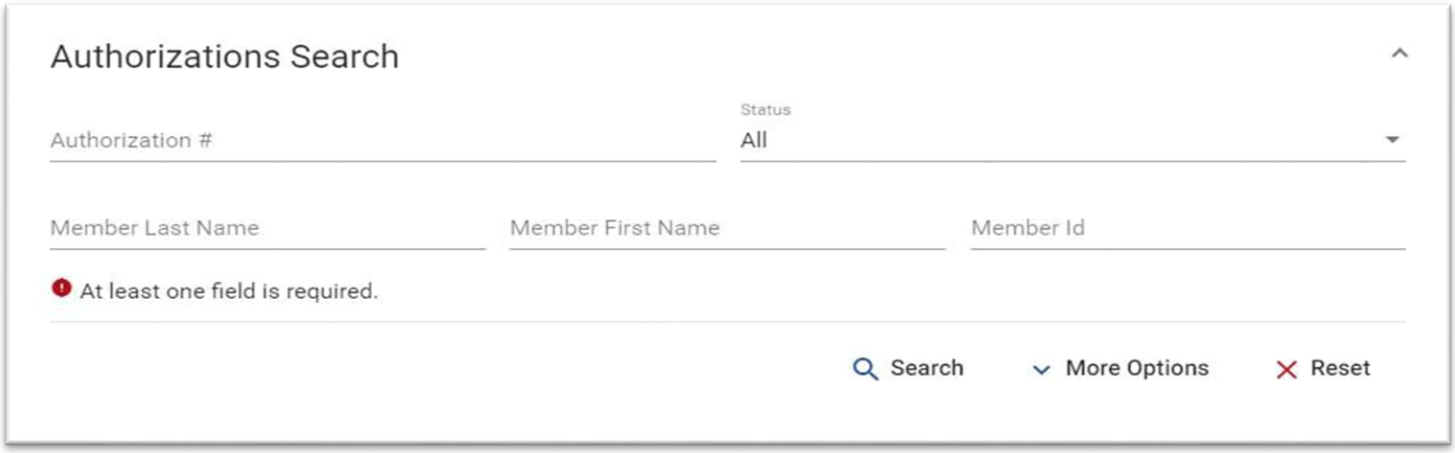
- Verifying if the Auth submission was successful
- Ability to view the status of the Auth
- Provides a centralized location to view all of your Auths without having to search

C) Authorization Search



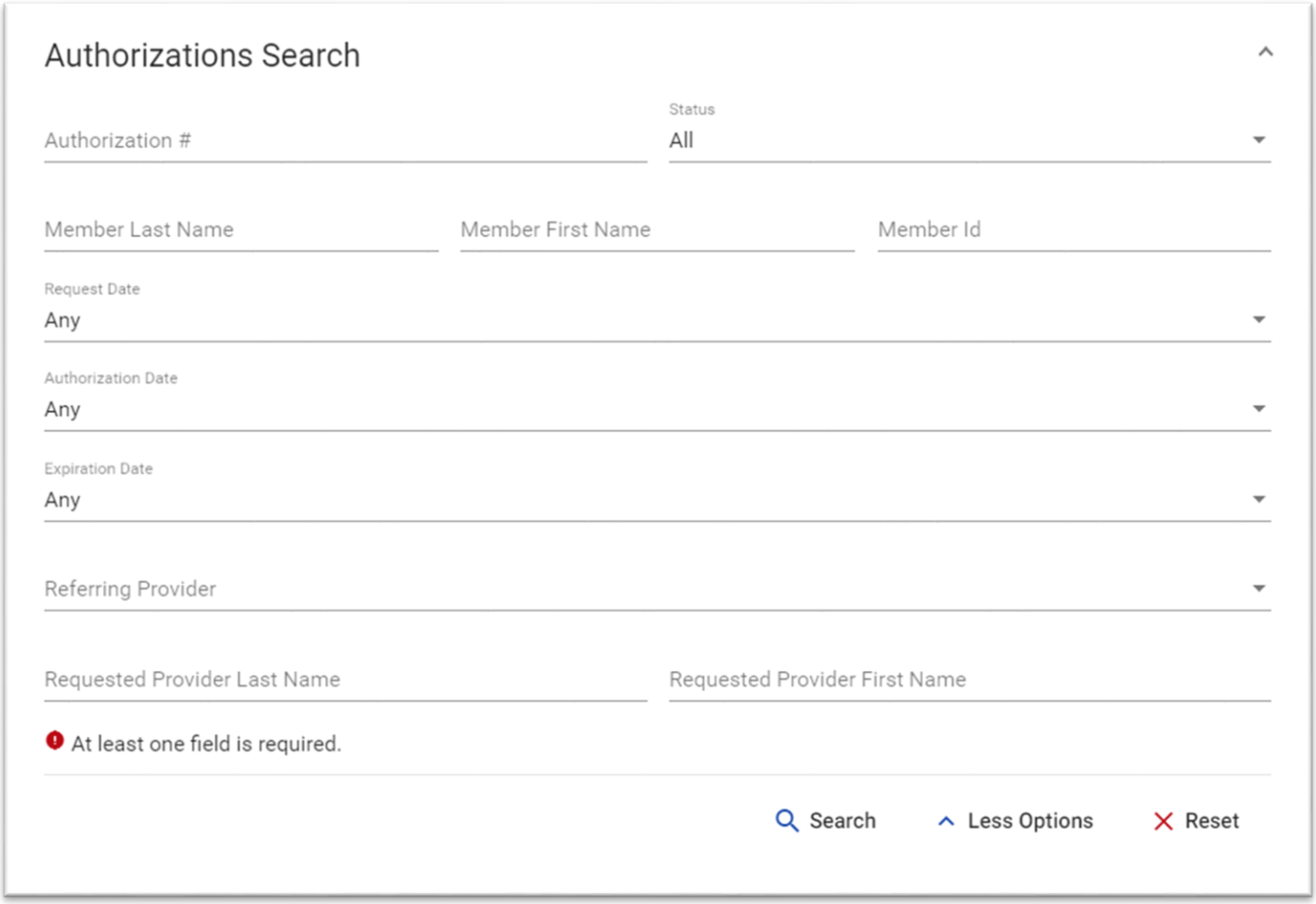
You can search for Authorizations by using the following fields:

- 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

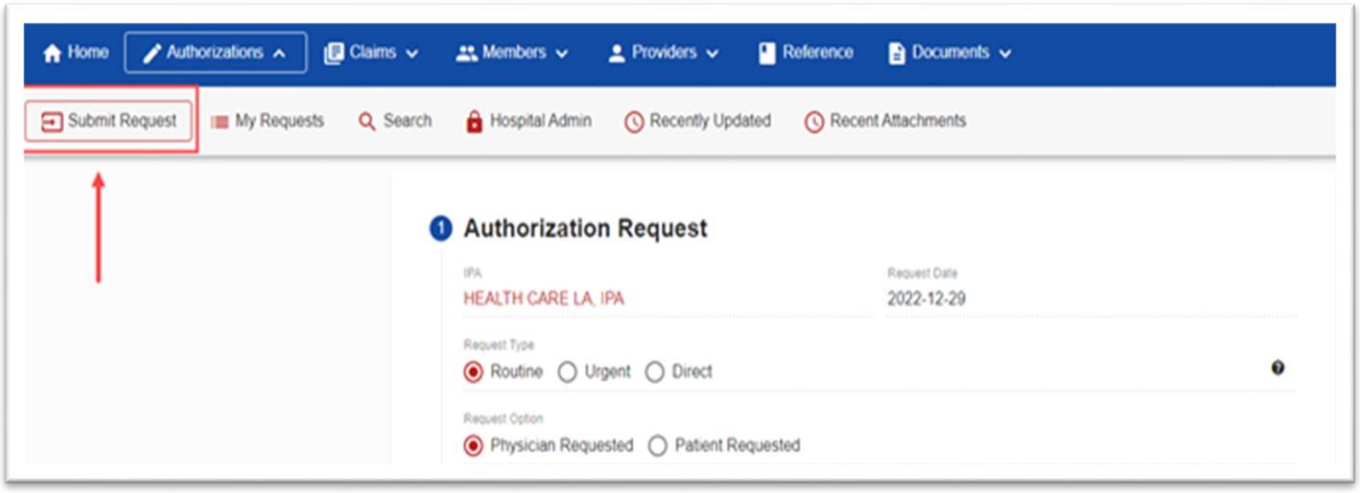


PCP AND SPECIALIST REFERRAL TRACKING

The PCP and Specialist are to track your member's open referrals to ensure the member is receiving the required care and that the PCP office obtains consult notes from the specialist. Your provider portal you will have a list of open authorizations for your member. The list consists of authorizations that are 90 days old in which there is no claim. Your office is to contact your member to determine if this authorization should be closed or if the member has been seen or is to schedule a later date.

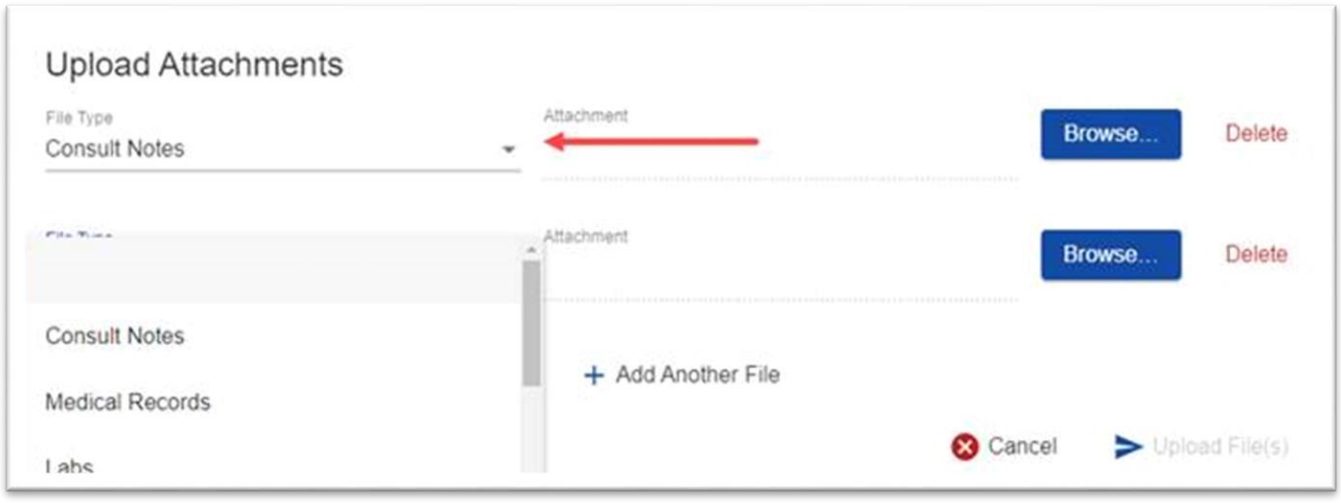
Please attach consult notes to encourage proper handling of the referral and related services:

1. Providers can attach notes and other documents when using the "Authorizations" > "**Submit Request**" form on the MPM Provider Web Portal.



2. Under section #7 - **Attachments**, Providers can select files to attach with their request.

3. Providers are able to select specific attachment categories from a drop-down list and can attach multiple files at a time.



Specialist Requirements/Responsibilities

- Document all work-up and treatments done and include with your request for authorization
- If the member has been seen, please forward your consult and/or progress notes to the member's Primary Care Physician
- Certain Health Plan contracts have an assigned hospital. Depending on the IPA, Hospital Capitated arrangements are in place for specific hospitals

Primary Care Physician Responsibilities

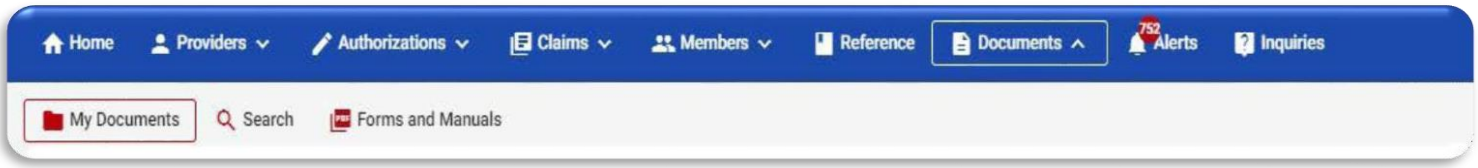
As a standard requirement under Medi-Cal, please document that you have received/read the consultation notes from the specialist and document any outreach to the member and/or specialist provider. As a PCP, you are responsible for coordinating the care for the needs of your members.

- If a member missed their appointment, please follow up with the member
- Document all work-up and treatments done and include with your request for authorizations

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: MPM Provider Web Portal 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 Enrollees – 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 is: 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.

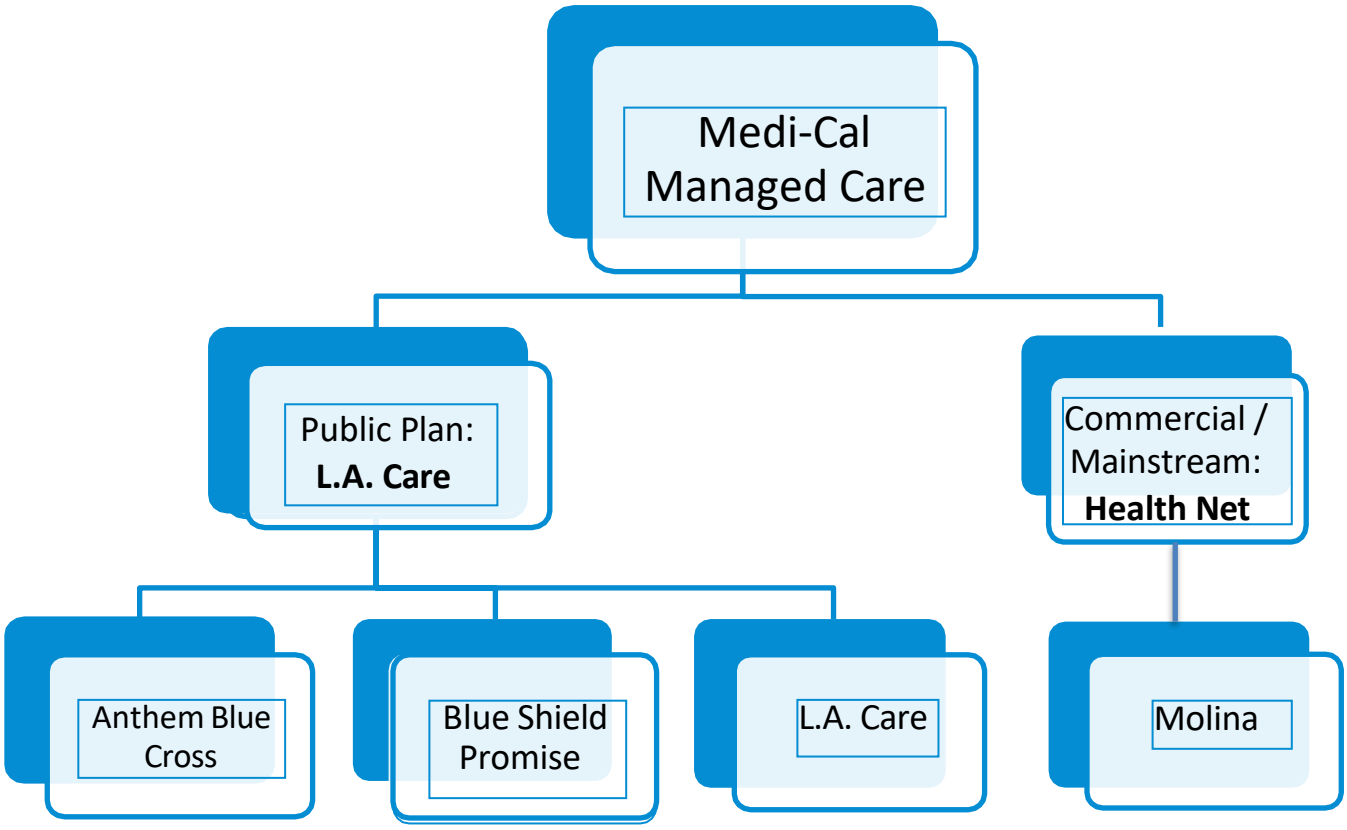
Fee-for-Service (FFS) Reports are available via Payspan

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

MEDI-CAL 2 PLAN MODEL



- For member transfers between Health Net and L.A. Care Health Plan, contact HCO
- For member transfers between L.A. Care Health Plan's Health Plan Partners, contact L.A. Care Health Plan: 888-4LA-CARE
- For member transfers between Molina Healthcare & Health Net, contact Health Net: 888-675-6110

Section 3: Utilization Management

MEDI-CAL MANAGED CARE REQUIREMENTS & SPECIFICATIONS

Enrollment and Disenrollment to/from a Contracted Health Plan is processed only by Health Care Options (HCO). Please refer members wishing to enroll/disenroll to HCO's 800 numbers listed below, by language:

For member transfers between Health Net and L.A. Care Health Plan contact HCO at the numbers listed above.

For member transfers between L.A. Care Health Plan and/or Plan Partners (Anthem/Blue Cross, Blue Shield of California Promise Health Plan), call L.A. Care Health Plan (888) 4LA- CARE.

For member transfers between Health Net and Molina Healthcare, contact Health Net at 800-675-6110.

TDD Line for Hearing Impaired: Telephone #: 800-430-7077

MEDI-CAL MEMBERS MAY CONTACT CONTRACTED HEALTH PLAN MEMBER SERVICES DEPARTMENT FOR PCP TRANSFERS WITHIN ANY GIVEN PLAN

Language	Contact Phone Number
English	(800) 430-4263
Armenian	(800) 840-5032
Cantonese	(800) 430-2022
Hmong	(800) 430-2022
Russian	(800) 430-7007
Spanish	(800) 430-3003
Cambodian	(800) 430-5005
Farsi	(800) 840-5034
Latin	(800) 430-4091
Vietnamese	(800) 430-8008

Contracted Health Plans Member Services Departments	
Alignment Health Plan	866-634-2247
Anthem/Blue Cross	888-285-7801
Blue Shield of California	800-424-6521
Blue Shield of California Promise Health Plan	800-605-2556
Brand New Day	866-255-4795
Cigna	800-882-4462
Health Net	800-675-6110
L.A. Care Health Plan	213-438-5407 213-694-1265
Molina Healthcare	800-435-3666 ext. 5500

Section 3: Utilization Management

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
- 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; and

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.

Section 3: Utilization Management

LINKED AND CARVED OUT SERVICES

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

ACUPUNCTURE

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

Anthem Blue Cross: Services will be provided by American Specialty Health Plan (ASH). Members may self-refer for this benefit under this health plan. ASH may be reached by calling (800) 678-9133.

Blue Shield of California Promise Health Plan: IPA contracted provider

Health Net: Services will be provided by American Specialty Health Plan (ASH). Members may self-refer for this benefit under this health plan. ASH may be reached by calling (800) 678-9133 option 2.

L.A. Care Health Plan: Services will be provided by American Specialty Health Plan (ASH). Members may self-refer for this benefit under this health plan. ASH may be reached by calling (888) 522-1298.

Molina Healthcare: Acupuncture is not a covered benefit under this health plan. Contact Molina Healthcare at (800) 675-6110.

CHIROPRACTIC

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

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

Blue Shield of California Promise Health Plan**:** IPA contracted provider.

Health Net: Only services in an FQHC or RHC will be provided by the health plan. Contact (800) 675-6110 for Health Net Member Services.

L.A. Care Health Plan: The health plan covers services for certain conditions associated with pregnancy and for members under age 21. Services for other members will be provided by American Specialty HealthPlan (ASH). Call ASH at (888) 522-1298 for self-referral.

Molina Healthcare: Services will be provided by the health plan. Contact (888) 665-4621 for Molina Healthcare 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.

Alignment Health Plan: Vision Services will be provided by Vision Service Plan (VSP). Members may self-refer for this benefit under this health plan. VSP can be reached by calling (800) 877-7195. Anthem/Blue Cross: Vision Services will be provided by Vision Service Plan (VSP).

Members may self-refer for this benefit under this health plan. VSP can be reached by calling (800) 877-7195.

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

Health Net: Vision Services to be provided by Envolve Vision. Members may self- refer for this benefit under the health plan by calling 1-800-675-6110.

L.A. Care Health Plan: Vision Services to be provided by Vision Service Plan (VSP). Members may self-refer for this benefit under this plan. VSP can be reached by calling (800) 877-7195.

Molina Healthcare Medical Centers: Vision Services to be provided by March Vision Care Group. Members may self-refer by calling (844) 336-2724.

LINKED AND CARVEOUT SERVICES

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. The CCS program requires prior authorization through CCS for all services to be funded through CCS, per the California Code of Regulations. Services are generally authorized starting from the date of referral, with specific criteria for urgent and emergency referrals. A full description of the CCS program is available at: www.dhcs.ca.gov/services/ccs/Pages/ProgramOverview.aspx

CCS provides funding for diagnosis, treatment and medical benefits (including medication and supplies) for eligible children. Care is delivered by CCS-paneled providers, CCS-approved facilities, Special Care Centers and other outpatient clinics. Additional services may be authorized by CCS based on a child's unique needs. This may include such necessary items as transportation to provider appointments, travel and lodging arrangements, special equipment and shift care. The state CCS program assesses the qualifications of each provider on its panel and maintains a list of specialists and hospitals that have been reviewed and found to meet CCS program standards. CCS also provides comprehensive medical case management services to all children enrolled in the 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 California Department of Public Health (CDHP) website at the below link for more information regarding CPSP. Comprehensive Perinatal Services Program (CPSP) includes a wide range of culturally competent services to Medi-Cal pregnant women, from conception through 60 days postpartum.

CPSP Service Elements Include:

1. Patient (Client) Orientation: CPSP practitioners provide an initial orientation and continue to orient the client to needed services, procedures, and treatments throughout her pregnancy.

2. Initial Assessments: The initial obstetric, nutrition, health education, and psychosocial assessments are the first steps taken to determine a client's individual strengths, risks, and needs in relation to her health and well-being during pregnancy. Ideally, all four assessments are completed within four weeks of entering care.

3. Individualized Care Plan (ICP): The ICP identifies and documents the client's strengths and a prioritized list of risk conditions/problems, sets goals for interventions, and identifies appropriate referrals.

4. Interventions: Appropriate obstetric, nutrition, health education, and psychosocial interventions during pregnancy enable a woman to increase control over and improve her health and the health of her baby. Interventions can include services, classes, counseling, referrals, and instructions as appropriate to the needs and risks identified on the ICP.

5. Reassessments: Reassessments are offered at least once each trimester and postpartum and serve as an opportunity to identify other risks and check the client's progress on those issues the woman wants to change.

6. Postpartum Assessment and Care Plan: The postpartum period is the time to assess the client's health, strengths, and needs in relation to infant care skills as well as any needs of the baby. A client may receive nutrition, health education, and psychosocial support services anytime throughout the 60-day postpartum eligibility period.

7. Providers offering CPSP services should maintain a Perinatal Services protocol.

When UM referral requests are received by IPA for OB services pertaining to Medi-Cal members, approvals will include reminder to provider for provision of CPSP services. Approval notices posted to portal will include a reminder in portal for provision of CPSP services. With provision of CPSP services, providers will include all elements of CPSP services in patients' medical records.

For more information on CPSP services, please visit: LA County Department of Public Health

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 sixteen or less adult beds.

DAY CARE HABILITATIVE SERVICES

Day Care Habilitative Services provided only to pregnant and postpartum women and Medi-Cal Kids & Teens 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.

DOULA SERVICES

Doula services will be available in fee-for-service Medi-Cal and through Medi-Cal managed care plans. Beneficiaries in a Medi-Cal Managed Care Plan (MCP) will receive doula services from their plan.

A Doula is a birth worker who provide health education, advocacy, and physical, emotional and nonmedical support for pregnant and postpartum persons before, during and after childbirth (perinatal period) including support during miscarriage, stillbirth and abortion. Doulas are not licensed or clinical providers, and they do not require supervision.

Covered Services

A recommendation for services authorizes all of the following:

- One initial visit
- Up to eight additional visits that may be provided in any combination of prenatal and postpartum visits
- Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion or miscarriage
- Up to two extended three-hour postpartum visits after the end of a pregnancy

Non-Covered Services

Doula services do not include diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure.

The following services are not covered under Medi-Cal or as doula services:

- Belly binding (traditional/ceremonial)
- Birthing ceremonies (i.e., sealing, closing the bones, etc.)
- Group classes on babywearing
- Vaginal steams
- Yoga
- Massage (maternal or infant)
- Photography
- Placenta encapsulation
- Shopping

For more detailed information, such as Doula services documentation requirements and eligibility criteria, please visit: Medi-Cal Provider Manual for Doula Services viewable at the DHCS website: Doula Services (doula) (ca.gov)

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 Medi-Cal Kids & Teens 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.

SABIRT (SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT)

SABIRT SERVICES MEDICARE

What's SBIRT?

SBIRT is an evidence-based, early intervention approach for people with non-dependent substance use before they need more extensive or specialized treatment. This approach differs from specialized treatment for those with more severe substance misuse or a SUD.

SBIRT Benefits

Using SBIRT services is easy in primary care settings. You can systematically screen people who may not seek substance use help and offer SBIRT treatment services access to:

- Reduce health care costs
- Decrease drug and alcohol use severity
- Reduce physical trauma risk
- Reduce patient-percentage who go without specialized treatment

Resources for Screening, Brief Intervention, and Referral to Treatment (SBIRT) | SAMHSA

COLLECTING SOCIAL DETERMINANTS OF HEALH 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 comprehensive 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.cdc.gov/about/sdoh/index.html

SHORT DOYLE DRUG MEDI-CAL (SD/MC)

SD/MC covers the following services listed: 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

Outpatient drug free treatment 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 eighteen, 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.

CALIFORNIA END-OF-LIFE OPTION (EOL)

The California End-of-Life Option Act (EOL) was effective June 9, 2016. EOL services are carve out for Medi-Cal Managed Care Plans (MCPs) covered by Medi-Cal Fee-for-Services (FFS). The EOL Act authorizes an adult who meets certain qualifications and has been determined by their attending physician to be suffering from a terminal disease and to be eligible to make a request for an aid-in-dying drug for the purpose of ending their life.

End-of-Life Care Services Eligibility Criteria:
The EOL Act authorizes an adult meeting End-of-Life Care Services eligibility criteria, determined by their attending physician to be suffering from a terminal disease and eligible to make a request for an aid-in-dying drug for the purpose of ending their life. EOL services include consultations and prescription of an aid-in-dying drug by an eligible MCP physician.

End-of-Life Care Services Eligibility Request Requirements:

- Procedures to make EOL requests include two oral requests, one written request, specified forms requesting an aid-in-dying drug under specified circumstances, and a final attestation
- The EOL Act requires End-of-Life Option related communications must be in the members medical records, including oral and written request for an aid-in-dying drug

Finding an End-of-Life Physicians:
Members are responsible for finding a Medi-Cal Fee-for-services (FFS) physician for all aspects of the End-of-Life (EOL) benefits. During an unrelated visit with a Managed Care Provider (MCP) physician, a member may provide an oral request for EOL services. If the MCP physician is enrolled with the Department of Health Care Services (DHCS) as a Medi-Cal FFS provider, the MCP physician may elect to become the member's attending physician as they proceed through steps in obtaining EOL services.

Please note:

- After the member's initial visit, following EOL services and related visits are no longer the responsibility of the MCP physician and must be completed by a Medi-Cal FFS attending physician or consulting physician
- If the MCP physician is not a Medi-Cal FFS provider, the MCP physician may document the oral request in the member's medical records as part of the visit
- The MCP physician should be responsible to advise the member that following the initial visit, the member must select a Medi-Cal FFS physician for all remaining EOL services requirements to be satisfied

Attending Physician Responsibilities:
Attending physicians must be willing to prescribe an aid-in-dying medication and make sure the member legally qualifies and to make the initial determination of all the following:

- Whether the member has the capacity to make medical decisions
- If there are indications the member has a mental disorder, the physician should refer the member to a mental health specialist
- If the referral is made, no aid-in-dying drugs are to be prescribed until the mental health specialist determines the member is not suffering from impaired judgement due to a mental disorder and has the capacity to make medical decisions
- Whether the member has a terminal disease
- Whether the member has voluntarily made the request for an aid-in-dying pursuant to Sections 443.2 and 443.3
- Whether the member is a qualified individual pursuant to subdivision of Section 443.1
- Explain all end-of-life options to the member and review what it means to ingest an aid-in-dying medication
- For members and their families who refuse hospice care, it is the responsibility of the MedPOINT Management Case Manager and the member's physicians to continue appropriate care
- Notify the next of kin the member's request for an aid-in-dying drug

Confirm that the member is making an informed decision by discussing all the following:

- The member's medical diagnosis and prognosis
- The probable result of ingesting the aid-in-dying drug
- Medication usage, storage, and disposal
- The possibility that the member may choose to obtain the aid-in-dying drug, but not take it
- The feasible alternative or additional treatment options including, but not limited to comfort care, hospice care, palliative care, and pain control

Offer an opportunity to withdraw or rescind their request for the aid-in-dying drug before prescribing the drug. Complete the Attending Physician Checklist and compliance form, as described in Section 443.22, include it and the consulting physician compliance form in the individual's medical record, and submit both forms to the State Department of Public Health.

MedPOINT Management will educate contracted providers regarding end-of-life services by, but not limited to:

- Educational posting on the MedPOINT Management website.
- Updating the MedPOINT Management Provider Manual to include policies and procedures that outline processes
- Provide provider trainings through webinars, newsletters, fax-blast and/or mailings

For more information on the California End of Life Option Act, such as necessary forms, statute and legislative history, please visit the California Department of Public Health at the following link:
VSB End of Life Option Act (ca.gov)

COMMUNITY HEALTH WORKER

CHW services are preventive health services and considered a Medi-Cal benefit as of 7/1/2022. CHW services delivered by a CHW are to prevent disease, disability and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHWs may include individuals known by a variety of job titles, such as promotors, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals. Supervising CHW Providers employ and oversee the CHW, ensures services are delivered to members and submit claims for services provided by CHWs. The Supervising CHW Provider must be a licensed Provider, a hospital, an outpatient clinic, a local health jurisdiction or a community-based organization.

Referrals And Eligibility

Written recommendations with medical eligibility can be made by a physician or other licensed practitioner of the healing arts with the scope of their practice by state law. Other licensed providers within their scope of practice include physician assistants, nurse practitioner, clinical nurse specialist, podiatrist, nurse midwives, licensed midwives, registered nurses, public health nurse, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses and pharmacists.

CHW services are considered medically necessary for Members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services.

The recommending provider must determine eligibility based on the presence of one or more of the following:

- Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed.
- Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels or childhood lead exposure, etc.) that indicate risk but do
- not yet warrant diagnosis of a chronic condition.
- Any stressful life event presented via the Adverse Childhood Events screening.
- Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse.
- Results of a SDOH screening indicating unmet health-related social needs, such as housing or food insecurity.
- One or more visits to a hospital emergency department (ED) within the previous six months.
- One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization.
- One or more stays at a detox facility within the previous year.
- Two or more missed medical appointments within the previous six months.
- Member expressed need for support in health system navigation or resource coordination services.
- Need for recommended preventive services, including updated immunizations, annual dental visit, and well childcare visits for children

CHW violence prevention services are available to members who meet any of the following circumstances as determined by a licensed practitioner:

- The Member has been violently injured as a result of community violence
- The Member is at significant risk of experiencing violent injury as a result of community violence
- The Member has experienced chronic exposure to community violence. CHW violence prevention services are specific to community violence (e.g., gang violence). CHW services can be provided to Members for interpersonal/domestic violence through the other pathways with training/experience specific to those needs.

For members who need multiple ongoing CHW services or continued CHW services after 12 units of services, a written care plan must be written by one or more licensed providers, which may include the recommending Provider and other licensed Providers affiliated with the CHW Supervising Provider. The care plan may not exceed a period of one year and must include:

- Specify the condition that the service is being ordered for and be relevant to the condition
- Include a list of other health care professionals providing treatment for the condition or barrier
- Contain written objectives that specifically address the recipient's condition or barrier affecting their health
- List the specific services required for meeting the written objectives
- Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the plan's objectives
- Supervising CHW Providers must submit the written care plan

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

Los Angeles County Department of Mental Health: (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.

TRANSITION OF BEHAVIORAL HEALTH SERVICES MANAGEMENT FOR MEDI-CAL MEMBERS TO BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

Effective 4/1/23, all Behavioral Health Services (BHS) previously managed and coordinated by Carelon Behavioral Health (formerly Beacon Health Options) will become the responsibility of Blue Shield of California Promise for Medi-Cal members.

- IF Medi-Cal Member has been receiving BHS from a Carelon network provider not contracted with Blue Shield of California and wants to continue seeing the provider, the member can file a continuity of care (COC) request with BSP by calling the Behavioral Health number on the back of their member ID card.
- COC request subject to approval

After 4/1/23, BSP Medi-Cal members may obtain a new referral for Mental Health Services by:

- Visiting this link for Blue Shield of California's find a doctor: www.blueshieldca.com/fad/home
- Or calling BSP at the number on the back of their member ID card
- Outpatient mental health does not require a physician referral or prior authorization

Specialty mental health services for serious mental health conditions, Medi-Cal members can self-refer, and/or providers can offer these resources to their patients so their patients can contact:

- Los Angeles County Mental Health Access Center Helpline (800) 854-7771, Option 1
- If applicable for IPA, for San Diego County Mental Health Access & Crisis Line (888) 724-7240

TRANSPORTATION SERVICES

Medi-Cal offers transportation to and from appointments for services covered by Medi-Cal. This includes transportation to medical, dental, mental health, or substance use disorder appointments, and to pick up prescriptions and medical supplies.

There are two types of transportation for appointments. When requesting transportation, please contact the transportation provider as soon as possible and before the appointment. You may request that transportation cover your appointment(s) if you have many.

Nonemergency Medical Transportation (NEMT)

- Transportation by ambulance, wheelchair van, or litter van for those who cannot use public or private transportation
- A prescription from a licensed provider is necessary.

List of Approved Nonemergency Medical Transportation Providers

Nonmedical Transportation (NMT)

- Transportation by private or public vehicle for people who do not have an alternate way to arrive at their appointment
- Nonmedical Transportation (NMT) is available to people with full-scope Medi-Cal or who are pregnant,
- including to the end of the month in which the 365th day postpartum falls

List of Approved Nonmedical Transportation Providers

ACUPUNCTURE SERVICES

Health Plan	Commercial	Medicare	Medi-Cal	EAE D-SNP	Covered CA
Alignment Health Plan Health Plan	N/A	Contact Plan Member Services (866) 634-2247	N/A	N/A	N/A
Anthem Blue Cross	Auth Required – HCLA	American Specialty Health Plan (ASH) (800) 678-9133	American Specialty Health Plan (ASH) (800) 678-9133	N/A	American Specialty Health Plan (ASH) (800) 678-9133
Blue Shield of California	American Specialty Health Plan (ASH) (800) 678-9133	American Specialty Health Plan (ASH) (800) 678-9133	N/A	N/A	N/A
Blue Shield of California Promise Health Plan	N/A	N/A	Auth Required – HCLA	American Specialty Health Plan (ASH) (800) 678-9133	N/A
Brand New Day	N/A	American Specialty Health Plan (ASH) (800) 678-9133	N/A	N/A	N/A
Cigna	Auth Required – HCLA	N/A	N/A	N/A	N/A
Health Net	American Specialty Health Plan (ASH) (800) 678-9133	American Specialty Health Plan (ASH) (800) 678-9133	American Specialty Health Plan (ASH) (800) 678-9133	American Specialty Health Plan (ASH) (800) 678-9133	American Specialty Health Plan (ASH) (800) 678-9133
L.A. Care Health Plan	N/A	N/A	American Specialty Health Plan (ASH) (800) 678-9133	American Specialty Health Plan (ASH) (800) 678-9133	Contact Plan Member Services (866) 522-2736
Molina Healthcare	N/A	Contact Plan Member Services (855) 665-4627	American Specialty Health Plan (ASH) (800) 678-9133	Contact Plan Member Services (855) 665-4627	Contact Plan Member Services (855) 665-4627

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

BEHAVIORAL HEALTH SERVICES

Health Plan	Commercial	Medicare	Medi-Cal	EAE D-SNP	Covered CA
Alignment Health Plan	N/A	Auth Required – HCLA	N/A	N/A	N/A
Anthem Blue Cross	Contact Behavioral Health Network (866) 621-0043	Auth Required – HCLA	Contact Behavioral Health Network (866) 621-0043	N/A	Contact Behavioral Health Network (866) 621-0043
Blue Shield of California	Contact Mental Health Services Administrator (MHSA) (877) 263-9870	Contact Plan Member Services (800) 544-0088	N/A	N/A	N/A
Blue Shield of California Promise Health Plan	N/A	N/A	Contact Provider Customer Care Team (800) 468-9935	Contact Provider Customer Care Team (800) 468-9935	N/A
Brand New Day	N/A	Auth Required – HCLA	N/A	N/A	N/A
Cigna	Contact Behavioral Health (800) 433-5768	N/A	N/A	N/A	N/A
Health Net	Contact Managed Health Network (MHN) (800) 646-5610	Contact Managed Health Network (MHN) (800) 646-5610	Contact Managed Health Network (MHN) (800) 646-5610	Contact Managed Health Network (MHN) (800) 646-5610	Contact Managed Health Network (MHN) (800) 646-5610
L.A. Care Health Plan	N/A	N/A	Carelon Behavioral Health (877) 344-2858	Carelon Behavioral Health (877) 344-2858	Carelon Behavioral Health (877) 344-2858
Molina Healthcare	N/A	Contact Behavioral Health Network (888) 665-4621	Contact Behavioral Health Network (888) 665-4621	Contact Behavioral Health Network (888) 665-4621	Contact Behavioral Health Network (888) 665-4621

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

CHIROPRACTOR SERVICES

Health Plan	Commercial	Medicare	Medi-Cal	EAE D-SNP	Covered CA
Alignment Health Plan	N/A	Not Covered Benefit	N/A	N/A	N/A
Anthem Blue Cross	Auth Required – HCLA	Contact Plan Member Services (800) 407-4627	Contact Plan Member Services (800) 407-4627	N/A	Auth Required – HCLA
Blue Shield of California	American Specialty Health Plan (ASH) (800) 678-9133	American Specialty Health Plan (ASH) (800) 678-9133	N/A	N/A	N/A
Blue Shield of California Promise Health Plan	N/A	N/A	Auth Required – HCLA	American Specialty Health Plan (ASH) (800) 678-9133	N/A
Brand New Day	N/A	American Specialty Health Plan (ASH) (800) 678-9133	N/A	N/A	N/A
Cigna	Contact Plan Member Services (800) 244-6224	N/A	N/A	N/A	N/A
Health Net	American Specialty Health Plan (ASH) (800) 678-9133	American Specialty Health Plan (ASH) (800) 678-9133	American Specialty Health Plan (ASH) (800) 678-9133	Not Covered Benefit	American Specialty Health Plan (ASH) (800) 678-9133
L.A. Care Health Plan	N/A	N/A	American Specialty Health Plan (ASH) (888) 522-1298	American Specialty Health Plan (ASH) (800) 848-3555	Not Covered Benefit
Molina Healthcare	N/A	Not Covered Benefit	Contact Plan Member Services (888) 665-4621	Not Covered Benefit	Not Covered Benefit

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

VISION SERVICES

Health Plan	Commercial	Medicare	Medi-Cal	EAE D-SNP	Covered CA
Alignment Health Plan	N/A	VSP (800) 877-7195	N/A	N/A	N/A
Anthem Blue Cross	Blue View Vision (866) 723-0515 *Contact Lenses - HCLA*	Contact Plan Member Services (800) 407-4627	VSP (844) 239-7644	N/A	Contact Plan Member Services (800) 407-4627
Blue Shield of California	Contact Vision Plan Administrator MES (877) 601-9083	Contact Vision Plan Administrator MES (877) 601-9083	N/A	N/A	N/A
Blue Shield of California Promise Health Plan	N/A	N/A	VSP (800) 877-7195	VSP (800) 877-7195	N/A
Brand New Day	N/A	Medical Eye Services (MES) (800) 877-6372	N/A	N/A	N/A
Cigna	Contact Vision Network (877) 478-7557	N/A	N/A	N/A	N/A
Health Net	EyeMed Vision Care (866) 392-6058	Envolve Vision (866) 392-6058	Envolve Vision (844) 820-8600	Envolve Vision (855) 464-3571	Contact Plan Member Services (800) 675-6110
L.A. Care Health Plan	N/A	N/A	VSP (800) 877-7195	VSP (800) 877-7195	Contact Plan Member Services (866) 522-2736
Molina Healthcare	N/A	March Vision Care (844) 336-2724	March Vision Care (866) 376-6780	March Vision Care (844) 336-2724	Contact Plan Member Services (855) 665-4627

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

HEALTH PLAN	PRODUCT LINE	PHONE NUMBER	HOURS	LANGUAGES	FACE-TO-FACE PRIOR NOTICE
Alignment	All	1-866-634-2247 TTY: 711	Oct 1-Feb 14: Sun-Sat 8:00am-8:00pm* Feb 15-Sept 30: Mon-Fri 8:00am-8:00pm* *except major holidays	Spanish, Korean, Chinese another threshold available on	Unavailable
Blue Cross	All	Business hours: 1-800-407-4627 After hours: 1-800-224-0336 TTY: 1-888-757-6034	24/7	Spanish, Chinese (Traditional), Vietnamese, Tagalog, Korean	3 days
Blue Shield of	All	1-800-541-6652 TTY: 1-800-794-1099	Mon-Fri 8:00am-5:00pm	Spanish, Chinese, (Traditional), Hindi, Vietnamese	5 days
Blue Shield Promise Health Plan	Medi-Cal Commercial Duals After Hours TTY (All)	1-800-605-2556 1-800-544-0088 1-855-905-3825 1-877-904-8195 Access #828201 1-888-877-5379	24/7	Spanish, Chinese, (Cantonese & Mandarin), Arabic, Armenian, Khmer, Korean, Farsi, Tagalog,	7 days
Brand New Day	All	1-866-255-4795 TTY: 1-866-321-5955	24/7	Spanish, Korean, Khmer, available on request	10 days

Section 3: Utilization Management

LINKED AND CARVED OUT SERVICES

HEALTH PLAN	PRODUCT LINE	PHONE NUMBER	HOURS	LANGUAGES	FACE-TO-FACE PRIOR NOTICE
Cigna	All	1-800-806-2059 Face-to-face: 1-800-997-1654 TTY: 711	Mon-Fri 8:00am-5:00pm	Spanish, Chinese (Traditional), another threshold available on request	10 days
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		
L.A. Care Health Plan	All	1-855-322-4034 TTY: 711	24/7	Spanish, Chinese (Cantonese & Mandarin), Arabic, Armenian, Khmer, Korean, Farsi, Tagalog, Vietnamese, Russian	10 days
Molina Healthcare	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-		
	TTY (All)	711	24/7		

Section 3: Utilization Management

EXPANDED MENTAL HEALTH BENEFITS

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 LA County Department of Mental Health (DMH).

For referrals to DMH, send the written consent (or documentation for a verbal consent via phone) with the screen form to the provider referral center via encrypted email to: screener@dmh.lacounty.gov or via eFax at: (562) 863-3971. LA County Department of Mental Health access center: (855) 425- 8141.

Services provided by LA 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

EXPANDED MENTAL HEALTH BENEFITS

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, f 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 Antisocial 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 OF CALIFORNIA PROMISE HEALTH PLAN	Blue Shield of California Behavioral Health Professional Network	(800) 468-9935
HEALTH NET	MHN	(888) 426-0030
L.A. CARE HEALTH PLAN	Carelon Health Strategies	(877) 344-2858
MOLINA HEALTHCARE	Molina Healthcare Mental Health	(888) 665-4621

Section 3: Utilization Management

EXPANDED SUBSTANCE ABUSE SERVICES

DEPARTMENT OF PUBLIC HEALTH (DPH) SERVICES PROVIDED BY PCPs:

- Health Education
- New Services – Screening, Brief Intervention & Referral to Treatment (SBIRT) for alcohol

NEW SERVICES PROVIDED BY DPH

- Outpatient Services:
- Outpatient drug free treatment
- Intensive outpatient treatment (newly expanded to all populations)
- Narcotic treatment services - methadone maintenance
- Naltrexone for opioid dependence (a Medi-Cal benefit through fee-for-service, outside of Drug Medi-Cal)
- Residential Services (newly expanded to all populations)
- Inpatient Services
- Voluntary Inpatient Detoxification Services (newly expanded with NO restriction of physical medical necessity)

REFERRALS

For referrals to County Substance Abuse Prevention & Control (DPH/SAPC) send written consent (or documentation for a verbal consent via phone) with the screen form to the provider referral fax at (626) 458-7637, then call the SAPC line at (888) 742- 7900.

SBIRT TRAINING

- SAMHSA funded – Addiction Technology Transfer Center Network: "Foundations of SBIRT" at: attcnetwork.org
- NIAAA Clinician's Guide Online Training "Video Cases: Helping Patients Who Drink Too Much" at: www.niaaa.nih.gov
- SBIRT Core Training Program: Screening, Brief Interventions, and Referral to Treatment at: www.sbirttraining.com/sbirtcore
- NAADAC's The Addiction Professional's Mini- Guide to Screening, Brief Intervention and Referral to Treatment (SBIRT) at: www.naadac.org/the-addiction-professionals-mini-guide-to-sbirt
- SBIRT Oregon Training Curriculum for Primary Care at: www.sbirtoregon.org
- Institute for Research, Education & Training in Addictions – SBIRT in Action – Another Vital Sign at: ireta.org.
- New York State's SBIRT Training Provider Certification at: oasas.ny.gov/providers

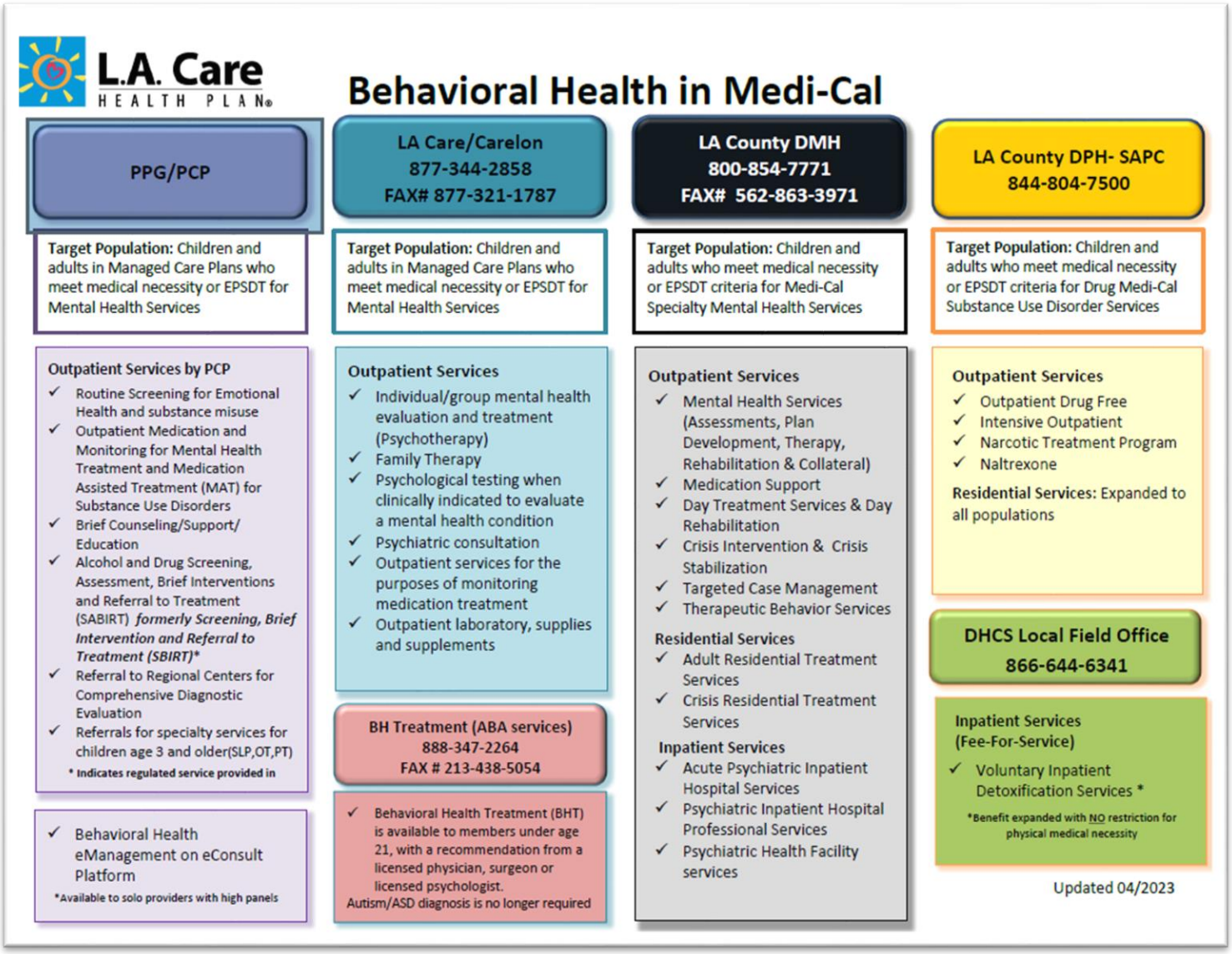
*Other trainings resources can be found on DHCS website at: www.dhcs.ca.gov

Section 3: Utilization Management

BEHAVIORAL HEALTH

L.A. CARE HEALTH PLAN - BEHAVIORAL HEALTH IN MEDI-CAL

Behavioral Health Contact:
Phone – (866) LACARE6 or (866) 522-2736
Website: [bh-made-simple.pdf (lacare.org)]



Section 3: Utilization Management

For L.A. Care Providers Only

BEHAVIORAL HEALTH SERVICES MADE SIMPLE

Line Of Business	BH Outpatient Non-Specialty (mild/moderate level of functional impairment)	BH Outpatient Specialty (High moderate and severe levels of functional impairment)	Substance Use Services	Inpatient Mental Health
MEDI-CAL	Carelon	DMH	DPH	DMH
LA Care Medicare Plus	Carelon	DMH	DPH	Carelon
MEDI-CAL with L.A. Care and Medicare FFS or Medicare Advantage Plans	Medicare FFS or MA Plans	DMH	DPH	Medicare FFS or MA Plans
PASC-SEIU	Carelon	Carelon	Carelon	Carelon
LA CARE COVERED	Carelon	Carelon	Carelon	Carelon

Non-Specialty: *Outpatient (office-based) medication services and individual/group therapy.*

Specialty: *Intensive outpatient and inpatient, medication management, targeted case management, crisis intervention/stabilization, and day treatment intensive/rehabilitation services.*

IPA/PPG Responsibility:

- ***Psychiatric consult in general medical, acute hospital or facility***

04/2023

Section 3: Utilization Management

BEHAVIORAL HEALTH SCREENING FORM

MH731

Behavioral Health Screening Form to Obtain Behavioral Health Assessment

Please complete and follow algorithm

***If this is an emergency, e.g. suicide/homicide with plan, please call 911** Referral Date:

eConsult, if available as per health plan policy, may be used in lieu of this form to determine need for or obtain behavioral health assessment.

REFERRING PROVIDER INFORMATION

Please indicate where the *Receiving Clinician* should send the disposition of the priority appointment:

Fax number: ( ) To the attention of:

MEMBER INFORMATION

Patient Name: (Last) (First) Date of Birth: / / ☐ M ☐ F

Medi-Cal # (CIN)/SSN: Current Eligibility: Language/cultural requirements:

Address: City: Zip: Phone: ( )

Caregiver/Guardian: Phone: ( )

Referring Clinician: Phone: ( )

Primary Care Provider Phone: ( ) Health Plan:

Behavioral Health Diagnoses (1) (2) (3)

Documents Included with Referral: ☐**Required consent completed** ☐MD notes ☐H&P ☐Assessment ☐Other:

Desired/existing behavioral health clinician/provider/program, if any:

List A - check all that apply:

- ☐Homelessness
- ☐Still symptomatic after 2 standard psychiatric med trials
- ☐History of bipolar disorder or manic episode
- ☐Excessive truancy or failing school
- ☐Substance and/or alcohol addiction and failed Screening and Brief Intervention (SBI)
- ☐Behavior problems (aggressive/self-destructive/assaultive)
- ☐Paranoid, hearing voices, seeing things, delusional
- ☐Excessive emergency room visits or hospitalizations
- ☐Significant functional impairment in key roles, (e.g., work, home, self-care)

List B - check all that apply if they occurred within the past 12 months:

☐>2 psychiatric hospitalizations ☐>2 incarcerations ☐Suicidal/homicidal ideation/behaviors without plan***

Referral algorithm based on checked boxes:

☐ *PRIORITY* 2 or more in list A and one in list B OR 2 or more in list B: **Fax form to DMH Appointment Line for priority appointment at (562) 863-3971**

☐ *ROUTINE* 3 or more in list A and none in list B OR one in both lists: **Call DMH ACCESS Center for routine referral at (800) 854-7771**

☐ *HEALTH PLAN REFERRAL* 1-2 in list A and none in list B OR only one in list B: **Call health plan's behavioral health network for consultation or non-specialty mental health services referral**

☐ *SUD ONLY* Substance and/or alcohol addiction and failed SBI alone: **Call the SASH Helpline at (844) 804-7500. No form is required.**

Pertinent Current/Past Information

Current symptoms and impairments:

Brief MH/SUD history:

Brief medical history/diagnosis:

Current Medication(s) & Dosage:

For Receiving Clinician Use ONLY

Instructions: **Fax this form to the number and person indicated at the top of the form**

*Referring provider to follow up with individual

Disposition of priority appointment: ☐ **Attended** ☐ **Rescheduled** ☐ **Did Not Show*** ☐ **Declined*** ☐ **Unable to Accept Insurance Type***

Assigned Case Manager/MD/Therapist Name: Phone: ( )

Date disposition sent to referral source: / / *Provider Communication Form* (MH 707) form attached

Rev. 1/16/19 Confidential Patient Information. See CA W&I Code Section 5328

Section 3: Utilization Management

BEHAVIORAL HEALTH SCREENING FORM - INSTRUCTIONS

Instructions for the Behavioral Health Screening Form to Obtain Specialty Behavioral Health Assessment

If this is an emergency situation, including plan for suicide and/or homicide, please call 911

Abbreviations: **H&P**: History and Physical Exam **SBI:** Screening and Brief Intervention

MH/SUD: Mental Health and Substance Use Disorder

Explanations:

- *'Medi-Cal # (CIN)/SSN'*: Enter the Medi-Cal Number of the client. If the Medi-Cal Number is unavailable, enter the client's Social Security Number.
- *'Current Eligibility'*: Choose the appropriate eligibility from the drop down menu, i.e., Medicare, Private Insurance, Medi-Cal, Medi-Medi, Indigent, etc. **Note:** If the patient is a **Cal MediConnect** member, please enter: "CMC/ (Name of Health Plan)" and the CMC ID #.
- *'Caregiver/Guardian'*: Parents (for minor), conservator, etc.
- *'Required consent completed'*: The release of Protected Health Information may require a signed authorization from the client or his/her representative. Individuals completing this form are advised to refer to their agency policy when making this determination.
- *'Desired/Existing behavioral health clinician/provider/program'*: Complete this section if member/client or referral source prefers a specific program, clinician, or provider that would meet member's individual needs. If member/client is currently receiving services from a mental health program, clinician, or provider, please indicate name and contact information.
- *'Excessive ER visits or 911 calls'*: Check this box if the number of visits or calls exceeds what is reasonably expected as a result of the patient's general physical and behavioral health conditions.

Referring provider:

- If the Member/Client has an existing behavioral health clinician/provider or an open/active case in a program, please refer him/her directly to that treating source and send the written consent (or documentation of a verbal consent via phone), when required, with the screening form to the treating source.
- For referrals to County Department of Mental Health Appointment Line, please send the written consent (or documentation of verbal consent via phone), when required, with the screening form to the ACCESS Appointment Line via , fax to (562) 863-3971, or via eConsult and then call the DMH line at (855) 425-8141.
- For referrals to County Department of Mental Health ACCESS Center, please call or direct the client to call, the ACCESS Center at (800) 854-7771. The client may also directly call or walk into a specialty mental health clinic to request services. To find the nearest specialty mental health clinic, please use the Service Locator at http://lacdmh.lacounty.gov/appASPNET/ServiceLocator/.
- For referrals to the **health plan's behavioral health network**, please send the written consent (or documentation of verbal consent via phone), when required, with the screening form to the appropriate fax number or e-mail address and then call the phone number listed (see chart on Page 4 for contact information). **Note:** For **L.A. Care** providers with access to the **eConsult platform**, you are able to send the screening form via this platform.
- For referrals to County **Substance Abuse Prevention & Control** (SAPC), no screening form is required. Please call the Substance Abuse Service Helpline (SASH) at **(844) 804-7500** to make the referral.

Section 3: Utilization Management

BEHAVIORAL HEALTH SCREENING FORM – INSTRUCTIONS

Receiving clinician:

- The "For Receiving Clinician Use ONLY" section must be completed and faxed to the number and person indicated at the top of the screening form as soon as the disposition of the initial appointment is known.
- The "Disposition of Initial Appointment" information must also be entered into the DMH Service Request Tracking System (SRTS) record.
- When required, the completed "Authorization to Exchange PHI" accompanying the "Behavioral Health Screening Form to Obtain Behavioral Health Assessment" permits a response to the referral source without further authorization.
- Complete and return the **Provider Communication Form** (MH 707) to the referring provider once the assessment has been completed. If it is determined that the individual's treatment need is better met at a different system of care/level of care, please refer and send the Provider Communication Form and completed assessment documents to the appropriate system of care/level of care.
- If the care is determined to be appropriately provided by the primary care physician, contact the health plan's behavioral health network.
- In the event of a disagreement as to the appropriate system of care/level of care, please forward the case to the appropriately identified individual responsible for dispute resolution within your system of care and continue with treatment while the decision is pending.
- If the Member/Client has requested services by himself/herself without a referral, please make sure to communicate with the identified primary care physician regarding the assessment outcome and/or disposition.

Section 3: Utilization Management

DIRECT REFERRAL PROGRAM

The Direct Referral program was developed to expedite member access to specialists for consultation, eliminating administrative barriers and facilitate PCP's role by coordinating patient's medical care.
If the service is a covered benefit, Primary Care Physicians may directly authorize referrals for initial consultations to IPA In-Network participating specialists, in the categories referenced below when medically necessary (do not wait for IPA Utilization Review Department approval).

Referrals qualifying for Direct access will auto-adjudicate through the MedPOINT Management web portal. Authorization is available for printing within 10-20 minutes of referral request.

The Direct Referral form is a guarantee for payment subject to the following exceptions: Charges for non-covered services or services rendered to patients whose coverage is no longer in effect are the patient's responsibility.

Authorization expires in sixty (60) days. Direct Referral Authorization is not valid for providers not participating on the IPA Panel. All follow-up care must be prior authorized by the utilization review department.
This protocol applies even when additional services are provided in conjunction with the initial consultation. Services related to CCS eligible conditions must be authorized by CCS. Health Care, L.A., IPA is not responsible for payment of services related to CCS eligible conditions.

All other services including inpatient and outpatient care continue to require precertification. All radiology providers require prescription order form in addition to IPA referral.
Member eligibility must be verified at encounter.
Member may self-refer for sensitive services such as family planning, abortions, sexually transmitted infections STIs, sterilization, HIV/AIDS testing.
Members may self-refer to Participating OBGYN providers. Obstetricians/ Gynecologists can directly refer members for the following services: pelvic ultrasounds, mammograms, DEXA scans, breast ultrasounds, Maternal AFIs and NSTs.

INITIAL CONSULTATION AND CODES			
CPT Code 99243: Medi-Cal		CPT Code 99203: Commercial and Medicare	
Cardiology	Maternal AFI	Ophthalmology	TAB (Medi-Cal only)
EKG (93000)	Maternal NST	Optometry (Blue Shield of California of California Promise Health Plan 92004, 92340-92342, 92352-92353, V2020)	
Gynecology	Obstetrics	Orthopedics	Urology
Radiology	Abdominal Ultrasound (76700)	Dexa Scan (77080)	OB Ultrasound
	X-Ray Extremity, Flat Plate, Chest	Pelvic Ultrasound (76856)	Venous Doppler

Section 3: Utilization Management

DIRECT REFERRAL PROGRAM

BREAST CANCER AND CERVICAL CANCER SCREENING

Breast cancer and cervical screenings may be performed without the need for prior authorization. Imaging centers and providers contracted with Health Care, L.A., IPA must provide direct access to breast cancer and cervical screenings, no prior authorization is required. Please refer to the table below for a listing of diagnostic services which do not require authorizations.

CPT CODE	DESCRIPTION
19102	Percutaneous image guided core breast biopsy
19103	Percutaneous vacuum assisted breast biopsy
19499	Unlisted breast procedure
77031	Stereotactic guidance
76942	Ultrasound guidance
77021	MR guidance
77032	Mammographic guidance
19295	Marker wire placement (clip)
76098	Radiological exam, surgical specimen
19290	Breast hookwire localization, initial state
19291	Breast hookwire localization, each additional site
38792	Injection procedure for sentinel node ID
38900	Intraoperative ID of sentinel node, includes dye when performed
77067	Screening mammography, producing direct digital image, bilateral, all views
77063	Screening digital breast tomosynthesis (3D), bilateral (used with code 77067)
77061	Digital breast tomosynthesis, unilateral
77062	Digital breast tomosynthesis, bilateral
G0279	Digital breast tomosynthesis, unilateral or bilateral
77065	Diagnostic mammography, producing direct digital image, unilateral, all views
77066	Diagnostic mammography, producing direct digital image, bilateral, all views
76641	Breast Ultrasound – complete scan of the breast
76642	Breast Ultrasound – limited or targeted ultrasound of the breast
19081	Breast biopsy w/local, specimen imaging, percutaneous, 1st lesion including stereo guidance
19083	Breast biopsy w/local, specimen imaging, percutaneous, 1st lesion including ultrasound guidance

Section 3: Utilization Management

TRANSITION OF CARE (TOC) PROCESS FOR POST DISCHARGED PATIENTS

NOTIFICATION OF ADMISSION
HCLA/MedPOINT TOC (Transition of Care) staff will send a PCP Admit notification list via Email or Fax to Designated Health Center (DHC) individual.

Notification includes members/patients with recent admissions from hospitals or skilled nursing facilities.
**This process should apply to all of Health Center service locations

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

Admission and Discharge Process:

- The hospitals (admitting) notify HCLA of the admissions via Fax or Phone call
- HCLA generates a tracking number in EZ-Cap
- PCP notification report is generated the next day and sent to the DHC individual via fax or email
- HCLA/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
- HCLA/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
- HCLA/MPM TOC Coordinator faxes/emails/calls PCP to notify of discharged members
- HCLA/MPM TOC Coordinator faxes/emails/calls the DHC individual (preferably while in-house) to schedule the appointment dates

Obtaining PCP Appointments can be made by phone, email or fax:
Phone Call: TOC Coordinator calls the DHC individual to schedule appointments of discharged members (preferably while in-house) by the PCP/provider.

Email: A list of discharged members and demographic information is sent via secured email to the DHC individual and is emailed back to the TOC Coordinator within two business days with the appointment information.

Fax: A list of discharged members and demographic information is sent via fax to DHC individual and is faxed back to the TOC Coordinator within two business days with the appointment information.

**Available Medical Records/TOC Packets are sent 1- 2 days prior to the scheduled visit unless the Health Center has EHR access to hospital medical records
**TOC Coordinators notify the members (preferably while in-house) of the scheduled PCP visit
**DHC individual and/or staff member of Health Center 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 comprised 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 818-702-0100 ext. 1834, Monday through Friday from 8:00 a.m. to 5:00 p.m.

Referrals may be submitted via fax or e-mail. E-mail: cm_notification@medpointmanagement.com
Fax: (818) 444-1203

Section 4: Provider Standards and Policies

TIMELY ACCESS TO CARE STANDARD

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 access 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 immediately.

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 enrollee lives, or 30 miles from where they work.
Availability: Health Plans should provide enrollees 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, (Specialty Care Physician) fifteen business days
- Preventive Care **Wait Time:** thirty calendar days
- Mental Health Appointment (non-physician) **Wait Time:** 10 business days**,** (ancillary provider) fifteen 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)

Emergent and Urgent Services when an Enrollee is outside of California

- Not applicable to Medicare plans
- California Health Plans must provider enrollees with instruction about how to access emergency services when the enrollee is outside of the plans services area consistent with California's timely access standards
- An emergency condition is "medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably" place the enrollee's health in serious jeopardy, seriously impair the enrollee's bodily functions, or cause serious dysfunction of any bodily organ or part. (Cal Health & Safety Code § 1317.)
- Urgently needed services are necessary to prevent injury or determination of the health of an enrollee

AFTER HOURS ACCESS REQUIREMENTS

After Hours Access audits are conducted routinely to ensure physician offices have appropriate after hours telephone recordings that direct patients to an emergency room or urgent care facility in order to access immediate care. An on-call phone number or nurse'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 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:

1. 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.
2. Get the member's number and advise a physician will call them back within the 30 minutes, OR
3. If a member indicates a need for interpreter services, facilitate the contact by 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:

1. Please hold and you will be connected to (Dr. Name)
2. You may reach the on-call doctor directly by calling (give number)
3. 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.
4. Our Urgent Care Center is located at (give address/phone number)

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 Health Care LA, 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

INITIAL HEALTH APPOINTMENT

The Individual Health Education Behavioral Assessment (IHEBA) or Staying Healthy Assessment (SHA), an age-specific questionnaire developed to enable PCPs to assess a member's acute, chronic and preventative health needs are no longer components of the Individual Health Appointment (IHA) beginning Jan 1, 2023.

An Initial Health Appointment (IHA), previously called Initial Health Assessment, now refers to appointment(s) required to be completed within 120 days of Managed Care Plan (MCP) enrollment for new members. Elimination of the IHEBA/SHA does not change the requirement to include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases as part of the IHA. Providers may choose to continue to use the IHEBA/SHA as their preferred tool to identify behaviors that place members at risk if they desire to do so.

For more detailed information, please visit the Department of Healthcare Services: www.dhcs.ca.gov

Initial Health Appointment (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

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.

Please visit the Provider Resources tab at MedPOINT Management for provider training and education on a variety of topics including, but not limited to clinical guidelines and useful information regarding HCC scores, CPSP CHDP/Regional Programs, Cultural Linguistics, Nurse Advice Lines and useful training and tips like Advanced Directives, When to Release Health Information under HIPAA Law, and Critical Incident Reporting.

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, however 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 readministered 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.

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	✓		✓	✓

SHA DOCUMENTATION BY PCP

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

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: medi-cal.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
- 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

PROVIDER PROCEDURES AND RESPONSIBILITIES

Responsibilities Applicable To All Providers

Our providers must fulfill their roles and responsibilities with the highest integrity. We lean on their extensive healthcare education, experience and dedication to our members.

There are a number of responsibilities applicable to all providers. Responsibilities include the following:

- After-hours services
- Eligibility verification
- Collaboration
- Confidentiality
- Continuity of care
- Licenses and certifications
- Mandatory reporting of abuse
- Medical records standards and documentation
- Office hours
- Open clinical dialog/affirmative statement
- Oversight of non-physician practitioners
- Prohibited activities
- Provider contract terminations
- Termination of ancillary provider/patient relationship
- Updating provider information
- Fully complying with all terms and conditions of the DHCS contract including ownership and control disclosures, audits and inspections of subcontractors, and monitoring activities related to care coordination, data reporting and other functions

Prohibited Activities

- Billing eligible members for covered services
- Segregating members in any way from other persons receiving similar services, supplies or equipment
- Discriminating against members or Medicaid participants

Note: Services should always be provided without regard to race, religion, sex, color, national origin, age or physical/behavioral health status.

Section 5: Encounter Data, Claims and Billing

CLAIMS AND ENCOUNTER ATA 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
(866) 575-4120
Payer ID: MPM06
www.officeally.com

ENCOUNTER DATA REQUIREMENTS

All encounter information must be received by the 15th of the following month from date of service. The 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 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 billing submission and superbills. 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, needs to be included:

1. Insured's I.D. # (Box1a.)
2. Patient's Name (Box 2)
3. Patients Birth Date (Box3)
4. Sex (Box 3)
5. Patient's Address (Box 5)
6. Claim Codes (Designated 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 24J.)
13. Federal Tax I.D. Number "TIN" (Box25)
14. Signature of Physician or Supplier (Box31)
15. Service Facility Location Information (Box32)
16. Service Facility Location NPI Number (Box 32.a)
17. Billing Provider Info and PH # (Box33)
18. Billing Provider NPI (Box33a)

120 DAY HEALTH ASSESSMENT

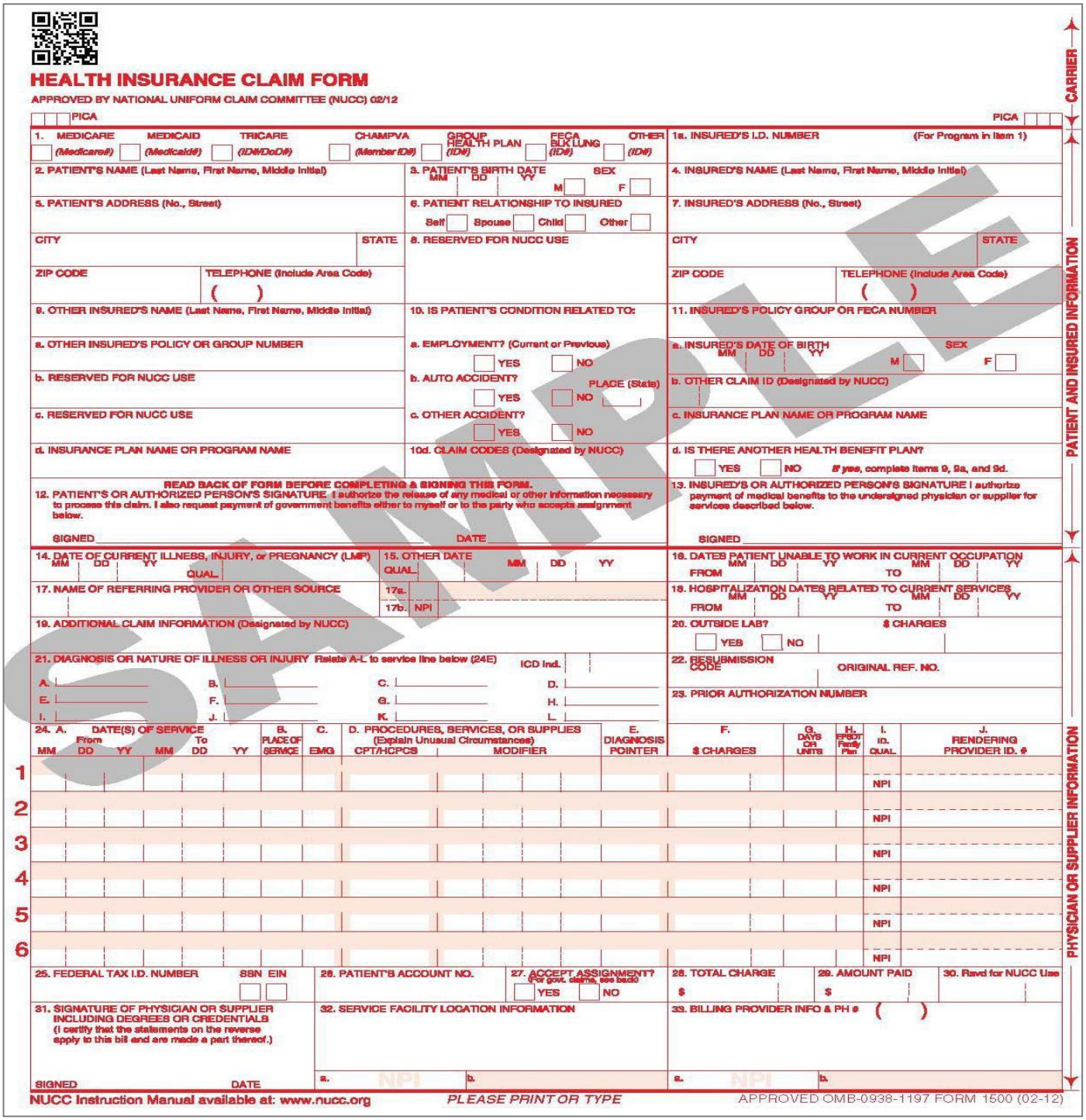
Follow up attempts for 120 Day Health Assessment are the responsibility of the PCP.

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM (CHDP) ENCOUNTERS AND GUIDELINES

Some Health Plans require CHDP encounters to be submitted via the CMS-1500 form to both the IPA and the Health Plan to qualify. The Department of Health Care Services (DHCS) phased out of the PM 160 Information Only (INF) form submission requirement for CHDP providers; however, Anthem Blue Cross requires the submission of PM 160 forms. Anthem Blue Cross pays claims without the PM160 submission but requires the forms to capture HEDIS and other data. To determine submission guidelines by Health Plan, see CDHP Billing Protocols.

Section 5: Encounter Data, Claims and Billing

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'.



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 gov. 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

Section 5: Encounter Data, Claims and Billing

HCLA BILLING MATRIX FOR SERVICES WHERE FINANCIAL RESPONSIBILITY VARIES BETWEEN IPA AND HEALTH PLAN

HEALTH PLAN	IMMUNIZATIONS	CHDP	CONTRACEPTIVE DEVICE	DEPO-PROVERA
Alignment Health Plan	Submit CMS 1500 to HCLA, Paid Fee-for-Service	NA	Submit CMS 1500 to HCLA, included in IPA capitation	(Medicare) Submit CMS 1500 to HCLA, included in IPA capitation
Anthem Blue Cross (Medi-Cal)	Adult Vaccines & Non CHDP Submit CMS 1500 to HCLA, included in IPA capitation	Plan financial responsibility. To qualify for Blue Cross CHDP payment, submit encounter via CMS 1500 to Plan. In addition to Plan submission, encounter must be submitted via CMS 1500 to IPA (electronic via Office Ally - preferred) using standard CPT codes.	Submit CMS 1500 to HCLA, included in IPA capitation	Submit CMS 1500 to HCLA, included in IPA capitation
Anthem Blue Cross (Commercial)	Submit CMS 1500 to HCLA, included in IPA Capitation	NA	Submit CMS 1500 to HCLA, included in IPA Capitation	Submit CMS 1500 to HCLA, included in IPA Capitation
Blue Shield of California	Submit CMS 1500 to HCLA, included in IPA Capitation	NA	Bill Blue Shield of California	Submit CMS 1500 to HCLA, included in IPA Capitation
Blue Shield of California Promise Health Plan (Medi-Cal)	Adult Vaccines & Non CHDP Submit CMS 1500 to HCLA, included in IPA Capitation	IPA financial responsibility included in capitation. Submit encounter via CMS 1500 to IPA (electronic via Office Ally preferred) using standard CPT codes.	Oral: Bill Blue Shield of California Promise Health Plan Other: Submit CMS 1500 to HCLA, included in IPA Capitation	Bill Blue Shield of California Promise Health Plan
Brand New Day	Submit CMS 1500 to HCLA, Paid Fee-for-Service	NA	NA	NA

Section 5: Encounter Data, Claims and Billing

HCLA BILLING MATRIX FOR SERVICES WHERE FINANCIAL RESPONSIBILITY VARIES BETWEEN IPA AND HEALTH PLAN

HEALTH PLAN	IMMUNIZATIONS	CHDP	CONTRACEPTIVE DEVICE	DEPO-PROVERA
Cigna	Submit CMS 1500 to HCLA, included in IPA Capitation	NA	Oral: Bill Cigna Device: Submit CMS 1500 to HCLA, included in IPA Capitation	Submit CMS 1500 to HCLA, included in IPA Capitation
Health Net (EAE D-SNP)	Submit CMS 1500 to HCLA, included in IPA Capitation	NA	NA	NA
Health Net (Commercial)	Submit CMS 1500 to HCLA, included in IPA Capitation	NA	Submit CMS 1500 to HCLA, included in IPA Capitation	Submit CMS 1500 to HCLA, included in IPA Capitation
Health Net (Covered CA)	Submit CMS 1500 to HCLA, Paid Fee-for-Service	NA	Submit CMS 1500 to HCLA, Paid Fee-for-Service	Submit CMS 1500 to HCLA, Paid Fee- for-Service
Health Net (Medi-Cal)	Adult Vaccines & Non CHDP Submit CMS 1500 to HCLA, included in IPA Capitation	IPA Risk	Submit CMS 1500 to HCLA, included in IPA Capitation	Submit CMS 1500 to HCLA, included in IPA Capitation

Section 5: Encounter Data, Claims and Billing

HCLA BILLING MATRIX FOR SERVICES WHERE FINANCIAL RESPONSIBILITY VARIES BETWEEN IPA AND HEALTH PLAN

HEALTH PLAN	IMMUNIZATIONS	CHDP	CONTRACEPTIVE DEVICE	DEPO-PROVERA
Health Net (Medicare)	Submit CMS 1500 to HCLA, Paid Fee-for-Service	NA	Bill Health Net	NA
L.A. Care Health Plan (EAE D-SNP)	Submit CMS 1500 to HCLA, included in IPA Capitation	NA	Bill L.A. Care Health Plan	Bill L.A. Care Health Plan
L.A. Care Health Plan (Covered California)	Submit CMS 1500 to HCLA, Paid Fee-for-Service	NA	Submit CMS 1500 to HCLA, Paid Fee-for-Service	Submit CMS 1500 to HCLA, Paid Fee-for-Service
L.A. Care Health Plan (Medi-Cal)	Adult Vaccines & Non CHDP Submit CMS 1500 to HCLA, included in IPA Capitation	Plan financial responsibility. To qualify for L.A. Care Health Plan CHDP payment, submit encounter via CMS 1500 to Plan. In addition to Plan submission, encounter must be submitted via CMS 1500 to IPA (electronic via Office Ally preferred) using standard CPT codes.	IUD or Diaphragm: Submit CMS 1500 to HCLA, included in IPA Capitation Other: Bill to HCLA	Bill L.A. Care Health Plan
Molina Healthcare (Covered California)	Submit CMS 1500 to HCLA, Paid Fee-for-Service	NA	Submit CMS 1500 to HCLA, Paid Fee-for-Service	Bill Molina Healthcare
Molina Healthcare (Medi-Cal)	Adult Vaccines & Non CHDP Submit CMS 1500 to HCLA, included in IPA Capitation	IPA financial responsibility included in capitation. To qualify for Molina Healthcare CHDP payment, submit encounter via CMS 1500 to Plan. In addition to Plan submission, encounter must be submitted via CMS 1500 to IPA (electronic via Office Ally preferred) using standard CPT codes.	Submit CMS 1500 to HCLA, included in IPA Capitation	Bill Molina Healthcare
Molina Healthcare (Medicare & EAE D-SNP)	Bill Molina Healthcare	NA	(Medicare) NA (EAE D-SNP) Bill Molina Healthcare	Bill Molina Healthcare

Section 5: Encounter Data, Claims and Billing

HCLA BILLING MATRIX FOR SERVICES WHERE FINANCIAL RESPONSIBILITY VARIES BETWEEN IPA AND HEALTH PLAN

FOR YOUR CHDP ENCOUNTERS TO QUALIFY, YOU MUST SUBMIT CORRECT FORMS TO ALL CHECKED PARTIES

HEALTH PLAN	HEALTH PLAN CMS 1500	IPA CMS 1500	Vaccines: VFC	NOTES
ANTHEM BLUE CROSS	√	√	√	Submit Plan CMS 1500: P.O. Box 60007 Los Angeles, CA 90060-0007 In addition, CMS 1500 encounter must be submitted to the IPA. CHDP is Plan financial responsibility.
Blue Shield of California Promise Health Plan		√	√	CHDP is IPA financial responsibility included in capitation. No additional Blue Shield of California Promise Health Plan incentive.
Health Net	√	√	√	CHDP is IPA financial responsibility. CMS 1500 encounter must be submitted to the IPA.
L.A. CARE	√	√	√	Submit CMS 1500 to Plan: PO Box 811580 Los Angeles, CA 90081 CHDP is Plan financial responsibility.
MOLINA HEALTHCARE You must preregister for the program. **Contact Molina Healthcare: (562) 435-3666**	√	√	√	CHDP is IPA financial responsibility. Molina Healthcare offers additional incentive based on electronic encounter to IPA. Member enrollment must be over two hundred. PCP must be enrolled in the program.

CLAIM TIMELINESS
Contracted providers will have 45 days from date of service to submit claims. Non-contracted providers will have 180 calendar days from date of service to submit claims.

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.

CLAIM REJECTION
If a claim is rejected during Office Ally or the payer's scrubbing process, your claims will be sent to Claim Fix. These 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: MPM Provider Web Portal

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 enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the Date of Service and provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

DISPUTE RESOLUTION SUBMISSION
Provider Disputes submitted must include the information listed above, for each contracted Provider Dispute.
Via Mail: P.O. Box 570790, Tarzana, CA 91357

TIME PERIOD FOR SUBMISSION
Contracted provider disputes must be received by IPA 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.

Contracted 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 to IPA within thirty (30) working days of your receipt of a returned contracted provider dispute.

ACKNOWLEDGMENT OF DISPUTES
All incoming disputes will be acknowledged upon receipt of the dispute regardless of whether or not the dispute is complete within fifteen 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 IPA at: 866-423-0060, option 3.

INSTRUCTIONS FOR FILING SUBSTANTIALLY SIMILAR CONTRACTED PROVIDER DISPUTES
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

1. 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.

2. CONTESTED NOTICE

If the provider contests IPA's notice of overpayment of a claim, the provider, within 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.

3. 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.

4. 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) rules, once a service has been rendered without obtaining prior authorization, it is considered to be 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 the 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 responsible only for co-payment amounts and services determined as exclusions and limitations to the health plan explanation of benefits.

Section 5: Encounter Data, Claims and Billing

COVERED CALIFORNIA

CONTRACTED HEALTH PLANS	
NAME OF HMO	**TYPE OF CONTRACT**
ANTHEM BLUE CROSS	Anthem Blue Cross Market Place HMO
HEALTH NET	Community Care HMO
L.A. CARE	L.A. Care Covered HMO
MOLINA HEALTHCARE	Molina Healthcare Market Place HMO

Eligibility and benefit information should be confirmed at each visit via Health Plan Web Portal or Customer Service Department. Schedule of Benefits for each of the metal levels with detailed information is available on plan websites.

ELIGIBILITY AND BENEFITS		
Health Plan	**Website**	**Phone #**
Anthem Blue Cross	Anthem Blue Cross	(866) 755-2680
Healthnet	Healthnet	(800) 675-6110
L.A. Care	L.A. Care	(855) 222-4239
Molina Healthcare	Molina Healthcare	(855) 322-4075

WHAT IF MEMBER DOES NOT SHOW AS ELIGIBLE VIA WEBSITE OR THROUGH PLAN CUSTOMER SERVICE?
Direct the member to contact the Health Plan Member Services Department

MEMBER SERVICES DEPARTMENT	
Health Plan	**Phone**
Anthem Blue Cross	(800) 331-1476
Healthnet	(888) 926-4988
L.A. Care	(855) 270-2327
Molina Healthcare	(888) 858-2150

Section 5: Encounter Data, Claims and Billing

COVERED CALIFORNIA

CO-PAYMENTS

COPAYS: MULTIPLE CO-PAYS APPLY IF MULTIPLE SERVICES ARE RENDERED

- Verify if copayments are applicable via Health Plan website or Members Services Department.
- If all services are rendered within your clinic multiple copay(s) apply.

Example:

* Co-payments do not apply to preventive care services, prenatal care or for pre-conception visits.

LAB DRAW AND X-RAY COPAYS

- Lab draw and x-ray only have co-pays for Outpatient Laboratory Provider, Radiology Center and Outpatient Hospitals

SPECIALIST OFFICE VISIT COPAYS

- Specialty office visit copay(s) may apply for services rendered by a specialist within your clinic. This applies even though HCLA does not reimburse separately for these services. Examples include Allergy, Cardiology, OB/GYN, Podiatry, etc.

HEALTH PLAN, PCP OR IPA CHANGES

HOW AND WHEN CAN A MEMBER CHANGE PLANS?

- Members can change plans only during open enrollment
- Members can change PCP and IPA within their plan at any time
- For more information, visit: www.coveredca.com

BILLING

WHO DO WE BILL FOR SERVICES?

Under your IPA Agreement, services to Covered California members are paid on a FFS Basis. All claims must be submitted to HCLA for reimbursement. Services are reimbursed at 70% of the current Medicare allowable rates less applicable copayments.

Section 5: Encounter Data, Claims and Billing

FINANCIAL RESPONSIBILITY FORM (ENGLISH VERSION)

Health Care LA, IPA

FINANCIAL RESPONSIBILITY FORM

Member Acknowledgement of Financial Responsibility

Provider, Please check one of the following:

☐ Your Plan has indicated that the services listed are not covered under your benefit plan.

☐ Your benefits have not been verified. In the event that we determine that the services listed are not covered under your benefit plan, you will be responsible for the cost of that service.

Provider: This form must be used for HCLA members who wish to receive healthcare services from you that may not be covered by their Benefit Plan. Acknowledgement of responsibility must include specific information regarding date of service, services provided, and billed amounts.

Member: Your signature on this form acknowledges that you agree to bear full financial responsibility for all services provided as listed below if:

- The services are not covered under your Benefit Plan, or,
- The services have not been otherwise approved for payment by your Plan

Service Description:

(Any service not described as a covered benefit in the member's Evidence of Coverage.)

_____

_____

_____ _____

Patient's Signature | Date of Service

_____ _____

Patient's Printed Name | Permanent Address

_____ _____

Signature of Responsible Party (on behalf of dependent) | City, State, Zip

_____ _____

Responsible Party Printed Name (on behalf of dependent) | Telephone Number

*Place a copy of patient's driver's license below, if not on file in chart.

Health Care LA, IPA · P.O. Box 570590 · Tarzana · CA · 91357 · Tel 818-702-0100 · Fax 818-702-9128

Section 5: Encounter Data, Claims and Billing

FINANCIAL RESPONSIBILITY FORM (SPANISH VERSION)

Health Care LA, IPA

FORMULARIO DE RESPONSABILIDAD FINANCIERA

Aceptación de responsabilidad financiera por parte del miembro

Proveedor, por favor marque una de las siguientes:

☐ Su Plan ha indicado que los servicios mencionados no están cubiertos por su plan de beneficios.

☐ Sus beneficios no han sido verificados. Si determinamos que los servicios mencionados no están cubiertos por su plan de beneficios, usted será responsable del costo de ese servicio.

Proveedor: Se debe utilizar este formulario para los miembros de HCLA (Health Care LA [Atención Médica LA]) que deseen recibir de usted servicios de atención medica que pueden no estar cubiertos por su Plan de Beneficios. La aceptación de responsabilidad debe incluir información especifica relacionada con la fecha del servicio, los servicios provistos y las cantidades facturadas.

Miembro: Su firma en este formulario indica que está de acuerdo en aceptar la responsabilidad financiera total por todos los servicios provistos mencionados a continuación, si:

- Los servicios no están cubiertos por su Plan de Beneficios, o,
- El pago de los servicios no ha sido aprobado de otro modo por su Plan

Descripción del servicio:

(Todo servicio no descrito como un beneficio cubierto en la Constancia de Cobertura del miembro).

_____

_____

_____ _____

Firma del paciente Fecha del servicio

_____ _____

Nombre del paciente en letra de molde Dirección permanente

_____ _____

Firma de la parte responsable (en nombre del dependiente) Ciudad, estado, código postal

_____ _____

Nombre de la parte responsable en letra de molde (en nombre del dependiente) Número telefónico

*Coloque una copia de la licencia de manejar del paciente a continuación, si no está archivada en la historia clínica.

Health Care LA, IPA · P.O. Box 570590 · Tarzana · CA · 91357 · Tel 818-702-0100 · Fax 818-702-9128

Section 5: Encounter Data, Claims and Billing

COVERED CALIFORNIA

CALIFORNIA CHILDREN'S SERVICES (CCS)
Children needing specialized medical care may be eligible for the California Children's Services (CCS) program. CCS is a California medical program that treats children with certain physical conditions and who need specialized medical care. This program is available to all children in California whose families meet certain medical, financial and residential eligibility requirements. Services provided through the CCS program are coordinated by the local county CCS office.

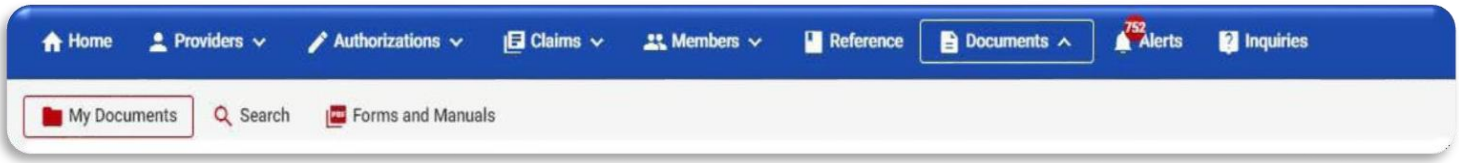
If a member's PCP suspects or identifies a possible CCS eligible condition, he/she may refer the member to the local county CCS program. The CCS program (local or the CCS Regional Office) will determine if the member's condition is eligible for CCS services.
If determined to be eligible for CCS services, a Covered California Member continues to stay enrolled in the Qualified Health Plan Product (QHP). He or she will be referred and should receive treatment for the CCS eligible condition through the specialized network of CCS providers and/or CCS approved specialty centers. These CCS providers and specialty centers are highly trained to treat CCS eligible conditions. HCLA will continue to provide primary care and prevention services that are not related to the CCS eligible conditions, as described in this document. HCLA will also work with the CCS program to coordinate care provided by both the CCS program and the plan. HCLA will continue to provide all other medical services not related to CCS diagnosis.

The CCS office must verify residential status for each child in the CCS program. If your child is referred to the CCS program, you will be asked to complete a short application to verify residential status, financial eligibility and ensure coordination of your child's care after the Hospital Network.

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: MPM Provider Web Portal 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

payspan.

Register for PAYSPAN

It is: 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)

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 designed to monitor and evaluate quality, appropriateness, and the outcome of care services alongside processes by which they are delivered to IHP members objectively and systematically.

Specific activities in the QM program include, and 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 5- 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

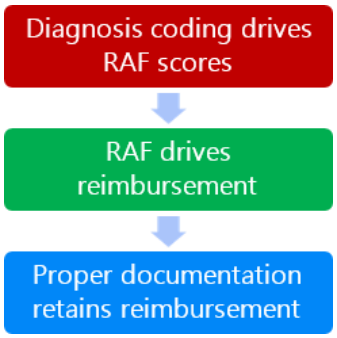
- Provider education and support
- Correct billing
- EHR template updates
- Check MPM clinical alert dashboard
- Submission of encounter with all documented diagnosis

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 Health Plan to adjust Health Plan payments
- Based on enrollee 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

CULTURAL COMPETENCY PROGRAM

Serving members requires supporting their cultural and linguistic 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 interpreters' services?
The provider conducting the consultation or treatment plan is to schedule 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 s
- Services

Health Plan Incentives

<table>
<tr><td>Anthem Blue Cross</td><td>Provider</td><td>Covered CA</td><td>2022 California Provider Quality Incentive Program-HMO</td><td>• For each HEDIS measure gap closed for the member's provided to you, you will receive a payment of $100. This is per gap, not per member. Some members may have more than one gap.
• All services must be completed by December 31, 2022.</td></tr>
<tr><td>Blue Shield Promise</td><td>Provider</td><td>Medicare Advantage HMO and Commercial HMO</td><td>In Office Assessment (IOA) Provider Incentive Program 2023</td><td>The IOA Incentive Program applies to Blue Shield Medicare Advantage HMO and commercial HMO members receiving an annual comprehensive health evaluation during their membership with Blue Shield. Each eligible member's IOA form contains information about their potential care gaps and HCC's that need to be evaluated and assessed during the measurement year.
Payment and Schedule
<table><tr><th>Incentive Infomormation</th><th>IOA form Timeliness (≤ 60days from DOS) &met 80% Care Gap</th><th>IOA Form Timeliness (> 60 Days Form DOS) & Met 80% Care Gap</th><th>2023 Pay payment Processing dates*</th></tr><tr><td>Tier 1:
• DOS ≤ 7/31/2023
• Submission ≤ 10/15/2023</td><td>$300</td><td>$150</td><td>•July 5,2023
• Oct 2,2023</td></tr><tr><td>Tier 2:
• DOS ≥ 8/01/2023
• Submission ≤ 02/29/2024</td><td>$150</td><td>$75</td><td>• Januray 2,2024
• 3, 2024
(final Payment)</td></tr></table>
To receive incentive payment, three requirements must be satisfied:
1. The IOA form must be completed thoroughly by a practitioner. The assessment can be performed using one of the following formats:
i. In person office visit, or
ii. Telehealth- must use an interactive audio and video telecommunication system
2. Blue Shield must receive a claim/encounter record.
i. The record must contain a G code (G0438 or G0439) or an E&M code (992x or 993x).
ii. Claims for telehealth must contain place of service code "02"
iii. Patient's Home or "10"
3. Documentation must support at least 80% of potential chronic conditions
* Forms are saved on your sFTP.
Select health centers have been selected to participate, Contact your Coding Analyst for more information</td></tr>
<tr><td>Brand New Day</td><td>Provider</td><td>Medicare</td><td>STARs Annual Wellness Exam (AWE) 2023</td><td>Providers who use an approved BND/CHP AWV form and submit a completed form and copy of the progress note will qualify for an AWE Incentive payment. For the AWV form to be complete, the following must be present: • All Risk Adjustment and Quality Gaps must be addressed • All AWV forms must be signed by a clinician • All AWV forms must be submitted with a copy of a progress note• Submit an electronic encounter for the visit using of the following HCPCS codes (G0438, G0439, G0468). Can be submitted through Cozeva or the SFTPUsing Cozeva • Base Rate: $175• Bonus if submitted by 8/1/2023 $25• Bonus for SNP members $25• Potential Total: $225Non Cozeva • Base Rate: $125• Bonus if submitted by</td></tr>
</table>

				8/1/2023 $25• Bonus for SNP members $25• Potential Total: $175Payments will be made Quarterly, within 45 days of the quarter end.
Brand New Day	Provider	Medicare	CAHPS Provider Incentive Program (CPIP) 2023	Brand New Day (health plan or Health Plan)-sponsored surveys (CAHPS simulation) will be administered to a random sample of the health plan population over a two-year period. The identified measures will be calculated for both years and compared. Reconciliation occurs at the health plan level, responses and results are not aggregated. If it is determined that the provider group performed better year-over-year (YOY), then an incentive is triggered for that measure equal to $5 per-member-per-year (PMPY). If the provider group performed considerably better in a measure YOY, achieving an increase of at least 5%, the incentive will increase to $10 PMPY. Maximum payment of $40 PMPY is achieved if all measures improve 5% or more YOY ($10 PMPY x 4 measures = $40 PMPY). Membership used to determine payment for the program, shown below, is calculated using active members at the close of the benchmark year's Open Enrollment period (i.e., April 1, 2022).
Health Net	Provider	Medi-Cal	HEDIS Improvement Program (HIP) 2023 – PCPs	The HIP Program rewards PCPs for care gaps closed in 14 HEDIS measures. BCS- $75, CBP- $100, CCS- $25, CIS10- $200, COL- $20, DEV- $50, HBD<9- $120, IHA- $30, IMA2- $100, LSC- $25, TFL-CH- $20, W30-6+- $50, W30+2- $50, WCV- $50. Interim Payment: 09/30/23 (based on June 2023 data). Final payment: 07/31/24 (based on December 2023 data). Data submission closes: 03/31/24. 2023 Cozeva Qtr. 1 payment: 06/30/23 (data through March 2023) Qtr. 2 payment: 09/15/23 (data through June 2023) Qtr. 3 payment: 12/15/23 (data through September 2023) Qtr. 4 payment: 03/15/24 (data through December 2023) Final payment: 07/15/24 (reconciled data through December 2023) HIP is offered to 9 counties: Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Stanislaus, Tulare.
LA Care	Provider	D-SNP	CMC Annual Wellness Exam (AWE) Incentive Program 2023	Payment is $350 for each completed and coded AWE form submitted by 12/31/23. Complete information required includes AWE Form and PHQ-9 section. * Forms are saved on your sFTP. *Select health centers and patients have been selected to participate, Contact your Coding Analyst for more information.
Molina	Provider	Medi-Cal	2022 Pay for Performance Medi-Cal PCP HEDIS P4P Program Updates	The PCP P4P Program is effective as of 1/1/22 and requires a minimum of 200 Medi-Cal members to qualify for Cervical Cancer Screening (CCS) and A1c <8 performance bonus. No minimum on other measures below. P4P Bonus measures include:

				• CCS ($25), CDC A1c<8 ($100), Prenatal Notification Form ($75 per form), Childhood immunization, immunization for adolescent, blood lead screening, well child visits
Molina	Provider	Medi-Cal	HEDIS Partner Award Program for FQHCs/RHCs	[2023 details expected by May]. Up to $3 PMPM based on the number of measures that meet the MY2022 NCQA Medicaid 50th or 75th Percentile or YOY improvement. Measures are likely to be similar to last year: BCS, CCS, WCV, CIS-10, CHL, CDF (Depression Screening and Follow-up), CDC≤9%, CBP, IMA-2, LSC, PPC Prenatal, PPC Postpartum, Follow-Up after ED Visit for Substance Abuse, Follow-up after ED visit for Mental illness, W30A (0-15 mos.), W30B (15-30 mos.) and SDOH codes. Encounters must be received within 60 days of date of service. For questions email: MHCQuality@MolinaHealthCare.com[2023 details expected by May]. Up to $3 PMPM based on the number of measures that meet the MY2022 NCQA Medicaid 50th or 75th Percentile or YOY improvement. Measures are likely to be similar to last year: BCS, CCS, WCV, CIS-10, CHL, CDF (Depression Screening and Follow-up), CDC≤9%, CBP, IMA-2, LSC, PPC Prenatal, PPC Postpartum, Follow-Up after ED Visit for Substance Abuse, Follow-up after ED visit for Mental illness, W30A (0-15 mos.), W30B (15-30 mos.) and SDOH codes. Encounters must be received within 60 days of date of service. For questions email: MHCQuality@MolinaHealthCare.com
Molina	Provider	Medicare, Cal Medi-connect	Provider Preventive & Chronic Condition Management Program (PPCC, formerly AEP/MIP)	Payment is $125 for EMR note + claim + form submitted within 30 days of date of service for select members. Video telehealth visits are acceptable. Contact your HCLA Coding Analyst for more information.

Health Net	FQHC	Medi-Cal	Clinic HEDIS Improvement Program (C-HIP) 2023 - FQHCs	This financial incentive program for FQHC/RHC/IHS awards providers for meeting the minimum performance level (MPL) and having a certain % of improvement (1% for providers meeting MPL and 2% for providers below MPL) in 14 HEDIS measures. Be an FQHC and open to accepting new enrollees (open panels). Does not apply to clinics at maximum capacity. 2023 HEDIS measures included: Women's Health: BCS, CCS, IHA Pediatric Visits: CIS10, DEV, IHA, LSC, TFL-CH, IMA2, W30-15, W30-30, WCV. Chronic Care: CBP, COL, HBD<9, IHA Payment is max $3.08 PMPM (per member per month) 14 measures x $0.22= $3.08. IHA payment methodology $0.11 PMPM/measure for improvement ONLY. Improvement rate for IHA must be >25% to quality for payment. Advance Payment: 03/31/23, (based on MY2021 data against 2023 criteria). Interim Payment: 10/31/23 (based on June 2023 data) captures MPL only. Final Payment for improvement made on: 07/31/24 (based on December 2023 data) and captures MPL+ improvement. Data submission closes: 03/31/24. Providers receives incentive if they improve over last year and receives a separate incentive if they meet or exceed NCQA 50th percentile benchmark. C-HIP is offered to 9 counties: Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Stanislaus, Tulare. No Cozeva incentive payment option in 2023.
Anthem Blue Cross	Member	Commercial and Covered CA	Member Incentive Program – Preventive Care 2022	Adult and pediatric members who receive a mailing from Anthem with screenings due receive a $25 Visa gift card for each preventive screening completed for the following HEDIS measures: CDC A1c Test, CDC Eye Exam, CDC Nephropathy, BCS, CCS and WCV (age 3-21). Incentives are offered during June to December (Eye, CCS, A1c and BCS) or May to December (Nephropathy, WCV). Covered CA members who complete their mammogram will receive a $50 gift card
Anthem Blue Cross	Member	Medicare DSNIP	Gap Closure Member Incentive	4th Qtr. updates: Targeted members receive an invitation to attest to completion of BCS and AWV. - $75 gift cards to Medicare members who close the BCS gap - $25 gift cards to DSNP members who get their annual visit done this year No provider facing material available yet.

<table>
<tr><td>Anthem Blue Cross</td><td>Member</td><td>Medi-Cal</td><td>Healthy Rewards Program 2023</td><td>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</td></tr>
<tr><td>Blue Shield Promise</td><td>Member</td><td>Medi-Cal</td><td>2023 HEDIS Care Gap Fulfillment Member Incentive Program</td><td>Sharing the process and FAQs for the Novu Member Incentive Fulfillment Process with the Health Navigators and for other QI Interventions. Member Incentives are meant to support exiting member outreach interventions. Please refer to Intervention Leads for intervention details and to confirm measures included in outreach.
Gift card to members for completing healthcare activities self and provider attestation: Care Gap Fulfillment Mailed Incentive Program
<table><tr><th>Care Gap Closed</th><th>Gift Card Amount</th></tr><tr><td>W30-1: Well child 0-15 months (completion of 6 visits before 15 months of age)</td><td rowspan="8">$25.00</td></tr><tr><td>W30-2: Well child 15-30 months (completion of 2 visits by 30 months of age)</td></tr><tr><td>IMA: Immunization for adolescents – series completion before child's 13th birthday</td></tr><tr><td>CIS: Childhood immunizations – series completion before child's 2nd birthday</td></tr><tr><td>CHL: Chlamydia Screening in Women by 12/31/2023</td></tr><tr><td>CBP: Controlling Blood Pressure</td></tr><tr><td>CDC-T: Diabetes HbA1c test by12/31/2023 (one per year)</td></tr><tr><td>LSC: Lead Screening in Children (at least one capillary or venous lead blood test for lead poisoning before child's 2nd birthday)</td></tr><tr><td>WCV: Well child and adolescent visits by 12/31/2023</td><td rowspan="3">$50.00</td></tr><tr><td>PPC-Post: Postpartum care (on or between 7 and 84 days after delivery)</td></tr><tr><td>PPC-Pre: Prenatal visit in the first trimester, or for new members to the plan, within 42 days of enrollment.</td></tr><tr><td>BCS: Breast cancer screening by 12/31/2023</td><td rowspan="2">$100.00</td></tr><tr><td>CCS: Cervical cancer screening visits by 12/31/2023</td></tr></table>
1.Let BSPHP know which gift card eligible measures the provider group will conduct member outreach for
2.Once the member is scheduled and/or comes in to close the care gap, ask the member if they prefer a Target or Walmart gift card and confirm the member's mailing address
3.Once the member completes the screening, the group can confirm with BS by providing the member's information via secure email OR we can wait until the gap closes on the CAR report as confirmation
4.Once step 3 is done, BSPHP alerts Novu and they mail the gift card to the member (gift card issuance can take up to 4 - 6 weeks)
Blue Shield Contact persons: Elisa Ward
Elisa.Ward@blueshieldca.com (HCLA)</td></tr>
</table>

<table>
<tr>
<td>Blue Shield Promise</td>
<td>Member</td>
<td>Medi-Cal</td>
<td>Healthy Rewards Incentive Program</td>
<td>To improve the quality of care of our member by incentivizing them to complete select preventive health activities.
• Program Launch Date 05/18/2023
• Program end date 12/31/2023
<table><tr><th>Health Care Activity</th><th>Award Gift Card Amount</th></tr><tr><td>Well Child Visits Part I
(age birth to 15 months)</td><td>$10 per visit (up to 6 visits)</td></tr><tr><td>PLUS a Bonus Reward</td><td>$25 (for completing all 6 visits)</td></tr><tr><td>Well Child Visits Part II
(age 15 months to 30 months)</td><td>$25 per visit
(up to 2 visits)</td></tr><tr><td>Annual Well Child Visit (ages 3-17)</td><td>$50/1 per calendar year</td></tr><tr><td>Annual Well Visit (ages 18-21)</td><td>$50/1 per calendar year</td></tr><tr><td>Pap test</td><td>$100/1 per calendar year</td></tr><tr><td>Breast Cancer Screening</td><td>$100/1 per calendar year</td></tr><tr><td>Diabetes Blood Test (A1C) – Q4 launch</td><td>$25/1 per calendar year</td></tr><tr><td>*New* HPV Shot (ages 11-12) – pending launch</td><td>$25/1 per calendar year</td></tr></table>
Choose your reward online, by mail, or over the phone.
Online: www.blueshieldca.com/promise/healthyrewards/LA
When you go online to report an activity, you can choose from more reward options ad download some right away.
Mail: Send the healthcare activity coupons found in this packet to:
Fulfillment Center- Po Box 7185 Rantoul, IL 61866-9951
Phone: 1-866-549-4627 (TTY: 711)
Monday - Friday 5:a.m- 7p.m. PT
Saturday: 7a.m.-12p.m.PT</td>
</tr>
<tr>
<td>Molina</td>
<td>Member</td>
<td>Covered CA</td>
<td>My Health Perks Incentive Program</td>
<td>Beginning on January 1, 2023, all Molina Marketplace subscribers, and dependent 18 years and older are eligible for Molina's new health and wellness program: My Health Perks.

All eligible members will have the opportunity to earn a $50 gift card upon completion both of the following activities:
- Complete an annual routine wellness exam with their Primary Care Provider
- Complete a Health Risk Assessment via the my Wellness tab on the My Molina portal

Member will need to register on the MyMolina Portal at: http://m.memeber.molinahealthcare.com/member/login and navigate to "My health perks" on the My Wellness Page. A link available to members on my Wellness page will take member to Health Risk Assessment.

Member will earn 25 reward points for the completion of each individual activity. Member who completes both activities will earn 50 total rewards points, which are then redeemable for either a physical or digital $50 gift of their choosing via the "rewards" button via the link available to members on the My Wellness page of the My Molina portal. A member will only be able to redeem for one $50 gift card once they've obtained 50 total rewards point. Member do not have the option to redeem 25 points for a $25 gift card. Member Cannot divide 50 reward point into two $25 gift cards.</td>
</tr>
</table>

				Eligible members must be enrolled with Molina Marketplace to redeem reward.
Blue Shield of California	Member	Medicare	Appreciation Program	Program Facts, Incentivized Measures,& Rewards Population • All Medicare Members can redeem for the incentives whether they meet the measures continuous 12-month enrollment criteria or not. Any member who is eligible for the benefit under the plan has access to the reward. • Targeting will not vary monthly - If a member is targeted at the beginning of the year, they will be targeted for all of 2023. • "Targeted" member are: • Member who will be sent additional mailer regarding this program. • Member who fall under the specific targeting criteria for each measures • Medicare member who are historically non-compliant and non-compliant for: 1) Breast Cancer screening 2) Colorectal Cancer Screening 3) Osteoporosis Management in women Incentive measures & amounts -Annual wellness Visit (AWV) $50 -Flu Shot (Flu) $10 - Breast Cancer Screening (BCS) $50 - Colorectal Cancer Screening $50 - Osteoporosis Management in Women (OMW) $50 When will member get their gift card? •Digital : available within 24 hours (after attestation) • Physical gift card: Available within 5-10 business days (after attestation) Program contact information: • Website: bscappreciation.healthmine.com • Phone Number: 1-866-352-0892 (8:00am to 6:00pm PST) Monday - Friday, excluding holidays

<table>
<tr>
<td>Molina</td>
<td>Member</td>
<td>Medicare</td>
<td>Medicare Member Incentives</td>
<td>Medicare Member Incentives has created a program for Medicare members in 2023.
• Postcards were mailed out to eligible members 06/12/2023
• Attestation forms will be mailed to the member to retune for gift card
(no postage needed)
<table>
<tr><th>Screening</th><th>Description</th><th>Accepted Dates of Service</th><th>Medicare
CA
DSNP, MAPD, FIDE</th></tr>
<tr><td>Annual Wellness Visit</td><td>Completion of Medicare Annual Visit which consists of completion of HRA, routine measurements, review of medical and family history, current prescriptions, and advance care planning.</td><td>1/1/2023 - 12/31/2023</td><td>35</td></tr>
<tr><td>Blood Pressure Screening</td><td>Completion of blood pressure screening with provider</td><td>1/1/2023 - 12/31/2023</td><td>35</td></tr>
<tr><td>Breast Cancer Screening</td><td>Completion of mammogram to screen for breast cancer</td><td>1/1/2023 - 12/31/2023</td><td>35</td></tr>
<tr><td>Colon Cancer Screening</td><td>Completion of fecal occult blood test, flexible sigmoidoscopy, colonoscopy, computed tomography colonography, OR stool DNA test to screen for colon cancer</td><td>1/1/2023 - 12/31/2023</td><td>50</td></tr>
<tr><td>Diabetes A1 Test</td><td>Completion of hemoglobin A1c test to measure blood sugar levels for members with diabetes</td><td>1/1/2023 - 12/31/2023</td><td>35</td></tr>
<tr><td>Diabetes Eye Exam</td><td>Completion of comprehensive eye exam to check for signs of diabetic retinopathy for members with diabetes</td><td>1/1/2023 - 12/31/2023</td><td>35</td></tr>
<tr><td>Flu Shot</td><td>Completion of flu shot with provider or pharmacy</td><td>1/1/2023 - 12/31/2023</td><td>35</td></tr>
<tr><td>Osteoporosis Management</td><td>Completion of bone mineral density scan or prescription for a drug to treat osteoporosis in women who suffered a fracture</td><td>1/1/2023 - 12/31/2023</td><td>50</td></tr>
</table>
</td>
</tr>
<tr>
<td>Brand New Day</td>
<td>Member</td>
<td>Medicare</td>
<td>Member Rewards Plus Program</td>
<td>Rewards Plus Program Visa Gift cards for completing preventive screening complete before December 31st:
Earn up to $150 in Rewards:
$50 for Annual Wellness Exam
$25 for Health Risk Assessment
$10 for Diabetic Member Screenings
$30 for mammogram
$25 for colorectal cancer screening
$10 for flu shot after September 1st, 2023

Rewards are loaded on a Rewards Plus Card to use at selected retailers for health related and personal care items. Call 1-877-280-6207, TTY 711 for questions.</td>
</tr>
<tr>
<td>LA Care</td>
<td>Member</td>
<td>Medi-Cal, Covered CA</td>
<td>Healthy Mom Program 2023</td>
<td>This member incentive program aids in educating mothers about the importance of the postpartum visit, provides appointment reminders, and creates a positive relationship between mothers and the health plan. L.A. Care Covered CA and Medi-Cal women who have just given birth can receive a $40 gift card incentive for attending their postpartum appointment 21-56 days after delivery.</td>
</tr>
<tr>
<td>LA Care</td>
<td>Member</td>
<td>Covered CA</td>
<td>My Health in Motion Rewards Program 2023</td>
<td>The program is designed to encourage LACC members to participate in online based health and wellness activities, including completing a health assessment survey, enrolling in health coaching, and completing weight management and smoking cessation workshops. Enrolled members receive varying points for each completed activity, which can be used to redeem gift cards instantly. 1 point = $1 in value.</td>
</tr>
<tr>
<td>LA Care</td>
<td>Member</td>
<td>Medi-Cal</td>
<td>Family Resource Center New Member</td>
<td>L.A. Care Medi-Cal members can receive a $10 gift card for attending a Family Resource Center (FRC) orientation, which provides information on the various offerings at L.A. Care's six FRC locations. L.A. Care members can receive a gift card once for attending the</td>
</tr>
</table>

			Orientation 2023	Member Orientation. One gift card per household. L.A. Care member (or guardian) must be present.
LA Care	Member	Covered CA	Follow-up after Hospitalization (FUH) Member Incentive 2023	The goal of the FUH Member Incentive is to increase the 30-day compliance rate for a follow-up visit with a provider after the member is discharged from an inpatient facility with a principle diagnosis for a mental health disorder. The member will receive a $25 debit card when they go in for their visit. This program is in collaboration with Beacon.
Molina	Member	Covered CA	My Health Perks Incentive Program	Beginning on January 1, 2023, all Molina Marketplace subscribers, and dependent 18 years and older are eligible for Molina's new health and wellness program: My Health Perks. All eligible members will have the opportunity to earn a $50 gift card upon completion both of the following activities: • Complete an annual routine wellness exam with their Primary Care Provider • Complete a Health Risk Assessment via the my Wellness tab on the My Molina portal Member will need to register on the My Molina Portal at: http://m.memeber.molinahealthcare.com/member/login and navigate to "My health perks" on the My Wellness Page. A link available to members on my Wellness page will take member to Health Risk Assessment. Member will earn 25 reward points for the completion of each individual activity. member who completes both activities will earn 50 total rewards points, which are then redeemable for either a physical or digital $50 gift of their choosing via the "rewards" button via the link available to members on the My Wellness page of the My Molina portal. A member will only be able to redeem for one $50 gift card once they've obtained 50 total rewards point. Member do not have the option to redeem 25 points for a $25 gift card. Member Cannot divide 50 reward point into two $25 gift cards. Eligible members must be enrolled with Molina Marketplace to redeem reward.
Blue Shield	Staff Incentive	Medicare	2023 IOA Office Staff Incentive Program	The Office Staff Incentive Program is an initiative for office staff to support network primary care physicians (PCPs) by reaching out to members and remind them to visit their PCPs. The IOA Incentive Program applies to Blue Shield Medicare Advantage HMO and commercial HMO members receiving an annual comprehensive health evaluation during their membership with Blue Shield. Each eligible member's IOA form contains information about their potential care gaps and HCC's that need to be evaluated and assessed during the measurement year. Program Period: • Eligible Date of Service (DOS): 01/01/2023 through 12/31/2023 • IOA Form Submission Date: 03/01/2023 through 02/29/2024 Payment and Schedule: Tier 1:

				• DOS ≤ 7/31/2023 • Submission ≤ 10/15/2023 • IOA Form Timeliness (≤ 60 days from DOS) & met 80% Care Gap) $50 • IOA Form Timeliness (> 60 days from DOS) & met 80% Care Gap) $25 Tier 2: • DOS ≥ 8/1/2023 • Submission ≤ 2/29/2024 • IOA Form Timeliness (≤ 60 days from DOS) & met 80% Care Gap) $25 • IOA Form Timeliness (> 60 days from DOS) & met 80% Care Gap) $25 2023 payment process dates* • 07/05/2023 • 10/02/2023 • 01/02/2024 • 04/03/2024 (final payment) Th

Section 6: Quality Management

ACTIONABLE MONTHLY REPORT

Ambulatory Care Sensitive Conditions (ACSC) Report
Use this report to ensure patients have been scheduled for follow-up to their admission and that Ambulatory Care Sensitive Conditions are being managed.

Re-Admission Report
Four recommended strategies for improving transition of care are:

- Provision of timely access to follow-up care and placement of a reminder call to the patient, review of discharge summary
- Review of care plan with coordination of any needed home services and equipment and reconciliation of medications, and
- Instruction regarding self-management, warning signs and any needed follow-up appointment
- Instruction regarding self-management, warning signs and any needed follow-up appointment

Emergency Room Visits
Use this report to identify member(s) with one or more ER visits. Flag member in EMR where possible. Outreach to member to discuss availability of After-Hours availability, nurse advice line and appropriate use of the ER.

Member Aging into Medicare Coverage 64+ years of age
Use this report to outreach to these members to anchor them to your practice through one of HCLA's Medicare plans: Blue Shield of California Promise Health Plan and Molina Healthcare. Note that while the open enrollment period for Medicare is once a year October 15 through December 7 for enrollment the following January, members aging into the program may enroll within the initial enrollment period which is 3 months before turning sixty-five and up to 3 months after turning sixty-five. Medi-Medi patients may enroll or dis-enroll at any time into a Medicare plan. Now is the time to anchor these members before your competition goes after them.

Medi-Cal Members Identified as Dual Eligible (Med-Medi)
Use this list to outreach to these patients to encourage them to enroll with you under a Medi-Medi plan. For example: Blue Shield of California Promise Health Plan, Health Net, L.A. Care and Molina Healthcare.

Eligibility Report
Enrollment Strategies:

- Customer Service – Team Approach to Enrollment
- Anchor New Patients – 120-day Health Assessment (IHA)
- Outreach and Follow-up Terminated Member Reports
- Mine Patient Data to Identify Medi-Medi Members for Potential Enrollment into Managed Care Plans
- Ensure Newborn Retention and Enrollment through Patient Education and Use of Newborn Enrollment Forms

HCC Scores
Minimum RAF Score goal is 1.00. Make sure all services have been entered for Annual Wellness visit. Documenting health history is key to ensuring members HCC reflects health status. Clinic Report Card – Medi-Cal Line of Business (Adult Combined). This report is used to monitor performance against IPA average. Medi-Cal of Business (Pediatric). This report is used to monitor performance against IPA average: HEDIS Report Card and STARs Report Card.

Section 6: Quality Management

ACTIONABLE QUARTERLY REPORT

Ambulatory Care Sensitive Conditions (ACSC) Report
The ACSC report to ensure patients have been scheduled for follow-up to their admission and that Ambulatory Care Sensitive Conditions are being managed.

Re-Admission Report
Four recommended strategies for improving transition of care are:

- Provision of timely access to follow-up care and placement of a reminder call to the patient, review of discharge summary
- Review of care plan with coordination of any needed home services and equipment and reconciliation of medications, and
- Instruction regarding self-management, warning signs and any needed follow-up appointment

Emergency Room Visits

Use this report to identify member(s) with one or more ER visits. Flag member in EMR where possible. Outreach to member to discuss availability of After-Hours availability, nurse advice line and appropriate use of the ER.

Member Aging into Medicare Coverage 64+ years of age
Use this report to outreach to these members to anchor them to your practice through one of HCLA's Medicare plans: Blue Shield of California Promise Health Plan and Molina Healthcare. Note that while the open enrollment period for Medicare is once a year October 15 through December 7 for enrollment the following January, members aging into the program may enroll within the initial enrollment period which is 3 months before turning sixty-five and up to 3 months after turning sixty-five. Medi-Medi patients may enroll or dis-enroll at any time into a Medicare plan. Now is the time to anchor these members before your competition goes after them.

Medi-Cal Members Identified as Dual Eligible (Med-Medi)
Use this list to outreach to these patients to encourage them to enroll with you under a Medi-Medi plan. For example: Blue Shield of California Promise Health Plan, Health Net, L.A. Care and Molina Healthcare.

Eligibility Report

Enrollment Strategies:

- Customer Service – Team Approach to Enrollment
- Anchor New Patients – 120-day Health Assessment (IHA)
- Outreach and Follow-up Terminated Member Reports
- Mine Patient Data to Identify Medi-Medi Members for Potential Enrollment into Managed Care Plans
- Ensure Newborn Retention and Enrollment through Patient Education and Use of Newborn Enrollment Forms

HCC Scores
Minimum RAF Score goal is 1.00. Make sure all services have been entered for Annual Wellness visit. Documenting health history is key to ensuring members HCC reflects health status.

Section 7: Compliance

COMPLIANCE PROGRAM

Five Things You Need to Know About Compliance

1. We are all responsible for compliance and are obligated to report potential compliance issues
2. If you do not understand something, speak up. Ask the Compliance Officer
3. If you suspect a compliance issue, report it to the Compliance Officer
4. All reports will be investigated and treated as confidential
5. Anyone who makes a report in good faith is protected from retaliation by law

Suspect a Compliance Issue?

Utilize the following options:

- Call the Compliance Hotline at: **866-423-0060, x1531**
- Email the Compliance Officer at: ComplianceConcerns@medpointmanagement.com
- Submit an anonymous report via: Compliance Concern Survey

General Compliance Training

All providers and staff must complete General Compliance Training upon hire and annually after that. Please visit: MedPOINT Provider Training to access this training module and view additional non-compliance reporting mechanisms, helpful resources, and references. We may ask you to provide evidence of provider and staff compliance training using sign-in sheets or completion certificates. This information must be kept for at least ten (10) years.

ETHICS AND INTEGRITY

Health Care LA, IPA is dedicated to conducting business honestly and ethically with you and our members. Making sound decisions as we interact with you, other healthcare providers, regulators, and others is necessary for our continued success and that of our business associates. Providers are expected to comply with this Code. We demonstrate individually and as an organization by complying with the applicable federal and state standards, statutes, regulations, sub-regulatory guidance, and contractual commitments. If you become aware of a violation of this Code, the law, or our policies—you must report it promptly. Following this Code is everyone's responsibility and enables us to deliver on our mission. Providers must distribute the Code of Conduct within ninety (90) days of hire and annually to all staff. You will find COC training at: MedPOINT Provider Training**.** We may ask you to provide evidence of provider and staff training using sign-in sheets or completion certificates. This information must be kept for at least ten (10) years.

ANTI-CORRUPTION POLICY

Health Care LA, IPA prohibits bribes, kickbacks, improper or illegal inducements, or other unlawful payments from being directly or indirectly offered, provided, or authorized in any way related to Health Care LA, IPA. All providers, office staff, volunteers, and temporary workers must comply with the anti-corruption laws that apply to Health Care LA IPA's operations, including the Foreign Corrupt Practices Act (FCPA) and the anti-corruption laws of the State and Federal government.

CONFLICTS OF INTEREST:
Providers must promptly notify Health Care LA, IPA and the IPA's members of any conflicts of interest or any basis for potential violations by the provider or provider's staff concerning laws, rules, and regulations that govern the provision of certain healthcare services, including Federal and State anti-kickback statutes, anti-corruption regulations, self-referral laws, and healthcare fraud or abuse.

- Visit CMS Medicare on the CMS website for more information on Stark Law.
- For a comparison of the AKS and Stark Law, refer to COMPARISON OF THE ANTI-KICKBACK STATUTE AND STARK LAW* (hhs.gov). To learn more about the Foreign Corrupt Practices Act (FCPA), click here: Foreign Corrupt Practices Act

EXCLUSION CHECKS
Health Care, L.A., IPA is required by its contracted health plans to ensure that our providers screen their practitioners, employees, contractors, volunteers, and any other individual working on behalf or closely with the providers. The screening is performed prior to hiring or contracting, then monthly after that. We may ask you to provide evidence of exclusion screenings. This information must be kept for at least ten (10) years.

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.
- Suspended and Ineligible Provider List at: Medi-Cal: Suspended and Ineligible Provider List

Fraud, Waste, and Abuse Training

All providers and staff must complete Fraud, Waste, and Abuse Training upon hire and annually after that. Please visit MPM Provider Training to access this training module. We may ask you to provide evidence of provider and staff compliance training using sign-in sheets or completion certificates. This information must be kept for at least ten (10) years.

MONITORING AND REPORTING
Health Care LA, IPA's Anti-Fraud, Waste, and Abuse program focuses on the prevention, detection, and investigation of false and abusive acts. Examples of fraud, waste, and abuse are billing for procedures not performed and physician kickbacks for referrals.

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 within 24 hours of notification or identification.

Utilize the following options:
Call the Compliance Hotline at: 866-423-0060, x1531
Email the Compliance Officer at: ComplianceConcerns@medpointmanagement.com

PROTECTED HEALTH INFORMATION AND THE HITECH ACT

Protected Health Information, or PHI, identifies a patient/member and relates to their past, present, or future health or condition, provision of care, or payment for care. Some of the requirements of HITECH are restrictions on certain disclosures, accounting of certain protected health information disclosures; access to certain information in electronic format and designating a third party be the recipient of the PHI, breach notification for unauthorized uses, and disclosure of unsecured PHI.

Confidentiality of Member information:
Effective 7/1/2022, AB1184 will require the Provider to accommodate requests for confidential communication of medical information regardless of whether there is a situation involving sensitive services or a situation in which disclosure would jeopardize the individual and their privacy.

The Provider shall not require a protected individual, as defined, to obtain the policyholder, primary subscriber, or other enrollee's authorization to receive sensitive services or to submit a claim for sensitive services if the protected individual has the right to consent to care.

The Provider will direct all communications regarding a protected individual's receipt of sensitive services directly to the protected individual and will prohibit the disclosure of that information to the policyholder, primary subscriber, or any plan enrollees without the authorization of the protected individual, as provided.

Breach Notification Rules
Providers are required to notify Health Care LA, IPA without unreasonable delay and no later than 60 days from the discovery of the breach that could impact Health Care LA, IPA members.

Utilize the following options:

- Call the Compliance Hotline at: 866-423-0060, x1531
- Email the Compliance Officer at: ComplianceConcerns@medpointmanagement.com

Medical Record Access and Restrictions

Members have certain rights to access, restrict and amend their records. Providers must have policies in place to address member needs.

- HHS's guidance on the HIPAA right of access is available at: HHS HIPAA Guidance
- HHS's guidance on the HIPAA Privacy Rule and personal representatives is available at: HHS HIPAA Guidance

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
CCLAC	California Association of Los Angeles County
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 Appointment
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
MCE	Medi-Cal Expansion
MCP	Managed Care Plan
MCR	Modified Community Rating
MD	Medical Doctor
MESH	Medical Staff Hospital Joint Venture
MH/CD	Mental Health/Chemical Dependency

GLOSSARY

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
RAF	Risk Adjustment Factor
RBRVS	Resource Based Relative Value Scale
RFP	Request for Proposal
RPI	Registered Provisional Immigrant
SIC	Standard Industry Code

GLOSSARY

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 DMHC

Link to DHS Managed Care Definitions PDF:
Managed Care Definitions