
EmanateHealth™
IPA

Contact Sheet
Quick Reference Sheet

AREA	CONTACT DETAILS
Provider Services	• Rafael Zepeda, Director Integrated Networks Desk: (626) 732-4177 Email: rzepeda@emanatehealth.org • Roxana Robles, Laboratory Liaison Cell: (626)483-2436 Email: rrobles@emanatehealth.org • IPASupport@EmanateHealth.org
Main Customer Service Line	• **Phone:** (877) 282-8272 or (626) 282-0288 • **Hours:** Mon-Fri., 8:30am – 5:00pm • **Scope:** Eligibility, Referrals, Claims, Provider, and Member Inquiries
Claims Submission	• Via Office Ally, use Payor ID#: **NMM01** • To submit via the NMM Portal, please email: portal.inquiries@nmm.cc (setup required) • **Mail:** 1680 S. Garfield Ave. # 201 Alhambra, CA 91801 (paper claims not recommended for contracted provider network)
Case Management	To report an admission: • Please fax the Face Sheet to: (626) 943 6321
Eligibility	To have a patient added urgently, you can email or call. • For emails, please send to: eligibility.dept@nmm.cc • For urgent requests, please call (877) 282-8272
Utilization Management	• Submissions: Please use the Portal at www.nmm.cc
Web Portal Assistance	• Technical Assistance: Portal: Portal.Help@nmm.cc • New Users: Portal.Inquiries@nmm.cc • Phone: (626) 943-6146 • Fax: (626) 943.-6350

Claim Encounter Data Submission Guidelines

The IPA network defines claims encounter data as the documentation of covered medical services performed by capitated providers (PCPs) and sub-specialists or vendors capitated for designated services. Providers are required to submit their encounter data within 45 days from date of service.

Providers must certify the completeness and truthfulness of their encounter data submissions, as required by the Department of Managed Health Care (DMHC). The IPA requires that providers submit all professional claim encounter data

- Compliance with regulatory reporting requirements of the DMHC
- Compliance with NCQA-HEDIS/STAR reporting requirements
- Provide the IPA with comparative data
- Produce the Provider Profile and Quality Index
- Utilization management oversight

Capitated Primary Care Providers or other capitated vendors non-compliant with claims encounter data submission will receive a corrective action plan (issued by the IPA network). Contracted providers who fail to comply with claims encounter data submission are subject to withhold in capitation reimbursement and/or termination.

Providers must submit encounter data on a monthly basis. EMANATE HEALTH IPA encourages providers with large volumes to submit encounter data more frequently, and will continuously monitor encounter data submissions for quality and quantity.

All data elements found in the CMS 1500 form must be populated for the submission to be complete. The data elements required on the paper based CMS 1500 form will serve as a minimum standard for electronic submissions (pages 28-29 include instructions on filling out the CMS 1500 form).

All data records must include the most current industry standard diagnosis, procedure (CPT-4, HCPCS), and place of service codes. All diagnosis codes must be reported to the highest level of specificity.

It is imperative that all capitated services be submitted on a regular basis. The health plans hold all contracted providers accountable for this statistical information regarding the patient population, especially when it comes to prevalent diseases, treatment outcomes, preventive medicine, etc.

Encounter data submission Per Member Per Year (PMPY) threshold by line of business are as follows:

Commercial/ Marketplace= 2.5 – 3.5 per member per year (overall)
Medi-Cal = 4.5 - 5.00 per member per year (overall)
Medicare = 12.00 per member per year (overall)

Claim Submission Guidelines

All claims for services provided to members of EMANATE HEALTH IPA must be submitted using one of the following methods:

1. **The preferred submission method is via the NMM Web Portal** (Refer to the *Web Portal User Guide)*
2. Office Ally (clearing house)
3. CMS 1500 Paper claims; via USPS to the following address:
   Network Medical Management
   EMANATE HEALTH IPA
   1680 S. Garfield Ave., Suite 201
   Alhambra, Ca 91801

Reminders for claim submissions

- Providers need to submit encounter data. Including services provided for capitated visits.
- Claims should always be billed using the highest level of specification: 4th or 5th digit diagnosis codes, if applicable.
- All Immunizations are paid by Vaccines for Children (VFC) for **Medi-Cal** line of business; Providers will still need to submit all encounter data to Allied Pacific IPA, the administration fee will to IPA for payment.

The following billing procedure is intended to provide a comprehensive source of instruction for billing personnel. The Health Insurance Claim Form or (CMS 1500 Form) answers the needs of many health insurers. It is a basic form prescribed by CMS for the insurance claim from physicians and suppliers, except for ambulance services. Our goal is to provide quality service to all of our patients. You can help accomplish this goal by following our billing instructions. Payment is dependent on sufficient / insufficient documents submitted (i.e. Operative Report, Patient Progress Report, notes and / or any other information on medical services or supplies). If information is insufficient, your claim may result in non-payment.

To ensure proper payment, please refer to the following instructions when completing the CMS 1500 Form: Items 1 – 12

Patient's and Insured's Information:

Box #	Instruction
1a.	Type the patient's ID Number or Social Security Number.
2.	Type the patient's Last Name, First Name, and Middle Initial (as shown on the patient's ID card).
3.	Type the patient's Date of Birth and Sex.
4.	Type Primary Insured's Name.
5.	Type patient's mailing address and telephone number.
6.	Patient relationship to insured (i.e. self, spouse, child, other)
9a.	Type other insured's policy or group number.
9d.	Type complete insurance plan and product. (I.e. Medicare, commercial, Medi-

	Cal).
11.	Type insured's policy or group number.
11c.	Type complete insurance plan and product (I.e. Medicare, commercial, Medi-Cal)
12.	Patient or authorized representative must sign and date this item, unless the signature is on file.
17.	Type or print the name of the referring or ordering physician (if applicable).
21.	Type or print the patient's diagnosis / condition. Please use the appropriate ICD-10 code number. ***Please use the highest 5-digit code applicable.***
23.	Type prior authorizations number for those procedures requiring professional review organization (PRO), prior approval, or attach Treatment Authorization Request (TAR).
24a.	Type the month, day, and year for each procedure service or supplies.
24b.	Type the appropriate place of service code number. Identify the location by either where the item is used or the service is performed.
24c	Type the procedure, service, or supply code number by using the CMS Common Procedure Coding System (HCPCS). If applicable, show HCPCS modifier with the HCPCS code. However, if you use an unlisted procedure code, include a narrative description.

24d.	Type the diagnostic code by referring to the code number shown on item 21 to relate the date of service and the procedure performed to the appropriate diagnosis. Please remember to use the highest specialty code applicable.
24g.	Type the charge for each service listed.
24f.	Type the number of days or units. This item is most commonly used for multiple visits.
25.	Type the physician's / supplier's federal tax ID number.
26.	Type the patient's account number assigned by the physician / supplier.
27.	Check the appropriate block to indicate whether the physician / supplier accept assignment.
28.	Type the total amount of charges for the services.
29.	Type the total amount that the patient paid on the submitted charges.
30.	Type the balance due.
31.	Type the physician / supplier, or his/her representative, must sign and date this item.
32.	Type the name and address of the facility if the services were performed in a hospital, clinic, laboratory, etc. If the name and address of the facility are the same as the biller's name and address shown on item 33, enter the word: "SAME".
33.	Type the name and address of the facility if the services were performed in a hospital, clinic, laboratory, etc.

Cleaning House Vendors

EMANATE HEALTH IPA and Network Medical Management have partnered with Office Ally as one of the methods for submitting encounters and claims. Providers are required to set up an account before they can start submitting all encounters and claims through Office

Ally. Please see Section 11 of the Provider Manual (page 37) for more information on how to submit encounters and claims.

- Payor ID Number for CVIPA under Office Ally: **NMM01**

Practices should contact Office Ally directly via phone at (866) 575-4120 or email at Info@OfficeAlly.com to set up an account.

Reminders for claims submissions:

- Providers need to submit encounter data, including services provided for capitated member visits
- Claims should always be billed using the highest level of specification; 4th or 5th digit diagnosis code, if applicable
- All immunizations are paid by Vaccines for Children (VFC) for Medi-Cal line of business; providers will only bill the IPA for the administration fee

Claims submitted via Network Medical Management Web Portal, Office Ally, or CMS 1500 hardcopy billing form must include the following information:

- Member's name
- Member's birth date
- Member's address
- Member's account number
- Diagnosis or nature of illness or injury (please use the appropriate code number and highest 5-digit code applicable)
- Referring or ordering provider (if applicable)
- Prior authorization number for procedures requiring professional review organization (PRO), prior approval, or attach Treatment Authorization Request (TAR)
- Month, day, and year for each procedure service or supplies
- Procedures, services or supplies (CPT/HCPCS/HDC Code/Modifier)

- Charges
- Days or units
- Rendering provider ID-UPIN, State License, and Tax ID if it uniquely identifies the provider
- Federal tax ID number
- Provider license or UPIN Number
- Total charge
- Amount member paid on submitted charge
- Balance due
- Signature of provider or supplies, including degrees or credentials (submitting paper)
- Provider billing name, address, zip code
- Name and address of the facility if the services were performed in a hospital, clinic, laboratory, etc.

Practices should note that payment is dependent on the submission of sufficient documentation (i.e., Operative Report, Patient Progress Report, notes and/or any other

information on medical services or supplies). If information is insufficient, the claim may result in non-payment.

Provider Disputes

DEFINITION: The Department of Managed Health Care promulgated regulations related to the claims settlement and dispute resolution practices of health plans and their delegated IPAs/Medical Groups ***("AB1455 Regulation").*** In order to comply with AB1455 Regulations, the California Code of Regulations has been revised by (DMHC) California Department of Managed Health Care by adding in Title 28 of the CCR sections 1300.71 and 1300.71.38 requirements for claims settlement practices, provider disputes and provider reports. The new administrative regulations will take effect on January 1, 2004.

POLICY: The AB1455 Regulation includes detailed information on how to submit claims and disputes to ***Network Medical Management*** as well as information on ***Network Medical Management*** claim on overpayment process. (*For further information on the AB1455 Regulation, please refer to the Department of Managed Health Care's website address: www.dmhc.ca.gov/library/regulations/existing and see the table for "Claims Settlement Practices/Dispute Resolution Mechanism" for a copy of the specific provisions.)*

PROCEDURE: ***CLAIMS SETTLEMENT PRACTICES AND DISPUTE RESOLUTION MECHANISM***

I. Claim submission instruction.

Claim submission address must be sent to the following:

- Via Mail: 1680 S. Garfield Avenue Suite 201
  Alhambra, CA 91801
- Via Physical Delivery: 1680 S. Garfield Avenue Suite 201
  Alhambra, CA 91801

A. **Contact information regarding Claim**. For claim filing requirements or status inquiries:

Call Network Medical Management, Claims department Customer Service at:

Telephone Number: (877) 282-8272

B. **Claim Submission Requirement**. The following is a list of claim timeliness requirement, claim supplemental information and claim documentation required based on your contract:

- ❖ Contracted Providers: 90 days from date of service
- ❖ Non-Contracted Providers: 180 days from date of service
- ❖ Supplemental or COB claims: 90 days from date of payment, date of contest, date of denial or notice from the primary payer.

Network Medical Management will send a written acknowledgment of receive paper claim a day after claim posting, within the 15 working day acknowledgement requirement.

I. Dispute Resolution Process for Contracted Provider

A. **Definition of Contracted Provider Dispute**. A contracted provider dispute is a provider's written notice to *Network Medical Management* 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 or contested or 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:

i. If the contracted provide dispute concerns a claim or a request for reimbursement of an overpayment of a claim from *Network Medical Management* 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;

ii. If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue; and

iii. 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.

B. **Contracted Provider Dispute to Network Medical Management**. Contracted provider disputes submitted to *Network Medical Management* must include the information listed in Section II.A., above, for each contracted provider dispute. All contracted provider disputes must be sent to the attention of *Network Medical Management* at the following:

Via mail: 1680 S. Garfield Avenue Suite 201

Alhambra, CA 91801

Via Physical Delivery: 1680 S. Garfield Avenue Suite 201 Alhambra, CA 91801

C. Time Period for Submission of Provider Dispute.

I. Contracted provider disputes must be received by Network Medical Management within **365 days** from last action date (date claim was closed or EOB was received) that led to the dispute (or the most recent action of there are multiple actions) that led to the dispute, or

II. In the case of inaction, contracted provider disputes must be received by within Network Medical Management **365 days** for Medi-Cal or Commercial LOB. Medicare is only 60 calendar days after the provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

III. Contracted provider disputes that do not include all required information as set forth above in Section II.A may be returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to Network Medical Management within **thirty (30)** working days of receipt of a returned provider dispute.

D. **Acknowledgement of Contracted Provider Dispute.** Network Medical Management will acknowledge receipt of all contracted provider disputes as follows:

i. Electronic contracted provider disputes will be acknowledged by Network Medical Management within **two (2)** Working Days of the Date of Receipt by Network Medical Management.

ii. Paper contracted provider disputes will be acknowledge by Network Medical Management within **fifteen (15)** Working Days of the Date of Receipt by Network Medical Management

E. **Contact *Network Medical Management* Regarding Contracted Provide Dispute.** All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to:

F. Time Period for Resolution and Written Determination of Contracted Provider Dispute. Network Medical Management will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five **(45)** Working Days or 60 calendar days after the Date of Receipt of the contracted provider dispute or the amended contracted provider dispute.

G. **Information retention.** Copies of provider dispute and the determination, including all notes, documents and other information the PPG used to reach its decision, must be retained for at least 7 years

II. Dispute Resolution Process for Non-Contracted Provider

A. **Definition of Non-Contracted Provider Dispute.** A non-contracted provider dispute is a non-contracted provider's written notice to Network Medical Management challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim. Each non-contracted provider dispute must contain, at a minimum, the following information: the provider's name, the provider's identification number, contact information, and:

i. If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from Network Medical Management to provider the following must be provided: a clear identification of the disputed item, the Date of Service and clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect;

ii. If the non-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, provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

iii. Medicare provide need to provider a waiver of liability (WOL) with the dispute for timely processing.

B. **Dispute Resolution Process**. The dispute resolution process for non-contracted Providers is the same as the process for contracted providers as set forth in Sections II.B., II.C., II.D., II.E., II.G., and II.H above.

III. Claim Overpayment

A. **Notice of Overpayment of a Claim**. If Network Medical Management determines that it has overpaid a claim Network Medical Management 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 Network Medical Management believes the amount paid on the claim was in excess of the amount due,

including interest and penalties on the claim. All requests for overpayments will be made within 365 days of the date of the overpayment.

B. **Contested Notice**. If the provider contests Network Medical Management notice of overpayment of claim, the provider, within 30 Working Days of the receipt of the notice of overpayment of a claim, must send written notice to Network Medical Management stating the basis upon which the provider believes that the claim was not overpaid. Network Medical Management will process the contested notice in accordance with Network Medical Management contracted provider resolution dispute process as described in Section II above.

C. **No Contest**. If the provider does not contest Network Medical Management notice of overpayment of claim, the provider must reimburse Network Medical Management within **thirty (30)** Working Days of the provider's receipt of the notice of overpayment of claim.

Payment Offset. Network Medical Management may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when; (i) the provider fails to reimburse Network Medical Management within the timeframe set forth in Section IV.C., above, and (ii) Network Medical Management contract with the provider specifically authorizes Network Medical Management 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, *Network Medical Management* 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.

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PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to:

***PROVIDER NPI:**	**PROVIDER TAX ID:**
***PROVIDER NAME:**	
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD ☐ Mental Health Professional ☐ Mental Health Institutional ☐ Hospital ☐ ASC
☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____
(please specify type of "other")

CLAIM INFORMATION ☐ Single ☐ Multiple "**LIKE**" Claims (complete attached spreadsheet) *Number of claims:*___

* **Patient Name:**		**Date of Birth:**
* **Health Plan ID Number:**	**Patient Account Number:**	**Original Claim ID Number:** (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	**Original Claim Amount Billed:**	**Original Claim Amount Paid:**

DISPUTE TYPE

☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Disputing Request For Reimbursement Of Overpayment
☐ Seeking Resolution Of A Billing Determination
☐ Contract Dispute
☐ Other:

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print)	**Title**	**Phone Number** ( )
Signature	**Date**	**Fax Number**

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)**
ICE Approved 10/5/07, effective 1/1/08

For Health Plan/RBO Use Only
TRACKING NUMBER _____ PROV ID# _____
CONTRACTED _____ NON-CONTRACTED _____

PROVIDER DISPUTE RESOLUTION REQUEST
For use with multiple "LIKE" claims (claims disputed for the same reason)

	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid
	Last	First						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

Page _____ of _____

[ ] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED
(Please do not staple)
ICE Approved 10/5/07, effective 1/1/08

CONTRACTED PROVIDERS CANNOT BALANCE BILL A MEDI-CAL and/or MEDICARE ELIGIBLE BENEFICIARY FOR ANY COVERED BENEFITS

Balance Billing is the practice of billing a member for the difference between what is reimbursed for a covered service and what the provider feels should have been paid. Network providers who engage in balance billing are in breach of their contract which prohibits this practice and may be subject to sanctions by the IPA, CMS, DHCS and other industry regulators.

CITRUS VALLEY INDEPENENT PHYSICIANS has been tasked with ensuring all contracted network providers have participated in education on the prohibition of balance billing.

Understanding Balance Billing: *A Primer for Contracted Providers*
Training will provide contracted providers' important regulatory clarification on balance billing, inclusive of the following information:

❖ **Purpose for this Training**

- With new managed care programs (i.e. Cal MediConnect, Covered California, PASCSEIU), members and providers may not always be aware of patient costs and fees associated with these programs
- Recent reports of balance billing warrant increased monitoring by health plans
- Identified need for provider and patient education on the prohibition of balance billing for covered services

❖ **What is Balance Billing?**

- When contracted providers or hospital change beneficiaries for Medi-Cal and/or Medicare covered services which include **copays, co-insurance, deductibles, or administrative fees.**
- When non-contracted or fee-for-service providers charging members who are enrolled in managed care for any part of the covered service.
- Provider offices charging administrative fees for appointments, completing forms, or referrals.

❖ **When Can a Provider Bill?**

- Providers may bill patients who have a monthly Medi-Cal share of cost obligation, but only until that obligation is met for the month.
- Medicare Part D patients, including Cal Medi-Connect, may have a cost share for some prescription drugs
- Cost for non-covered benefits
- L.A. Care plans and other Medi-Cal Payors, including L.A. Care Covered and PASC-SEIU Plans, may require co-pays and co-insurance fees.

❖ **Prohibition of Balance Billing**

- Federal and State regulations prohibits balance billing in its provider contracts
- Network providers who engage in balance billing are in breach of their contract with the IPA
- Providers who engage in balance billing may be subject to sanctions by the IPA, CMS, DHCS and other industry regulators.

❖ **Steps to Take When Balance Billing Occurs**

1. Tell the member – DO NOT PAY THE BILL!!
2. Verify eligibility and determine if the member is a Medi-Cal and/or Medicare member
3. Educate front office staff and billing departments about balance billing protections.
4. Educate patients about their eligibility status and about their rights.

❖ **Resources and Information**

Website: http://www.calduals.org/providers/physician-toolkit/

For more questions regarding Balance Billing, please contact **Provider Relations Department.**