2022
PROVIDER MANUAL

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BUSINESS CODE OF CONDUCT

The Business Code of Conduct (BCC) establishes ethical and legal guidelines for providing care and services on behalf of Network Medical Management. It demonstrates Network Medical Management's commitment to compliance and applies to all Board of Directors, employees, volunteers, physicians, third-party payors, subcontractors, independent contractors, vendors, consultants, and other employees.

Compliance with all Laws and Regulations

Network Medical Management will comply with all applicable laws and regulations. It is the responsibility of employees, volunteers, and business associates to be knowledgeable of and comply with such regulations in the following areas:

- Accurate Claims for Reimbursement
- Medical Necessity
- Accurate Business Records
- Cost Reports
- Refunds
- Kickback Prohibitions
- Co-Payments, Deductible & Discounts
- Honest Dealings with Payor, State, or Government Officials
- Cooperation of Audit and Investigations

SECTION 1.1

IPA Introduction

Emanate Health IPA is a group of physicians committed to providing you with quality, compassionate Healthcare. The Emanate Health Independent Physician Association (IPA) is a physician network serving The San Gabriel Valley's vibrant community.

The Emanate Health IPA is made up of more than 200 physicians, including primary care doctors and Specialists. Together, we have hundreds of years of medical expertise that we use to give you the best Treatment possible.

By selecting an IPA-affiliated doctor, you gain direct access to all of the Emanate Health hospitals and Services. That means we can easily get you lab work, radiology treatments, imaging and many other Exceptional programs without sending you somewhere far from home.

MSO Introduction

Network Medical Management (NMM) is a Management Services Organization (MSO) comprised of healthcare professionals and more than 600 employee associates serving the rapid growth of Independent Physicians Associations (IPAs) and Medical Groups. NMM has helped numerous IPAs and medical groups achieve their financial goals and organizational success. In 2016, NMM achieved its objective of transforming from an IPA model to an Integrated Population Health Model by facilitating best practices and turning them into a comprehensive healthcare organization which is truly accessible to all. Network Medical Management has now expanded its services to 10 counties in California providing management to over 1,200,000 members and a network of over 7,000 contracted physicians, making it one of the largest in California and the US.

As a management service organization our areas of operations include, utilization management, claims, eligibility, capitation, customer services, finance, contracting, credentialing, quality management, case management, IT systems, and provider services.

SECTION 1.2
CONTACT SHEET

EMANATE HEALTH IPA

IPA Administration	EMAIL
Dr.Gurjeet Kalkat, Medical Director	gkalkat@emanatehealth.org
Guadalupe Herrera, VP of Business Development	gherera@emanatehealth.org
Rafael U. Zepeda, Director Integrated Networks	rzepeda@emanatehealth.org
Deborah Lopez, Population Health Specialist/UM	delopez@emanatehealth.org
Roxana Robles, Laboratory/Radiology Liaison	rrobles@emanatehealth.org
Dr.Gurjeet Kalkat, Medical Director	gkalkat@emanatehealth.org

NETWORK MEDICAL MANAGEMENT
(877) 282-8272

Administration	
Kenneth Sim, M.D., Executive Chairman	
Thomas Lam, M.D., M.P.H, Co-Chief Executive Officer & President	
Brandon Sim, Co-Chief Executive Officer	
Eric Chin, Chief Financial Officer	
Jeremy R. Jackson, M.D., Chief Quality Officer	
Albert W. Young, M.D., M.P.H, Chief Administrative Officer	
Operations Management	**EMAIL**
Connie Li, Director of Provider Relations	CLi@networkmedicalmanagement.com
Christina Larez, Director of Credentialing	CLarez@networkmedicalmanagement.com
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Health Services	**EMAIL**
Dr. William Wang M.D., Medical Director of Health Services	WWang@ networkmedicalmanagement.com
Feodor Fermin, Health Services Delegation Oversight	FFermin@ networkmedicalmanagement.com
Mitch Agorrilla, Director of Health Services	MAgorrilla@networkmedicalmanagement.com

SECTION 1.3
NMM QUICK REFERENCE SHEET

AREA	CONTACT DETAILS
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 the NMM Web Portal** • **Via Office Ally, use Payor ID #: NMM01** • **Mail:** 1600 Corporate Center Dr. Suite # 101 Monterey Park, CA 91754 **Paper claims will not be accepted for contracted providers**
Case Management	To report an admission, • **Please fax: (**626) 943-6321
Eligibility	**To have a new patient added, you can:** • **Submit through the NMM Portal:** https://www.nmm.cc/provider-portal • For **urgent requests**, please call (877) 282-8272
Utilization Management	• **Submissions:** Please use the NMM Portal at: https://www.nmm.cc/provider-portal • **Faxes will be accepted in a limited basis at:** Routine: (626)943 6362 Urgent: (626)943 6363
Web Portal Assistance	• **Technical Assistance / New Users:** Portal.Help@networkmedicalmanagement • **Phone:** (626) 943-6146 • **Fax:** (626) 943-6350
Provider Services	• You can also email NMM Provider Relations Team at ProviderNetworkOperationsDept@networkmedicalmanagement.com

SECTION 1.4
CONTRACTED HEALTH PLANS

EMANATE HEALTH IPA currently contracts with Knox Keene licensed health plans in the areas and is contracted with the following health plans:

*******CONTRACTED HEALTH PLANS ******

HEALTH PLANS	PRODUCT LINES OF BUSINESS	CAPITATED HOSPITAL (Full Risk)
Aetna	Commercial & POS	
Alignment Health Plan	Medicare	
Anthem Blue Cross	Medi-Cal	Emanate Health Queen of the Valley Hospital
	Commercial & POS	
	Covered CA	
Blue Shield CA/Promise	Covered California	
	Commercial & POS	
	Medi-Cal	
	Medicare	
Brand New Day	Medicare	
Bright Health Plan	Medicare	
Central Health Plan	Medicare	
Clever Care Health Plan	Medicare	Emanate Health Queen of the Valley Hospital Emanate Health Inter Community Hospital Emanate Health Foothill Presbyterian Hospital
Cigna	Commercial & POS	
Health Net	Commercial & POS	
	Covered CA	
	Cal MediConnect	Emanate Health Queen of the Valley Hospital
	Medi-Cal	Emanate Health Queen of the Valley Hospital
	Medicare	Emanate Health Queen of the Valley Hospital
Humana	Medi-Cal	
L.A Care	Medi-Cal	Emanate Health Queen of the Valley Hospital
	Cal MediConnect	
	Covered California	
Molina	Medical	
	Medicare	
	Cal MediConnect	
	Covered California	
Wellcare Health Plan	Medicare	
Scan	Medicare	
United HealthCare/Secure Horizons	Medicare	Garfield Medical Center
	Commercial & POS	Garfield Medical Center

***Please note: Services are subject to contract institution between the health plan and hospital. All scheduled hospital services must have prior authorization.**

SECTION 1.5
CONTRACTED HOSPITALS

- Emanate Health Queen of the Valley Hospital
- Emanate Health Inter-Community Hospital
- Emanate Health Foothill Presbyterian Hospital

URGENT CARES

PLEASE REFER TO THE INSERT INCLUDED IN THIS MANUAL FOR FULL URGENT CARE LISTING

SECTION 1.6
CONTRACTED LABORATORY

Laboratory

POLICY: All laboratory procedures for Emanate Health IPA Members must be ordered through Emanate Health IPA contracted laboratory facilities. Providers should contact any of the below laboratory to set up an account, and to get access to their web portal.

PROCEDURE: When ordering routine laboratory procedures please use the Emanate Health IPA referral request form.

NON-ROUTINE: Any other complex laboratory procedure, please submit prior authorization to UM department at https://www.nmm.cc/provider-portal

For laboratory locations and hours of operation, please contact
Emanate Health IPA provider Relation Representative

LABORATORY LOCATIONS

- Emanate Health Queen of the Valley Hospital
1115 S. Sunset Ave West Covina, CA 91790

- Emanate Health Inter-Community Hospital
210 W. San Bernardino Road Covina, CA 91723

- Emanate Health Foothill Presbyterian Hospital
250 S. Grand Ave Glendora, CA 91741

Note: For Health Net Covered California Emanate Health IPA Members, they should be directed to Quest Diagnostics for laboratory services.

NOTE: Your office will be held liable for all charges if you use other non-contracted Laboratory Services without prior authorization

SECTION 1.7
WEB PORTAL & ONLINE SERVICES

Network Medical Management Web Portal

Network Medical Management's Provider Web Portal is a web-based application that enables practices to verify member eligibility, submit/view authorization requests, and submit/view claims data from any location with internet access. Providers can also take advantage of the portal to download a copy of the provider rosters (PCP and/or specialist) and can search individually for a provider (PCP and/or specialist) and/or ancillary service provider.

In order to set up a portal account, a practice must fill out the Web Portal New Account Registration Form available on https://www.nmm.cc/provider-portal. Provider may also contact Network Medical Management's Web Portal team by calling (626) 943-6146 or via email **Portal.Help@networkmedicalmanagement.com** .

Portal features include:

- Eligibility verification and status inquiry
- Authorization submission and status inquiry
- Claims submission and status
- New Documents (provider progress notes, hospital admit/discharge report, open authorization report, and more...)
- Member List (PCP)
- HEDIS Gap Report
- HCC RAF and Gap Reports
- Provider Resources and Member Educational Material

After an account has been set up, questions about the portal can be directed to Network Medical Management's Web Portal team.

Please visit us at:

https://www.emanatehealth.org

NetworkMedicalManagement.com

Office Ally

Providers are encouraged to setup an account to start submitting all claims through Office Ally. Network Medical Management has opted to partner with Office Ally for all claims submissions.

Please note our payer's ID is: **NMM01**

To setup an account with Office Ally, please contact them directly at (866) 575-4120, or you can email them at Info@OfficeAlly.com

SECTION 2.1
ELIGIBILITY VERIFICATION PROCESS

If it is a member's first time visiting a practice, the front office staff should ask the member for their health plan identification card or for a copy of the enrollment form and make a copy for their records. Each member identification card may look different, but most cards typically include the following elements:

- Member's Name
- Membership Number
- Group Number
- Type of Plan
- Effective Date
- Name of Provider (PCP)
- Name of Insurance Company – HMO/PPO/IPA
- Co-Payment Amount (varies; must be checked with member's current health plan)

Member eligibility must be verified at the time of the appointment, and a membership identification card is not necessarily valid proof of eligibility. If a practice is in doubt about a member's eligibility, front office staff may verify eligibility by calling Network Medical Management's Eligibility Department at (626) 282-0288, or by contacting the health plan directly online or by phone (see table below). Given the frequency of eligibility changes, it is always best to check eligibility directly with the health plans.

HEALTH PLAN	PHONE NUMBER	WEBSITE
Aetna	800-872-3862	https://aetna.com
Alignment	844-361-4712	https://www.alignmenthealthcare.com
Anthem Blue Cross	800-845-3604	https://www.anthem.com
Blue Shield	800-541-6652	https://www.blueshieldca.com
Blue Shield Promise	800-468-9935	https://www.blueshieldca.com/promise
Brand New Day	866-255-4795 Ext. 4032	https://bndhmo.com
Central Health Plan	866-314-2427	https://www.centralhealthplan.com
Cigna	800-244-6224	https://www.cigna.com
Health Net	800-641-7761	https://www.healthnet.com
Humana	800-626-2741	https://www.humana.com
LA Care	866-522-2736	www.lacare.org
Molina	888-665-4621	www.molinahealthcare.com
Scan	800-559-3500	https://www.scanhealthplan.com
United Healthcare	877-842-3210	https://www.uhc.com
Wellcare Health Plan	877-236-7162	https://www.wellcare.com/

Adding a New Member

If a practice is unable to locate a member on the web portal but had previously confirmed eligibility, the office staff should submit a request to add the member via the following:

- **Routine Requests**: NMM Provider Portal under Eligibility > Member Request. Please allow up to 24 hours for member to reflect on the portal.
- **Urgent Requests:** Via phone by calling (626) 282-0288. Member will be added within 30 minutes.

SECTION 2.2
ELIGIBILITY AND CAPITATION

On a monthly basis, all capitated providers will receive an eligibility and capitation report. Capitation is calculated over a six month period (indicated on the report) to capture enrollment retro-activity and current membership.

Information contained in the report includes the following:

- Member's first and last name
- Member's gender
- Member's age
- Member's health plan and identification number
- Member's PCP effective date
- Member's PCP termination date (if applicable)
- Capitation amount paid per member
- Capitation rate by member
- Capitation period by month (if any retro payments)
- Manual adjustments applied to a provider's current capitation payment
- Current month capitation payment

Primary Care Physicians Capitation payment is only available through electronic direct deposit; please complete the *Monthly Capitation Payment Direct Deposit Authorization* form.

*Refer to **Section 15** of this manual for MONTHLY CAPITATION PAYMENT DIRECT DEPOSIT AUTHORIZATION form*

VENDOR PORTAL – ELECTRONIC CAPITATION EOB

Network Medical Management is starting a green initiative to reduce our environmental impact and has begun to post all Primary Care Physician Capitation EOB files on the NMM Vendor Portal.

For authorization and security purposes, we require that the PCP office provide NMM an administrative email and/or mobile phone number in order to setup the credentials on the Vendor Portal.

Please contact the Provider Relations Department to set up your account.

ProviderNetworkOperationsDept@networkmedicalmanagement.com

For any eligibility or capitation related inquiries, please contact your assigned Provider Relations Specialists.

SECTION 3
PROVIDER RELATIONS

Provider Relations (PR) is committed to being accessible to all contracted physicians on a daily basis. To provide internal and external support to all IPA providers by providing guidance, training, education, direction and support to resolution of issues and/or concerns that would involve other departments. Responsible for handling and resolution of incoming provider inquiries, request and issues within IPA standards in high quality customer service and professional manner at all times.

Responsibilities

EMANATE HEALTH IPA Provider Relations Department works with contracted providers to ensure that the provider has the necessary information, resources, and assistance to work with the IPA. Their list of duties/responsibilities includes the following:

- Orienting providers to processes and services around customer service, utilization management, claims, eligibility, quality management, etc.
- Provider Manual distribution
- Issue resolution involving authorizations, claims, eligibility, capitation and contracting
- Provider education/training
- Disseminating network updates, including health plan policy changes/updates
- Health education material distribution
- Member enrollment issues
- Provider complaints
- Assistance with grievances
- HEDIS and HCC Support

EMANATE HEALTH IPA encourages providers to contact its Provider Relations Team with any questions or concerns.

Provider Relations Department
Direct: (626) 282-0288
Fax: (626) 943-6309
E-mail: ProviderNetworkOperationsDept@networkmedicalmanagement.com
Monday - Friday
8:30 a.m. – 5:00 p.m.

SECTION 4
PROVIDER REQUIREMENTS

All Contracted Providers must render services in accordance with the highest standards of competence, care and concern for the welfare and needs of Patient/ Participant/Clients and in accordance with the laws, rules and regulations of all governmental authorities having jurisdiction.

What to Do In Case Of an Emergency

If a EMANATE HEALTH IPA patient telephones you with an emergency, the first thing to do is determine whether the patient should call 9-1-1, go to the nearest emergency room, after hours convenient care center or to your office. **LICENSED PERSONNEL SHOULD HANDLE TRIAGE OF PATIENTS ONLY.**

If you determine that it is a life-threatening emergency, please instruct the patient to hang up the phone and dial 9-1-1 immediately.

If you determine that the patient is stable enough to go to the nearest emergency room, after hours convenient care center, or your office to be evaluated, please instruct the patient to be transported by another person. A patient should never be instructed to drive himself/herself in the event of a life-threatening situation. If patient is alone and unable to arrange transportation, please contact EMANATE HEALTH IPA to arrange ambulance service. If this occurs after 5:00 P.M., call (626) 282-0288 and speak to an on-call physician or case management contact.

Authority and Responsibility

The Health Services Management has the ultimate responsibility for the performance of the organization. The Management has delegated the ongoing and continuous oversight of all operations to the Executive Committee through the President and Chief Executive Officer. EMANATE HEALTH IPA does not through its contracts, or other arrangements, delegate authority of its decision-making process and authority. The IPA retains the right and authority over all key decisions affecting the corporation and its contracted provider operations and management.

The IPA has the authority and responsibility to implement, maintain, and enforce its policies governing Contractors' duties under their agreement(s) and/or governing oversight role. The IPA has the right and responsibility to conduct audits, inspections and/or investigations in order to oversee contractors' performance of duties described in their agreement(s) and to require Contractors to take corrective action if the IPA or the applicable federal or state regulator determines that corrective action is needed with regard to Contractors' duties under their agreement, and/or if Contractors fail to meet standards in the performance of those duties.

Contractors must cooperate with the IPA in its oversight efforts and must take corrective action as determines necessary to comply with the laws, accreditation standards, Payor Contract requirements and/or policies governing the duties of the Contractor or the oversight of those duties.

Medical Decision and Financial Statement

There is an established policy requiring practitioners and licensed utilization management staff responsible for utilization decisions to affirm that utilization decisions are based solely on appropriateness of care and services. Health Services Department does not reward practitioners or other individuals conducting utilization review decisions that result in under-utilization.

Open Communication with Patients

Providers are required to participate in candid discussions with their patients regarding all decisions about their care, including but not limited to, diagnosis, treatment plan, right to refuse or accept care, care decision dilemmas, advance directive options, and estimates of the benefits associated with available treatment options, regardless of the cost or coverage. Furthermore, patients must be provided clear explanations about the risks from recommended treatments, the length of expected disability, and the qualifications of the physicians and other health care providers who participate in their care. Moreover, providers must inform Medi-Cal members that they have the freedom of choice in obtaining Family Planning, Abortion Services, Sexually Transmitted Disease (STD) treatment, and Sensitive Services for Minors without prior authorization.

Provision of Services

Contracted Providers must agree to render professional medical services to Patients/Participants/Clients referred to the Contracted Provider by EMANATE HEALTH IPA (provided that the Contracted Provider's application for participation has been approved by IPA's Credentialing Committee) Contracted Specialist Providers may not provide services to Patients/Participants/Clients, except in an emergency, without first securing authorization from Management Department. In addition, Contracted Providers must consult with the IPA and other health professionals when so requested and must participate in peer review activities.

Standards of Practice and Compliance with Laws

Contracted Providers must comply with all applicable laws, rules and regulations of all governmental authorities relating to the licensure and regulation of health care providers and the provision of health care services. Providers must at all times conduct a professional medical practice that is consistent with the applicable State and Federal laws and with the prevailing standards of medical practice in the community. They are also expected to adhere strictly to the canons of professional ethics.

Availability

Contracted Providers must provide available and accessible services to Patient/ Participant/ Clients at all times and must agree to permit EMANATE HEALTH IPA to monitor and evaluate accessibility of care and to address problems that develop, which shall include but not be limited to, waiting time and appointments. Provider office must be open at least 16 hours per week and the Physician must be on site at least 8 hours per week. *Please refer to **SECTION 12.2** of this manual to review the ACCESS TO CARE STANDARDS.*

Provider Leave of Absence

If PCP is, for any reason, from time to time unable to provide Covered Services when and as needed, PCP may secure the services of a qualified covering physician who shall render such covered services otherwise required of PCP; provided, however, that the covering physician so furnished must be a physician approved by IPA (to include credentialed by the IPA) to provide covered services to Enrollees. PCP shall be solely responsible for securing the services of such covering physician and paying said covering physician for those covered services provided to Enrollees. PCP shall ensure that the covering physician:

A. Looks solely to PCP for compensation
B. Will accept IPA's peer review procedures
C. Will not directly bill Enrollees for Covered Services under any circumstances

D. Will, prior to all elective hospitalizations, obtain authorization in accordance with IPA utilization review program.

A provider who is on a medical leave of absence for over 30 days is subject to termination by the IPA without cause.
Contracted PCP must notify the IPA in writing within 48 hours in advance for any leave of absence longer than 2 days. Notifications shall be sent to Provider Relations Department via email at ProviderNetworkOperationsDept@networkmedicalmanagement.com or via fax at (626) 943-6309.

*Refer to **Section 15** of this manual for PROVIDER LEAVE OR ABSENCE form*

Surgery and Hospital Admissions

If a Contracted Provider is a physician or other health care professional who possesses hospital privileges, the Contracted Provider must maintain throughout the term of his/her agreement with EMANATE HEALTH IPA his/her medical staff membership at said hospital(s), and other privileges, which are deemed reasonably necessary by the IPA for the performance of the duties under the contract(s) with the IPA. Whenever a Contracted Provider recommends surgery for a Patient/Participant/ Client, the Contracted Provider must contact the IPA to obtain prior authorization for the proposed treatment. The Provider must work to perform said surgery at a contracted facility or financially responsible Health Plan contracted Hospital.

Confidentiality of Records

Contracted providers (physicians and non-physicians) must comply with all applicable confidentiality requirements imposed by Federal and State law. This includes the development of specific policies and procedures to demonstrate compliance. All information, records, data collected and maintained for the operation of the health care service plans or other payors with which the IPA is associated, and information pertaining to Contracted Providers, IPA Patient/ Participant/Clients, facilities and associations, will be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. IPA agreements may not be construed to require confidential treatment for any information that is subject to disclosure under the California Public Records Act.

Provider Termination Procedure

The provider must notify Provider Relations Department in writing of his/her intent to terminate their contract **at least 90 days before the intended effective date**. Network Medical Management will follow the termination clause in accordance with the provider contract. (**Termination involving Anthem Blue Cross Medi-Cal line of business requires 120 days advance notice**).

The following shall be confirmed by Provider Relations Department upon receipt of a termination request:

1. Reason for termination
2. Verify if the provider is affiliated with any other IPA managed by NMM

The following notifications will be sent out once termination has been processed:

- The IPA shall send out member notices 30-60 days prior to the effective date of termination to notify of the imminent termination of a specialist provider.
- The health plan shall send out member notices to notify of the imminent termination of a PCP provider.
- The IPA shall send out a letter to the provider acknowledging the termination effective date.

Continuing Care Obligation

In instances where a provider contract is terminated "without cause" and any Patients/ Participants/ Clients are receiving care for acute or serious chronic conditions, California state law (SB1129) requires that such Patients/Participants/ Clients have the right to continue to be treated by their terminated provider for up to 12 months, if they so request. In accordance with CA Health and Safety Code 1373.65(f), the IPA notifies members of the termination of specialists in the preferred network. The notification to members states "If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated period. Please contact your HMO's customer service department, and if you have any questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll- free number, 1-888-HMO- 2219, or at TDD number for the hearing impaired at 1- 877- 688- 9891, or online at www.hmohelp.ca.gov. "Without cause" includes terminations NOT attributable to quality of care issues, fraud, or other criminal activity.

EMANATE HEALTH IPA Patients/Participants/Clients may continue to be treated by the physician for up to 90 days, as long as the physician agrees to reasonable contract terms proposed by the IPA. This time period may be extended if the transfer of services is not considered safe. Some examples of acute medical conditions or serious conditions include, but are not limited to:

A. Second or third trimester of pregnancy (as applicable).
B. High-risk pregnancy (as applicable).
C. Recent surgery with subsequent complications requiring the patient to receive ongoing home health services.
D. Outpatient critical cases in the process of stabilization (such as intensive radiation therapy or treatment of uncontrolled diabetes); and/or
E. Terminal cases.

To assist the IPA in maintaining continuity of care for its Patients/ Participants/Clients, Contracted Providers are required to share the medical records of services rendered to Patients/ Participants/ Clients, provided that the appropriate release of information has been obtained. Upon a member reassignment or transfer, Contracted Providers must provide one copy of these records, at no charge, to the member's new physician. Upon request, additional copies must be provided at reasonable and customary copying costs, as defined by California Health and Safety Code 1792.12.

Compensation

Contracted Providers must only bill EMANATE HEALTH IPA for all approved services they provide to affiliate Patients/Participants/Clients, except for applicable copayments or deductibles. Providers may not seek any reimbursement for authorized services provided to IPA Patient/ Participant/ Clients from the Payors with which it contracts. Surcharges to Patient/ Participant/ Clients are strictly prohibited.

In the event that the IPA fails to pay Contracted Providers for authorized health care services rendered to a Patient/Participant/Client, including but not limited to insolvency, the Patient/ Participant/ Client will not be liable for any sums owed to Contracted Providers by the IPA. Under no circumstances may Contracted Providers or their agents, trustees or assignees maintain any action at law against any Patient/Participant/Client to collect sums owed to Contracted Providers by the IPA. *Please also refer to* ***Section 9.6*** *of this manual for additional information regarding* ***Balance Billing***.

Recovery from Third Parties: Lien Rights

Where duplicate coverage exists, Contracted Providers must assist the IPA in pursuing coordination of benefits or other permitted method of third-party recovery. Contracted Providers must identify and notify the IPA of all instances or cases in which Contracted Providers believe that an action by a Patient/ Participant/ Client involving the tort or workers' compensation liability of a third party or estate recovery

could result in recovery. Providers may not claim recovery of the value of covered services rendered to a Patient/Participant/Client in such cases or instances and must refer all cases or instances to EMANATE HEALTH IPA Provider Relations Department within thirty (30) days of discovery.

Books and Records

Contracted Providers must agree to maintain its books and records pertaining to the goods and services furnished under his/her agreement(s) with the IPA, to the cost thereof, in a form consistent with the general standards applicable to such book or record keeping. Providers must cooperate in order to enable the IPA to fulfill its contractual and statutory obligations, by allowing the IPA access to Contracted Providers' books, records, and other papers, including the following:

A. Retain such books and records for a term of at least ten (10) years from the close of the fiscal year in which the provider contract is in effect.
B. Comply with all requirements of the IPA contracts with Payors, as applicable.

In addition, these obligations are not terminated upon termination of the respective agreement(s) with the IPA whether by rescission or otherwise.

Independent Contractors

The sole interest and responsibility of the IPA with respect to such performance is to ensure that the services are rendered in a competent, efficient, and satisfactory manner. The legal relationship between the IPA and Contracted Providers or any of Contracted Providers' employees, associates or subcontractors, may not be construed to cause any such employee, associate or subcontractor to become or to be treated as an employee of the IPA.

Assignment and Delegation

Contracted Providers may not assign or delegate any of the duties covered in his/her contract(s) without the prior written consent from the IPA and its Payors, as applicable.

Non-Discrimination

Providers may not discriminate against Patient/ Participant/Clients in the rendition of services on the basis of race, color, national origin, ancestry, sex, marital status, sexual orientation or age. Additionally, providers may not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (including cancer), age (over 40), marital status, and/or family care leave. All providers must ensure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. They must also comply with the provisions of the Fair Employment and Housing Act and the applicable regulations promulgated thereunder. Please visit our website at https://www.nmm.cc/provider-resources additional for information regarding Cultural Competency.

Providers Charging Medi-Cal Members

California Welfare and Institutions Codes prohibits contracted health care providers from charging and/or collecting payment from managed Medi-Cal Members, or other persons on behalf of the Member, for filling out forms related to the delivery of medical care, missed appointments or copies of members medical/chart. Any Provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility shall not seek reimbursement nor attempt to obtain payment for the cost of those

covered health care services from the eligible applicant or recipient, or any person other than the department or a third-party payor who provides a contractual or legal entitlement to health care services.

Under no circumstances can a Health Care Provider deny or refuse service to a member for non-payment of a missed appointment, lack of payment for co-payments and owe balance or deductibles, as applicable.

A Health Care Provider that is not paid at billed charges may not pursue any balance billing or collection actions against any member. Such collections actions may include:
a. Sending or mailing bills to Member.
b. Calling the member with demands to pay outstanding balance.
c. Referrals to collection agency.

If the Provider of service continues to charge a Member in violation of this policy after being notified to stop, or sends the Member's account to a collections agency, the IPA reserves the right to inform the DMHC, DHCS or other regulatory agencies of the violation. In addition, the billing of Members is in violation of health plans policies and the IPA takes all necessary actions, up to and including termination of the Provider's participation with the network to ensure that such actions stop.

Member Medical Record Availability

Providers shall ensure that a medical record shall be established and maintained for each Member. Each Member's medical record shall be opened upon the Member's first visit. The record shall contain that information normally included in accordance with generally accepted medical and surgical practices and standards prevailing in the PCP's professional community.
PCP shall facilitate the sharing of medical information with other providers in cases of authorized referrals. Subject to applicable Federal and California laws and professional standards regarding the confidentiality of medical records. Providers shall make such records available to authorized IPA personnel in order for IPA to conduct its Utilization Review and Quality Management Programs. Providers shall provide to IPA and/or health Plans, **at no cost**, copies of the health plan member medical records for purpose of conducting quality management, case management and utilization management; Credentialing and peer review; claims processing; verification and payment; resolving member grievances and appeals; and other activities reasonably necessary for compliance with the standards of accreditation organizations and the requirements of State and Federal Law, including health plan's continuity of care obligations. Providers will cooperate with Quality Improvement (Q.I.) activities which include but are not limited to providing access to care.

SECTION 5
CREDENTIALING AND RE-CREDENTIALING

EMANATE HEALTH IPA is committed to providing quality care to its members. Consequently, Network Medical Management uses a rigorous process to evaluate providers. This process thoroughly evaluates a provider's experience, licensing and sanction activity, and quality of care.

Procedure

1. The Credentialing Committee is responsible for making decisions regarding provider credentialing. The Credentialing Department reviews each initial application with all supporting verifications and documentation prior to submission to the Credentialing Committee.
2. Initial Application: Network Medical Management uses the approved California Participating Physician Application (CPPA) and the Council for Affordable Quality Health care (CAQH) application. These applications will require the provider to provide information on:
    a. Reasons for inability to perform the essential functions as a provider, with or without accommodation
    b. Lack of present illegal drug use
    c. History of loss of license and felony convictions
    d. History of loss or limitations of privileges or disciplinary activities
    e. Attestation by the applicant of the correctness and completeness of the application. Attestations will cover seven (7) years for initial providers and three (3) years for re-credentialed providers
3. Completed application: Each applicant will be required to complete an application. In addition, the applicant will provide:
    a. Curriculum Vitae (CV)
    b. A copy of current State Medical or Dental License(s) (pocket license)
    c. A copy of a valid DEA certificate (if applicable)
    d. Face Sheet of Professional Liability Policy or Certification for past and present coverage, in the minimum amounts of $1 million per occurrence and $3 million aggregate
    e. Board Certification Certificates (if applicable)
    f. Certificates of Degree Completion (i.e., medical or dental school)
    g. Internships and Residency certificates of completion
    h. A copy of Educational Commission for Foreign Medical Graduates (ECFMG), if applicable
    i. Addendum A (Provider Rights)
    j. Addendum B (as applicable)
    k. HIV Designation Form
    l. Delegation of Service Agreements (mid-levels) (as applicable)
    m. Forms of identification issued by state or federal agency
    n. Social Security Card
    o. National Provider Identifier
    p. Request for Taxpayer Identification Number (W-9)
4. Incomplete application: The Credentialing Department will send three follow-up requests for missing information (e.g., any application which is incomplete, is not accompanied by all supporting documentation, does not include a signed Physician Provider Agreement or is dated more than three months prior to receipt). If the requested information is not received after the third request, the application will be considered inactive.
5. Primary source verification: Upon receipt of a completed application, Network Medical management will obtain and verify information. The Credentialing Department will obtain, through the most effective methods, additional information or clarification, as needed, to provide the Medical Director and

Credentialing Committee adequate information to make an informed decision regarding the applicant's qualifications.

6. Provider' rights (Due Process). Providers shall have:
    a. The right to review the information submitted in support of his/her credentialing application. Exception: Applicants are not review references, recommendations, or other information that is peer review- protected
    b. The right to respond to information obtained during the credentialing process, which varies substantially from the information provided to Network Medical Management by the applicant
    c. The right to correct information provided to Network Medical Management which the applicant considers to be erroneous
    d. The right to be informed upon request of the status of his/her credentialing/re-credentialing application
7. Re-applying: Providers denied by the Board of Directors will not be eligible to reapply for membership for a period of at least two (2) years.
8. Length of appointment: Providers will be credentialed for an initial period of not to exceed three years (36 months).
9. Errors and Omissions: The providers will be immediately notified in writing of any occurrence. A copy of the official report (if applicable) will be sent to the provider along with a letter of explanation.
10. All documents received will be date stamped and initialed.

All questions regarding credentialing and/or re-credentialing should be directed to the Credentialing Department at (877) 282-0288.

SECTION 6
PROVIDER SATISFACTION SURVEYS

EMANATE HEALTH IPA and its network partners are constantly making strides to improve satisfaction for their providers. In an effort to evaluate its performance, Network Medical Management conducts an annual member and provider satisfaction survey. The survey covers all areas of operations, including utilization management, case management, claims, eligibility, customer service, marketing, provider relations, and quality management.

The survey will allow us to identify how we are doing a health care provider and will help us advance and/or improve our services. Our survey covers all areas of operations that includes: utilization management, case management, claims, eligibility, customer service, marketing, provider relations, and quality management.

Please contact our Provider Relations Department if you need to speak with any PR Specialist.

EMANATE HEALTH IPA
Provider Relations Department
Direct: (626) 282-0288
E-Mail: ProviderNetworkOperationsDept@networkmedicalmanagement.com

SECTION 7.1
UTILIZATION MANAGEMENT PROGRAM

Utilization management involves evaluation of the necessity of services and the appropriateness of the selected level of care and procedures according to established criteria or guidelines. In the managed care system, the monthly revenue received by the IPA from the health plan for each member (also known as PMPM or per member per month) is fixed. Out of this revenue, all costs must be paid, which means that the resources must be effectively managed. If the costs exceed the revenue, the budget will be in deficit.

Utilization metrics are used to determine how much care is being utilized by a network's members. Typically, utilization is measured per thousand members so that it can be compared and analyzed across providers and practices. Some common utilization metrics are:

- ER/K: Emergency room visits per thousand members
- UC/K: Urgent care visits per thousand members
- Admits/K: Admissions per thousand members
- Bed days/K: Inpatient days per thousand members

These metrics represent some of the most costly points of care and are used to determine how well a provider/practice performs. The key to successful utilization is proactive identification and medical management of those members who are at risk for inappropriate utilization of the most costly points of care. It is important to determine if these members can be more appropriately treated in less acute settings and/or with targeted care management programs. In addition to the aforementioned list, utilization can also be measured through referral metrics on referral patterns to specialists and through encounter submission data which tracks the frequency with which providers see the network's members.

Along with Network Medical Management's Utilization Management Committee, EMANATE HEALTH IPA Utilization Management and Quality Management Committees will regularly monitor and assess the performance of its participants (e.g., Medical Director, Utilization Management and Quality Management Committee Members, Case Managers) involved in determining medical necessity, managing care and evaluating the effectiveness of the process and outcomes involved. The assessment is based on the ability to consistently apply specified utilization management criteria (e.g., Federal and State guidelines, health plan guidelines, MCG [formerly Milliman Care Guidelines], Health Care Management Guidelines).

A. Specialty Referral Data

Specialty referral data on contracted providers is collected and tabulated on a quarterly basis by Network Medical Management on behalf of EMANATE HEALTH IPA . Providers whose referral patterns differ significantly from the average will be identified and reviewed by the Utilization Management Committee. Potential outliers will be reviewed for differences in case mix, appropriateness of referrals and evidence of knowledge or skill gaps. A statistical report will be generated for each provider indicating referral performance relative to the mean and standard deviation of the group.

B. Hospital Admission/Re-admission

Outliers for hospital admission and/or re-admission may be due to intensive treatment for members or underutilization reflective of barriers to care, case mix differences or lack of access to effective preventive health care. Outliers will be identified using MCR guidelines.

C. Emergency Room Visits

High outliers for emergency room visits may be reflective of poor access to primary care, management issues, or be due to case mix differences. A combination of high emergency room use or low institutional use may raise concerns about barriers to primary care and to secondary care. Providers

with statistics higher than MCR guidelines or industry benchmarks will be flagged for possible access issues.

D. Feedback and Corrective Action

Providers reviewed by the EMANATE HEALTH IPA Utilization Management and Quality Management Committees will receive specific feedback and/or on-going education. Provider Corrective Action Plans (CAP) will be developed as appropriate at the recommendations of the Committees.

E. Referral to Non-contracted Provider

All members must be referred to a contracted and credentialed provider through EMANATE HEALTH IPA . In the event that a provider cannot be located for a particular health service, the referring provider must contact Network Medical Management's Utilization Management Department for further guidance. Providers who inappropriately refer a member to a non-contracted provider without prior authorization may be held responsible for the medical charges incurred.

F. Service Coordination

Network Medical Management is responsible for coordinating the following services on behalf of EMANATE HEALTH IPA :

- Acupuncture
- AIDS and AIDS-related conditions waiver program
- California Children Services (CCS)
- Chiropractic services
- Dental
- Direct observation therapy for treatment of tuberculosis
- Drug and alcohol treatment
- Kidney transplants
- Lead poisoning case management
- Local education agency assessment services
- Mental health
- Prayer or spiritual healing
- Community Based Adult Services (CBAS)
- Regional centers
- Vision
- Developmentally Disabled-Continuous Nursing Care (DD-CNC)
- Family Planning, Access, Care and Treatment Program (Family PACT)
- Transportation services
- Women Infants and Children (WIC)
- Pediatric Palliative Care Waiver (PPC)

SECTION 7.2
PROCESS FOR SUBMITTING A REFERRAL REQUEST

An authorization referral request must be submitted with **all** pertinent information to Network Medical Management for authorization prior to the provider performing any treatment and/or services. Incomplete medical information may cause a delay in the referral request. Providers are able to submit authorization referral requests 24 hours a day / 7 days a week. Providers are able to submit retro requests up to 90 days after date of service. Authorization approval, modification, deferred or denial determinations will be made based on medical necessity and will reflect the appropriate application of approved guidelines.

The request will be reviewed and completed accurately and timely within Industry Collaboration Effort (ICE), health plan and/or regulatory agency compliance standards as follows:

- **Urgent within 72 hours/three (3) calendar days (to be used if the 5 day turn-around time would seriously jeopardize the life, health and or ability to regain maximum function)**
- Routine within five (5) business days
- **Standing Referral** – may be subject to a treatment plan that may limit the number of visits to the specialist, limit the time for which the visits are authorized, or require the specialist to provide regular reports to the primary care physicians.

  Requests include:
  - Member demographics
  - Member diagnosis(s)
  - Required treatment(s)/testing
  - Requested frequency and time period/duration of treatment
  - Relevant history and physical, medical records, laboratory and radiology results.

For cases that need to be expedited (i.e., non-emergency services needed within 24 hours), providers should submit the request via the Network Medical Management Web Portal and contact Network Medical Management's Customer Service Department at (626) 282-0288.

Authorization Process

Providers wishing to submit an authorization referral request can log in to the Network Medical Management Web Portal at https://www.nmm.cc/provider-portal and follow the steps included in the *Web Portal User Guide* provided at the time of orientation.

After an authorization is submitted, the following process will occur:

1. If the requested medical treatment, service and/or procedure are covered by the health plan and meet the established criteria, the request will be approved for sixty (60) days. An approval letter is sent to the member via the U.S. Postal Services (USPS) and a fax is sent to the requesting provider, or it is posted on the provider's portal.
2. If additional information is required, Network Medical Management's Authorization Coordinator will contact the requesting provider and/or specialist by fax or telephone in order to obtain specific information as appropriate. If the case is pended for additional medical information these will be held for 14-45 days depending on the member's LOB
3. Once an approved decision is made the provider will be notified within 24 hours of the decision via fax and or posting to the portal.
4. If the authorization is denied, the reason for the denial, an alternative treatment, and the Utilization Management criteria will be included in the letter. The Medical Director and/or designee shall be available by telephone to discuss the case.

5. The letters denying or modifying requested services are sent to the member via USPS and via fax or posting to the portal to the requesting provider and the member's primary care provider within two (2) working days of the determination. Only a Medical Director or designee may make an adverse determination.

In some cases, a provider will be able to re-submit an authorization with new supporting documentation. Providers should attach additional supporting documentation to the authorization via the Network Medical Management Web Portal. If the provider is unable to upload the information, supporting documentation should be submitted via fax.

Treatment Authorization Request (TAR)

All Treatment Authorization Requests should be submitted through the web portal. However, a Treatment Authorization form is also available. Attach any medical information to support the request.

*Refer to **Section 15** of this manual for a copy of the TREATMENT AUTHORIZATION REQUEST form*

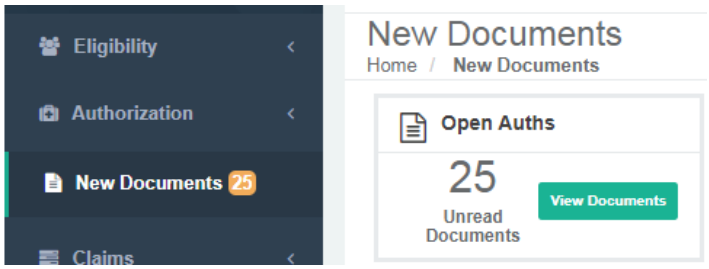
Standardized Prescription Drug Prior Authorization Form (Form No.61-211)

All providers must utilize the uniform Prescription Drug Prior Authorization Request form (Form No. 61-211)

*Refer to **Section 15** of this manual for STANDARD PRESCRIPTION DRUG PRIOR AUTHORIZATION form*

Specialty Referral Tracking

The PCP and Specialist is 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. On 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.



Specialist Requirements/Responsibilities

- Document all work-up and treatments done and include with your request for authorization
- **If the member was 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.

Hospice/Palliative Care - For the geriatric population and/or the terminally ill: Please document assessment and wishes

- End of life discussions related to advanced directive, palliative care and or hospice.
- Medi-Cal members 18 years and above with terminal disease have an End-Of-Life option that is covered as a Fee For Service under Medi-Cal that the member may wish to enroll in. The member will need to select a Fee For Service Provider to manage their future care.

SECTION 7.3
RECOMMENDED RECORDS AND CLINICAL GUIDELINES

The following section lists recommended records and clinical guidelines for specialty referrals. For each specialty (listed alphabetically) there are documents/information which EMANATE HEALTH IPA may require to evaluate medical necessity:

Allergy

- Clinical notes describing the member's signs and symptoms and conservative management attempted; e.g., nasal steroids
- Consult notes (if obtained) by ENT

Bariatric Surgery

- Completion of bariatric screening tool, to include member's height, weight, BMI, and attempts at weight reduction
- Psych and Cardiac consults

Cardiac consultation is appropriate for:

- Evaluation of member who is high-risk and who remains symptomatic or uncontrolled after provider (PCP) initiation of and titration of therapy
- Evaluation of member with unstable cardiac condition, including unstable angina
- Sustained or complex non-sustained ventricular arrhythmia
- Sustained or severely symptomatic supra ventricular arrhythmia
- Severe cardiomyopathy
- Angina despite maximal medication or markedly abnormal stress test
- Evaluation and surveillance of complex or cyanotic congenital disease
- Severe valvular disease
- Symptomatic
- Associated with LVD
- Atrial fibrillation (AF), if member is candidate for cardioversion or chronic AF with inability to control rate or patient is symptomatic with usual measures
- Chest pain with unstable pattern of angina, exercise stress test abnormal at low-level, ischemia with L V dysfunction, angina post M.I., suboptimal response to medications with limiting symptoms
- Palpitations, if member is having disabling symptoms or has had syncope or near syncope
- Members with new or frequent palpitations, particularly when associated with other symptoms in face of known CAD or significant LVD or other serious structural heart disease
- Request for cardiac rehabilitation must be initiated/recommended by cardiologist
  Information necessary with consultation request may include:
  - Clinical record documenting risk, condition and treatment regimen
  - EKG
  - Previous (outside) report of cardiac cath, PTCA, CABG, stress test, Echo, Chest x-ray, etc.

Endocrine

- Clinical record documenting medical need for service, member's signs and symptoms of concern, and treatment tried
- Current lab verifying deficiency/problems; e.g., thyroid panel
- Special diagnosis study reports; e.g., U.S., C.T., etc., which may have been obtained to validate/diagnose condition

Otolaryngology (ENT)

- Clinical record indicating concern, physical exam findings, signs and symptoms and conservative treatment tried; e.g., series of antibiotics (date and type), antihistamine, and/or steroid use (oral and/or nasal)
- Any current lab and/or x-ray finding specific to concern
- Any specialty consult that may have been accomplished; e.g., allergy consultation or FNA report (of neck node)
- Any diagnostic study which indicates pathology; e.g., biopsy, MRI, CT, etc., requiring surgical intervention
- Any outside records/consultations which indicate need for follow-up

Gastroenterology

- Clinical record documenting signs and symptoms; e.g., anorexia, weight loss, upper abdominal distress persistent after treatment, melena, fecal occult blood and conservative treatment tried.
- Current lab demonstrating concern; e.g., iron deficiency, anemia.
- Current radiology report demonstrating concern; e.g., Barium Enema
- Current specialty study/exam demonstrating concern; e.g., Barium Enema or UGI series report(s)
- Past specialty study/exam/surgical report demonstrating concern; e.g., previous Colorectal cancer operative report, colonoscopy or EGD with path report (specifically, previous polyp size and type)

General Surgery

- Clinical record documenting signs and symptoms of condition and treatment tried (if appropriate)
- Current lab demonstrating concern; e.g., CBC with diff
- Current radiology report demonstrating concern; e.g., KUB, U.S.
- Current specialty sh1dy/exam demonstrating concern; e.g., colonoscopy/sigmoidoscopy report with path findings

Genitourinary (G.U.)

- Clinical records indicating reason for consult, with treatment tried
- Urinalysis and, where appropriate, C&S (which should have been treated if positive growth)
- P.S.A. report, where appropriate. If elevated, need to include previous PSA result(s) or document if this was the first PSA study
- Any special diagnostic study

Nephrology

- Clinical records indicating concern with signs and symptoms of same and treatment attempted
- Current pertinent lab reports; e.g., BUN, Creatinine
- Reports of any special diagnostic study performed

Neurology

- Clinical record documenting concern, a neurology exam appropriate to the concern, as well as signs and symptoms
- If referral request is due to ALOC, mini-mental status exam should be included
- Report of previous (outside) consult/report indicating need for follow-up or further studies
- Results of any diagnostic study demonstrating concern relative to issue to be investigated. Neurology consults should be considered prior to requesting EMG/NCS

Neurosurgery

- Clinical record documenting signs and symptoms of condition, treatment tried, and neuro exam/deficit, etc.
- Current radiology/imaging reports demonstrating concern; e.g., MRI, CT.

- Consult report (if appropriate) from Neurology or Pain Specialist, suggesting further specialty care

Oncology

- Clinical record describing medical need; e.g., signs and symptoms of concern
- Current lab results
- If hospitalized, previous to consult request, copy of H&P and discharge summary
- Operative report (if surgical procedure has been accomplished) with pathology report
- Any staging studies (reports) accomplished

Orthopedics

- Ortho consult is appropriate for:
  - Evaluation of a condition to determine surgical remedy; e.g., osteoarthritis of hip or knee for possible replacement, possible torn ligament or meniscus, for possible orthoscopic procedure
  - Evaluation of and treatment plan advertisement of an orthopedic condition that has not been amenable to or is showing progressive disability despite usual conservative management
  - Evaluation of suspected aseptic neurosis, locked knee, unstable joint, acute or sub-acute effusions
- Provider (PCP) to submit clinical notes, to include history of concern and P.E. findings, signs and symptoms expressed by member and treatment regimen tried
- Current x-ray reports. Member should be instructed to pick up films and take to consult appointment, once request has been authorized
- Current labs pertinent to concern, as appropriate
- Any specialty procedure/study report that may have been done in or outside the group/IPA specific to the concern; e.g., MRI, previous operative notes

Pain Management

- Pain Management consults are generally appropriate for:
  - Chronic long-standing back pain
  - Pain unrelieved by conservative measures
- Current clinical notes documenting member's signs and symptoms and treatment previously tried; e.g., medication use, local injections
- Any consult (if appropriate) from neurology or neurosurgery indicating need for further specialist consultation
- X-ray or image report defining concern

Physical and Occupational Therapy

- Current clinical notes documenting member's condition and treatment previously attempted (e.g., rest, medications)
- Referral should advise therapist(s) of any specific movement limitations or restrictions (i.e., do not hyper-extend joint)

Podiatry

- Clinical record documenting signs and symptoms regarding concern and conservative management attempted
- Any comorbidities
- X-ray report of feet/foot
- Copies of any previous podiatry provider reports

Pulmonary

- Clinical record documenting signs and symptoms of concern and treatment attempted
- Radiology report; e.g., chest x-ray
- 0_2 sat results

- Previous consult relative to concern or indicating need for follow-up
- Copy of any specialty diagnostic report demonstrating concern; e.g., chest CT, MRI, pulmonary function exam
- Spirometry
- Request for pulmonary rehabilitation may require Pulmonologist endorsement

Rheumatology

- Clinical record documenting signs and symptoms of concern and treatment attempted
- Lab reports documenting/demonstrating concern; e.g., Rheumatology studies, CBC with differential and platelets, chemistry panel 18, sedimentation rate, C reactive protein, rheumatoid factor, ANA
- X-ray reports documenting/demonstrating concern (if accomplished)
- Specialty reports demonstrating concern; e.g., bone density, MRI

Vascular Surgery

- Clinical record documenting signs and symptoms of concern and treatment attempted
- X-ray/Specialty study report documenting concern; e.g., U.S., previous Angiography report
- Copy of previous consult (outside IPA) indicating need for follow-up

SECTION 7.4
DENIALS

Members and providers will receive written notification of any denial of medical treatment, service and/or procedure.

1. All denials for service will be handled in a timely manner and will be entered into the system for tracking purposes.
2. Utilization review criteria are applied consistently and the assessment information is clearly documented by the Medical Director or designee. Approval, modification, deferred or denial determinations will be based on medical necessity, benefit coverage and approved criteria and guidelines.
3. All expedited appeals will be processed in compliance with timeframe required by Centers for Medicare and Medicaid Services (CMS) and in accordance to health plans' processes.
4. Only providers may make an adverse determination; they will use clinical reasoning and approved criteria and/or clinical guidelines to determine medical necessity.
5. The requesting provider may at any time contact EMANATE HEALTH IPA Medical Director or designee during normal working hours to discuss determination of medical appropriateness.
6. Common reasons for denials:
    a. The provider is not contracted with EMANATE HEALTH IPA
    b. The service does not meet utilization review criteria or benefits
    c. The member is not eligible
    d. The service is not a covered benefit (this includes "Carve-Out" plans)
    e. The member's benefits for that service have been exhausted

TTY numbers available
Procedures and Criteria are disseminated to members and provider upon request by calling our Customer Service department at (877) 282-8272 Opt.1, Monday through Friday between 9AM and 5PM. For members with impaired hearing, member can call our TTY telephone at 877-735-2929, Monday Through Friday between the hours of 8.30am to 5pm. A requesting practitioner may call Network Medical Management to discuss a denial, deferral, modification, or termination decision with the physician (or peer) reviewer at (877) 282-8272 ext.6195. **This phone line is open 24 hours per day / 7 days per week.** All calls will be returned within 24 hours.

SECTION 7.5
APPEALS

Member Appeal

It is the policy of Network Medical Management to refer all member appeals to the appropriate health plan. The health plan will contact Network Medical Management for appropriate information needed to resolve the member's issue. Network Medical Management will contact the provider to obtain the requested information, which must be submitted within the timeframe guidelines mandated by each health plan.

Provider Appeal

The Utilization Management Committee will review all denial and appeal determinations on a regular basis. If the provider chooses to appeal the determination for a denial of a requested service, the appropriate medical information is gathered by the Utilization Management Coordinator for review by the Medical Director and/or the Utilization Management Committee.

Requesting providers must resubmit new authorization with supporting documentation with reason for appeal. If appropriate, the appeal will be reviewed at the next regularly scheduled Utilization Management Committee meeting. All expedited appeals are reviewed by the Medical Director or designee immediately, and all expedited appeal responses are made within seventy-two (72) hours. Determinations to modify, reverse, or uphold the original decision will be completed and processed within five (5) days of appeal. Reversals of denials for requests for expedited appeals are processed immediately. The requesting provider shall receive written notification of the outcome.

SECTION 7.6
INPATIENT CASE MANAGEMENT

A. Availability

Network Medical Management's Case Management Department provides 24/7 on-call coverage for contracted providers. Providers needing to reach Case Management after hours or on weekends should call (877) 282-8272. The answering service will contact the appropriate on-call provider for any problem that may arise after hours, including emergency room authorizations or after-hour patient calls. If a member feels they have a serious medical condition, they will be instructed to hang up and dial 911 or to go to the nearest emergency room.

B. Hospital Admissions

Non-business hours

All non-emergency hospital admissions must be authorized. Hospitals calling after hours to report a hospitalization will be put in contact with the designated Case Manager who will coordinate the member's care accordingly. The answering service has access to contact the Case Manager after hours and on weekends. The provider should notify Network Medical Management of any admissions by calling (877) 282-8272 in the event they are contacted by the hospital regarding a hospitalization.

C. Business Hours

Providers requesting to admit a member into the hospital should contact Network Medical Management's Case Management Department. The provider may need to submit an authorization request for the hospital admission.

D. Hospitalists

In an effort to coordinate hospital admissions, Network Medical Management provides hospitalists on call. The Case Management Department will be contacted by the admitting hospital for notification purposes. The Case Manager will contact the hospitalist assigned to coordinate the member's care. Network Medical Management encourages providers to contact its Case Management Department in the event that they receive notification of an admission or if they require assistance on directing the member to the appropriate hospital. Case Management is available 24 hours a day, 7 days week at (877) 282-8272. Admission face sheets and in-patient medical records can be faxed to Case Management at (626) 943-6392.

SECTION 8
MEDI-CAL/STATE PROGRAMS

1. California Children's Services Program

The California Children's Services (CCS) program is a state and county-funded program that serves children under the age of 21 who have acute and chronic conditions such as cancer, congenital anomalies and other serious medical conditions that benefit from specialty medical care and case management. State statutes and contracts require that CCS program services be carved out to the applicable health plan. As a result, upon identification of a CCS-eligible condition, providers must refer a child to the local CCS program or contact Network Medical Management to assist with the referral to CCS.

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

NMM will flag members who are receiving services from California Children's services (CCS) and or the Regional Center. When entering a referral, your office will receive a "pop up" telling you that your member has one of the 2 services or if your member is a Medi-Cal recipient 21 years old or younger, is the request a possible CCS condition.

NOTE: If your member is receiving services with CCS or at the Regional Center, you are required to document this in the member's medical records at each visit.

2. The Vaccines for Children Program (VFC)

The Vaccines for Children (VFC) Program helps provide vaccines to children whose parents or guardians may not be able to afford them. This helps ensure that all children have a better chance of getting their recommended vaccinations on schedule. Vaccines available through the VFC Program are those recommended by the Advisory Committee on Immunization Practices (ACIP). These vaccines protect babies, young children, and adolescents from 16 diseases.

Funding for the VFC program is approved by the Office of Management and Budget (OMB) and allocated through the Centers for Medicare & Medicaid Services (CMS) to the Centers for Disease Control and Prevention (CDC). CDC buys vaccines at a discount and distributes them to grantees—i.e., state health departments and certain local and territorial public health agencies—which in turn distribute them at no charge to those private physicians' offices and public health clinics registered as VFC providers.

Determining Eligibility

A child is eligible for the VFC Program if he or she is younger than 19 years of age and is one of the following:

- Medicaid-eligible
- Uninsured
- Underinsured
- American Indian or Alaska Native

Children whose health insurance covers the cost of vaccinations are not eligible for VFC vaccines, even when a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier because the plan's deductible had not been met.

Underinsured children are eligible to receive vaccines only at Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC). An FQHC is a type of provider that meets certain criteria under Medicare and Medicaid programs. To locate an FQHC or RHC, contact the state VFC coordinator.

For additional information please visit www.cdc.gov/vaccines/programs/vfc/providers

For chart of "2020 Immunizations for Children from Birth Through 6 Years Old" visit: https://www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf

3. California Immunization Registry (CAIR)

The California Immunization Registry (CAIR) is the immunization registry for Los Angeles, San Bernardino, Riverside and Orange County. It is a secure, confidential computer system, also call an "immunization registry" to help keep track of immunizations (shots) and sure patients get all the shots they need at the right time. CAIR is part of the state and national effort to improve the tracking and delivery of immunizations to improve the health of all children, families and communities.

CAIR is **FREE** to all health care providers who give immunizations as well as other organizations that have immunization requirements and/or provide assessment and referral for immunizations (e.g. schools).

The following agencies are eligible to use CAIR:

- Healthcare providers who give immunizations. This includes health department-based clinics, non-profit/community clinics, private medical practices and hospitals.
- Schools, Daycare and camp facilities
- Women, Infants and Children Program (WIC)
- County and State Foster Care offices
- California Work Opportunity Program (Cal Works) program
- Health Plans
- State and County Health Departments

Some of the features of CAIR include:

- Keeps an updated immunization record in one central place that can be accessed by approved doctors and agencies
- Allows doctors/agencies to retrieve and update immunization records at the time of the patient visit
- Automatically determines the immunizations a patient needs at each visit based on the most up-to-date state and national recommendations
- Can be used to maintain immunization records for any age individual, so it can be used for childhood as well as adult and travel immunization activities
- Prints reminder postcards for doctors to send to patients
- Prints an official copy of the California Immunization Record ("yellow card") for parents as well as the official California School Immunization Record ("blue card")
- Produces reports that help doctors manage their immunization services and vaccine inventory
- Helps respond to emergency events such as vaccine recalls or natural disasters

We encourage all our primary care physicians who are treat pediatric patients to enroll and participate in the **CAIR program, all you need is a computer, printer, and Internet access. CAIR** staff will guide you through the setup process, provide training to your staff and are available for ongoing support.

To obtain additional information, visit California Immunization Registry Portal (CAIR): https://cair.cdph.ca.gov/CAPRD/portalInfoManager.do

4. Childhood Disability and Prevention Program (CHDP)

The Child Health and Disability Prevention (CHDP) is a preventive program that delivers periodic health assessments and services to low income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

Health assessments are provided by enrolled private physicians, local health departments, community clinics, managed care plans, and some local school districts. The Child Health and Disability Prevention (CHDP) is a preventive program that delivers periodic health assessments and services to low income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

LA Care (and Plan Partner) members under the age of 16 must be seen by a CHDP certified physician. CHDP well-child health assessments and immunizations should be rendered in accordance with the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule. CHDP well-child health assessments and immunizations should be rendered in accordance with the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule.

Please note, children should be referred for Dental Care as follows:

- Beginning at age one as required by California *Health and Safety Code* Section 124040 (6)(D)
- At any age if a problem is suspected or detected.
- Every six (6) months for maintenance of oral health
- Every three (3) months for children with documented special health care needs when medical or oral condition can be affected; and for other children at high risk for dental caries.

Starting July 1, 2017 California state DHCS required that CHDP *Confidential Screening and Billing Report* (PM 160) claim form would no longer be used to bill for CHDP Early and Periodic Screening, Diagnosis and Treatment (EPSDT) health assessments, immunizations and ancillary services for dates of service on or after July 1, 2017. For these dates of service, qualified Medi-Cal providers enrolled in the CHDP program must bill CHDP/EPSDT services on a *CMS-1500*, *UB-04* claim form or electronic equivalent. Providers should note the national codes cannot be submitted on the PM 160. Providers need to check individual Health Plan protocols for submission of CHDP claims and encounters.

For a CHDP program code conversion, providers may refer to:
https://files.medi-cal.ca.gov/pubsdoco/newsroom/25768_Cd_Conv_Table.pdf

5. Comprehensive Perinatal Services Program (CPSP)

Comprehensive Perinatal Services Program 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.

6. Sterilization and Family Planning Services

Pursuant to state and federal requirement, sterilization services (tubal ligation or vasectomy) may be obtained by Medi-Cal members at any qualified family planning provider, in or out of the Network Medical Management's HMO Medi-Cal specific network.
Providers of sterilization services for Medi-Cal members must adhere to informed consent procedures as detailed in Title 22, Section 51305,

The PM 330 consent forms, which contain federal funding language, must be used as mandated by the state of California.

When submitting a request for authorization, please include the following required documents. Failure to submit a copy of the signed PM330 and documentation of the member receiving the DHCS booklet may cause delay in the review process.

Following are important considerations regarding Family Planning and Sterilization Services:

- Members may access family planning services both within and outside of NMM on a self-referral basis without prior authorization.
- PCP may conduct Pap Smears in their office and OB/GYNs may provide a wider scope of services.
- Family planning services are provided to members of childbearing age to enable them to determine the number and spacing of children. Services include all methods of birth control approved by the FDA.
- Members of childbearing age may access Family Planning services listed below from out of plan family planning providers to temporarily or permanently prevent or delay pregnancy.

- PCPs and OB/GYNs performing sterilization services will document referrals and family planning services information in member's chart, as well as provide information to NMM.
- Member must be at least 21 years of age, mentally competent to understand the nature of the proposed procedure and not be institutionalized. At least 30 days but no more than 180 days have passed between the date of written informed consent and the date of sterilization except in some instances advised the individual that no federal benefits may be withdrawn because of the decision not to be sterilized
- One copy of the state of California approved booklets, in English or Spanish, must be furnished to the member, along with consent forms. Sterilization Consent forms (in English and Spanish can be downloaded from the Medi-Cal website located at www.medi-cal.ca.gov or by calling the Telephone Service Center (TSC) at 1-800-541-5555.

The following list of family planning services may be provided to Medi-Cal members by an in-network of out-of-network family planning practitioner:

- Health education and counseling necessary to make informed choices and understand contraceptive methods.
- Verbal H & P limited to immediate problems.
- Lab tests, if medically indicated, as part of the decision-making process for choice of contraceptive methods.
- Follow-up care for complications associated with contraceptive methods issued by the family planning practitioner.
- Provision of contraceptive pills, devices, and supplies
- Provision and insertion of Norplant
- Tubal ligation
- Vasectomies
- Pregnancy testing and counseling
- Diagnosis and treatment of STDS, if medically indicated (STD diagnosis and treatment provided during a family planning encounter are considered part of family planning services).
- Screening, testing and counseling of at-risk individuals for HIV (HIV diagnosis and treatment provided during a family planning encounter is considered part of family planning services).
- Therapeutic and elective abortions are not considered part of family planning services.
- Infertility studies, reversal of voluntary sterilization, hysterectomy for sterilization and transportation are not covered under Medi-Cal program and therefore are not available to Medi-Cal members under family planning or other services.
- Members may access LHD clinics and family planning clinics for diagnosis a d treatment of an STD episode. For community providers other than LHD and family planning providers, out of plan services are limited to one office visit per disease episode for the purposes of:
    - Diagnosis and treatment of vaginal discharge and urethral discharge
    - STDs that are amenable to immediate diagnosis and treatment those include syphilis, gonorrhea, Chlamydia, herpes simplex, chancroid, trichomoniasis, HPV, non-gonococcal urethritis, lymphogranuloma venerum and granuloma inguinale and evaluation and treatment of pelvic inflammatory disease.

Women, Infant and Children's Program (WIC) Supplemental nutritional options for children 5 and under and or your pregnant members, including breast feeding and formula options

- Health Plan supplemental benefits (Health Plan specific)
    - Car Seats, Coupons, etc.
- Please encourage your patient to select a contracted Pediatrician with NMM IPAs.
- Our Provider Network Representative for a list of contracted Pediatricians.

7. Early Start/Early Intervention Developmental Disabilities and Regional Centers Care Coordination

Primary Care Physicians and Providers should ensure coordination of primary and specialty care and provision of routine preventive services as needed for Medi-Cal members receiving Early start /Early Interventions at Regional centers.

A. Anyone can make a referral, including parents, medical care providers, neighbors, family members, foster parents, and day care providers.
B. The first step that parents may take is to discuss their concerns with their health care provider/doctor. Provider or parents can also call the local regional center or school district to request an evaluation for the child.
C. If the child has a visual impairment, hearing impairment, or severe orthopedic impairment, or any combination of these, provider or parents/guardians may contact the school district for evaluation and early intervention services.
D. After contacting the regional center or local education agency, a service coordinator will be assigned to help the child's parents through the process to determine eligibility.

Within 45-days the regional center or local education area shall:

a) Assign a service coordinator to assist the family through evaluation and assessment procedures.
b) Parental consent for evaluation is obtained.
c) Schedule and complete evaluations and assessments of the child's development.

Based on the child's assessed developmental needs and the families concerns and priorities as determined by each child's Individualized Family Service Plan (IFSP) team, early intervention services may include:

1) assistive technology
2) audiology
3) family training, counseling, and home visits
4) health services
5) medical services for diagnostic/evaluation purposes only
6) nursing services
7) nutrition services
8) occupational therapy
9) physical therapy
10) psychological services
11) service coordination (case management)
12) social work services
13) special instruction
14) speech and language services
15) transportation and related costs
16) vision services

Member's medical records with their Primary Care Physician reflect collaboration between the Regional Center/Early Start/Early Intervention program or California Children's Services(CCS) and the PCP (i.e., MD notes [DDS or ES/EI provider]; referral from or to the Regional Center and/or Early Start program for ages 0-3). In addition, medical record reflects coordination of specialist services with the Health Plan network as applicable.

8. Alcohol and Substance Abuse; Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.

L.A. Care and Plan Partner primary care physicians are required to screen their patients for alcohol misuse under the expanded Medi-Cal behavioral health benefit. A highly effective method is the SBIRT approach. Health care practitioners can help support prevention and care through SBIRT: Provide screening and brief intervention when signs of a disorder are present and refer the patient for medically necessary treatment. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for substance use disorders.

SBIRT:

- **Screening** quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- **Brief intervention** focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- **Referral to treatment** provides those identified as needing more extensive treatment with access to specialty care.

Evidence has shown that interventions significantly improve health in non-dependent drinkers. Similarly, benefits also occur to those with a substance use disorder. In May 2013, the US Preventive Services Task Force recommended that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with SBIRT.

For more information regarding care for Substance Use Disorders, please contact the Department of Public Health/Substance Abuse Prevention & Control (DPH/SAPC) at 1-888-746-7900 (TTY/TDD 800-735-2929).

Following are suggested codes that may be used by Line of Business (as of 9/15/2017):

Line of Business	Code	Description
Commercial Insurance	CPT 99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes.
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes
Medicaid	H0049	Alcohol and/or drug screening.
	H0050	Alcohol and/or drug screening, brief intervention, per 15 minutes.

9. Medi-Cal Rx

Starting January 1, 2022 Medi-Cal Pharmacy Benefits will be administered through the fee-for-service delivery system Medi-Cal Rx. Please visit the DHCS Medi-Cal Rx website for more information. https://medi-calrx.dhcs.ca.gov

Overview

Medi-Cal Rx will include all pharmacy services billed as a pharmacy claim, including but no limited to

- Outpatient drugs (prescription and over-the counter), including Physician Administered Drugs or PADs
- Enteral nutrition products
- Medical Supplies
- Adult vaccinations
- Medi-Cal Fee-For-Service Contract Drug list is posted on the Medi-Cal Rx website https://medi-calrx.dhcs.ca.gov

Medi-Cal Rx Portal Access Registration

Physicians must register for portal access to submit request for drugs, products and supplies covered under Medi-Cal Rx. Please use https://medi-calrx.dhcs.ca.gov/provider/ and click on the "register" link to sign up. The verification process takes time and involves mailing and receiving of actual "Personal Identification Number or PIN" in the mail in order to complete the registration process. Allow time for the mailing process before you are able to obtain drugs, products and supplies for your patients.

All Medi-Cal Rx covered items will NOT be accepted through the Network Medical Management web portal, they must go through the authorization process under the Medi-Cal Rx program.

10. Behavioral Health Treatment

A mental health assessment should be conducted at each visit and documented in the patient's chart. To refer a member for behavioral health treatment, please refer to the member's health plan for coverage information.

SECTION 9.1
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 60 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 should submit encounter data no later than 60 days from the date of service. 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 (SECTION 10.2 of this manual includes instructions on filling out the CMS 1500 form).

Member Information:	**Provider of Service Information:**	**Referring physician information:**
• Member name • Member identification number • Member gender • Member date of birth • Medical Group/IPA and facility number • Patient chart number	• Name • National Provider ID (NPI) • UPIN • Federal Tax Identification (TIN) • Physician State License Number • DEA number	• Name • NPI • UPIN • TIN • Physician State License number • DEA number

All data records must include the most current industry standard diagnosis (ICD-10-CM), 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 our patient population, especially when it comes to prevalent disease, 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)

Encounter data can be submitted using one of the following three methods:

1. NMM Web Portal – https://www.nmm.cc/provider-portal
2. Office Ally (clearing house) Payers' ID: **NMM01**
3. CMS 1500 form. Complete all sections indicated in the preceding example for a clean encounter submission; **(Effective July 1st, 2017, Network Medical Management will no longer accept paper claims for contracted providers. All claims must submit through electronic means.)**

Encounter data must be submitted within **60 days** from date of service. **Diagnosis codes must be reported to the highest level of specificity if it is available.**

SECTION 9.2
CLAIM SUBMISSION GUIDELINES

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

- Web Portal – https://www.nmm.cc/provider-portal (Preferred submission method)
- Office Ally (clearing house)
- CMS 1500 Paper claims; via USPS to the following address:
  Network Medical Management
  EMANATE HEALTH IPA
  1600 Corporate Center Dr., Suite#101
  Monterey Park, CA 91754

Effective July 1, 2017, we will no longer accept paper claims from contracted providers. All claims must be submitted in electronic format.

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.
- Although all immunizations for members under 19 years with **Medi-Cal** line of business are paid by Vaccines for Children (VFC); Providers will still need to submit all encounter data to EMANATE HEALTH 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 elements of the CMS 1500 Form

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.

SECTION 9.3
CLEARING HOUSE VENDOR

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.

Payor ID Number for EMANATE HEALTH IPA 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.

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
- 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.

SECTION 9.4
ELECTRONIC REMITTANCE ADVICE (ERA)

It is the policy of NETWORK MEDICAL MANAGEMENT to provide eligible providers the means of receiving electronic remittance advice (ERA/835) in lieu of paper. NETWORK MEDICAL MANAGEMENT has a standard procedure that is followed through to ensure provider registrations for ERA's are processed in a timely manner.

The ERA registrations are completed for Providers no later than eighteen (18) business days upon receiving a fully completed ERA Enrollment form.

PROCEDURE:

1. Eligible providers will submit via email a fully completed ERA Enrollment form to ProviderNetworkOperationsDept@networkmedicalmanagement.com
2. All information provided from the submitted ERA Enrollment Form will be verified by the Provider Relations department. Any discrepancies in the form will be relayed back for corrections to the contact's name provided from the enrollment form.
3. Testing Phases:
    1) Encounter team will coordinate testing with requesting provider to ensure data is received accordingly.
    2) Upon successful testing with provider, ERA will be moved into production.

For more information on ERA Enrollment, contact the Provider Relations Department

Direct Line: (626) 282-0288
E-mail: ProviderNetworkOperationsDept@networkmedicalmanagement.com

*Refer to **Section 15** of this manual for the ERA ENROLLMENT form*

SECTION 9.5
PROVIDER DISPUTE RESOLUTION PROCESS

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"). 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:* https://www.dmhc.ca.gov/

I. Claim submission instruction.

A. Claim submission address must be sent to the following:

Via Mail or Physical Delivery:

1600 Corporate Center Dr., Suite#101
Monterey Park, CA 91754

B. 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

C. 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.

II. 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:

1) 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;
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; and

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.

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 or Physical Delivery:

1600 Corporate Center Dr., Suite #101
Monterey Park, CA 91754

C. Time Period for Submission of Provider Dispute.
1) 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
2) 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.
3) 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:
1) 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.
2) 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

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.

D. 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.

*Refer to **Section 15** of this manual for the PROVIDER DISPUTE RESOLUTION REQUEST form*

SECTION 9.6
BALANCE BILLING

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 with the health plan and medical group which prohibits this practice and may be subject to sanctions by Health Plans, CMS, DHCS and other industry regulators.

Network Medical Management has been tasked with ensuring all contracted network providers have participated in education on the prohibition of balance billing. This is a requirement for all providers contracted for Medi-Cal and/or Cal MediConnect plans. Providers who are contracted with EMANATE HEALTH IPA under multiple provider groups are required to take the above training only once.

Guiding Principle

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

❖ 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 charge 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 MediConnect, may have a cost share for some prescription drugs
- Cost for non-covered benefits
- Certain plans may require co-pays and co-insurance fees.

❖ Prohibition of Balance Billing

- Per Federal and State regulations, all health plans have included prohibitions on balance billing in its provider contracts
- Network providers who engage in balance billing are in breach of their contract with the health plans and medical group.

- Providers who engage in balance billing may be subject to sanctions by health plans, 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**

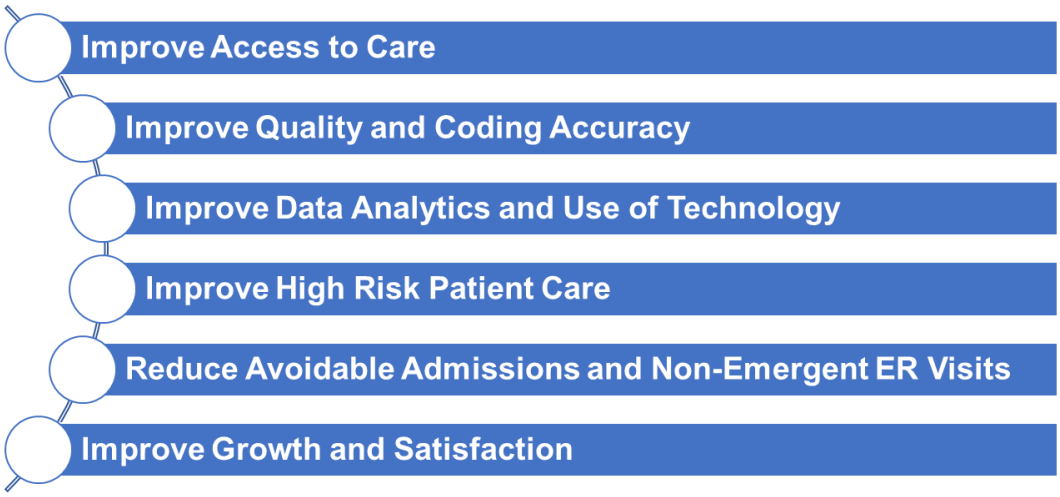
Website: http://www.calduals.org/providers/physician-toolkit/

For more questions regarding Balance Billing, contact the Provider Relations Department

Provider Relations Department
Direct Line: (626) 282-0288
E-mail: ProviderNetworkOperationsDept@networkmedicalmanagement.com

SECTION 10.1
POPULATION HEALTH INTRODUCTION

As the health care landscape continues to shift from a fee-for-service, volume based-model to a quality-driven, value-based care model, population health plays a critical part in providing the framework and tools to help providers drive to success. Population health management is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. The goals of Network Medical Management's population health program are to provide the highest quality of care in the most cost-effective manner and to ensure high patient and provider satisfaction. With these goals in mind, our population health program will be grounded and focused on our 6 Pillars of Population Health Performance. Our 6 Pillars of Population Health Performance are:



In relation to "Improve Quality and Coding Accuracy," the subsequent sections will provide more detailed information on how quality outcomes are reflected through Health Effective Data and Information Set (HEDIS) measures and how the member's risk adjustment factor (RAF) reflects the complexity of the member's health condition through Hierarchical Condition Categories (HCCs). Whether it's capturing HCCs or addressing/closing HEDIS measures, the work that the provider and his/her office staff does is critical to the performance of our population health program.

The subsequent sections provide more details regarding quality HEDIS measures and risk adjustment components.

SECTION 10.2
HEALTH EFFECTIVE DATA & INFORMATION SET (HEDIS) OVERVIEW

HEDIS is a tool used by more than 1,000 health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of more than 90 measures across 6 domains of care. With data collection and technical specifications, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS results themselves to identify areas for improvement.

Each health plan implementing HEDIS is required to collect data and report HEDIS results based on the technical specifications of the HEDIS measurement sets. Health plans report their HEDIS rates separately for each product line and provide this reporting on their internal websites and marketing materials. To ensure the validity of HEDIS results, all data are rigorously audited by certified auditors using a process designed by The National Committee of Quality Assurance (NCQA).

Consumers also benefit from HEDIS data through the State of Health Care Quality report, a comprehensive look at the performance of the nation's health care system. HEDIS data also are the centerpiece of most health plan "report cards".

To ensure that HEDIS stays current, NCQA has established a process to evolve the measurement set each year. NCQA’s Committee on Performance Measurement, a broad-based group representing employers, consumers, health plans and others, debates and decides collectively on the content of HEDIS. This group determines what HEDIS measures are included and field tests determine how it gets measured.

SECTION 10.3
MEASURES AND CATEGORIES

HEDIS data is collected from the providers through encounters and chart audits. The following are the key measures that will be measured through HEDIS criteria:

Category		MEASURE	MEDICARE	COMMERCIAL	MEDI-CAL
Adult Health	1	Annual Wellness Visit (AWV)	✓		
	2	Care for Older Adults (COA)	✓		
	3	Colorectal Cancer Screening (COL)	✓	✓	
	4	Eye Exam for Patients with Diabetes (EED)	✓	✓	✓
	5	HbA1C Control for Patients with Diabetes (HBD)	✓	✓	✓
	6	Kidney Health Evaluation for Patient with Diabetes (KED)	✓	✓	✓
	7	Blood Pressure Control for Patients with Diabetes (BPD)			✓
	8	Controlling High Blood Pressure (CBP)	✓	✓	✓
	9	Transition of Care (TRC)	✓		
Women's Health	10	Breast Cancer Screening (BCS)	✓	✓	✓
	11	Cervical Cancer Screening (CCS)		✓	✓
	12	Osteoporosis Management in Women Who Had a Fracture (OMW)	✓		
	13	Chlamydia Screening in Women (CHL)		✓	✓
	14	Postpartum Care (PPC)		✓	✓
	15	Prenatal Care (PPC)		✓	✓
Pediatric Health	16	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)		✓	✓
	17	Immunization for Adolescents (IMA)		✓	✓
	18	Well Child Visits in the First 30 Months of Life (W30)		✓	✓
	19	Childhood Immunization Status (CIS)		✓	✓
	20	Child and Adolescent Well-Care Visits (WCV)		✓	✓
General Health	21	Annual Physical Exam		✓	✓
	22	Initial Health Assessment (IHA)	✓	✓	✓
Medication Related	23	Statin Therapy	✓	✓	✓
	24	Medication Adherence	✓		

For a complete summary of the most current HEDIS measures, please visit the NCQA website, http://www.ncqa.org/tabid/59/Default.aspx or reach out to:

Quality Care Improvement Team:
Tel: (626) 282-0288 Ext. 5548
E-mail: QualityImprovement@networkmedicalmanagement.com

SECTION 10.4
HEDIS ENGAGEMENT – PRIMARY CARE PHYSICIAN

All contracted PCPs are required to participate with the IPA network in HEDIS (including STAR measures) program. The IPA network will provide the PCP with gaps in care (GIC) reports, monthly eligibility, and other adhoc reports provided by the health plans. GIC reports & other adhoc reports will be provided electronically to the PCP at least on a quarterly basis.

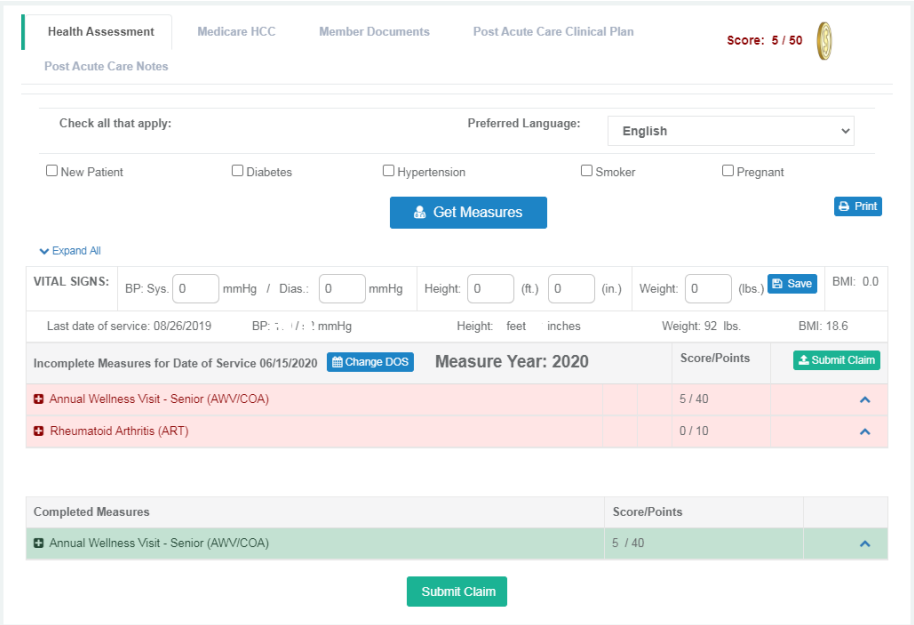
The PCP and IPA network will review the GIC reports to address the following:

1) Patients assigned with true "gap in care"
2) Patients assigned who have had the screening/test but maybe new to the IPA and/or PCP. The IPA and PCP will work on collecting supplemental data to report findings to the applicable health plan
3) Patients who are non-compliant with disease or preventative care management

The IPA network will work with the health plans to maximize administrative and encounter data transactions. The IPA network will provide the PCP with reference and resources to ensure appropriate CPT, CPT II, and ICD-10 codes are utilized by the PCP when billing. The IPA will monitor the PCP claims encounter data submissions to ensure appropriate service codes are utilized for compliance with HEDIS/STAR measures criteria.

PCP providers can use the NMM Web Portal system to monitor patients with gaps in care. The NMM Web Portal provides indicators (see image example below) for patients who have completed or require specific measures. It integrates data collected from: Encounter data, Laboratory data, Radiology data, and Health Plan data. We encourage the PCP office to use the resources provided by the IPA to monitor patients with gaps in care to ensure the IPA is compliant with health plan & State standards for preventative or disease management measures.

The NMM Web Portal can be accessed through: https://www.nmm.cc/provider-portal

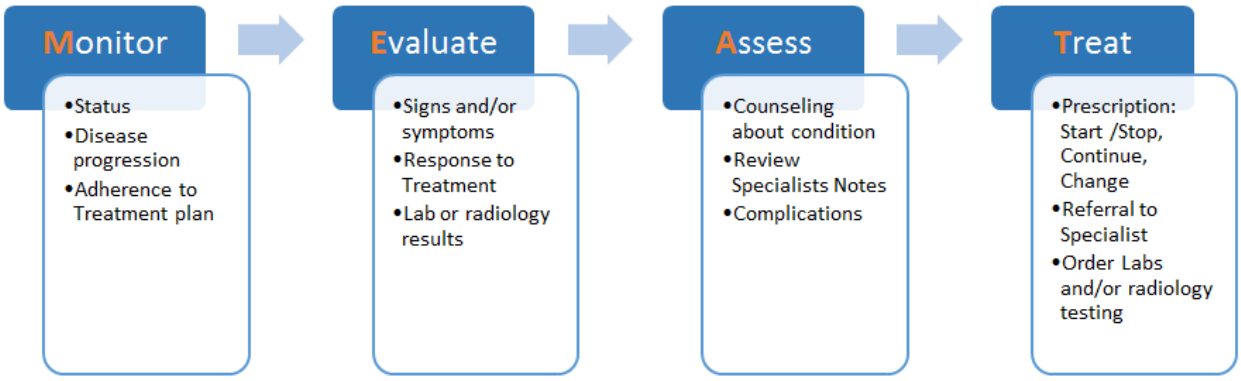


SECTION 10.5
RISK ADJUSTMENT - MEDICARE

Risk Adjustment Documentation Requirements

To ensure the accuracy and integrity of the risk adjustment data submitted to CMS:

- All diagnosis codes submitted must be documented in the medical record and must be documented as a result of face-to-face visit
- Diagnosis must be accurately coded according to ICD-10 CM guidelines
- Assessing all conditions at least once annually
- Reported diagnosis must be supported by **M.E.A.T.**



Risk Adjustment Factor (RAF)

- Risk adjustment is calculated using an actuarial tool developed to predict the cost of healthcare for covered beneficiary/enrollee
- A risk adjustment score is determined by using a combination of demographic information (Age, Sex, Status) along with disease information to predict future healthcare costs for enrollees
- The score is highest for the sickest patients as determined by a combination of factors
- Risk Score of 1.000 reflects the Medicare incurred expenditures of an average beneficiary/enrollee

Disease Interactions

- Disease Interactions allow for additive factors based on conditions and disabled status increase funding
- Additional risk score added automatically when certain diseases are coded together
  - ✓ Congestive Heart Failure and Diabetes
  - ✓ Congestive Heart Failure and Chronic Obstructive Pulmonary Disease
  - ✓ Congestive Heart Failure and Arrhythmia
  - ✓ Congestive Heart Failure and Renal
  - ✓ Cardiorespiratory Failure and Chronic Obstructive Pulmonary Disease
  - ✓ Disorders of Immunity and Cancer
  - ✓ Substance Use Disorder and Psychiatric

Hierarchical Condition Categories (HCCs)

- Developed by CMS for Risk adjustment of the Medicare Advantage Program (Medicare Part C)
- Predictive Model using current year data to predict next year's risk
- HCC categories are additive

- Data Derived from:
  - ✓ Inpatient Diagnosis
  - ✓ Outpatient Diagnosis
  - ✓ Provider Office Diagnosis
  - ✓ Clinically trained non-physician provider

Comparison of RAF Score – Documentation and Coding Complexity

All Conditions Coded Complex		Some Conditions Coded Moderate		No Conditions Coded Healthy	
69 year old female (non-dual)	**0.323**	**69 year old female (non-dual)**	**0.323**	**69 year old female (non-dual)**	**0.323**
DM w/chronic complications	0.302	DM w/chronic complications	0.302		0.000
CHF	0.331	CHF	0.331		0.000
COPD	0.335		0.000		0.000
Disease Interaction DM/CHF	0.121	Disease Interaction DM/CHF	0.121		0.000
Disease Interaction CHF/COPD	0.155		0.000		0.000
TOTAL RAF	**1.567**	**TOTAL RAF**	**1.077**	**TOTAL RAF**	**0.323**

***Estimated Score for illustration purposes.**

Documentation Guidelines Available on Web Portal:

- ✓ Atherosclerosis of Aorta (AAA)
- ✓ Cancer
- ✓ Chronic Obstructive Pulmonary Disease (COPD)
- ✓ Chronic Kidney Disease (CKD)
- ✓ Eligible Progress Note with Chart Mechanics
- ✓ Dementia
- ✓ Rheumatoid Arthritis
- ✓ Senile Purpura

SECTION 11
INITIAL HEALTH ASSESSMENT

The first responsibility that you have to new patients is a first check-up as soon as possible after the member enrolls in the health plan. An "initial health assessment," visit is the key to early identification of health problems, treatment, and establishing a strong relationship between the doctor and the new patient. But for members who are new to managed care or are unfamiliar with the importance of preventive care, initial health assessments don't always occur. The PCP must ensure that each member completes an IHA and Staying Healthy Assessment (SHA) as a component of IHA in accordance with the following guidelines and timeframes prescribed below

1. Initial Health Assessment Requirements

The IHA must be performed using the age-appropriate DHS-approved assessment tools. DHS has standardized assessment tools to be administered during office visits, reviewed at least annually and re-administered by the doctor at the appropriate age intervals.
What qualifies as an initial health assessment visit?

- A scheduled office visit for a complete history and physical examination
- An office visit for a specific problem is an opportunity to start an initial health assessment with documentation. Subsequent scheduled appointments must be completed within the 60- or 120-day timeframe.

The initial health assessment must consist of a history and physical examination with an individual health education behavioral assessment that enables a PCP to comprehensively assess the member's current acute, chronic and preventive health needs.

What does not qualify as an initial health assessment visit?

- An office visit for a specific problem without documentation of starting an initial health assessment with subsequent scheduled appointments for completion within the 60- or 120-day timeframe.
- Urgent care or an emergency visit.

When a member is able to manage a specific medical problem, the doctor may want to take advantage of these episodic visits to perform all or parts of the initial health assessment.

What are a Doctor's responsibilities regarding initial health assessments?

1. Schedule every new member for the initial health assessment within the identified timeframe.
2. Provide adequate documentation of the assessments, including the health education behavioral assessment, follow-up care, any exemptions from the initial health assessment and coordination of care in the medical records.
3. The IHA must be conducted in a culturally and linguistically appropriate manner for all patients, including those with disabilities.
4. Provide documentation of all attempts to schedule an initial health assessment, including the follow-up or missed and broken appointments, and periodic preventive screenings.
5. If unsuccessful with getting the IHA scheduled, PCPs are required to make at least three documented attempts that demonstrate their unsuccessful efforts to contact a member to schedule an IHA, including at least one telephone contact and one written contact.
6. New members who change their PCP within 120 days of enrollment are still required to receive an IHA within the initial 120-day period. If an IHA was completed by the previous PCP, the new PCP should obtain a copy of the previous IHA to receive credit for completion.

2. Mandated Timeframes

Initial health assessments are age dependent and are required to be provided within mandated timeframes as follows:

- **For children under the age of 18 months:** within 60 calendar days following enrollment, or within the timelines established by the American Academy of Pediatrics (www.aap.org) for ages two and younger, whichever is less.
- **For children 18 months and older**: within 120 calendar days of enrollment. The assessment must include the elements of the California Child Health and Disability Prevention (CHDP) Program (www.dhs.ca.gov/pcfh/cms/chdp); arrange for immunizations necessary to ensure that a child is up to date for their age; and include an age-appropriate health education behavioral assessment.
- **For adults over the age of 21**: within 120 calendar days of enrollment and should include an initial complete history and physical examination as well as a health education behavioral risk assessment.
- **For Covered California members All Ages**: within 90 days of enrollment.

3. Staying Healthy Assessment (SHA)

All Members must receive the SHA during their IHA. The SHA is the Individual Health Education Behavioral Assessment (IHEBA) developed by the Department of Health Care Services (DHCS). SHA forms are usually now used in lieu of IHEBA forms. The goals of the SHA are to assist providers with:

- Identifying and tracking high-risk behaviors of MCP members.
- Prioritizing each member's need for health education related to lifestyle, behavior, environment, and cultural and linguistic needs.
- Initiating discussion and counseling regarding high-risk behaviors.
- Providing tailored health education counseling, interventions, referral, and follow-up.

4. Follow Up Care

For follow-up care identified at the time of the initial health assessment, appropriate diagnostic and treatment services are required to be initiated as soon as possible but no later than 60 calendar days following either a preventive screening or other visits that identify a need for follow-up care.
For members identified with complex or chronic conditions prior to enrollment or upon completion of the initial health assessment, the doctor is responsible for adequately documenting appropriate referrals made to linked and carved-out service programs, including CCS, Department of Mental Health, Regional Centers, EPSDT Supplemental Services as well as basic care management/care coordination efforts.

REFERENCES

1) MMCD Policy Letter 08-003. http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL%202008/PL08-003.PDF.
2) MMCD Policy Letter 13-001. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2013/PL13-001.pdf

SECTION 12.1
QUALITY MANAGEMENT

Procedures

QM promotes the highest quality of medical care and service to members by performing ongoing evaluation and modifications.

QM Identifies and resolve issues that directly or indirectly affect member care.

Quality Management Committee Meetings:

- Special studies & trending
- Preventative Health Services
- Development/Implement Clinical
- Practice Guidelines
- Policy and Procedures
- Grievance Resolution
- Access Monitoring
- Culturally and Linguistically Appropriate Services (CLAS)

All Primary Care Physician offices will be audited on a routine basis by Network Medical Management and on a periodic basis by all HMO companies.

It is imperative that your office be kept tidy and that all logs are kept current and available for these audits.

If you need assistance preparing for audits, please contact our Quality Management Department at (626) 282-0288. Network Medical Management will assist you in any way that we can to make sure that you are audit-ready at all times.

Grievances and Appeal Process

It is the policy of Network Medical Management to refer all member grievances and appeals to the appropriate Health Plan, to ensure members are provided appropriate medical care of the highest possible quality.

The health plan will contact Network Medical Management for appropriate information needed to resolve the member's issue. Network Medical Management will contact the provider to obtain the information requested, which must be submitted within the time guidelines mandated by each health plan.

SECTION 12.2
ACCESS TO CARE STANDARDS

Quality and Health care access standards established by EMANATE HEALTH IPA ensure all members have access to health care services. We monitor performance annually for each of these standards as part of our quality improvement program. This enables us to identify areas for improvement. EMANATE HEALTH IPA access standards are listed below in accordance with California Managed Health Care Coalition, health plan and NCQA standards.

Access Criterion	EMANATE HEALTH IPA Standard
Primary Care Provider (PCP) Accessibility Standards:	
Routine Primary Care Appointment (Non-Urgent)	Within 10 business days of request
Urgent Care Appointment	Within 48 hours of request
Emergency Care	Immediate, 24 hours a day, 7 days per week
Preventive Care	Within 10 business days of request- 30 calendar days for Medicare
First Prenatal Visit	Within 10 business days of request
Specialty Care Provider (SPC) Accessibility Standards:	
Routine Specialty Care Appointment (Non-Urgent)	Within 15 business days of request
Urgent Care Appointment	Within 96 hours of request
Ancillary Care Accessibility Standards:	
Routine Ancillary Care Appointment (Non-Urgent)	Within 15 business days of request
Behavioral Care Accessibility Standards:	
Routine Behavioral Care Appointment (Non-Urgent)	Within 15 business days of request (Physicians) Within 10 business days of request (Non-Physicians)
Urgent Care Appointment	Within 48 hours of request
Life Threatening Emergency	Immediately
Non-Life Threatening Emergency	Within 6 hours of request
Emergency Care	Immediate, 24 hours a day, 7 days per week
After-Hours Care Standards:	
After-Hours Care	• Automated systems must **provide emergency 911 instructions** • Automated system or live party (office or professional exchange service) answering the phone must offer a reasonable process to connect the caller to the PCP or covering physician • Offer a **call-back** from the PCP, covering physician, or triage/screening clinician **within 30 minutes**
Physician Telephone Responsiveness:	
In-Office Waiting Room Time	Within 30 minutes
Speed of Telephone Answer	Within 30 seconds
Missed Appointments	Within 48 hours to reschedule

Network Medical Management defines the access criterion as follows:

1. Preventive care: Care or services provided to prevent disease/illness and/or its consequences. For example, an annual physical exam, immunizations, or a disease screening program.
2. Specialty care: Medical care provided by a specialist, such as a cardiologist or a neurologist.
3. Routine primary care: Services that include the diagnosis and treatment of conditions to prevent further complications and/or severity. These are non-acute or non-life or limb threatening.
4. Urgent care: Care given for a condition(s) that could be expected to deteriorate into an emergency or cause prolonged impairment, such as acute abdominal pain, fever, dyspnea, serious orthopedic injuries, vomiting, and persistent diarrhea.
5. After-hours non-urgent phone call: Examples include a Rx refill, questions regarding current treatment plan or problem identified.
6. After-hours emergency/urgent phone call: A call made for a life-threatening illness or accident requiring immediate medical attention for which delay could threaten life or limb.
7. Waiting time: the period from scheduled appointment time until seen by provider in exam room (assuming that member arrives on time). The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.
8. Ancillary services: Include, but not limited to, the provisions of pharmaceutical, laboratory, optometry, prosthetic, or orthopedic supplies or services, suppliers of durable medical equipment, home-health service providers, and providers of mental health or substance abuse services.
9. Triage or screening: The assessment of a member's health concerns and symptoms for the purpose of determining the urgency of the member's need for care.

Providers are encouraged to accept walk-in members in case of unforeseen circumstances, and should let members know of their office policy for same day appointments. Members have access to their provider or designee twenty-four (24) hours a day, seven (7) days a week.

SECTION 12.3
HEALTH EDUCATION PROGRAMS

Providers are encouraged to inform members about Health Education programs offered by EMANATE HEALTH IPA and contracted Health Plan organizations which is available in the threshold languages and different formats. The following is a list of health education programs which are available:

Other topics to talk to your doctor about:

- Asthma
- Childhood Obesity
- Diabetes
- Drug and Alcohol Problems
- Exercise
- Family Planning/Birth Control
- How to Quit Smoking
- Nutrition
- Parenting
- Prenatal Health (for pregnant women)
- Safety Tips
- STDs and HIV
- Tobacco Cessation
- Weight Problems

NETWORK MEDICAL MANAGEMENT
HEALTH EDUCATION REFERRAL PROCESS

1. Complete Treatment Authorization Request (TAR).
2. Retain copy of TAR in Medical Record and document Health Education referral in progress notes.
3. Fax to Utilization Review Department at number specified on the TAR corresponding to Medical Group.
4. Utilization Review Coordinators will enter into system and give an authorization number.
5. Utilization Review Coordinators will forward a copy of the TAR to QM/Health Education Department for tracking purposes only.
6. QM Coordinator will log data on respective Health Education Log per Medical Group. QM Coordinator will find a Health Education facility for the member and contact the member by phone. A letter is mailed to the member and a copy of the letter is faxed to the PCP. QM Coordinator will follow up with member for confirmation of attendance.
7. Loop closure will be via communication between health educator at the facility and QM coordinator with documentation of member attendance.

If your office needs Health Education (HE) Materials,

*Refer to **Section 15** of this manual for the HEALTH EDUCATION MATERIAL REQUEST form*

SECTION 12.4
MEDICAL RECORD STANDARD

It is the policy of Network Medical Management to ensure that the medical record is maintained in a manner that is consistent with the legal requirements, current, protected, relevant, standardized, detailed, organized, available to practitioners at each patient encounter, facilitates coordination and continuity of care, and permits effective, timely, confidential, quality review, care and service. It is the policy of Network Medical Management to distribute this policy to all practitioners and to ensure its practitioners comply with these standards.

I. The records serve as the basis for planning and maintaining the quality of patient care. Records that are devoid of pertinent medical information may impact other treating physicians or health professional's ability to provide appropriate care. Failure to maintain adequate and accurate records relating to the provision of services constitutes unprofessional conduct. (Business & Professions Code 2266)
II. Reimbursement for services may be limited or denied unless documentation supports the level of care that the physician is charging for.
III. Incomplete medical records documentation may interfere with a physician's peer's ability to perform peer review and therefore maintain quality health care delivery and may subject the physician to disciplinary action or severe sanction by outside review agencies.
IV. The medical records are often a physician's best evidence in a professional liability lawsuit. Inadequate medical records may undermine a physician's ability to defend him or herself.
V. It is recommended that each physician office site employ a process for ensuring that pertinent medical information pertaining to medical and non-medical services rendered to members is available at each patient visit and that periodic purging and archiving of medical records information be conducted in accordance with all applicable state and federal laws. Network Medical Management has adopted a seven- (7) year minimum period from the last medical visit in which to purge and archive medical records. (10 yrs. for Medi-care members) Records of minors must be maintained for at least one (1) year after a minor has reached age 18, but in no event for less than seven (7) years. Member medical information and records must be stored in an anonymous manner, and if disposed of must be destroyed in a way such that information is not identifiable, this may mean reformatting, shredding, or another form of destruction, depending on the media involved. It is of Network Medical Management's policy that medical records be retained for seven (7) year to provide for retention of patient care and to establish facts regarding the patient's condition and course of treatment, should those facts ever come into question. *(10 years for Medicare members) (5 years for Medi-Cal & Healthy Families from the end of the current *Fiscal Year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created or the Contract is terminated) (For Molina medical records must be kept for 10 years-all product lines)*
VI. Occasionally an entry may be made in a medical record that is incorrect due to a mistake or clerical error. If such an entry is discovered, it should be corrected. The erroneous entry itself should not be obliterated or erased. Rather, a line should be marked through it to indicate the error, with the current date and initials of the person making the correction alongside the entry. Obliteration of the entry with correction fluid so that it may not be read, may raise a question later as to what the entry contained or why it was erroneous and may jeopardize the defense of a medical mal-practice case should one be filed. Modifying or altering of a medical record for fraudulent purposes is prohibited by law and may result in both disciplinary action by the California Medical Board and criminal action punishable as a misdemeanor. (B&P Code 2262 & Penal Code 471.5)

The chart should be maintained and organized in the following manner:

1. An individual record is maintained for each patient. Each patient medical record will be individualized, format standardized, organized and secure and permit effective confidential member care, and quality review.
2. Each patient medical record will be filed and stored in a central place (restricted from public access), utilizing a standardized and centralized medical group network tracking system assuring ease and accuracy of filing, retrieval, availability and accessibility as well as confidentiality. *The staff must be periodically trained on and have evidence of confidentiality and HIPPA guidelines.*
3. Member identification is on each page, which includes first and last name, and or unique patient number established for use on clinical site. Electronically maintained records and printed records from electronic systems contain patient identification.
4. Biographical/personal data will include name, date of birth, address, employer name/phone, sex, home phone, work phone, principle spoken/written language, marital status and insurance information which will be kept in the member's health care record.
5. Member's emergency contact information will be documented in the medical record. This will include the name and phone number of a relative or friend or a home, work, pager, cellular or message phone number. If patient is a minor, the emergency contact must be a parent or guardian. If patient refused to provide information, "refused" is noted in medical record.
6. Entries must contain author authentication including, title and date.
7. Entries must be legible to someone other than the writer.
8. Medical records are consistently organized, content and formats of printed and or/electronic records within the practice site are uniformly organized.
9. Charts contents are securely fastened.
10. There must be evidence that Advanced Health Directive or evidence information has been offered and discussed to adult patient 18 years of age and over.
11. Documentation to occur within 24 hours of patient visit.
12. A clearly identifiable chronic problems/significant conditions (inclusive of behavioral health) are listed will be maintained and dated in the medical chart such as on a problem list. A chronic problem is defined as one which is of long duration, shows little change or is slow progression. *Absence of chronic problems will be noted on the problem list.*
13. A clearly identifiable current continuous medication is listed with name, strength, route, dosage, duration, dates of initial or refill prescriptions and quantity of all prescribed medications will be noted and maintained in the medical chart. Discontinued medication will be noted in the progress notes and stop date will be noted in the medication list.
14. All services provided directly by the PCP, reasons for and results of ancillary services, diagnostic and therapeutic services. *This includes all diagnostic and therapeutic services for which a member was referred by a practitioner such as home health nursing reports, specialty physicians' reports, hospital discharge reports and physical therapy reports.*
15. Allergies and adverse reactions shall be prominently displayed on either the front of the chart or inside cover, in addition to other areas, such as the problem list and on each visits progress note. If member has no allergies or adverse reaction, "No Known Allergies" (NKA), "No known Drug Allergies" (NKDA), also needs to be noted in the medical record.
16. History of present illness is documented. Physical exam to be documented related to presenting complaint. (includes subjective and objective information)
17. Diagnosis or medical impression, clinical findings and evaluation to be documented regarding each visit.
18. Plan of treatment to be documented and to be consistent with findings and care is medically appropriate.
19. Follow-up plan and date of return visit, if indicated is noted specifically in weeks, months, or as needed.
20. Unresolved and/or continuing problems are addressed in subsequent visit(s).

21. Evidence of continuity of care between PCP and specialists if applicable via progress note notation indicating review of consultant's reports and actions taken by PCP if necessary or that patient was contacted. Evidence of appropriate use of consultants, if applicable. All requested referral information to be placed in the member's medical records. *The medical Record will include identification for all practitioners participating in member's care and information on services they render.*
22. Evidence of appropriates utilization of labs and other diagnostic studies with reasons for and results of studies. All labs and diagnostic reports should reflect PCP review via initials and date. This includes pertinent inpatient records that must be maintained in the office medical record. These records may include but are not limited to the following: history and physical, surgical procedure reports, ER reports and/or discharge summaries.
23. Missed/failed appointment, cancellations and follow-up contacts/outreach efforts are noted in the medical the medical record to ensure appropriate medical care and monitor member non-compliance. "No-show", "Rescheduled" or "Canceled" is noted in the medical records as applicable. Practitioner documents intervention in the medical records.
24. Evidence of compliance with established practice guidelines and related policies and procedures. (e.g., Confidentiality, Missed Appointments, Notification of Test Results, After Hours Calls, Treatment Consent)
25. Documentation shall substantiate medical care rendered.
26. Initial Health Assessment (IHA) must be completed on all members within 120 days of effective date of enrollment into the plan or documented within 12 months of prior member's enrollment. This assessment must include a comprehensive history and physical, assessment to determine health practices, values, behaviors, beliefs, literacy levels and health educational needs.
27. Individual Health Education Behavioral Assessment (IBEHA), for new members must be conducted within 120 days of effective enrollment date as part of the initial health assessment. Existing members, age-appropriate IBEHA is conducted at member's next non-acute care visit, but no later than next scheduled health-screening exam. The tool is re-administered at appropriate age intervals.
28. The member's primary language will be noted in the medical record.
29. Linguistics needs for non or limited English proficient members will be prominently noted in the medical record. Request for language and or interpretation services will be documented. The member's refusal of these services will also be documented. Evidence of documentation on request for and refusal of Language interpretive services (see policy #138).
30. Tracking of record location when out of filing system will be accomplished by way of a tickler system indicating chart whereabouts.
31. Medical record data obtained between visits will be forwarded to the PCP's office for review and incorporation into the patient's chart.
32. Adult patients (18 years and older) who inspect their medical records are allowed to provide a written addendum to the records if the patient believes that the records are incomplete or inaccurate. This addendum is included when disclosed to other parties.
33. Medical records will be transferred among practitioners when a member changes to a new PCP (prior to the member's first visit with the new PCP). The privacy of the medical record will be safeguarded in transit. Requested information will be delivered in a timely manner (prior to the member's first visit with the new PCP) to ensure continuity of care. A practitioner furnishing a referral service will report appropriate information to the referring practitioner/provider in a timely manner. Also the record contains referral notes from medical practitioners to behavioral health practitioners (as applicable) and documented evidence of clinical feedback (i.e. consultations report inclusive of diagnosis, treatment plan, and psychopharmacological medication, as applicable) Practitioners will request information from other treating practitioners as necessary to provide care in a timely manner. *For Senior Members there is no charge for medical record and information transfer. Release of medical records to the member should include reasons but not limited to member's request and quality improvement activities.*

Disclosure of Medical Information/HIPPA- The expanded definition of "individually identifiable" (includes name, address, phone number, SS number, email address, etc.)

- Prohibition of requiring a patient as a condition to receiving Healthcare services to sign an authorization, release, consent or waiver permitting disclosure of medical information subject to confidentiality protection under the law.
- Medical information is release after member authorization and in accordance with applicable Federal or State law.
- A member has the right to authorize/deny the release of PHI beyond uses for treatment, payment or Health Care operations
- Disclosures and security measures for PHI meet the requirements under HIPPA
- In the event of improper use or disclosure of PHI steps will be taken to notify the health plan by self-reporting.

Health Maintenance documentation should include the following:

A. Appropriate adult past medical history documentation to include:
   1. Smoking habits
   2. Alcohol use
   3. Substance abuse history
   4. Family planning, reproductive health history
   5. Surgical procedures
   6. Illnesses & serious accidents
   7. Discharge summaries from hospitalized members
   8. In-patient hospital admissions
   9. For members seen >/= times) is easily identified and includes serious accidents, operations, and illnesses.

B. Appropriate Children/Adolescents past medical history documentation to include:
   1. Smoking history
   2. Alcohol usage/history of substance abuse for patients over 12 years of age
   3. Surgical procedures
   4. Childhood illnesses
   5. Personal/psychosocial/family history
   6. Completed and current record
   7. Documentation of education and age appropriate preventive/risk screening services and risk factors in accordance with NETWORK MEDICAL MANAGEMENT practice guidelines (including behavioral health practice guidelines (if applicable).
   8. For members seen </= 18 years), past medical history relates to prenatal care, birth, operations, and childhood illnesses.

Pediatric Preventive Services Documentation should include the following:

A. Referral to Health Assessment Procedure to notify beneficiary to receive a health assessment:
   1. For members under the age of 18 months, the PCP is responsible to perform an initial health assessment (IHA) within 60 days of enrollment or within periodicity timelines established by American Academy of Pediatrics (AAP) for age two and younger whichever is less.
   2. For members 18 months of age and older upon enrollment, including all adults, the PCP is responsible for ensuring an initial health assessment (IHA) is performed within 120 days of enrollment.

B. Initial Health Assessment documentation for Medi-Cal (CHDP PM 160 INF) and Healthy Families (Staying Healthy Assessment form) members should include:
   1. Health Developmental history

2. Unclothed physical examination
3. Assessment of nutritional Status
4. Inspection of ears nose, mouth, throat, teeth and gums (any referrals if applicable which include but not limited to: dental care, eye care)
5. Vision Screening
6. Hearing Screening
7. Tuberculosis Testing, Laboratory Testing for anemia, diabetes, and urinary tract infections.
8. Testing for sickle cell trait and Lead Poisoning
9. Immunizations appropriate to age following recommendations of : Advisory Committee on Immunization Practices of the American Academy of Pediatrics
10. Health education and anticipatory guidance.

C. Periodicity Assessments should include:
   1. Person's Eligible for periodic assessments shall receive one assessment during each designated age period. Providers must follow the schedule recommended by the American Academy of Pediatrics.

D. Appropriate Health Education Documentation to include:
   1.Date of health education intervention Type and topic of health education Intervention (i.e. one-on-one class, sub group).
   2.Patient feedback or comments regarding health Intervention.
   3.Referrals to other classes if applicable.
   4.Follow-up from previous health interventions with explicit notations in the medical record particularly for consultation, abnormal lab and imaging study results

E. **Community Resource- Documentation in the patient charts if receiving services from/through**
   1. **California Children's Services (CCS)**
   2. **Regional Center**
   3. **Women, Infants, and Children (WIC)**

Advance Directives

Advance directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under state law and signed by a patient, that explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes know.

EMANATE HEALTH IPA physicians shall provide to each adult (18 years and older) subscriber (incapacitated included) an Advance Directive Brochure on the first visit or when reasonably feasible. Also, the PMG/IPA will assist 18 years of age and older in their understanding of advance directives. This information may be given to the enrollee's family or surrogate. The provider (staff) is instructed to follow-up to ensure that the information is given directly to the individual at the appropriate time.

In accordance with title 22 of California Code of Regulations, medical records for adults 18 years and older must include documentation; documentation of discussion; whether the member has been informed of (advance directive brochure), or has or has not executed, an advance directive, such as a durable power of attorney for health care (DPAHC), by the primary care physician. Forms are available at Advance Health Care Directive Registry | California Secretary of State www.sos.ca.gov

Additionally, you may refer to the NMM Web Portal under the section "Provider Recourses" for a copy of an Advanced Directive form.

SECTION 13.1
CULTURAL AND LINGUISTIC SERVICES

Culturally and linguistically appropriate services areas include:

A. Identification of Limited English Proficient (LEP) and hearing-impaired members and recording language preferences/American Sign Language in medical charts.

B. Posting signs at all member key points of contact to inform LEP and hearing-impaired members on the availability of free interpreter services.

C. Ability to access interpreter services through Network Medical Management and or health plans for medical and non-medical points of contact.

D. Ensuring access to free interpreter services to LEP and hearing-impaired members on a 24-hour basis which includes an after-hours protocol on how to access interpreter services. This also includes face-to-face and over-the-telephone interpreter services.

E. Offering interpreter services and recording request/refusal of interpreter services in LEP or hearing-impaired member's medical chart. Minors are prohibited to be used as interpreters except in emergency/life threatening situations.

F. Attend and/or promote cultural competency training/resources for providers and staff. Ensure qualifications of bilingual staff are kept on file.

G. Making member-informing and health education materials available to LEP members in the threshold languages and also in alternative formats such as Braille, large print etc.

H. Having the right of the members/providers to file a grievance when a C&L is not met and having the availability of the form in the threshold languages and how to obtain it. If a practice needs materials it should fill out the Material Needs Form (page 50) and contact the Quality Management department at (626) 282-0288.

Practices should contact Network Medical Management's Customer Service Department at (877) 282-8272 or the member's health plan to obtain more information on how to access cultural and linguistic services for members of EMANATE HEALTH IPA .

*Refer to **Section 15** of this manual for insert titled **Health Plan Language Assistance*** . This is a listing of language assistance resources by health plan.

SECTION 13.2
CULTURAL & LINGUISTIC SERVICES – PROVIDER RESPONSIBILITY

The California Department of Health Services (DHS) and Network Medical Management (NMM) and its affiliates expect providers/practitioners to adhere to the following:

24-Hour Access to Interpreters

When the Provider/Practitioner does not speak the members' language, he/she must ensure 24-hour access to interpreters for members whose primary language is not English. To access interpreters for NMM members at no cost to you or the patient call Language Line Services at 1-800-367-9559, access code for Network Medical Management is **2554** or ID **295164** or utilizes free interpretation services provided by the contracted health plan. It is never permissible to ask a family member to interpret.

State and Federal laws state that it is never permissible to turn away or limit the services provided to them because of language barriers. It is also never permitted to subject a member to unreasonable delays due to language barriers or provide services that are lower in quality than those offered in English. Linguistic services must be provided at no cost to the member.

Documentation

If a patient insists on using a family member as an interpreter, or refuses the use of interpreter services, after being notified of his or her right to have a qualified interpreter at no cost document this in the member's medical record.

All counseling and treatment done via an interpreter should be noted in the medical record by stating that such counseling and treatment was done via interpreter services. Practitioners should document who provided the interpreter service. That information could be the name of their internal staff or someone from a commercial vendor such as Language Line. Information should include the interpreters' name, operator code number and vendor.

Should your member refuse to utilize the Interpretative Services, please complete the Request/Refusal for Interpretive Services Form and place in the member's medical record.

Facility Signage

DHS requires that Practitioner offices post important signs in the threshold languages such as the "free interpretation services" poster. Check the health plan's website for downloadable signs in a variety of languages. If you need particular signage and cannot locate it, contact Quality Management Department for assistance at (626) 282-0288 ext.6207.

SECTION 13.3
NMM LANGUAGE LINE SERVICES INFORMATION

Language Line Automated Access offers a fast and efficient way to connect to a professional Interpreter, anytime, anywhere. Language Line Automated is an over-the-phone interpretation service that ` more than 140 languages, 24 hours a day. The following is a *Quick Reference Guide* of how to use this free service provided for your office by Network Medical Management. Please ensure that all users in your office know how to use the conference feature on their phone for this service to be used efficiently.

Login Information:
Toll Free Line: 1-800-367-9559
Client ID# 295164
Access Code: 2554

Help Information:
Customer Service Line: 1-800-752-6096 Option 1
E-mail: www.LanguageLine.com

1. Place the non-English speaker on Conference Hold.
   A. If you are placing an outbound call, access the Interpreter first and then place the call to the non-English speaker.
2. Dial Language Line Services at 1-800-367-9559
3. Follow Prompts
   A. Press 1 for Spanish.
      - Say "help" if you encounter a problem. Your call will be transferred to a representative.

   B. Press 2 for all other languages.
      - Speak the name of the desired language clearly; (e.g., "Chinese", "Japanese"). *Say only the language name* – do not add any other words. The system will repeat your request and ask that you:
      - Press 1 to confirm the language.
      - Say "help" if you encounter a problem. Your call will be transferred to a representative.
4. Enter your 6-digit Client ID# (provided above) on the telephone keypad.
5. Enter your numeric Access Code (provided above) followed by the pound sign (#) on the telephone keypad.
6. Your Interpreter is connected to the call. Brief the Interpreter about the nature of the conversation and provide specific information to be relayed to the non-English speaker.
7. Add non-English speaker to the line after you have briefed the Interpreter.

Should your member refuse to utilize the Interpretative Services, please complete the Request/Refusal for Interpretive Services Form and place in the member's medical record.

*Refer to **Section 15** of this manual for the REQUEST/REFUSAL FOR INTERPRETIVE SERVICES form*

SECTION 14
COMPLIANCE AND ADDITIONAL PROVIDER TRAINING

Compliance Training

Network Medical Management has developed this Training Program to ensure commitment with all applicable Federal, State, and Health Plan standards. This Training Program is to be a comprehensive statement of the responsibilities and obligations of all provider staff (includes temporary staff) who interact with and/or provide covered services to EMANATE HEALTH IPA beneficiaries. All contracted providers and their clinical staff shall review and attest to the completion of the following material within 90 days of becoming contracted with the IPA and Annually thereafter.

- **CMS Fraud, Waste & Abuse (FWA) & General Compliance** (*False Claims Act, OIG & SAM Listing)*
- **Cultural Competency Training**
- **HIPAA Privacy Training**
- **Standard of Conduct**
- **Model of Care Training (MOC)**

For full training material on all topics listed above, refer to:
https://www.networkmedicalmanagement.com/providers/provider-resources

Reporting Froud Waste and Abuse to NMM

Detecting and preventing FWA is the responsibility of everyone, including providers, provider staff, sub-contractor, and members. NMM has written policies and procedures to address the prevention, detection, and investigation of suspicious activity. NMM also conducts compliance training and regularly publishes articles related to FWA on the Company's Intranet site. The Company has also established an Ethics Hot Line (1-626-943-6286) for employees, plan members, agents, and vendors to report suspected FWA anonymously.

If you have any questions or concerns, please contact our Compliance Department via phone, fax, email, or mail

Compliance Hotline: (626) 943-6286
Fax: (626) 943-6329
Email: fwacompliance@networkmedicalmanagement.com
Mailing Address: 1668 South Garfield Ave. 2nd Floor, Alhambra, CA 91801 (please address to NMM Compliance Department).

You can also email the questions or findings at fwacompliance@networkmedicalmanagement.com.
Compliance Program is approved by Governing Board.

Additional Provider Training

In addition, this Provider Manual will be made available on NMM's Web Portal for providers to review and will be updated on an annual basis. As a regulatory requirement, provider offices must attest to completing an annual review of UM policies, updates, clinical criteria, and other programs outlined below. Trainings below are subject to audit and may change periodically.

(Information on topics below can be found throughout the manual in their respective sections)	SECTION
• **Access to Care Standards**	**12.2**
• **Advance Directives**	**12.4**
• **Behavioral Health Treatment** (BHT)	**8**
• **California Children's Service Program** (CCS)	**8**
• **California Immunization Registry Program** (CAIR)	**8**
• **Childhood Disability and Prevention Program** (CHDP)	**8**
• **Comprehensive Perinatal Services Program** (CPSP)	**8**
• **Contracted provider (PCP / SPC) responsibilities**	**7.2**
• **Contracted specialist requirements**	**7.2**
• **Early Start/Early Intervention Developmental Disabilities and Regional Centers**	**8**
• **Family Planning Services** *(Women, Infant and Children's (WIC) Program & Health Plan Supplemental Benefits)*	**8**
• **General UM Provider Updates** *sent via fax and/or available within your provider web portal account*	**15***
• **Hospice / Palliative Care**	**7.2**
• **Initial Health Assessment Guidelines**	**11**
• **Language Assistance Program** (LAP) *see PDF Insert*	**15***
• **Medi-Cal Balance Billing Guidelines**	**9.6**
• **Screening, Brief Intervention, and Referral to Treatment** (SBIRT) *Alcohol and Substance Abuse*	**8**
• **Specialty Referral Tracking**	**7.2**
• **Standing Referral Requirements**	**7.2**
• **Sterilization PM330 and DHCS Education Booklet requirement**	**8**
• **Vaccine for Children Program** (VFC)	**8**

Upon reviewing all training material, an attestation form must be signed and returned to The signature will indicate that the provider and all clinical staff members have reviewed the training material for all listed topics for the given year.

Attestation form is to be returned to Provider Relations Dept at:
ProviderNetworkOperationsDept@networkmedicalmanagement.com| Fax: (626) 943-6309.

SECTION 15
FORMS AND ADDITIONAL ATTACHMENTS

The following forms and attachments are included with this Provider Manual

1. 2022 New Provider Training Attestation Form
2. Patient's Rights and Responsibilities
3. Request/Refusal for Interpreter Services Form
4. Direct Deposit Form (for capitated services only)
5. Electronic Remittance Advice (ERA) Memo/Form
6. Health Education Materials Request Form
7. Treatment Authorization Request Form
8. Standard Prescription Drug Prior Authorization Form
9. Provider Leave of Absence Form
10. Health Plan Language Assistance
11. Urgent Care Listing
12. Children's Vaccine Schedule