2021
PROVIDER MANUAL

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Section 1: Introduction and Overview
Overview:

Emanate Health IPA (CVIP) is a new, high quality medical group available to you and your family in the East San Gabriel Valley. CVIP is made up of over 180 physicians, including specialists, who are dedicated to providing you quality, compassionate health care.

By selecting a Primary Care Physician affiliated with CVIP you will gain direct access to Queen of the Valley Hospital in West Covina, Inter-Community Hospital in Covina and Foothill Presbyterian Hospital in Glendora. All hospitals are affiliated with Citrus Valley Health Partners, a comprehensive health care system that offers lab, radiology, retail pharmacies, outpatient rehabilitation services and many other exceptional programs.

Mission Statement

Our mission is to provide high quality and affordable care to our patients.
Values

- We care about our patients and advocate for them.
- We provide the same quality care that we would want our families to receive.
- We respect each other and are ethical in our business dealings.
- We are careful with our financial resources
- We seek to find better ways to deliver care to our patients.

MSO Introduction

Network Medical Management (NMM) is a Management Services Organization (MSO) comprised of healthcare professionals and more than 300 employee associates serving the rapid growth of its IPAs and Medical Groups. NMM provides comprehensive administrative support to Independent Physicians Associations (IPAs) and medical groups, pursuing both quality patient-care and profitability.

In 1994, a team of physicians formally established Network Medical Management (NMM). Since then, NMM has helped numerous IPAs and medical groups achieve their financial goals and organizational success. In 2016, NMM have achieved our objectives 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 650,000 members.

As health care industry continues to evolve, NMM remains at the forefront, anticipating changes and their impacts to the clients. NMM believes in a solid infrastructure and technology, which ensure the delivery of an integrated health care system with the highest efficiency and accuracy.

Section 1.1

Contact Sheet
EMANATE HEALTH IPA

Administration	EMAIL
Dr. Gurjeet Kalkat, Medical Director	gkalkat@emanatehealth.org
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NETWORK MEDICAL MANAGEMENT
(877) 282-8272

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Provider Network Operations	**Ext.**	**EMAIL**
Web Portal Help Desk		Portal.Inquiries@nmm.cc

Section 1.1
Contact Sheet

Quick Reference Sheet

AREA	CONTACT DETAILS
Provider Services	• Roxana Robles, Physician Relations Liaison Cell: (626) 646-3154 Email: rroble@emanatehealth.org • IPA Email Support: IPASupport@emanatehealth.org
Main Customer Service Line	• **Phone:** (877) 282-8272 or (626) 282-0288 • **Hours:** Mon-Fri., 8:30am – 5:00pm • **Scope:** Eligibility, Referrals, Claims, Provider, and Member Inquiries
Claims Submission	• Via Office Ally, use Payor ID#: **NMM01** • To submit via the NMM Portal, please email: portal.inquiries@nmm.cc (setup required) • **Mail:** 1680 S. Garfield Ave. # 201 Alhambra, CA 91801 (paper claims not recommended for contracted provider network)
Case Management	To report an admission: • Please fax the Face Sheet to: (626) 943 6321
Eligibility	To have a patient added urgently, you can email or call. • For emails, please send to: eligibility.dept@nmm.cc • For urgent requests, please call (877) 282-8272
Utilization Management	• Submissions: Please use the Portal at www.nmm.cc
Web Portal Assistance	• Technical Assistance: Portal: Portal.Help@nmm.cc • New Users: Portal.Inquiries@nmm.cc • Phone: (626) 943-6146 • Fax: (626) 943.-6350

Section 1.2
CONTRACTED HEALTH PLANS & HOSPITALS

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

PLAN	LINES OF BUSINESS
Aetna	• Commercial & POS
Alignment	• Medicare
Anthem Blue Cross	• Medi-Cal • Medicare/Senior • Commercial & POS
Blue Shield	• Medicare/Senior • Commercial & POS • Covered California
Blue Shield CA Promise	• Medi-Cal • Medicare/Senior
Central Health Plan	• Medicare/Senior
Cigna	• Commercial & POS
Clever Care	• Medicare
Health Net	• Medi-Cal • Medicare/Senior • Cal MediConnect • Covered California • Commercial & POS
Humana Health Plan	• Medicare/Senior
L.A. Care	• Medi-Cal • Cal MediConnect • Covered California
Molina Health Plan	• Medi-Cal • Medicare • Cal MediConnect

ANCILLARY CONTRACTS

TYPE	VENDOR/PROVIDER
Laboratory Radiology/Imaging	Emanate Health: • Queen of the Valley Hospital • Inter-Community Hospital • Foothill Presbyterian Hospital
DME	Express RX

CAPITATED HOSPITALS

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

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:

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

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, sending an email to **Eligibility.Department@nmm.cc**, logging on to Network Medical Management's Web Portal at **https://www.nmm.cc/Portal**, 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.

Note: If a practice is unable to locate a member on the web portal but had previously confirmed eligibility, the office staff should submit the Eligibility Request Form (page 51), copy the member identification card onto the form and fax the form to Network Medical Management's Eligibility Department at (626) 943-6352.

Health Plan Contact Information:

HEALTH PLAN	PHONE NUMBER	WEBSITE
Aetna	800-872-3862	https://aetna.com
Alignment	866-634-2247	https://www.alignmenthealthplan.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
Central Health Plan	866-314-2427	https://www.centralhealthplan.com
Clever Care	833-388-8168	https://clevercarehealthplan.com/
Cigna	800-244-6224	https://www.cigna.com
Health Net	800-641-7761	https://www.healthnet.com
Humana	800-448-6262	https://www.humana.com
LA Care	866-522-2736	www.lacare.org
Molina	888-665-4621	www.molinahealthcare.com

Section 2.2
Eligibility and Capitation Report

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 identification number
- HMO: Capitated health plan with capitated membership
- Effective date: Member's effective date with the provider
- Term date: Member's termination date with the provider
- CAP: Capitation paid amount for the capitation period
- CAP/member: Capitation rate by member
- CAP month/year: Capitation period by month
- Adjustment column: Shows any manual adjustments applied to a provider's current capitation payment
- Member months to date: Cumulative total of member months for the capitation period
- Capitation dollars earned to date: Total capitation earned for the capitation period

- Adjustment column: Shows any manual adjustments applied to a provider's current capitation payment
- Gross capitation due: Current capitation payable for the capitation period

- Capitation previously earned: Capitation previously paid for the capitation period minus the current month payment
- Net capitation due: Current month capitation payment

For any eligibility of capitation related inquiries, please call (626) 282-0288.

Section 3.1
Provider Relations

EMANATE HEALTH IPA provides support to providers seeking information about items such as network operations, credentialing, contracts and payment schedules as part of their commitment to providing effective and timely communication with all providers.

Responsibilities

EMANATE HEALTH IPA and Network Medical Management's Provider Relations Department work 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

EMANATE HEALTH IPA encourages providers to contact its Managers of Contracting and Provider Relations or Network Medical Management's Provider Relations Department with any questions or concerns.

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.

Section 4.1
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. EMANATE HEALTH IPA retains the right and authority over all key decisions affecting the corporation and its contracted provider operations and management.

EMANATE HEALTH IPA has the authority and responsibility to implement, maintain, and enforce EMANATE HEALTH IPA policies governing Contractors' duties under their agreement(s) and/or governing oversight role. EMANATE HEALTH 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 EMANATE HEALTH 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 EMANATE HEALTH 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.

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

Section 4.2
Compliance with all Laws and Regulations

EMANATE HEALTH IPA 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 & Discounts
- Honest Dealings with Payor, State, or Government Officials
- *Cooperation of Audit and Investigations*

Section 4.3
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.

Section 4.4
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.

Section 4.5
Contract Provisions

Additionally, Contracted Providers must comply with the following provisions, which are part of the provider's official contract:

Section 4.6
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 & Mid-Level provider application for participation has been approved by EMANATE HEALTH IPA Credentialing Committee. Contracted Specialist or Ancillary 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 EMANATE HEALTH IPA and other health professionals when so requested and must participate in peer review activities.

Section 4.7
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.

Section 4.8
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.

Section 4.9
Covering Providers

Providers must give EMANATE HEALTH IPA reasonable, advance, written notice of any periods of unavailability (e.g., vacation). In such cases, Contracted Providers must agree to arrange for the services of another qualified professional in the same specialty, satisfactory to EMANATE HEALTH IPA , to render services to any Patient/Participant/Clients referred during the term of the absence. Compensation for services rendered during such absence will be paid only to Contracted Providers and he/she must accordingly compensate the Covering Provider.

Section 4.10
Provider Leave of Absence

If the Contracted Provider is, for any reason, from time to time unable to provide Covered Services when and as needed, the Contracted Provider may secure the services of a qualified covering physician who shall render such covered services otherwise required of the Contracted Provider; 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. The Contracted Provider shall be solely responsible for securing the services of such covering physician and paying said covering physician for those covered services provided to Enrollees. The Contracted Provider shall ensure that the covering physician:

1. Looks solely to the Contracted Provider for compensation
2. Will accept IPA's peer review procedures,
3. Will not directly bill Enrollees for Covered Services under any circumstances
4. Will, prior to all elective hospitalizations, obtain authorization in accordance with IPA utilization review program.

The Contracted Provider must notify the IPA in writing 14 calendar days in advance for any leave of absence. Notifications shall be sent to Provider Relations Department via email at ProviderRelations.Dept@nmm.cc or via fax at (626) 943-6309.

Section 4.11
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 EMANATE HEALTH IPA for the performance of the duties under the contract(s) with EMANATE HEALTH IPA. Whenever a Contracted Provider recommends surgery for a Patient/Participant/ Client, the Contracted Provider must contact EMANATE HEALTH IPA to obtain prior authorization for the proposed treatment. The Provider must work to perform said surgery at a EMANATE HEALTH IPA contracted facility or financially responsible Health Plan contracted Hospital.

Section 4.12
Medical Documentation

After the initial office consultation with a EMANATE HEALTH IPA Patient/ Participant/ Client, Contracted Providers must submit to EMANATE HEALTH IPA an Initial Consultation and Follow-Up report. Health records must contain all information necessary to comply with documentation standards as outlined in Section 24 "Medical Policy & Procedure".

Section 4.13
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 EMANATE HEALTH IPA is associated, and information pertaining to Contracted Providers, EMANATE HEALTH IPA Patient/ Participant/Clients, facilities and associations, will be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. EMANATE HEALTH IPA agreements may not be construed to require confidential treatment for any information that is subject to disclosure under the California Public Records Act.

Section 4.14
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 90 days, if they so request. In accordance with CA Health and Safety Code 1373.65(f), EMANATE HEALTH 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 EMANATE HEALTH IPA 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 EMANATE HEALTH 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.

Section 4.15 Compensation

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

In the event that EMANATE HEALTH IPA fails to pay Contracted Providers for authorized health care services rendered to a EMANATE HEALTH IPA Patient/Participant/Client, including but not limited o insolvency, the Patient/Participant/Client will not be liable for any sums owed to Contracted Providers by EMANATE HEALTH IPA IPA. Under no circumstances may Contracted Providers or their agents, trustees or assignees maintain any action at law against any EMANATE HEALTH IPA Patient/Participant/Client to collect sums owed to Contracted Providers by EMANATE HEALTH IPA IPA.

Section 4.16 Recovery from Third Parties: Lien Rights

Where duplicate coverage exists, Contracted Providers must assist EMANATE HEALTH IPA in pursuing coordination of benefits or other permitted method of third party recovery. Contracted Providers must identify and notify EMANATE HEALTH 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 GROUP Provider Relations Department within thirty (30) days of discovery.

Section 4.17 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 EMANATE HEALTH IPA 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 EMANATE HEALTH IPA to fulfill its contractual and statutory obligations, by allowing EMANATE HEALTH 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 EMANATE HEALTH IPA contracts with Payors, as applicable.

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

Section 4.18
Independent Contractors

The sole interest and responsibility of EMANATE HEALTH 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 EMANATE HEALTH 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 EMANATE HEALTH IPA IPA.

Section 4.19
Assignment and Delegation

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

Section 4.20
Non-Discrimination

Providers may not discriminate against EMANATE HEALTH IPA 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 insure 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.

Section 4.21
Due Process

EMANATE HEALTH IPA offers it's contracted providers "due process" by notifying providers in writing of the reason(s) for participation denial, suspension or termination from contracted network.

Providers have the right to request and to be offered due process in appealing initial determinations. EMANATE HEALTH IPA processes reports to the Medical Board of California (MBC-805 report) and/or the National Practitioner Data Bank (NPDB) when required to do so by State and Federal law.

Section 4.22
Confidential Information-Release to the Patient/Participant/Client

EMANATE HEALTH IPA will substantiate the identity of the individual patient/ participant/ client, e.g., ID number, date of service, etc., before releasing any information. A written request signed by the patient/participant/client or representative will be required to release medical records. Additionally, all requests for confidential information not directly related to scope of patient/participant/client management program will be in writing, stating the requester's name, the specific information being requested and how the information will be used and no additional information will be released other than that which is requested.

Section 4.23
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 EMANATE HEALTH IPA missed appointment, lack of payment for co-payments and owe balance or deductibles, as applicable.

The following procedures will be followed when a Provider attempts to charge a Member for any missed appointment:

1. EMANATE HEALTH IPA will call the Provider and educate regarding the inappropriate practice of charging for a missed appointment.
2. If a Provider insists on charging the Members, EMANATE HEALTH IPA will send a letter educating the Provider, which includes a reference to Title 22 § 51002 of the California Administrative Code that prohibits Providers of service from billing Medi-Cal Members at EMANATE HEALTH IPA sole discretion, EMANATE HEALTH IPA can provide the Member with a toll-free number to report the Provider for Medi-Cal fraud.

3. If a Provider continues the practice of charging for missed appointments, EMANATE HEALTH IPA will contact the health plan and request that a DHCS Fraud Investigator contact the Provider.
4. Under no circumstances can a Provider deny service to a Member for nonpayment
    a. of a missed appointment charge.

Providers can charge EMANATE HEALTH IPA members a nominal fee of $20 for filling out any of the following forms:

1. History and Physical form that is school specific and the PM 160 will not meet the school requirement;
2. Sports Physical;
3. Disability forms; and
4. Utility Company Medical Baseline Program Applications.

A Health Care Provider that is not paid at billed charges may not pursue any balance billing or collection actions against any EMANATE HEALTH IPA Member. Such collections actions may include:

1. Sending or mailing bills to Member;
2. Calling the member with demands to pay outstanding balance;
3. 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, EMANATE HEALTH 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 EMANATE HEALTH IPA takes all necessary actions, up to and including termination of the Provider's participation with the network to ensure that such actions stop.

Section 5
Member and Provider Satisfaction Surveys

EMANATE HEALTH IPA and its network partners are constantly making strides to improve satisfaction for their members and 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 allows EMANATE HEALTH IPA and Network Medical Management to evaluate and improve the quality of their services.

Network Medical Management's Provider Relations staff will work with contracted providers on key member satisfaction survey questions (e.g., access, overall satisfaction, specialty access) and will distribute member satisfaction survey results to contracted providers upon completing their analysis.

Section 6.1
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., health plan guidelines, MCG [formerly Millikan], 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 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 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 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 6.2
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 Manager Mitch Agorrilla at (877) 282-8272 ext. 6088. 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 6.3
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. Providers are able to submit retro requests 30 days after date of service. Thereafter, requests should be submitted in a form of a claim along with supporting documentation. Providers are able to submit authorization referral requests 24 hours a day/7 days a week. 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) business days
Routine within five (5) business days
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.

Section 6.4
Authorization Process

Providers wishing to submit an authorization referral request can log in to the Network Medical Management Web Portal at **www.nmm.cc/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.
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.
3. If an authorization is pended, a form is faxed to the requesting provider requesting additional information within 24 hours of the decision.

   a. If the case is pended for additional medical information, requests will be upheld no longer than five (5) business days for routine and 24 hours if marked as urgent. There will be notification to requesting providers within 24 hours of the decision.
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 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.

Section 6.5
Treatment Authorization Request (TAR)

All Treatment Authorization Requests must be submitted on a Treatment Authorization form which is available in Section 28 Forms of this manual.

Section 6.6
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). See section 26 Forms in this manual.

Section 6.7
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 consult Cardiac

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

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

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 secondary 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) 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
- 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 6.8
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 The service does not meet utilization review criteria or benefits
    b. The member is not eligible
    c. The service is not a covered benefit (this includes "Carve-Out" plans)
    d. 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; Monday through Friday between the hours of 9.30am to 2.30 pm. All calls will be returned within 24 hours.

Section 6.9
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 upholds 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
Contracted Laboratory

Laboratory and Radiology services must be done at contracted facilities through Emanate Health Foothill Presbyterian, Emanate Health Queen of the Valley and Emanate Health Intercommunity Hospital.

Reports will be delivered to provider offices via courier service. You can also view reports via Emanate Health Meditech Expanse system. Please contact Emanate Health Service Desk at (626) 813-4989 or email ServiceDesk@EmanateHealth.org for access. For additional help please contact Mary C. Fernandez at MFernandez@EmanateHealth.org.

Covered California Members Health Net and Blueshield –Services to these members can be done at the facilities listed above through Emanate Health Foothill Presbyterian, Emanate Health Queen of the Valley and Emanate Health Intercommunity Hospital **ONLY** if services are pre-authorized.

Lab pick-ups – Specimens pick-up available by courier must make arrangements with Roxana Robles. Email rrobles@emanatehealth.org.

IMPORTANT DISCLAIMER: Practices may be held responsible for all charges if they use or send a EMANATE HEALTH IPA member to an outside/non-contracted laboratory.

Section 8
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.

Section 9
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 [1]
- 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 details, consult the "Which Children are Eligible" section.

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

Figure 1. Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2018.
(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE [FIGURE 2]).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded in gray.

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19-23 mos	2-3 yrs	4-6 yrs	7-10 yrs	11-12 yrs	13-15 yrs	16 yrs	17-18 yrs
Hepatitis B[1] (HepB)	1st dose	←2nd dose→			←3rd dose→												
Rotavirus[2] (RV) RV1 (2-dose series); RV5 (3-dose series)			1st dose	2nd dose	See footnote 2												
Diphtheria, tetanus, & acellular pertussis[3] (DTaP: <7 yrs)			1st dose	2nd dose	3rd dose			←4th dose→				5th dose					
Haemophilus influenzae type b[4] (Hib)			1st dose	2nd dose	See footnote 4		←3rd or 4th dose, See footnote 4→										
Pneumococcal conjugate[5] (PCV13)			1st dose	2nd dose	3rd dose		←4th dose→										
Inactivated poliovirus[6] (IPV: <18 yrs)			1st dose	2nd dose	←3rd dose→							4th dose					
Influenza[7] (IIV)					Annual vaccination (IIV) 1 or 2 doses								Annual vaccination (IIV) 1 dose only				
Measles, mumps, rubella[8] (MMR)					See footnote 8		←1st dose→					2nd dose					
Varicella[9] (VAR)							←1st dose→					2nd dose					
Hepatitis A[10] (HepA)							←2-dose series, See footnote 10→										
Meningococcal[11] (MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos)			See footnote 11											1st dose		2nd dose	
Tetanus, diphtheria, & acellular pertussis[13] (Tdap: ≥7 yrs)														Tdap			
Human papillomavirus[14] (HPV)														See footnote 14			
Meningococcal B[12]															See footnote 12		
Pneumococcal polysaccharide[5] (PPSV23)														See footnote 5			

Range of recommended ages for all children | Range of recommended ages for catch-up immunization | Range of recommended ages for certain high-risk groups | Range of recommended ages for non-high-risk groups that may receive vaccine, subject to individual clinical decision making | No recommendation

NOTE: The above recommendations must be read along with the footnotes of this schedule.

References: https://www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf

Section10
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 immunizations 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

Section 11.1
Quality Improvement – Health Effective Data & Information Set (HEDIS) Overview

Health Care Effectiveness Data and Information Set (HEDIS) is a nationally used set of measures utilized by health plans to measure healthcare performance.

The measures are provided through technical specifications set forth by The National Committee of Quality Assurance (NCQA). NCQA provides the oversight of the clinical and technical knowledge that evolve and develop the HEDIS measurement sets.

Each health plan implementing HEDIS are 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 population and provide this reporting on their internal websites, and marketing materials.

Health Plan organizations collect data for Commercial HMO and PPO, Medicaid, Medicare HMO and PPO, Health Net Cal MediConnect Plan (Medicare-Medicaid), and Exchanges (Marketplace) PPO, EPO and HMO lines of business. NCQA HEDIS Technical Specifications determines the measures reported for each line of business.

Section 11.2
MEASURES AND CATEGORIES

NCQA allows three methods for calculating the rate of a measure. Measures can fall into one of three categories; administrative, hybrid or medical record only. In addition, each measure has a timeframe specification that every health plan must adhere to. The timeframe or look back period may go beyond the measurement year.
Administrative measures are defined as measures that can only be collected through encounter/claims, supplemental and pharmacy sources. The measures are reported on the entire membership across each line of business.

The following are administrative measures:

- ☐ Breast Cancer Screening (BCS)
- ☐ Asthma Medication Ratio (AMR)
- ☐ Chlamydia Screening in Women (CHL)
- ☐ Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)
- ☐ Appropriate Testing for Children with Pharyngitis (CWP)
- ☐ Osteoporosis Management in Women Who Had a Fracture (OMW)
- ☐ Appropriate Treatment for Children with Upper Respiratory Infection (URI)
- ☐ Use of Imaging Studies for Low Back Pain (LBP)
- ☐ Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)
- ☐ Annual Monitoring for Patients on Persistent Medications (MPM)
- ☐ Pharmacotherapy Management of COPD Exacerbation (PCE)
- ☐ Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
- ☐ Use of Appropriate Medications for People with Asthma (ASM)
- ☐ Plan all Cause Readmission (PCR)
- ☐ Medication Management for People with Asthma (MMA)
- ☐ Adults Access Preventive/Ambulatory Health Services (AAP)
- ☐ Use of Spirometry Testing in

Hybrid measures are defined as measures that can be collected through

encounter/claims, supplemental sources, pharmacy sources *and* medical record review. Annually each health plan is required to collect a sample of the eligible population via medical record review between December and May.

The following are hybrid measures:

- Adult Body Mass Index (ABA)
- Care of Older Adults (COA)
- Childhood Immunization Status (CIS)
- Comprehensive Diabetes Care (CDC)
- Immunizations for Adolescents (IMA)
- Medication Reconciliation Post Discharge (MRP)
- Cervical Cancer Screening (CCS)
- Prenatal and Postpartum Care (PPC)
- Colorectal Cancer Screening (COL)
- Lead Screening in Children (LSC)
- Human Papillomavirus Vaccine for Female
- Adolescents (HPV)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)

Section 11.3
Primary Care Physician – HEDIS Engagement

All contracted PCP's 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. Gaps in Care reports & other adhoc reports will be provided electronically to the PCP on a quarterly basis.

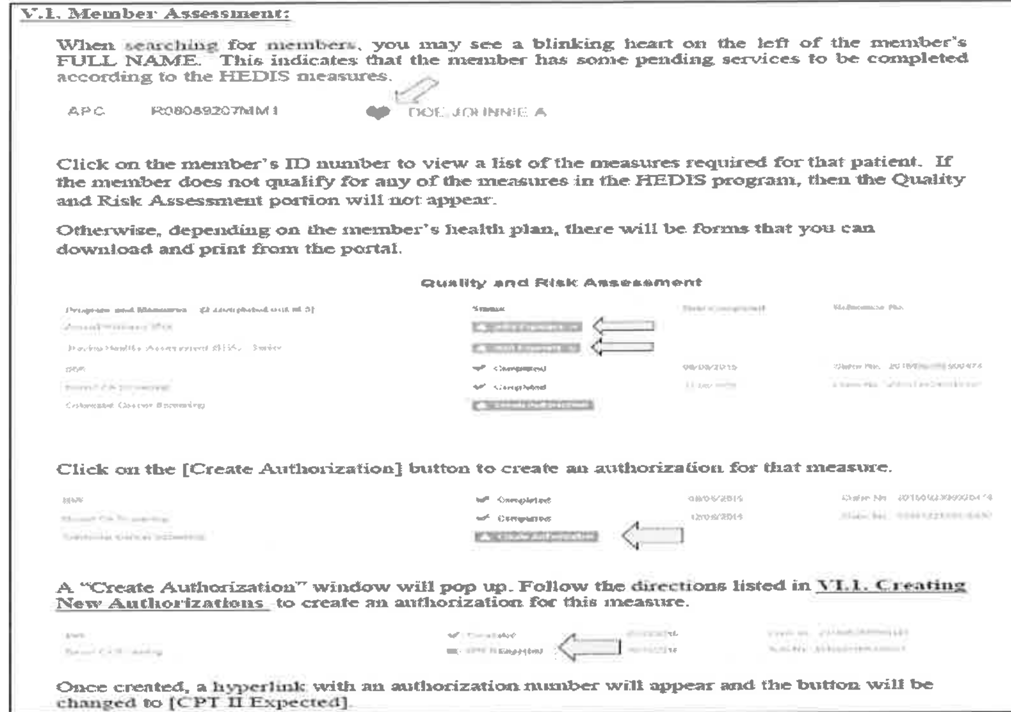
The PCP and IPA network will review the GIC reports to address the following:

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. 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.

Example) NMM Web Portal Image: HEDIS indicator



V.I. Member Assessment:

When searching for members, you may see a blinking heart on the left of the member's FULL NAME. This indicates that the member has some pending services to be completed according to the HEDIS measures.

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Click on the member's ID number to view a list of the measures required for that patient. If the member does not qualify for any of the measures in the HEDIS program, then the Quality and Risk Assessment portion will not appear.

Otherwise, depending on the member's health plan, there will be forms that you can download and print from the portal.

Quality and Risk Assessment

Click on the [Create Authorization] button to create an authorization for that measure.

A "Create Authorization" window will pop up. Follow the directions listed in VI.1. Creating New Authorizations to create an authorization for this measure.

Once created, a hyperlink with an authorization number will appear and the button will be changed to [CPT II Expected].

Section 12.1
Initial Health Assessment

An "initial health assessment," or a visit that occurs soon after a member enrolls, is the key to early identification of health problems, treatment, and establishing a strong relationship between the provider and the new member. For many members who are new to managed care or are unfamiliar with the importance of preventive care, initial health assessments don't always take place.

The Initial Health Assessment must be performed using the age-appropriate DHS-approved assessment tools. DHS has standardized assessment tools (Staying Healthy Assessment [SHA]) to be administered during office visits, reviewed at least annually and re-administered by the doctor at the appropriate age intervals. The initial health assessment must consist of a history and physical examination with an individual health education behavioral assessment that enables a provider to comprehensively assess the member's current acute, chronic and preventive health needs.

The Staying Healthy Assessment (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 Staying Healthy Assessment (SHA) are to assist IPA 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.

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.

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.

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

- Schedule every new member for the initial health assessment within the identified timeframe (see “Mandated Timeframes” section below).

- 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.
- Provide documentation of all attempts to schedule an initial health assessment, including the follow-up or missed and broken appointments, and periodic preventive screenings.

Section 12.2 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 provider is responsible for adequately documenting appropriate referrals made to linked and carved-out service programs, including CCS, Department of Mental Health, Regional Centers, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Supplemental Services as well as basic care management/care coordination efforts.

	Policies and Procedures **Utilization Management Department**

Policy Number:	**Policy Name: Initial Health Assessment**

☒ **Cal-MediConnect** ☒ **Commercial** ☐ **Medicare Advantage** ☒ **MediCal**

Date Approved by UMC:		**Effective Date:**	**10/1/2018**
		Replaces Policy	
Revision Date:		**Last Approval Date:**	
Signature:	(on-file)		

PURPOSE:

An IHA consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA). An IHEBA enables a provider of primary care services to comprehensively assess the member's current acute, chronic, and preventive health needs as well as identify those members whose health needs require coordination with appropriate community resources and other agencies for services not covered under Managed Care Plan (MCP) contracts.

Section 12.3
Staying Healthy Assessment

The Staying Healthy Assessment (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 Staying Healthy Assessment (SHA) are to assist IPA 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.

To reduce the prevalence of chronic disease for Managed Care Plan members and decrease costs over time, MCP providers should use the SHA to identify health-risk behaviors and evidence-based clinical prevention interventions that should be implemented. Managed Care Plans and IPAs will use interventions that combine patient education with behaviorally oriented counseling to assist members with acquiring the skills, motivation, and support needed to make healthy behavioral changes.

DHCS recently updated the SHA in collaboration with MCP representatives and providers. All assessment questions were updated in accordance with the **guidelines of the US Preventive Services Task Force** and other relevant governmental and professional associations.

POLICY:

Network Medical Management IPAs must ensure that each member completes an IHA and SHA as a component of IHA in accordance with the following guidelines and timeframes prescribed below (Also Refer to Table 1):

- **New Members**

  New MediCal and CalMediConnect members 18 months and older must complete the IHA inclusive of SHA within 120 days of the effective date of enrollment as part of the IHA. The effective date of enrollment as defined by DHCS

is the first day of the month following notification by the Medi-Cal Eligibility Data System (MEDS) that a member is eligible to receive services from the Health Plan and IPAs.
For NMM affiliated IPAs, MediCal, Covered California and CalMediConnect eligibility date is defined by the health plans and IPAs will follow that date. Timeframes for completion of IHAs are as follows:

- **New members under 18 months must complete IHA within 60 days of enrollment.**
- **IHAs should be completed within 90 Days for Covered California Members.**
- **IHAs should be completed for Medical members older than 18 months and CMC members within 120 days of being eligible to receive services from the Health Plans.**

- **Current Members**

  Current members who have not completed an updated SHA must complete it during the next preventive care office visit (e.g. well-baby, well-child, well-woman exam), according to the SHA periodicity table.

- **Pediatric Members**

  Members 0–17 years of age must complete the SHA during the first scheduled preventive care office visit upon reaching a new SHA age group. PCPs must review the SHA annually with the patient (parent/guardian or adolescent) in the intervening years before the patient reaches the next age group.

- **Adolescents**

  Adolescents (12–17 years) should complete the SHA without parental/guardian assistance beginning at 12 years of age, or at the earliest age possible to increase

  the likelihood of obtaining accurate responses to sensitive questions. The PCP will determine the most appropriate age, based on discussion with the parent/guardian and the family's ethnic/cultural background.

- **Adult and Senior Members**

  There are no designated age ranges for the adult and senior assessments, although the adult assessment is intended for use by 18 to 55 year olds. The age at which the PCP should begin administering the senior assessment to a member should be based on the patient's health and medical status, and not exclusively on the patient's age. The adult or senior assessment must be re-administered every 3 to 5 years, at a

minimum. The PCP must review previously completed SHA questionnaires with the patient every year, except years when the assessment is re-administered.

- **Provider Requirements:**

A. Primary Care Physicians (PCPs), with assistance from their IPAs, are required to schedule and provide an IHA within sixty (60) days, ninety (90) days or one hundred twenty (120) days of enrollment for Members, depending on the line of business as indicated above.

B. NMM requires PCPs to have processes in place to notify and facilitate access to IHA's for Medi-Cal Members.

C. NMM and IPAs require that PCPs maintain documentation of all attempts to inform Member of the need for an IHA.

D. NMM and affiliated IPAs require PCPs to adhere to the current edition of the Guide to Clinical Preventive Services of the U.S. Preventive Services Task Force for preventive services for asymptomatic healthy adults.

E. NMM requires that PCPs provide preventive services for Members under age 21 as specified by the most recent American Academy of Pediatrics (AAP) and/or Child Health and Disability Prevention (CHDP) Program age-specific guidelines.

POLICY SCOPE

The IHA policy covers the following populations:

1) MediCal members
2) Covered California members
3) Cal Medi-Connect Members

DEFINITIONS:

1) **DHCS-** California Department of Healthcare Services.

2) **IHA-** Initial Health Assessment. IHA is a comprehensive Assessment that is completed during the member's initial encounter with a selected or assigned primary care physician (PCP), appropriate medical specialist, or non-physician medical provider and must be documented in the member's medical record. The IHA allows the Primary Care Provider and member to meet, identify, and address current care needs, and form a working partnership toward managing the member's health.

3) **IHEBA -** the Individual Health Education Behavioral Assessment developed by the Department of Health Care Services (DHCS). The IHEBA is a required component of the Initial Comprehensive Health Assessment (IHA). An IHEBA enables a provider of primary care services to comprehensively assess the member's current acute, chronic, and preventive health needs as well as identify those members whose health needs require coordination with appropriate community resources.

4) **MEDS-** Medical Eligibility Data System. Determine member eligibility and date due for the IHA.

5) **SHA-** Staying Healthy Assessment. The SHA is the Individual Health Education Behavioral Assessment (IHEBA) developed by the Department of Health Care Services (DHCS). SHA forms are now usually used instead of IHEBA forms during IHAs.

PROCEDURE

A) An IHA consists of the following components:

1. Behavioral history - review of pertinent health related behaviors including smoking, alcohol and drug use, exercise, etc.
2. Review of past medical and social history;
3. Review of systems - review of signs and symptoms related to all major organ systems;
4. Review of current medication use;
5. Review of preventive services - review of status of Member in terms of needed preventive services (e.g., immunizations, PAP test). The needed preventive services should either be provided on the day the IHA is performed, or additional visits scheduled to provide them;
6. Physical exam (including mental status) sufficient to assess the Member's acute, chronic, preventive health needs, and psychosocial needs;
7. Diagnostic tests - ordering of appropriate diagnostic tests, as needed; and
8. Development of Problem List and Medication List, if appropriate.
9. Recommended SHA questionnaire to be used and placed in Medical Records. The SHA forms are available at: http://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx

B) All Members must receive the Staying Healthy Assessment (SHA) during their IHA.

C) PCPs, in collaboration with their IPA, are responsible for informing Medi-Cal Members of the need for an IHA. Following steps will be taken by IPA to assist the PCPs:
   a. PCPs will be provided with an IHA education flyer with receipt of their eligibility lists each month.
   b. New members enrolled with PCPs will be identified on their eligibility lists?
   c. **Member Services Department Activities for IHA and Member Education:**
      i. New member Eligibility lists are provided to NMM's member services department each month.
      ii. Member services department staff will call all new members to:
         1. Notify then of the need for an IHA
         2. Availability of IHA and visiting their Primary Care Physician within the 60 or 120 days as deemed necessary.
      iii. Member services will make 3 call attempts to reach the member.
      iv. If member is not reached after 3 attempts, a postcard reminder for IHAs will be mailed to the member.

D) PCPs are responsible for assessing Medi-Cal Members of the need for and scheduling of, if necessary, an IHA at any time they see the Member for an acute or chronic illness visit prior to performing the IHA. If the Member has had a comprehensive health assessment within twelve (12) months, the PCP must document the specifics in the medical record.

E) PCPs are responsible for follow-up of missed appointments, for the IHA for all Members.

F) PCPs are responsible for arranging follow-up visits or referrals for their Members that have significant health problems identified during the IHA.

G) Providers can access their provider portal for a current list of Members eligible for an IHA.

H) Exceptions From IHA Requirements:
   a. Completed 12 months prior to enrollment: If all IHA elements were completed within 12 months prior to the member's effective date of enrollment. If the member's newly assigned PCP did not perform the IHA, the PCP must record that findings have been reviewed and updated accordingly.
   b. Members not continuously enrolled in the plan for required number of days.
   c. Disenrolled members: If members were disenrolled before IHA due date.

d. Members refusing IHA: Must be recorded in Medical Record.
e. Missed Scheduled appointment and two documented attempts to reschedule have been unsuccessful.

I) Provider Education:

a. IHA Flyer Distribution
b. Flyer includes detailed information on IHA requirements and elements to be covered by PCPs.
c. The following items are also a component of PCP Education.
    i. Instructions on how to use the SHA or DHCS approved alternative assessment.
    ii. Documentation requirements.
    iii. Timelines for administration, review, and re-administration.
    iv. Specific information and resources for providing culturally and linguistically appropriate patient health education services/interventions.
    v. Specific information regarding SHA resources and referral.
d. Notification of members needing IHA in provider portal.
e. New provider in service to include detailed information on completing IHAs
f. IHA information on NMM website.

J) Monitoring IHA performance by Network PCPs:

a. Quarterly review of a sample of medical records for high volume PCPs to assess IHA performance.
b. Health Plan assessment tool will be used.
c. Deficiencies will be recorded and providers notified of their results.

REFERENCES

1) Initial Health Assessment, Title 17 Section 6846-6847, Title 22, CCR, Section 53851 (b)(1)
2) MMCD Policy Letter 08-003. http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL%202008/PL08-003.PDF.
3) MMCD Policy Letter 13-001. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2013/PL13-001.pdf

ATTACHMENTS:

1) Table 1- SHA Periodicity
2) Table 2- IHA Visit Codes

3) Table 3-IHA Provider Education Flyer

TABLE 1 **SHA PERIODICITY**

Forms	Periodicity	Administer	Administer/Re-administer		Review
DHCS Form SHA Form Numbers Alternatively IHEBA forms may be used.	Age Groups	Within 120 (Or 60 days for Ages 0-6 Months) Days of Enrollment	1st Scheduled Exam(After Entering New Age Group)	Every 3- 5 Years	Annually (Intervening Years)
DHCS 7098 A	0-6 Months	√	√		
DHCS 7098 B	7-12 Months	√	√		
DHCS 7098 C	1-2 Years	√	√		√
DHCS 7098 D	3-4 Years	√	√		√
DHCS 7098 E	5-8 Years	√	√		√
DHCS 7098 F	9-11 Years	√	√		√
DHCS 7098 G	12-17 Years	√	√		√
DHCS 7098 H	Adult	√		√	√
DHCS 7098 I	Senior	√		√	√

Table 2

IHA VISIT CODES

IHA Visit Codes Description	CPT or Diagnosis Code(s)
OFFICE/OUTPATIENT VISIT NEW	99201, 99202, 99203, 99204, 99205
OFFICE/OUTPATIENT VISIT EST	99211, 99212, 99213, 99214, 99215
OFFICE CONSULTATION	99241, 99242, 99243, 99244, 99245
NURSING FACILITY INIT	99304, 99305, 99306
DOMICILE/R-HOME VISIT NEW PAT	99326, 99327, 99328
HOME VISIT NEW PATIENT	99341, 99342, 99343, 99344, 99345
HOME VISIT EST PATIENT	99348, 99349, 99350
INIT PM E/M NEW PAT INFANT	99381
INIT PM E/M NEW PAT 1–4 YRS	99382
PREV VISIT NEW AGES 5–11	99383
PREV VISIT NEW AGES 12–17	99384
PER PM REEVAL EST PAT INFANT	99391
PREV VISIT EST AGE 1–4	99392
PREV VISIT EST AGE 5–11	99393
PREV VISIT EST AGE 12–17	99394
BEHAV CHNG SMOKING 3–10 MIN	99406
BEHAV CHNG SMOKING > 10 MIN	99407
INIT NM EM PER DAY NON-FAC	99461
History and Physical, new patient; age 12–20 years	C001A
History and Physical, routine; age 12–20 years	C001B
History and Physical, new patient; age 5–11 years	C002A
History and Physical, routine; age 5–11 years	C002B
History and Physical, new; age 1–4 years	C003A
History and Physical, routine; age 1–4 years	C003B
History and Physical, new; age 0–1 year	C004A
ALCOHOL AND/OR DRUG SCREENING	H0049
ALCOHOL AND DRUG SRVC BRF PER 15 MIN	H0050
COMP MULTIDISCIPLINARY EVALUATION	H2000
INITIAL ANTEPARTUM OFFICE VISIT	Z1032
INITIAL NUTRITIONAL ASSESSMENT/DE	Z6200
SUBSEQUENT NUTRITIONAL ASSESSMENT	Z6202
INIT PSYCHOSOCIAL ASSESS/DEVEL FIRS	Z6300
NEW CLIENT ORIENTATION EA 15 MIN	Z6400
INITIAL HEALTH ED ASSESS/DEVELOP 30	Z6402
SUB HEALTH ED ASSESS/DEVELOP 15 MIN	Z6404
INITIAL COMPREHENSIVE NUTRITION	Z6500
ENCOUNTER FOR GENERAL ADULT MEDICAL EXAMINATION WITHOUT ABNORMAL FINDINGS	Z00.00
ENCOUNTER FOR GENERAL ADULT MEDICAL EXAMINATION WITH ABNORMAL FINDINGS	Z00.01
ENCOUNTER FOR ROUTINE CHILD HELATH EXAMINATION WITH ABNORMAL FINDINGS	Z00.121
ENCOUNTER FOR ROUTINE CHILD HEALTH EXAMINATION WITHOUT ABNORMAL FINDINGS	Z00.129
ENCOUNTER FOR OTHER GENERAL	Z00.8

EXAMINATION	
ENCOUNTER FOR OTHER ADMINISTATIVE EXAMINATIONS	Z02.89
ENCOUNTER FOR PRE-EMPLOYMENT EXAMINATION	Z02.1
ENCOUNTER FOR EXAMINATION FOR RECRIUTMENT TO ARMED FORCES	Z02.3

IHEBA/SHA Codes

Description	CPT Code
ASSESS HLT BEHAVE INITIAL/IHEBA/Staying Healthy Assessment (Initial)	96150
ASSESS HLT BEHAVE INITIAL/IHEBA/Staying Healthy Assessment (Subsequent Visits)	96151

INITIAL HEALTH ASSESSMENT (Within 120 Days upon Enrollment)

Elements to be included in Medical Records based on age.

For All Members

1. **The medical record reflects a SHA/IHEBA assessment has been conducted.**
2. The medical record reflects diagnostic, treatment and follow-up services for symptomatic findings or risk factors identified in the IHA within 60 days following discovery
3. **The medical record reflects TB screening for all applicable members**
4. If IHA has not been completed, the medical record reflects attempts to schedule IHA per Health Plan policy
5. If the IHA has not been completed due to Missed appointments, the medical record reflects documented missed appointments and at least two (2) attempts for follow-up, as appropriate

MEMBERS (Ages 0-21 yrs.)

1. For members under 21 years of age, the medical record reflects completion of an age appropriate IHA according to the most recent edition of the American Academy of Pediatrics (AAP) age specific guidelines and periodicity schedule.
2. The medical record reflects a dental screening /oral assessment and dental referral starting at age 3 or earlier, if warranted
3. The medical record includes documented lab testing for anemia, diabetes and/or urinary tract infection. (if applicable)
4. The medical record includes identification, treatment and follow-up on obese members
5. The medical record includes documented age-appropriate immunizations
6. **The medical record includes a documented testing for lead poisoning in IHA (if appropriate).** (Lead level checks at ages 12 mos. or 24 mos.) Lead level range-above 15 should be referred to Los Angeles Lead Program.[1]

Adult Members

1. For Asymptotic Adults, the medical record reflects completion of an age appropriate IHA according to the most current edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) as documented by a history & physical & review of organ systems.
2. The medical record includes colon and rectal cancer screening for adults 50 to70 years old
3. The medical record includes immunizations for adults as required

Female Members

1. The medical record includes a documented breast examination over the age of 40 years

2. The medical record includes a documented Mammogram at age 50 and over.
3. The medical record includes documented Osteoporosis screening for females 65 years and older.
4. Chlamydia screen for all sexually active females aged 24 and older who are determined to be at high-risk for Chlamydia infection using the most current CDC guidelines
5. Screening for cervical cancer in women age 21 to 65 years with cytology (Pap smear) every 3 years
6. The medical record reflects that the HPV immunization was offered to age appropriate females (9-26).

SPD/CMC Members

1. The Health Risk Assessment for the SPD member is present in the medical record.
2. The SPD member has received all necessary information regarding their treatment and services so that they can make an informed choice
3. The medical record reflects that the SPD member agrees with the plan for treatment and services

Section 13
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

Section 14
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 MediCal 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.

Section 15
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.

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 child bearing 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.

Section 16
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 MediCal members receiving Early start /Early Interventions at Regional centers.

Section 16.1
Referrals to the Early Start Program

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:

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

Section 16.2
Services Provided

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:

i. assistive technology
ii. audiology
iii. family training, counseling, and home visits
iv. health services
v. medical services for diagnostic/evaluation purposes only
vi. nursing services
vii. nutrition services
viii. occupational therapy
ix. physical therapy
x. psychological services
xi. service coordination (case management)
xii. social work services
xiii. special instruction
xiv. speech and language services
xv. transportation and related costs
xvi. vision services

Section 16.3
Coordination of Care

Member's medical records with their Primary Care Physician reflect collaboration between the Regional Center/Early Start/Early Intervention program 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.

Section 17
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).

Section 17
Alcohol and Substance Abuse; Screening, Brief Intervention, and Referral to Treatment (SBIRT) *continued...*

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.

Section 18
Quality Management

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.

Section 18.1
Quality Management Department

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
- 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.

Section 18.2
Health Education

Providers are encouraged to inform members about Health Education programs offered by Allied Pacific of California 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
- 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
- Weight Problems

NETWORK MEDICAL MANAGEMENT
HEALTH EDUCATION REFERRAL PROCESS

I. Complete Treatment Authorization Request (TAR).

II. Retain copy of TAR in Medical Record and document Health Education referral in progress notes.

III. Fax to Utilization Review Department at number specified on the TAR corresponding to Medical Group.

IV. Utilization Review Coordinators will enter into system and give an authorization number.

V. Utilization Review Coordinators will forward a copy of the TAR to QM/Health Education Department for tracking purposes only.

VI. 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.

VII. Loop closure will be via communication between health educator at the facility and QM coordinator with documentation of member attendance.

Health Education Material Request Form

If your office is in need of Health Education Materials, please fill out this assessment form and fax response to (626) 943-6383.

Provider Name: ______________________________
Provider Address: ______________________________
Provider Telephone: ______________________________
Provider Fax Number: ______________________________
Provider Health Plan Contracts: ______________________________

1. Would you like more information about health education classes?

   ________Yes ________No

2. Do you have health education materials in your office?

   ________Yes ________No

3. What sources have you used to obtain health materials?

   ____

4. Please Circle Health Education Materials needed in your office and specify languages

Advance Directive	Hypertension	Medi-Cal Materials
Asthma	Men's Health	Healthy Family
Breastfeeding	Nutrition	Staying Healthy
Cholesterol	Pregnancy	WIC Services
Congestive Heart Failure	STD's	Parenting
Depression	Stress Management	Other: ________
Diabetes Mellitus	Smoking Cessation	____________
Family Planning	Weight Management	
Gyn. Disorders	Women's Health	

English Spanish Chinese Other: __________

Completed by: ______________________ Sent: ______________________

NETWORK MEDICAL MANAGEMENT USE ONLY

Date Health Education Materials sent to Provider: ______________ By: ______________

Section 18.4
Grievances and Appeals 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' issue. Network Medical Management will contact the provider to obtain the information requested, which must be submitted within the tine guidelines mandated by each health plan.

Section 18.5
Access Criterion-Appointment and Time Elapsed Grid

Purpose
To define the standards for member access to routine/specialty appointments, preventive care, after hours, emergency care, telephone access and behavioral health needs.

Policy
It is the policy of Network Medical Management to provide access to members in accordance with California Managed Health Care Coalition, health plan and NCQA standards. Network Medical Management has adopted the DMHC access standards. Network Medical Management will make these Access Standards and any updates available via the Provider Manual and fax blasts.

Access Criterion-Appointment Type	NMM Time-Elapsed Standard
Preventive Care Appointment	Within 15 calendar days – 20 days for Medicare members and 30 calendar days for Medi-Cal for adults and within 10 calendar days for children (or with-in 120 days for adults of enrollment)
Specialty Appointment	Within 14 calendar days
Routine Primary Care Appointment	Within 7 calendar days
Access to PCP	24 hours a day, 7 days a week for all LOB
Urgent Care Appointment (PCP & SPC)	Within 24 hours If the urgent care appointment does not require prior authorization it is within 48 hours (24 hrs. for Medi-Cal) and if it does require prior authorization it is within 96 hours of the request for appointment, with some exceptions
Non-urgent Appointment (PCP & SPC)-excludes physicals and wellness checks	Non urgent appointments for PCP: within 10 business days (7 days for Medi-Cal) and SPC: within 15 business days of the request for appointment (15 days for Medi-Cal), with some exceptions
Well Child Exams/Physicals	Within 2 weeks
Non-urgent, acute illness	3 days or as directed by the provider
Timely Access-Advanced Access (PCP)	Includes appointments with a PCP or other qualified primary care provider such as NP or PA within the same or the next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the member prefers not to accept the appointment offered within the same or the next business day.
Sensitive Services	Sensitive Services must be made available to members preferably within 24 hours but not exceed 48 hours of appointment request.

	Sensitive Services are services related to: • Sexual assault • Drug or alcohol abuse • Pregnancy • Family Planning • Sexually Transmitted Disease • Outpatient mental health treatment and counseling • Minors under 21 years of age may receive these services without parental consult. • 1st prenatal visit must offer the appointment within 5 business days of request for Medi-Cal members. Confidentiality will be maintained in a manner that respects the privacy and dignity of the individual.
Ancillary Services	Non-urgent services for the diagnosis or treatment of injury, illness, or other health condition: within 15 business days of the request for appointment, with some exceptions
Emergency Care (In & Out of Area)	Immediate disposition of member to the appropriate care setting
After Hours Phone Emergency	Respond immediately and refer to 911/ER & addresses the needs of non-English speaking members
After Hours Phone Urgent	Respond within 30 minutes
After Hours Phone Non-Urgent	Respond within 24 hours every day
Telephone Access	Live person answers within 30 seconds, 24/7, call wait times to be answered <30 seconds, call abandonment rate quarterly average within 5%
Member Service Contact	By telephone
Waiting Time (PCP and SPC)	Preferably not to exceed 15 minutes in office waiting time for scheduled appointments otherwise no greater than 30 minutes.
Appointment Waiting Time	The time from the initial request for health care services by member or the member's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or medical group (if delegated) and completing any other condition or requirement of the plan or its contracting providers.
Initial Health Assessment (enrollee age 18 months and older)	Must be completed within 120 calendar days
Initial Health Assessment (enrollee age 18 months and younger)	Must be completed within 60 calendar days
Self-Referral for Preventive Care, Mammography exams+*, Flu Vaccine+*, Women's Health Care	Annually, *Direct Access: within the contracted network – no authorization required (Medicare)
ER approval for post-stabilization services	Automatically

Out of Area Temporary Urgently Needed Services	No authorization required (Medicare only)
Behavioral Health Access Criterion	**Network IPA/Medical Group Standard**
Life-threatening Needs	A member with life-threatening emergency needs is seen immediately.
Non-life-threatening Needs	A member with non-life-threatening emergency needs has access to care within 6 hours.
Urgent Needs	A member with urgent needs has access to care within 24 hours. If it does not require prior authorization it is within 48 hours & if it does, 96 hours from the request for appointment, with some exceptions.
Non-Urgent Appointment	Non-urgent appointments with a mental health care provider: within 10 business days of the request for an appointment (with some exceptions) and with a mental health care provider; within 10 business days of the request, with some exceptions.
Routine Needs	A member with routine needs has access within 10 working days.
Telephone Access	A member has telephone access to screening and triage; abandonment rates do not exceed 5% at any given time.
Follow-up Care Post-Hospitalization for Mental Illness	One follow-up encounter with a mental health provider within 7 calendar days after discharge and one follow-up encounter with a mental health provider within 30 calendar days after discharge (must provide both).

Network Medical Management defines the above criteria 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 19.1
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 45 days from date of service.

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

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

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

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

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

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

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

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

Commercial/ Marketplace= 2.5 – 3.5 per member per year (overall)

Medi-Cal = 4.5 - 5.00 per member per year (overall)
Medicare = 12.00 per member per year (overall)

Section 19.2
Claim Submission Guidelines

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

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

Reminders for claim submissions

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

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

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

Patient's and Insured's Information:

Box #	Instruction
1a.	Type the patient's ID Number or Social Security Number.

2.	Type the patient's Last Name, First Name, and Middle Initial (as shown on the patient's ID card).
3.	Type the patient's Date of Birth and Sex.
4.	Type Primary Insured's Name.
5.	Type patient's mailing address and telephone number.
6.	Patient relationship to insured (i.e. self, spouse, child, other)
9a.	Type other insured's policy or group number.
9d.	Type complete insurance plan and product. (I.e. Medicare, commercial, Medi-Cal).
11.	Type insured's policy or group number.
11c.	Type complete insurance plan and product (I.e. Medicare, commercial, Medi-Cal)
12.	Patient or authorized representative must sign and date this item, unless the signature is on file.
17.	Type or print the name of the referring or ordering physician (if applicable).
21.	Type or print the patient's diagnosis / condition. Please use the appropriate ICD-10 code number. ***Please use the highest 5-digit code applicable.***
23.	Type prior authorizations number for those procedures requiring professional review organization (PRO), prior approval, or attach Treatment Authorization Request (TAR).
24a.	Type the month, day, and year for each procedure service or supplies.
24b.	Type the appropriate place of service code number. Identify the location by either where the item is used or the service is performed.
24c	Type the procedure, service, or supply code number by using the CMS Common Procedure Coding System (HCPCS). If applicable, show HCPCS modifier with the HCPCS code. However, if you use an unlisted procedure code, include a narrative description.

Section 19.2
Claims Submission Guidelines *continued…*

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 19.3
Cleaning House Vendors

EMANATE HEALTH IPA and Network Medical Management have partnered with Office Ally as one of the methods for submitting encounters and claims. Providers are required to set up an account before they can start submitting all encounters and claims through Office Ally. Please see Section 11 of the Provider Manual (page 37) for more information on how to submit encounters and claims.

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

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

Reminders for claims submissions:

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

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

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

- Charges

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

Practices should note that payment is dependent on the submission of sufficient documentation (i.e., Operative Report, Patient Progress Report, notes and/or any other information on medical services or supplies). If information is insufficient, the claim may result in non-payment.

Section 19.4
Provider Disputes

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

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

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

I. Claim submission instruction.

Claim submission address must be sent to the following:

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

Alhambra, CA 91801

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

Call Network Medical Management, Claims department Customer Service at:

Telephone Number: (877) 282-8272

B. **Claim Submission Requirement**. The following is a list of claim timeliness requirement, claim supplemental information and claim documentation required based on your contract:
- ❖ Contracted Providers: 90 days from date of service
- ❖ Non-Contracted Providers: 180 days from date of service
- ❖ Supplemental or COB claims: 90 days from date of payment, date of contest, date of denial or notice from the primary payer.

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

I. Dispute Resolution Process for Contracted Provider

A. **Definition of Contracted Provider Dispute**. A contracted provider dispute is a provider's written notice to *Network Medical Management* and/or the member's applicable health plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim. Each contracted provider dispute must contain, at a minimum the following information: provider's name; provider's identification number; provider's contact information, and:

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

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

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

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

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

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

C. **Time Period for Submission of Provider Dispute.**

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

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

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

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

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

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

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

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

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

II. Dispute Resolution Process for Non-Contracted Provider

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

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

ii. If the non-contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the Date of Service, provider's position on the dispute, and an

enrollee's written authorization for provider to represent said enrollees.

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

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

III. Claim Overpayment

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

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

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

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

Payment Offset. Network Medical Management may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when; (i) the provider fails to reimburse Network Medical Management within the timeframe set forth in Section IV.C., above, and (ii) Network Medical Management contract with the provider specifically authorizes Network Medical Management to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, *Network Medical Management* will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS

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

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

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

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

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

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

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

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

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

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

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

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

Page _____ of _____

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

Section 19.5 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 which prohibits this practice and may be subject to sanctions by the IPA, CMS, DHCS and other industry regulators.

Emanate Health IPA has been tasked with ensuring all contracted network providers have participated in education on the prohibition of balance billing.

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

❖ **Purpose for this Training**

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

❖ **What is Balance Billing?**

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

❖ **When Can a Provider Bill?**

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

❖ **Prohibition of Balance Billing**

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

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

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

❖ **Resources and Information**

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

For more questions regarding Balance Billing, please contact below department:

Provider Relations Department
Direct Line: (626) 282-0288

Section 20
Electronic Remittance Advice (ERA)

1. PURPOSE:
   a. To effectively enroll eligible providers requesting to receive electronic remittance advice (ERA/835) files from NETWORK MEDICAL MANAGEMENT.

2. POLICY:
   a. It is the policy of NETWORK MEDICAL MANAGEMENT to provide eligible providers the means of receiving electronic remittance advice in lieu of paper. NETWORK MEDICAL MANAGEMENT has a standard procedure that is followed through to ensure provider registrations

for ERAs are processed in a timely manner.

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

3. PROCEDURE:
   a. Eligible providers will submit via email a fully completed ERA Enrollment form to ProviderNetworkOperations.Dept@nmm.cc
   b. All information provided from the submitted ERA Enrollment Form will be verified by the Provider Network Operations department. Any discrepancies in the form will be relayed back for corrections to the contact name provided from the enrollment form. Upon complete verification, submitted ERA Enrollment form will then be forwarded via email to Encounter.Data@nmm.cc with the subject line of ERA Registration.
   c. Testing Phases:
      i. Encounter team will coordinate with Rule meister and clearing house for first phase testing.
      ii. Once ERA testing has passed with the clearing house, second phase of testing will be performed with requesting provider.
      iii. Upon successful testing with provider, ERA will be moved into production.
   d. Changes and updates to this policy and procedure will be made on an as-needed basis
   e. Network Medical Management ERA Enrollment Form

**See section 28 for ERA form **

Section 21.1
Protecting Patient Privacy

Protecting the privacy of all members is essential to EMANATE HEALTH IPA and Network Medical Management. Information about our members must be maintained in the strictest confidence in compliance with Sections 1374.8 and 1399.900 et seq. of the California Health and Safety Code (www.ca.gov/HealthSafety/LawsAndRegs.html), Section 56.10 of the California Civil Code (www.leginfo.ca.gov/.html/civ_table_of_contents.html), and the Health Insurance Portability and Accountability Act (HIPAA). The HIPAA of 1996 addresses the efficiency and effectiveness of data exchange for financial and administrative transactions and the security and privacy of health care information. Key components of the regulations are: 1) privacy 2) transactions and code sets 3) security 4) unique identifiers, and 5) enforcement. HIPAA regulations require health plans, providers and health care clearinghouses to protect the privacy of protected health information (PHI). A summary of the HIPAA Privacy Rule can be found at:

www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html;

To ensure the most up-to-date information, providers should visit:
www.hhs.gov/ocr/privacy/index.html.

PHI includes information about a member's physical or mental condition, medical history or treatment and/or any one of the following:

- Social Security Number
- Family identification number
- Member number
- Address, or
- Any other member identification number or detail that would allow identification of the individual member

Some of the most important considerations and issues that practices should be aware of when dealing with confidentiality and PHI are listed as follows:

1. Except to the extent expressly authorized by the member, EMANATE HEALTH IPA practices may not intentionally share, sell or otherwise use any medical information for any purpose not necessary to provide the health care services to the member.
2. All personal and clinical information related to members is considered confidential. This may include, but is not limited to:
    a. Medical information relating to physical or medical condition.
    b. Medical history or medical treatment that provides sufficient detail to allow identification of the member and/or any one of the following:
        i. Social Security Number
        ii. Family identification number
        iii. Member name
        iv. Medical information collected during the utilization management process for the purposes of managing the quality of health care resources
        v. Claims records or files containing data pertaining to claims or certification of requested services, including member grievance materials, and
        vi. Member data collected during the enrollment and underwriting process
3. The fact that a member is established with EMANATE HEALTH IPA is not considered confidential.
4. Clinical information received verbally may be documented in a database. The database may include a secured system restricting access to only those with authorized entry.

Computers must be protected by a password known only to the computer user assigned to that computer. Computers will not be left unattended if any computer screen displays member or provider information.

5. Electronic, facsimile, or written clinical information received is secured, with limited access to employees to facilitate appropriate patient care. No confidential information or documents will be left unattended (e.g., open carts, bins, trays) at any time. Hard copies of all documents will not be visible during breaks or time spent away from desks.
6. Written clinical information will be stamped “confidential” with a warning that the information release is subject to State and Federal law.
7. Confidential information will be stored in a secure area and medical information will be disposed of in a manner that maintains confidentiality, i.e., paper shredding and destroying of recycle bin materials.
8. Any confidential information used in reporting to other departments or to conduct training activities, which may include unauthorized staff, will be “sanitized” (i.e., all identifying information blacked out), to prevent the disclosure of confidential medical information.
9. All records related to quality of care, unexpected incidence investigations, or other peer review matters are privileged communications under California Health & Safety Code section 1370 and California Evidence Code section 1157.
10. These records are maintained as confidential. All such written information will be stamped “confidential”, with a warning that release is subject to state and federal law. Information is maintained in locked files.

Privacy and Health Information Disclosure

Privacy regulations establish basic rights for members and their PHI. Regulations propose that members have a right to receive a written notice of information practices of the entity, and that they have a right to request and amend inaccurate or incomplete PHI. The entity must provide a means for individuals to lodge complaints about the entity's information practices.

Covered entities must designate a privacy official, develop a privacy training program for employees, and implement safeguards to protect PHI from misuse, and develop a system of sanctions for employees and business partners who violate the entity's policies and procedures.

Confidential Information: Release to the Member

1. No written request is required for information/documents that the member would normally have access to, such as copies of claims.
2. EMANATE HEALTH IPA will substantiate the identity of the individual member by identifying their ID number, date of service, etc. before releasing any information.
3. A written request signed by the member or representative will be required to release medical records.
4. All requests for confidential information not directly related to scope of the member management program will be in writing, stating the requester’s name, the specific information being requested and how the information will be used.

5. Information will be limited to only those person(s) who have a need to know and/or as required by law.
6. No additional information will be released other than that which is requested.

Section 22.1
Cultural and Linguistic Services

1) 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 IPA.

PCP Responsibility for Cultural & Linguistic Services

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 Allied Physicians 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.

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 22.3
Interpreter Services

Protocol to Request a Face to Face Interpreter

When is face-to face interpretation recommended?

- To explain complex medical consultation or education (i.e. medical diagnosis, treatment options, insulin instructions, etc.) to a limited- English proficient (LEP) or hearing impaired member.
- When an LEP or hearing impaired member requests it.

Please follow these instructions when requesting a face to face interpreter for a Health Plan member, including for the hearing impaired:

- Provider must call the member's designated health plan as listed below

NO LESS THAN 7 DAYS IN ADVANCE.

- The provider must verify the member's eligibility. Once eligibility is verified, the provider will arrange for an interpreter.
- Please have the following information ready:

    1. Provider's Name
    2. Provider's Telephone Number
    3. Contact Person
    4. Language requested (including American Sign Language)
    5. Patient's Name and ID Number
    6. Patient's Gender
    7. Date of Appointment
    8. Time of Appointment
    9. Type of Appointment (i.e. routine exam, specialist, OB/GYN, etc.)
    10. Duration of Appointment
    11. Location of Appointment

- Please make sure to provide your member with date and time of appointment.

Health Plan	Contact Number
Blue Cross Medi-Cal	1-800-407-4627
Care 1st Health Plan	1-800-605-2556
Health Net Medi-Cal	1-800-977-3073
L.A Care Health Plan	1-888-450-2272
Molina Health Care	1-800-526-8196 ext. 4247

PLEASE CONTACT THE DESIGNATED HEALTH PLAN AT LEAST 24 HOURS IN ADVANCE IF THE APPOINTMENTHAS BEEN CANCELLED OR RESCHEDULED.

Section 22.4
Language Line Services Guidelines

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.

Log In 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.

❖ 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 A. Press 1 for Spanish.
❖ Say “help” if you encounter a problem. Your call will be transferred to a representative.

3 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 form for Interpretive Services and place in the member's medical records.

Section 22.5
Request/Refusal Form for Interpretive Services

Patient Name: ____

Primary Language: ____

- ☐ Yes, I am requesting interpretive services.

  Language: ____

- ☐ I prefer to use my family or friend as an interpreter. (Interpreters must be over 18 years of age)
- ☐ No, I do not require interpretive services.
- ☐ N/A

  Please explain:
  ____
  ____
  ____

______________________________ ______________________
Patient Signature Date

- Please place in patient's medical record.

Other languages are available upon request. (Spanish, Chinese, Vietnamese, Armenian, Russian, Khmer)

Section 23.1
Credentialing and Re-credentialing Policy and Procedure

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.

EMANATE HEALTH IPA requires all Contracted Provider to maintain practice licensures in compliance with State or CMS requirements. All Contracted Providers and Mid-Level providers shall be processed through the IPA Credentialing Committee before seeing assigned members (assigned to the IPA). Contracted Providers and Mid-Level providers must maintain licensure and comply with re-credentialing requirements in order to maintain Contracted Provider status.

Procedure

1. The Credentialing Committee is responsible for making decisions regarding provider credentialing. The Credentialing Coordinator 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. Clear copies of permit to supervise/operate radiology/fluoroscopy (if applicable)
    f. Board Certification Certificates (if applicable)
    g. Certificates of Degree Completion (i.e., medical or dental school)
    h. Internships and Residency certificates of completion

i. A copy of Educational Commission for Foreign Medical Graduates (ECFMG), if applicable
j. CPR or PALS Card
k. Activity Report from another clinic/hospital for the previous two years
l. Proof of 50 hours of Category I continuing medical education activities for the previous two (2) years. Copies of actual certificates/hospital verification of course attended (CMA printout card containing hours only is not acceptable)
m. Addendum A
n. Addendum B (as applicable)
o. Addendum C
p. Provider Rights
q. HIV Designation Form
r. Completed Privileging form (as applicable)
s. Delegation of Service Agreements (mid-levels) (as applicable)
t. Forms of identification issued by state or federal agency
u. Social Security Card
v. National Provider Identifier
w. 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 Credentialing Department at (877) 282-8272 ext. 6267.

Section 24
Medical Records Policy and Procedure

I. Purpose
To assure timely, consistent and complete medical record documentation that is detailed, organized, allows effective patient care, quality review, appropriate health management and is in compliance with NCQA Standards.

II. Policy
It is the policy of Network Medical Management to ensure that the medical record is maintained in a manner that is consistent with legal requirements and permits effective, timely and confidential care and service. It is the policy of Network Medical Management to distribute this policy to all providers and to ensure its providers comply with these standards.

1. The records serve as the basis for planning and maintaining the quality of care. Records that are devoid of pertinent medical information may impact other treating providers 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)
2. Reimbursement for services may be limited or denied unless documentation supports the level of care that the provider is charging for.
3. Incomplete medical records documentation may interfere with the ability to perform peer review and therefore maintain quality health care delivery and may subject the provider to disciplinary action or severe sanction by outside review agencies.
4. The medical records are often a provider's best evidence in a professional liability lawsuit. Inadequate medical records may undermine a provider's ability to defend themselves.
5. It is recommended that each practice employ a process for ensuring that pertinent medical information pertaining to medical and non-medical services rendered to members is available at each 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 Medicare 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 member'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).

6. 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).
7. The chart should be maintained and organized in the following manner:
    a. An individual record is maintained for each member. Each member medical record will be individualized, format standardized, organized and secure and permit effective confidential member care and quality review.
    b. Each member 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.
    c. Member identification is on each page, which includes first and last name, and or unique member number established for use on clinical site. Electronically maintained records and printed records from electronic systems contain member identification.
    d. 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.
    e. 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 the member is a minor, the emergency contact must be a parent or guardian. If the member refused to provide information, "refused" is noted in medical record.
    f. Entries must contain author authentication including title and date.
    g. Entries must be legible to someone other than the writer.
    h. Medical records are consistently organized, content and formats of printed and or/electronic records within the practice site are uniformly organized.
    i. Charts contents are securely fastened.

j. There must be evidence that Advanced Health Directive or evidence information has been offered and discussed to adult member 18 years of age and over.
k. Documentation to occur within 24 hours of member visit.
l. 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.
m. 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.
n. 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 provider such as home health nursing reports, specialty provider reports, hospital discharge reports and physical therapy reports.
o. 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.
   History of present illness is documented. Physical exam to be documented related to presenting complaint.
p. Diagnosis or medical impression, clinical findings and evaluation to be documented regarding each visit.
q. Plan of treatment to be documented and to be consistent with findings and care is medically appropriate.
r. Follow-up plan and date of return visit, if indicated is noted specifically in weeks, months, or as needed.
s. 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 if that member 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 providers participating in member's care and information on services they render.
t. Evidence of appropriate 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.
u. Missed/failed appointments, 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. Provider documents intervention in the medical records.

v. 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).
w. Documentation shall substantiate medical care rendered.
x. 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.
y. 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.
z. The member's primary language will be noted in the medical record.
aa. Linguistics needs for non-English speaking 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.
bb. Tracking of record location when out of filing system will be accomplished way of a tickler system indicating chart whereabouts.
cc. Medical record data obtained between visits will be forwarded to the PCP's office for review and incorporation into the member's chart.
dd. Adult members (18 years and older) who inspect their medical records are allowed to provide a written addendum to the records if the member believes that the records are incomplete or inaccurate. This addendum is included when disclosed to other parties.
ee. Medical records will be transferred among providers 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 provider furnishing a referral service will report appropriate information to the referring provider in a timely manner. Also
the record contains referral notes from medical providers to behavioral health providers (as applicable) and documented evidence of clinical feedback (i.e. consultations report inclusive of diagnosis, treatment plan, and psychopharmacological medication, as applicable) Providers will request information from other treating providers 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.

8. Disclosure of Medical Information/HIPPA
   The expanded definition of "individually identifiable" (includes name, address, phone number, SS number, email address, etc.):
   a. Prohibition of requiring a member as a condition to receiving health care services to sign an authorization, release, consent or waiver permitting disclosure of medical information subject to confidentiality protection under the law.
   b. Medical information is release after member authorization and in accordance with applicable Federal or State law.
   c. A member has the right to authorize/deny the release of PHI beyond uses for treatment, payment or health care operations
   d. Disclosures and security measures for PHI meet the requirements under HIPPA
   e. In the event of improper use or disclosure of PHI steps will be taken to notify the health plan by self-reporting.

9. Health Maintenance Documentation should include the following:
   a. Appropriate adult past medical history documentation, which includes:
      i. Smoking habits
      ii. Alcohol use
      iii. Substance abuse history
      iv. Family planning, reproductive health history
      v. Surgical procedures
      vi. Illnesses and serious accidents
      vii. Discharge summaries from hospitalized members
      viii. Inpatient hospital admissions

   b. Appropriate Children/Adolescents past medical history documentation, which includes:
      i. Smoking history
      ii. Alcohol usage/history of substance abuse for members over 12 years of age
      iii. Surgical procedures
      iv. Childhood illnesses
      v. Personal/psychosocial/family history
      vi. Completed and current record
      vii. 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

10. Pediatric Preventive Services Documentation should include the following:

    a. Referral to Health Assessment Procedure to notify beneficiary to receive a health assessment:

i. For members under the age of 18 months, the provider (PCP) is responsible to perform an initial health assessment (IHA) within 60 days of enrollment or within periodicity timelines established by
ii.
iii. American Academy of Pediatrics (AAP) for age two and younger, whichever is less.
iv. 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.

11. Initial Health Assessment documentation for Medi-Cal (CHDP PM 160 INF) and Healthy Families (Staying Healthy Assessment form) members should include:
    a. Health developmental history
    b. Unclothed physical examination
    c. Assessment of nutritional status
    d. Inspection of ears nose, mouth, throat, teeth and gums (any referrals if applicable which include but not limited to: dental care, eye care)
    e. Vision screening
    f. Hearing screening
    g. Tuberculosis testing, laboratory testing for anemia, diabetes, and urinary tract infections
    h. Testing for sickle cell trait and lead poisoning
    i. Immunizations appropriate to age following recommendations of: Advisory Committee on Immunization Practices of the American Academy of Pediatrics
    j. Health education and anticipatory guidance

12. Periodicity Assessments should include:
    a. 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.

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

14. Communication, review and approval of the Medical Record Standards policy and procedure shall be accomplished as follows:
    a. Annual review/revision and approval in Quality Improvement Committee
    b. Promulgation to practice sites via mailings/meetings, provider visits
    c. Inclusion in orientation of new providers

Section 24.3
Advanced Directives

I. PURPOSE:

To provide guidelines for assuring that patients are given the opportunity to clearly decide their medical care in advance of possibly becoming mentally or physically incapacitated and unable to make the appropriate decision.

II. POLICY:

It is the policy of **NETWORK MEDICAL MANAGEMENT** to provide its patients age 18 years and older with information and advice about their right to make decisions regarding medical treatment before they become too ill to speak or decide for themselves and to comply with the state law in which the service is provided.

III. DEFINITION:

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.

IV. ATTACHMENT:

Advance Directive Forms

PROCEDURE:

a) **NETWORK MEDICAL MANAGEMENT** 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.

b) 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.

Section 25
Web-Portal

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 (page 51) and contact Network Medical Management's Web Portal team via email at portal.help@nmm.cc or by calling (626) 943-6146. Once account information is set up, providers can access the portal at the following address: https://www.nmm.cc/Portal. Portal features include:

- Authorization status inquiry
- Authorization submission
- Claims submission and status
- Provider rosters
- Member eligibility verification

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

Section 26
Fraud, Waste and Abuse

Network Medical Management
Fraud, Waste, and Abuse Training

February 2019

Network Medical Management

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- APPENDIX B: JOB AIDS
- POST-ASSESSMENT

ACRONYMS

The following acronyms are used throughout the course

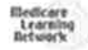
ACRONYM	DEFINITION
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
EPLS	Excluded Parties List System
FCA	False Claims Act
FDRs	First-tier, Downstream, and Related Entities
FWA	Fraud, Waste, and Abuse
HIPAA	Health Insurance Portability and Accountability Act
LEIE	List of Excluded Individuals and Entities
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MLN	Medicare Learning Network®
NPI	National Provider Identifier
OIG	Office of Inspector General
PBM	Pharmacy Benefits Manager
WBT	Web-Based Training

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

INTRODUCTION

Welcome to the **Network Medical Management (NMM)** Combating Medicare Parts C and D Fraud, Waste, and Abuse Training (FWA). This training models the training developed by CMS and incorporates additional information specific to NMM.

The training developed by CMS can be found in the Medicare Learning Network® (MLN).



INTRODUCTION

Publications & Multimedia

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts

Events & Training

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNGenInfo/Events-and-Training.html

Newsletters & Social Media

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg

Continuing Education

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNGenInfo/Continuing-Education.html

INTRODUCTION

This training assists Medicare Parts C and D plan Sponsors' employees, governing body members, and their first-tier, downstream, and related entities (FDRs) to satisfy their annual fraud, waste, and abuse (FWA) training requirements in the regulations and sub-regulatory guidance at:

- 42 Code of Federal Regulations (CFR) Section 422.503(b)(4)(vi)(C)
- 42 CFR Section 423.504(b)(4)(vi)(C)
- CMS-4159-F, Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs
- Section 50.3.2 of the Compliance Program Guidelines (Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual)

Sponsors and their FDRs are responsible for providing additional specialized or refresher training on issues posing FWA risks based on the employee's job function or business setting.

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

INTRODUCTION

42 Code of Federal Regulations (CFR) Section 422.503

https://www.ecfr.gov/cgi-bin/text-idx?SID=[illegible]&mc=true&node=pt42.3.422[illegible]422_1503

42 CFR Section 423.504

https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=[illegible]&mc=true&r=PART&n=pt42.3.423#se42.3.423_1504

CMS-4159-F, Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs

https://www.gpo.gov/fdsys/pkg/FR-2014-05-23/pdf/2014-11734.pdf

Chapter 9 of the Medicare Prescription Drug Benefit Manual

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf

Chapter 21 of the Medicare Managed Care Manual

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

INTRODUCTION

Why Do I Need Training?

- Every year billions of dollars are improperly spent because of FWA. It affects everyone—including you. This training will help you detect, correct, and prevent FWA. You are part of the solution.
- Combating FWA is everyone's responsibility! As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund.

INTRODUCTION

Training Requirements: Plan Employees, Governing Body Members, and First-Tier, Downstream, or Related Entity (FDR) Employees

- Certain training requirements apply to people involved in Medicare Parts C and D. All employees of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs) (collectively referred to in this course as "Sponsors") must receive training for preventing, detecting, and correcting FWA.
- FWA training must occur within 90 days of initial hire and at least annually thereafter.
- More information on other Medicare Parts C and D compliance trainings and answers to common questions is available on the CMS website.

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

INTRODUCTION

FWA Training Requirements Exception

There is one exception to the FWA training and education requirement. FDRs meet the FWA training and education requirements if they met the FWA certification requirement through either:

- **Accreditation as a supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)**
- **Enrollment in Medicare Part A (hospital) or B (medical) Program**

If you are unsure if this exception applies to you, contact your management team for more information.

INTRODUCTION

Navigating and Completing This Course

- Anyone providing health or administrative services to Medicare enrollees must satisfy general compliance and FWA training requirements. You may use this WBT course to satisfy the FWA requirements.
- This course consists of two lessons and a Post-Assessment. Successfully completing the course requires completing all lessons and scoring 70 percent or higher on the Post-Assessment. After successfully completing the Post-Assessment, you'll get instructions to print your certificate. If you do not successfully complete the course, you can review the course material and retake the Post-Assessment.
- You do not have to complete the course in one session; however, you must complete at least one lesson before exiting the course. You can complete the entire course in about 30 minutes. After you successfully complete this course, you receive instructions on how to print your certificate.

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

INTRODUCTION

Course Objectives

When you complete this course, you should correctly:

- Recognize FWA in the Medicare Program
- Identify the major laws and regulations pertaining to FWA
- Recognize potential consequences and penalties associated with violations
- Identify methods of preventing FWA
- Identify how to report FWA
- Recognize how to correct FWA

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 1: WHAT IS FWA?

Lesson 1: Introduction and Learning Objectives

This lesson describes fraud, waste, and abuse (FWA) and the laws that prohibit it. It should take about 10 minutes to complete. Upon completing the lesson, you should be able to correctly:

- Recognize FWA in the Medicare Program
- Identify the major laws and regulations pertaining to FWA
- Recognize potential consequences and penalties associated with violations

LESSON 1: WHAT IS FWA?

Fraud

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

The Health Care Fraud Statute makes it a criminal offense to knowingly and willfully execute a scheme to defraud a health care benefit program. Health care fraud is punishable by imprisonment up to 10 years. It is also subject to criminal fines up to $250,000

In other words, fraud is intentionally submitting false information to the Government or a Government contractor to get money or a benefit.

LESSON 1: WHAT IS FWA?

Waste and Abuse

- Waste includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.
- Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.

LESSON 1: WHAT IS FWA?

For the definitions of fraud, waste, and abuse, refer to Section 20, Chapter 21 of the Medicare Managed Care Manual and Chapter 9 of the Prescription Drug Benefit Manual on the Centers for Medicare & Medicaid Services (CMS) website.

Chapter 21 of the Medicare Managed Care Manual

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf

Chapter 9 of the Prescription Drug Benefit Manual

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf

LESSON 1: WHAT IS FWA?

Examples of FWA

Examples of actions that may constitute Medicare fraud include:

- Knowingly billing for services not furnished or supplies not provided, including billing Medicare for appointments the patient failed to keep
- Billing for nonexistent prescriptions
- Knowingly altering claim forms, medical records, or receipts to receive a higher payment
- Examples of actions that may constitute Medicare waste include:
- Conducting excessive office visits or writing excessive prescriptions
- Prescribing more medications than necessary for treating a specific condition.

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 1: WHAT IS FWA?

Examples of FWA, Continued…

- Ordering excessive laboratory tests
- Examples of actions that may constitute Medicare abuse include:
- Unknowingly billing for unnecessary medical services
- Unknowingly billing for brand name drugs when generics are dispensed
- Unknowingly excessively charging for services or supplies
- Unknowingly misusing codes on a claim, such as upcoding or unbundling codes

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 1: WHAT IS FWA?

Differences Among Fraud, Waste, and Abuse

- There are differences among fraud, waste, and abuse. One of the primary differences is intent and knowledge. Fraud requires intent to obtain payment and the knowledge the actions are wrong. Waste and abuse may involve obtaining an improper payment or creating an unnecessary cost to the Medicare Program but do not require the same intent and knowledge.

LESSON 1: WHAT IS FWA?

Understanding FWA

To detect FWA, you need to know the **law**.

The following pages provide high-level information about the following laws:

- Civil False Claims Act, Health Care Fraud Statute, and Criminal Fraud
- Anti-Kickback Statute
- Stark Statute (Physician Self-Referral Law)
- Exclusion from all Federal health care programs
- Health Insurance Portability and Accountability Act (HIPAA)

For details about specific laws, such as safe harbor provisions, consult the applicable statute and regulations.

LESSON 1: WHAT IS FWA?

Civil False Claims Act (FCA)

The civil provisions of the FCA make a person liable to pay damages to the Government if he or she knowingly:

- Conspires to violate the FCA
- Carries out other acts to obtain property from the Government by misrepresentation
- Conceals or improperly avoids or decreases an obligation to pay the Government
- Makes or uses a false record or statement supporting a false claim
- Presents a false claim for payment or approval

For more information, refer to 31 United States Code (USC) Sections 3729–3733

https://www.gpo.gov/fdsys/pkg/USCODE-2016-title31/pdf/USCODE-2016-title31-subtitleIII-chap37-subchapIII.pdf

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 1: WHAT IS FWA?

Damages and Penalties

Any person who knowingly submits false claims to the Government is liable for three times the Government's damages caused by the violator plus a penalty.

EXAMPLES

A Medicare Part C plan in Florida:

- Hired an outside company to review medical records to find additional diagnosis codes it could submit to increase risk capitation payments from CMS
- Was informed by the outside company that certain diagnosis codes previously submitted to Medicare were undocumented or unsupported
- Failed to report the unsupported diagnosis codes to Medicare
- Agreed to pay $22.6 million to settle FCA allegations

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 1: WHAT IS FWA?

Civil FCA (continued)

Whistleblowers

A whistleblower is a person who exposes information or activity that is deemed illegal, dishonest, or violates professional or clinical standards.

- Protected: Persons who report false claims or bring legal actions to recover money paid on false claims are protected from retaliation.
- Rewarded: Persons who bring a successful whistleblower lawsuit receive at least 15 percent, but not more than 30 percent, of the money collected.

LESSON 1: WHAT IS FWA?

Health Care Fraud Statute

- The Health Care Fraud Statute states, "Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud any health care benefit program ... shall be fined under this title or imprisoned not more than 10 years, or both."
- Conviction under the statute does not require proof the violator had knowledge of the law or specific intent to violate the law. For more information, refer to 18 USC Sections 1346-1347.

  https://www.gpo.gov/fdsys/pkg/USCODE-2016-title18/pdf/USCODE-2016-title18-partI-chap63-sec1346.pdf

LESSON 1: WHAT IS FWA?

Health Care Fraud Statute Examples

A Pennsylvania pharmacist:

- Submitted claims to a Medicare Part D plan for non-existent prescriptions and drugs not dispensed
- Pleaded guilty to health care fraud
- Received a 15-month prison sentence and was ordered to pay more than $166,000 in restitution to the plan

The owner of multiple Durable Medical Equipment (DME) companies in New York:

- Falsely represented themselves as one of a nonprofit health maintenance organization's (that administered a Medicare Advantage plan) authorized vendors
- Provided no DME to any beneficiaries as claimed
- Submitted almost $1 million in false claims to the nonprofit; $500,000 was paid
- Pleaded guilty to one count of conspiracy to commit health care fraud

LESSON 1: WHAT IS FWA?

Criminal Health Care Fraud

Persons who knowingly make a false claim may be subject to:

- Criminal fines up to $250,000
- Imprisonment for up to 20 years
- If the violations resulted in death, the individual may be imprisoned for any term of years or for life. For more information, refer to 18 USC Section 1347. https://www.gpo.gov/fdsys/pkg/USCODE-2016-title18/pdf/USCODE-2016-title18-partI-chap63-sec1347.pdf

LESSON 1: WHAT IS FWA?

Anti-Kickback Statute

The Anti-Kickback Statute prohibits knowingly and willfully soliciting, receiving, offering, or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid, in whole or in part, under a Federal health care program (including the Medicare Program).

For more information, refer to 42 USC Section 1320a-7b(b).

42 USC Section 1395nn

https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXVIII-partE-sec1395nn.pdf

Physician Self-Referral webpage

https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral

the Act, Section 1877

https://www.ssa.gov/OP_Home/ssact/title18/1877.htm

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 1: WHAT IS FWA?

Damages and Penalties

Violations are punishable by:

- A fine up to $25,000
- Imprisonment up to 5 years

For more information, refer to the Social Security Act (the Act), Section 1128B(b).

Example

From 2012 through 2015, a physician operating a pain management practice in Rhode Island:

- Conspired to solicit and receive kickbacks for prescribing a highly addictive version of the opioid Fentanyl
- Reported patients had breakthrough cancer pain to secure insurance payments
- Received $188,000 in speaker fee kickbacks from the drug manufacturer
- Admitted the kickback scheme cost Medicare and other payers more than $750,000
- The physician must pay more than $750,000 restitution and is awaiting sentencing.

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 1: WHAT IS FWA?

Stark Statute (Physician Self-Referral Law)

The Stark Statute prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has:

- An ownership/investment interest or
- A compensation arrangement

Exceptions may apply. For more information, refer to 42 USC Section 1395nn.

LESSON 1: WHAT IS FWA?

Stark Statute (Physician Self-Referral Law), Continued...

Damages and Penalties

Medicare claims tainted by an arrangement that does not comply with the Stark Statute are not payable. A penalty of around $24,250 can be imposed for each service provided. There may also be around a **$161,000** fine for entering into an unlawful arrangement or scheme. For more information, visit the Physician Self-Referral webpage and refer to the Act, Section 1877.

Example

A California hospital was ordered to pay more than $3.2 million to settle Stark Law violations for maintaining 97 financial relationships with physicians and physician groups outside the fair market value standards or that were improperly documented as exceptions.

LESSON 1: WHAT IS FWA?

Civil Monetary Penalties (CMP) Law

The Office of Inspector General (OIG) may impose civil penalties for several reasons, including:

- Arranging for services or items from an excluded individual or entity
- Providing services or items while excluded
- Failing to grant OIG timely access to records
- Knowing of and failing to report and return an overpayment
- Making false claims
- Paying to influence referrals

For more information, refer to 42 USC 1320a-7a and the Act, Section 1128A(a).

42 USC 1320a-7a

https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7a.pdf

The Act, Section 1128A(a)

https://www.ssa.gov/OP_Home/ssact/title11/1128A.htm

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 1: WHAT IS FWA?

Damages and Penalties

The penalties can be around $15,000 to $70,000 depending on the specific violation. Violators are also subject to three times the amount:

- Claimed for each service or item or
- Of remuneration offered, paid, solicited, or received

Example:

A California pharmacy and its owner agreed to pay over $1.3 million to settle allegations they submitted unsubstantiated claims to Medicare Part D for brand name prescription drugs the pharmacy could not have dispensed based on inventory records.

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 1: WHAT IS FWA?

Exclusion

- No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the OIG. The OIG has authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE).
- The U.S. General Services Administration (GSA) administers the Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including the OIG. You may access the EPLS on the System for Award Management (SAM) website.
- When looking for excluded individuals or entities, check both the LEIE and the EPLS since the lists are not the same. For more information, refer to 42 USC Section 1320a-7 and 42 Code of Federal Regulations (CFR) Section 1001.1901.

LEIE

https://exclusions.oig.hhs.gov

EPLS

https://www.sam.gov

42 USC Section 1320a-7

https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7.pdf

42 Code of Federal Regulations (CFR) Section 1001.1901

https://www.gpo.gov/fdsys/pkg/CFR-2016-title42-vol5/pdf/CFR-2016-title42-vol5-sec1001-1901.pdf

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 1: WHAT IS FWA?

Example:

A pharmaceutical company pleaded guilty to two felony counts of criminal fraud related to failure to file required reports with the U.S. Food and Drug Administration concerning oversized morphine sulfate tablets. The pharmaceutical firm executive was excluded based on the company's guilty plea. At the time the convicted executive was excluded, there was evidence he was involved in misconduct leading to the company's conviction.

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 1: WHAT IS FWA?

Health Insurance Portability and Accountability Act (HIPAA)

- HIPAA created greater access to health care insurance, strengthened the protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.
- HIPAA safeguards deter unauthorized access to protected health care information. As an individual with access to protected health care information, you must comply with HIPAA.
- For more information, visit the HIPAA webpage. https://www.hhs.gov/hipaa

LESSON 1: WHAT IS FWA?

Damages and Penalties

Violations may result in Civil Monetary Penalties. In some cases, criminal penalties may apply.

Example:

A former hospital employee pleaded guilty to criminal HIPAA charges after obtaining protected health information with the intent to use it for personal gain. He was sentenced to 12 months and 1 day in prison.

LESSON 1: WHAT IS FWA?

Lesson 1 Summary

There are differences among fraud, waste, and abuse (FWA). One of the primary differences is intent and knowledge. Fraud requires the person have intent to obtain payment and the knowledge his or her actions are wrong. Waste and abuse may involve obtaining an improper payment but the same intent and knowledge.

Laws and regulations exist that prohibit FWA. Penalties for violating these laws may include:

- Civil Monetary Penalties
- Civil prosecution
- Criminal conviction, fines, or both
- Exclusion from all Federal health care program participation
- Imprisonment
- Loss of professional license

LESSON 1: WHAT IS FWA?

You completed Lesson 1: What Is FWA?

Now that you have learned about FWA and the laws and regulations prohibiting it, let's look closer at your role in the fight against FWA.

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Lesson 2: Introduction and Learning Objectives

This lesson explains the role you can play in fighting against fraud, waste, and abuse (FWA), including your responsibilities for preventing, reporting, and correcting FWA. It should take about 10 minutes to complete. Upon completing the lesson, you should correctly:

- Identify methods of preventing FWA
- Identify how to report FWA
- Recognize how to correct FWA

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Where Do I Fit In?

As a person providing health or administrative services to a Medicare Part C or Part D enrollee, you are likely an employee of a:

- Sponsor (Medicare Advantage Organization [MAO] or a Prescription Drug Plan [PDP])
- First-tier entity (Examples: Pharmacy Benefit Management [PBM]; hospital or health care facility; provider group; doctor's office; clinical laboratory; customer service provider; claims processing and adjudication company; a company that handles enrollment, disenrollment, and membership functions; and contracted sales agents)
- Downstream entity (Examples: pharmacies, doctor's office, firms providing agent/broker services, marketing firms, and call centers)
- Related entity (Examples: Entity with common ownership or control of a Sponsor, health promotion provider, or SilverSneakers®)

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Where Do I Fit In? (continued)

I am an employee of a Part D Plan Sponsor or an employee of a Part D Plan Sponsor's first-tier or downstream entity.

The Part D Plan Sponsor is a CMS Contractor. Part D Plan Sponsors may enter into contracts with FDRs. This stakeholder relationship flow chart shows examples of functions that relate to the Sponsor's Medicare Part D contracts. First-tier and related entities of the Part D Plan Sponsor may contract with downstream entities to fulfill their contractual obligations to the Sponsor.

Examples of first-tier entities include call centers, PBMs, and field marketing organizations. If the first-tier entity is a PBM, then the pharmacy, marketing firm, quality assurance firm, and claims processing firm could be downstream entities. If the first-tier entity is a field marketing organization, then agents could be a downstream entity.

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Where Do I Fit In? (continued)

I am an employee of a Part C Plan Sponsor or an employee of a Part C Plan Sponsor's first-tier or downstream entity.

The Part C Plan Sponsor is a CMS Contractor. Part C Plan Sponsors may enter into contracts with FDRs. This stakeholder relationship flow chart shows examples of functions relating to the Sponsor's Medicare Part C contracts. First-tier and related entities of the Medicare Part C Plan Sponsor may contract with downstream entities to fulfill their contractual obligations to the Sponsor.

Examples of first-tier entities may be independent practices, call centers, health services/hospital groups, fulfillment vendors, field marketing organizations, and credentialing organizations. If the first-tier entity is an independent practice, then a provider could be a downstream entity. If the first-tier entity is a health service/hospital group, then radiology, hospital, or mental health facilities may be the downstream entity. If the first-tier entity is a field marketing organization, then agents may be the downstream entity. Downstream entities may contract with other downstream entities. Hospitals and mental health facilities may contract with providers.

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

What Are Your Responsibilities?

- You play a vital part in preventing, detecting, and reporting potential FWA, as well as Medicare noncompliance.
- FIRST, you must comply with all applicable statutory, regulatory, and other Medicare Part C or Part D requirements, including adopting and using an effective compliance program.
- SECOND, you have a duty to the Medicare Program to report any compliance concerns and suspected or actual violations of which you may be aware.
- THIRD, you have a duty to follow your organization's Code of Conduct that articulates your and your organization's commitment to standards of conduct and ethical rules of behavior.

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

How Do You Prevent FWA?

- Look for suspicious activity
- Conduct yourself in an ethical manner
- Ensure accurate and timely data and billing
- Ensure coordination with other payers
- Know FWA policies and procedures, standards of conduct, laws, regulations, and CMS' guidance
- Verify all received information

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Stay Informed About Policies and Procedures

- Know your entity's policies and procedures.
- Every Sponsor and First-Tier, Downstream and Related Entity (FDR) must have policies and procedures that address FWA. These procedures should help you detect, prevent, report, and correct FWA.
- Standards of Conduct should describe the Sponsor's expectations that:
  - All employees conduct themselves in an ethical manner
  - Appropriate mechanisms are in place for anyone to report noncompliance and potential FWA
  - Reported issues will be addressed and corrected
  - Standards of Conduct communicate to employees and FDRs compliance is everyone's responsibility, from the top of the organization to the bottom.

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Report FWA

- Everyone must report suspected instances of FWA. NMM's Code of Conduct clearly states this obligation. Sponsors may not retaliate against you for making a good faith effort in reporting.
- Report any potential FWA concerns you have to your compliance department or NMM's compliance department. NMM's compliance department will investigate and make the proper determination. NMM has a Special Investigations Unit (SIU) dedicated to investigating FWA and utilizes the Compliance Hotline and reporting mechanisms for reporting FWA.

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Report FWA

Every Sponsor must have a mechanism for reporting potential FWA by employees and FDRs. Each Sponsor must accept anonymous reports and cannot retaliate against you for reporting.

- Review your organization's materials for the ways to report FWA.
- When in doubt, call your Compliance Department or FWA Hotline.

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

How to Report Potential FWA

NMM Employees:

Call NMM's Compliance Officer:
Rus Billimoria 626-943-6280

Compliance Hotline: 626-943-6286
24 hours a day/7 days a week
You may report anonymously and confidentially

Email: fwacompliance@nmm.cc

Drop Box

First-Tier, Downstream, or Related Entity (FDR) Employees

- Talk to a Manager or Supervisor
- Call your Ethics/Compliance Help Line
- Report to NMM or Sponsor

Beneficiaries

- Call NMM or Sponsor's Compliance Hotline or Customer Service
- Call 1-800-Medicare

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Reporting FWA Outside Your Organization

- If warranted, Sponsors and FDRs must report potentially fraudulent conduct to Government authorities, such as the Office of Inspector General (OIG), the U.S. Department of Justice (DOJ), or CMS.
- Individuals or entities who wish to voluntarily disclose self-discovered potential fraud to OIG may do so under the Self-Disclosure Protocol (SDP). Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a Government- directed investigation and civil or administrative litigation.

Details to Include When Reporting FWA

When reporting suspected FWA, include:

- Contact information for the information source, suspects, and witnesses
- Alleged FWA details
- Alleged Medicare rules violated
- The suspect's history of compliance, education, training, and communication with your organization or other entities

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

WHERE TO REPORT FWA

HHS Office of Inspector General:

- Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950
- Fax: 1-800-223-8164
- Email: HHSTips@oig.hhs.gov
- Online: Forms.OIG.hhs.gov/hotlineoperations/index.aspx

For Medicare Parts C and D:

- National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) at 1-877-7SafeRx (1-877-772-3379)

For all other Federal health care programs:

- CMS Hotline at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048

Medicare beneficiary website: Medicare.gov/forms-help-and-resources/report-fraud-and-abuse/fraud-and-abuse.html

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Correction

Once fraud, waste, or abuse is detected, promptly correct it. Correcting the problem saves the Government money and ensures your compliance with CMS requirements.

Develop a plan to correct the issue. Ask your organization's compliance officer about the development process for the corrective action plan. The actual plan is going to vary, depending on the specific circumstances. In general:

- Design the corrective action to correct the underlying problem that results in FWA program violations and to prevent future noncompliance.
- Tailor the corrective action to address the particular FWA, problem, or deficiency identified. Include timeframes for specific actions.
- Document corrective actions addressing noncompliance or FWA committed by a Sponsor's employee or FDR's employee, and include consequences for failure to satisfactorily complete the corrective action.
- Monitor corrective actions continuously to ensure effectiveness.

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Corrective Action Examples

Corrective actions may include:

- Adopting new prepayment edits or document review requirements
- Conducting mandated training
- Providing educational materials
- Revising policies or procedures
- Sending warning letters
- Taking disciplinary action, such as suspension of marketing, enrollment, or payment
- Terminating an employee or provider

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Indicators of Potential FWA

Now that you know about your role in preventing, reporting, and correcting FWA, let's review some key indicators to help you recognize the signs of someone committing FWA.

The following pages present potential FWA issues. Each page provides questions to ask yourself about different areas, depending on your role as an employee of a Sponsor, pharmacy, or other entity involved in delivering Medicare Parts C and D benefits to enrollees.

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Key Indicators: Potential Beneficiary Issues

- Does the prescription, medical record, or laboratory test look altered or possibly forged?
- Does the beneficiary's medical history support the services requested?
- Have you filled numerous identical prescriptions for this beneficiary, possibly from different doctors?
- Is the person receiving the medical service the beneficiary (identity theft)?
- Is the prescription appropriate based on the beneficiary's other prescriptions?

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Key Indicators: Potential Provider Issues

- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Does the provider bill the Sponsor for services not provided?
- Does the provider write prescriptions for diverse drugs or primarily for controlled substances?
- Is the provider performing medically unnecessary services for the member?
- Is the provider prescribing a higher quantity than medically necessary for the condition?
- Does the provider's prescription have their active and valid National Provider Identifier on it?
- Is the provider's diagnosis for the member supported in the medical record?

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Key Indicators: Potential Pharmacy Issues

- Are drugs being diverted (drugs meant for nursing homes, hospice, and other entities being sent elsewhere)?
- Are the dispensed drugs expired, fake, diluted, or illegal?
- Are generic drugs provided when the prescription requires dispensing brand drugs?
- Are PBMs billed for unfilled or never picked up prescriptions?
- Are proper provisions made if the entire prescription is not filled (no additional dispensing fees for split prescriptions)?
- Do you see prescriptions being altered (changing quantities or Dispense As Written)?

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Key Indicators: Potential Wholesaler Issues

- Is the wholesaler distributing fake, diluted, expired, or illegally imported drugs?
- Is the wholesaler diverting drugs meant for nursing homes, hospices, and Acquired Immune Deficiency Syndrome (AIDS) clinics, marking up the prices, and sending to other smaller wholesalers or pharmacies?

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Key Indicators: Potential Manufacturer Issues

- Does the manufacturer promote off-label drug usage?
- Does the manufacturer knowingly provide samples to entities that bill Federal health care programs for them?

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Key Indicators: Potential Sponsor Issues

- Does the Sponsor encourage or support inappropriate risk adjustment submissions?
- Does the Sponsor lead the beneficiary to believe the cost of benefits is one price, when the actual cost is higher?
- Does the Sponsor offer beneficiaries cash inducements to join the plan?
- Does the Sponsor use unlicensed agents?

LESSON 2: YOUR ROLE IN THE FIGHT AGAINST FWA

Lesson 2 Summary

- As a person providing health or administrative services to a Medicare Part C or D enrollee, you play a vital role in preventing fraud, waste, and abuse (FWA). Conduct yourself ethically, stay informed of your organization's policies and procedures, and keep an eye out for key indicators of potential FWA.
- Report potential FWA. Every Sponsor must have a mechanism for reporting potential FWA. Each Sponsor must accept anonymous reports and cannot retaliate against you for reporting.
- Promptly correct identified FWA with an effective corrective action plan.

APPENDIX A: RESOURCES

Glossary

For glossary terms, visit the Centers for Medicare & Medicaid Services Glossary.

https://www.cms.gov/apps/glossary

APPENDIX B: JOB AIDS

Job Aid A: Applicable Laws for Reference

Anti-Kickback Statute 42 USC Section 1320a-7b(b)

Civil False Claims Act 31 USC Sections 3729–3733

Civil Monetary Penalties Law 42 USC Section 1320a-7a

Criminal False Claims Act 18 USC Section 287

Exclusion 42 USC Section 1320a-7

Criminal Health Care Fraud Statute 18 USC Section 1347

Physician Self-Referral Law 42 USC Section 1395nn

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

APPENDIX B: JOB AIDS

42 USC Section 1320a-7b(b)

https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7b.pdf

31 USC Sections 3729-3733

https://www.gpo.gov/fdsys/pkg/USCODE-2016-title31/pdf/USCODE-2016-title31-subtitleIII-chap37-subchapIII.pdf

42 USC Section 1320a-7a

https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7a.pdf

18 USC Section 287

https://www.gpo.gov/fdsys/pkg/USCODE-2016-title18/pdf/USCODE-2016-title18-partI-chap15-sec287.pdf

42 USC Section 1320a-7

https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXI-partA-sec1320a-7.pdf

18 USC Section 1347

https://www.gpo.gov/fdsys/pkg/USCODE-2016-title18/pdf/USCODE-2016-title18-partI-chap63-sec1347.pdf

42 USC Section 1395nn

https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/pdf/USCODE-2016-title42-chap7-subchapXVIII-partE-sec1395nn.pdf

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

APPENDIX B: JOB AIDS

Job Aid B: Resources

Health Care Fraud Prevention and Enforcement Action Team Provider Compliance Training

OIG's Provider Self-Disclosure Protocol

Physician Self-Referral

Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians

Safe Harbor Regulations

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

APPENDIX B: JOB AIDS

Health Care Fraud Prevention and Enforcement Action Team Provider Compliance Training

https://oig.hhs.gov/compliance/provider-compliance-training

OIG's Provider Self-Disclosure Protocol

https://oig.hhs.gov/compliance/self-disclosure-info/files/Provider-Self-Disclosure-Protocol.pdf

Physician Self-Referral

https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral

Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1254524.html

Safe Harbor Regulations

https://oig.hhs.gov/compliance/safe-harbor-regulations

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

APPENDIX B: JOB AIDS

Job Aid C: Where to Report Fraud, Waste, and Abuse (FWA)

HHS Office of Inspector General:

- Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950
- Fax: 1-800-223-8164
- Email: HHSTips@oig.hhs.gov
- Online: forms.OIG.hhs.gov/hotlineoperations/index.aspx

For Medicare Parts C and D:

- National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) at 1-877-7SafeRx (1-877-772-3379)

For all other Federal health care programs:

- CMS Hotline at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048

HHS and U.S. Department of Justice (DOJ): Medicare.gov/forms-help-and-resources/report-fraud-and-abuse/fraud-and-abuse.html

Network Medical Management Combating Medicare Parts C and D Fraud, Waste, and Abuse Training

Network Medical Management General Compliance Training

February 2019 Network Medical Management

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ACRONYMS

The following acronyms are used throughout the course.

ACRONYM	TITLE TEXT
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
FDR	First-tier, Downstream, and Related Entity
FWA	Fraud, Waste, and Abuse
HHS	U.S. Department of Health & Human Services
MA	Medicare Advantage
MAO	Medicare Advantage Organization
MA-PD	MA Prescription Drug
MLN	Medicare Learning Network®
OIG	Office of Inspector General
PDP	Prescription Drug Plan

INTRODUCTION

Welcome to the Network Medical Management (NMM) Medicare Parts C and D General Compliance Training. This training models the training developed by CMS and incorporates additional information specific to NMM's compliance program.

The training developed by CMS can be found in the Medicare Learning Network® (MLN).

The Medicare Learning Network® (MLN) offers free educational materials for health care professionals on the Centers for Medicare & Medicaid Services (CMS) programs, policies, and initiatives. Get quick access to the information you need.

INTRODUCTION

Publications & Multimedia

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts

Events & Training

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNGenInfo/Events-and-Training.html

Newsletters & Social Media

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg

Continuing Education

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNGenInfo/Continuing-Education.html

Network Medical Management Medicare Parts C and D General Compliance Training

INTRODUCTION

This training assists NMM employees, governing body members, and their first-tier, downstream, and related entities (FDRs) to satisfy their annual general compliance training requirements in the regulations and sub-regulatory guidance at:

- 42 Code of Federal Regulations (CFR) Section 422.503(b)(4)(vi)(C)
- 42 CFR Section 423.504(b)(4)(vi)(C)
- Section 50.3 of the Compliance Program Guidelines (Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual)
- The "Downloads" section of the CMS Compliance Program Policy and Guidance webpage

Network Medical Management Medicare Parts C and D General Compliance Training

INTRODUCTION

Completing this training in and of itself does not ensure that NMM has an "effective Compliance Program."

NMM and their FDRs are responsible for establishing and executing an effective compliance program according to the CMS regulations and program guidelines.

INTRODUCTION

Why Do I Need Training?

- Every year, billions of dollars are improperly spent because of fraud, waste, and abuse (FWA). It affects everyone—including you. This training helps you detect, correct, and prevent FWA. You are part of the solution.
- Compliance is everyone's responsibility! As an individual who provides health or administrative services for Medicare enrollees, every action you take potentially affects Medicare enrollees, the Medicare Program, or the Medicare Trust Fund.

INTRODUCTION

Training Requirements: NMM Employees, Governing Body Members, and First-Tier, Downstream, or Related Entity (FDR) Employees

- Certain training requirements apply to people involved in Medicare Parts C and D. All employees of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs) (collectively referred to in this course as "Sponsors") must receive training about compliance with CMS program rules.
- You may need to complete FWA training within 90 days of your initial hire. More information on other Medicare Parts C and D compliance trainings and answers to common questions is available on the CMS website. Please contact your management team for more information.

Network Medical Management Medicare Parts C and D General Compliance Training

INTRODUCTION

Learn more about Medicare Part C

Medicare Part C, or Medicare Advantage (MA), is a health insurance option available to Medicare beneficiaries. Private, Medicare-approved insurance companies run MA programs. These companies arrange for, or directly provide, health care services to the beneficiaries who enroll in an MA plan.

MA plans must cover all services Medicare covers with the exception of hospice care. They provide Part A and Part B benefits and may also include prescription drug coverage and other supplemental benefits.

Learn more about Medicare Part D

Medicare Part D, the Prescription Drug Benefit, provides prescription drug coverage to Medicare beneficiaries enrolled in Part A and/or Part B who enroll in a Medicare Prescription Drug Plan (PDP) or an MA Prescription Drug (MA-PD) plan. Medicare- approved insurance and other companies provide prescription drug coverage to individuals living in a plan's service area.

Medicare Parts C and D compliance trainings and answers to common questions

https://www.cms.gov/Outreach-and- [illegible]

Network Medical Management Medicare Parts C and D General Compliance Training

INTRODUCTION

Navigating and Completing This Course

- Anyone who provides health or administrative services to Medicare enrollees must satisfy general compliance and FWA training requirements. You may use this course to satisfy the general compliance training requirements.
- This course consists of one lesson and a Post-Assessment. Successfully completing the course requires completing the lesson and scoring 70 percent or higher on the Post-Assessment.
- You do not have to complete this course in one session; however, you must complete the lesson before exiting the course. You can complete the entire course in about 25 minutes. After you successfully complete this course, you receive instructions on how to print your certificate.

INTRODUCTION

Course Objectives

After completing this course, you should correctly:

- Recognize how a compliance program operates
- Recognize how compliance program violations should be reported

LESSON: NMM COMPLIANCE PROGRAM TRAINING

Introduction and Learning Objectives

- This lesson outlines effective compliance programs. It should take about 45 minutes to complete. After completing this lesson, you should correctly:
  - Recognize how a compliance program operates
  - Recognize how compliance program violations should be reported

Network Medical Management Medicare Parts C and D General Compliance Training

LESSON: NMM COMPLIANCE PROGRAM TRAINING

Compliance Program Requirement

- The Centers for Medicare & Medicaid Services (CMS) requires Sponsors to implement and maintain an effective compliance program for its Medicare Parts C and D plans. An effective compliance program must:
  - Articulate and demonstrate an organization's commitment to legal and ethical conduct
  - Provide guidance on how to handle compliance questions and concerns
  - Provide guidance on how to identify and report compliance violations

Network Medical Management Medicare Parts C and D General Compliance Training

LESSON: NMM COMPLIANCE PROGRAM TRAINING

What is an Effective Compliance Program?

An effective compliance program fosters a culture of compliance within an organization and, at a minimum:

- Prevents, detects, and corrects non-compliance
- Is fully implemented and is tailored to an organization's unique operations and circumstances
- Has adequate resources
- Promotes the organization's Standards of Conduct
- Establishes clear lines of communication for reporting non-compliance
- An effective compliance program is essential to prevent, detect, and correct Medicare non-compliance as well as fraud, waste, and abuse (FWA). It must, at a minimum, include the seven core compliance program requirements.

Network Medical Management Medicare Parts C and D General Compliance Training

LESSON: NMM COMPLIANCE PROGRAM TRAINING

Seven Core Compliance Program Requirements

CMS requires an effective compliance program to include seven core requirements:

1. Written Policies, Procedures, and Standards of Conduct
   - These articulate the Sponsor's commitment to comply with all applicable Federal and State standards and describe compliance expectations according to the Standards of Conduct.
2. Compliance Officer, Compliance Committee, and High-Level Oversight
   - The Sponsor must designate a compliance officer and a compliance committee accountable and responsible for the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program.
   - The Sponsor's senior management and governing body must be engaged and exercise reasonable oversight of the Sponsor's compliance program.
3. Effective Training and Education
   - This covers the elements of the compliance plan as well as preventing, detecting, and reporting FWA. Tailor this training and education to the different employees and their responsibilities and job functions.

Network Medical Management Medicare Parts C and D General Compliance Training

LESSON: NMM COMPLIANCE PROGRAM TRAINING

Seven Core Compliance Program Requirements (continued)

4. Effective Lines of Communication
   - Make effective lines of communication accessible to all, ensure confidentiality, and provide methods for anonymous and good- faith compliance issues reporting at Sponsor and first-tier, downstream, or related entity (FDR) levels.
5. Well-Publicized Disciplinary Standards
   - Sponsor must enforce standards through well-publicized disciplinary guidelines.
6. Effective System for Routine Monitoring, Auditing, and Identifying Compliance Risks
   - Conduct routine monitoring and auditing of Sponsor's and FDR's operations to evaluate compliance with CMS requirements as well as the overall effectiveness of the compliance program.

Network Medical Management Medicare Parts C and D General Compliance Training

LESSON: NMM COMPLIANCE PROGRAM TRAINING

Seven Core Compliance Program Requirements (continued)

7. Procedures and System for Prompt Response to Compliance Issues
   - The Sponsor must use effective measures to respond promptly to non-compliance and undertake appropriate corrective action.
   - Note: Sponsors must ensure that FDRs performing delegated administrative or health care service functions concerning the Sponsor's Medicare Parts C and D program comply with Medicare Program requirements.

Network Medical Management Medicare Parts C and D General Compliance Training

LESSON: NMM COMPLIANCE PROGRAM TRAINING

Compliance Training: Sponsors and Their FDRs

- CMS expects all Sponsors will apply their training requirements and "effective lines of communication" to their FDRs. Having "effective lines of communication" means employees of the Sponsor and the Sponsor's FDRs have several avenues to report compliance concerns.

LESSON: NMM COMPLIANCE PROGRAM TRAINING

Ethics: Do the Right Thing!

- As part of the Medicare Program, you must conduct yourself in an ethical and legal manner. It's about doing the right thing!
- Act fairly and honestly
- Adhere to high ethical standards in all you do
- Comply with all applicable laws, regulations, and CMS requirements
- Report suspected violations

LESSON: NMM COMPLIANCE PROGRAM TRAINING

How Do You Know What Is Expected of You?

Now that you've read the general ethical guidelines on the previous page, how do you know what is expected of you in a specific situation?

- Standards of Conduct (or Code of Conduct) state the organization's compliance expectations and their operational principles and values. Organizational Standards of Conduct vary. The organization should tailor the Standards of Conduct content to their individual organization's culture and business operations. Ask management where to locate your organization's Standards of Conduct. This training includes information specific to NMM's Code of Conduct later in the slides.
  - Reporting Standards of Conduct violations and suspected non-compliance is everyone's responsibility.
  - An organization's Standards of Conduct and Policies and Procedures should identify this obligation and tell you how to report suspected non-compliance.

Network Medical Management Medicare Parts C and D General Compliance Training

LESSON: NMM COMPLIANCE PROGRAM TRAINING

What Is Non-Compliance?

Non-compliance is conduct that does not conform to the law, Federal health care program requirements, or an organization's ethical and business policies. CMS identified the following Medicare Parts C and D high risk areas:

- Agent/broker misrepresentation
- Appeals and grievance review (for example, coverage and organization determinations)
- Beneficiary notices
- Conflicts of interest
- Claims processing
- Credentialing and provider networks
- Documentation and timeliness requirements
- Ethics
- FDR oversight and monitoring
- Health Insurance Portability and Accountability Act (HIPAA)
- Marketing and enrollment
- Pharmacy, formulary, and benefit administration
- Quality of care

Network Medical Management Medicare Parts C and D General Compliance Training

LESSON: NMM COMPLIANCE PROGRAM TRAINING

Know the Consequences of Non-Compliance

- Failure to follow Medicare Program requirements and CMS guidance can lead to serious consequences, including:
- Contract termination
- Criminal penalties
- Exclusion from participating in all Federal health care programs
- Civil monetary penalties
- Additionally, your organization must have disciplinary standards for non-compliant behavior. Those who engage in non-compliant behavior may be subject to any of the following:
  - Mandatory training or re-training
  - Disciplinary action
  - Termination

For more information, refer to the Compliance Program Guidelines in the Medicare Prescription Drug Benefit Manual and Medicare Managed Care Manual.

Network Medical Management Medicare Parts C and D General Compliance Training

LESSON: NMM COMPLIANCE PROGRAM TRAINING

Medicare Prescription Drug Benefit Manual

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter9.pdf

Medicare Managed Care Manual

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf

Network Medical Management Medicare Parts C and D General Compliance Training

LESSON: NMM COMPLIANCE PROGRAM TRAINING

Network Medical Management (NMM) Compliance Policy and Code of Conduct

- NMM has implemented a Compliance Policy and Code of Conduct that articulates its commitment to complying with applicable laws and regulations and describes the structure of NMM's compliance program.
- A copy of NMM's Compliance Policy and Code of Conduct can be found at http://www.nmm.cc/nmm/en/docs/compliance_program/NMMFWACompliancePolicyAndProgram.pdf.

Network Medical Management Medicare Parts C and D General Compliance Training

LESSON: NMM COMPLIANCE PROGRAM TRAINING

NMM Code of Conduct

NMM is committed to:

1. Conducting its business in accordance with the **highest standards of ethical conduct**
2. Conducting its business activities with integrity and in full compliance with the federal, state and local laws governing its business; and
3. Complying with all federal and state regulatory requirements related to the CMS requirements including the detection, correction and prevention of FWA.

This commitment applies to relationships with its members, enrollees, federal, state and local governments, vendors, competitors, auditors and all public and government bodies. Most importantly, it applies to all Covered Persons.

Network Medical Management Medicare Parts C and D General Compliance Training

LESSON: NMM COMPLIANCE PROGRAM TRAINING

Possible disciplinary action for non-compliance with the NMM Compliance Policy and Code of Conduct shall depend on the degree of severity of noncompliance and may include, but shall not be limited to:

1. Warnings (oral)
2. Reprimands (written)
3. Probation
4. Demotion
5. Suspension without pay
6. Referral to counseling
7. Withholding of a promotion or salary increase or other financial penalties
8. Termination
9. Failure to renew agreements
10. Contract termination
11. Restitution of damages
12. Referral for criminal prosecution to law enforcement agencies, CMS as appropriate

LESSON: NMM COMPLIANCE PROGRAM TRAINING

- NMM's disciplinary action will be pursued on a fair and equitable basis, and employees at all levels of NMM shall be subject to the same disciplinary action for the commission of similar offenses, including management. NMM's Human Resources Director, in conjunction with the Compliance Officer and Compliance Committee, will serve as the appropriate body to ensure that the imposed discipline is proportionate and administered fairly and consistently in compliance with NMM's policies and procedures.
- NMM's disciplinary standards shall be well-publicized and shall be disseminated and available. Enforcement of disciplinary standards will require an effective working relationship between the Compliance Officer, Human Resources and other areas of NMM maintaining primary responsibility for administering discipline.

LESSON: NMM COMPLIANCE PROGRAM TRAINING

NON-COMPLIANCE AFFECTS EVERYBODY

Without programs to prevent, detect, and correct non-compliance, we all risk:

- Harm to beneficiaries, such as:
  - Delayed services
  - Denial of benefits
  - Difficulty in using providers of choice
- Other hurdles to care Less money for everyone, due to:
  - High insurance copayments
  - Higher premiums
  - Lower benefits for individuals and employers
  - Lower Star ratings
  - Lower profits

Network Medical Management Medicare Parts C and D General Compliance Training

LESSON: NMM COMPLIANCE PROGRAM TRAINING

How to Report Potential FWA

NMM Employees:

Call NMM's Compliance Officer:
Rus Billimoria 626-943-6280

Compliance Hotline: 626-943-6286
24 hours a day/7 days a week
You may report anonymously and confidentially

Email: fwacompliance@nmm.cc

Drop Box

First-Tier, Downstream, or Related Entity (FDR) Employees

- Talk to a Manager or Supervisor
- Call your Ethics/Compliance Help Line
- Report to NMM or Sponsor

Beneficiaries

- Call NMM or Sponsor's Compliance Hotline or Customer Service
- Call 1-800-Medicare

Network Medical Management Medicare Parts C and D General Compliance Training

LESSON: NMM COMPLIANCE PROGRAM TRAINING

Don't Hesitate to Report Non-Compliance

- When you report suspected non-compliance in good faith, the Sponsor can't retaliate against you.

Each Sponsor must offer reporting methods that are:

- Anonymous
- Confidential
- Non-retaliatory

Network Medical Management Medicare Parts C and D General Compliance Training

LESSON: NMM COMPLIANCE PROGRAM TRAINING

What Happens After Non-Compliance Is Detected?

Non-compliance must be investigated immediately and corrected promptly. Internal monitoring should ensure:

- No recurrence of the same non-compliance
- Ongoing CMS requirements compliance
- Efficient and effective internal controls
- Protected enrollees

Network Medical Management Medicare Parts C and D General Compliance Training

LESSON: NMM COMPLIANCE PROGRAM TRAINING

What Are Internal Monitoring and Audits?

- Internal monitoring activities include regular reviews confirming ongoing compliance and taking effective corrective actions.
- Internal auditing is a formal review of compliance with a particular set of standards (for example, policies, procedures, laws, and regulations) used as base measures.

LESSON: NMM COMPLIANCE PROGRAM TRAINING

Lesson Summary

- Organizations must create and maintain compliance programs that, at a minimum, meet the seven core requirements. An effective compliance program fosters a culture of compliance.
- To help ensure compliance, behave ethically and follow your organization's Standards of Conduct. Watch for common instances of non-compliance, and report suspected non-compliance.
- Know the consequences of non-compliance, and help correct any non-compliance with a corrective action plan that includes ongoing monitoring and auditing.

Compliance Is Everyone's Responsibility!

Prevent: Operate within your organization's ethical expectations to prevent non-compliance!

Detect & Report: Report detected potential non-compliance!

Correct: Correct non-compliance to protect beneficiaries and save money!

LESSON: NMM COMPLIANCE PROGRAM TRAINING

You've completed the lesson!

You have now learned about compliance programs and **NMM's** Code of Conduct.

APPENDIX A: RESOURCES

Glossary

For glossary terms, visit the Centers for Medicare & Medicaid Services Glossary.

https://www.cms.gov/apps/glossary

Network Medical Management Medicare Parts C and D General Compliance Training

APPENDIX B: JOB AIDS

Job Aid A: Seven Core Compliance Program Requirements

The Centers for Medicare & Medicaid Services (CMS) requires that an effective compliance program must include seven core requirements:

1. Written Policies, Procedures, and Standards of Conduct
    - These articulate the Sponsor's commitment to comply with all applicable Federal and State standards and describe compliance expectations according to the Standards of Conduct.
2. Compliance Officer, Compliance Committee, and High-Level Oversight
    - The Sponsor must designate a compliance officer and a compliance committee accountable and responsible for the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program.
    - The Sponsor's senior management and governing body must be engaged and exercise reasonable oversight of the Sponsor's compliance program.
3. Effective Training and Education
    - This covers the elements of the compliance plan as well as preventing, detecting, and reporting FWA. Tailor this training and education to the different employees and their responsibilities and job functions.

Network Medical Management Medicare Parts C and D General Compliance Training

APPENDIX B: JOB AIDS

Seven Core Compliance Program Requirements (continued)

4. Effective Lines of Communication
    - Make effective lines of communication accessible to all, ensure confidentiality, and provide methods for anonymous and good- faith compliance issues reporting at Sponsor and first-tier, downstream, or related entity (FDR) levels.
5. Well-Publicized Disciplinary Standards
    - Sponsor must enforce standards through well-publicized disciplinary guidelines.
6. Effective System for Routine Monitoring, Auditing, and Identifying Compliance Risks
    - Conduct routine monitoring and auditing of Sponsor's and FDR's operations to evaluate compliance with CMS requirements as well as the overall effectiveness of the compliance program.

Network Medical Management Medicare Parts C and D General Compliance Training

APPENDIX B: JOB AIDS

Seven Core Compliance Program Requirements (continued)

7. Procedures and System for Prompt Response to Compliance Issues
    - The Sponsor must use effective measures to respond promptly to non-compliance and undertake appropriate corrective action.
    - Note: Sponsors must ensure that FDRs performing delegated administrative or health care service functions concerning the Sponsor's Medicare Parts C and D program comply with Medicare Program requirements.

Network Medical Management Medicare Parts C and D General Compliance Training

JOB AID B: RESOURCES

Compliance Education Materials: Compliance 101

https://oig.hhs.gov/compliance/101

Health Care Fraud Prevention and Enforcement Action Team Provider Compliance Training

https://oig.hhs.gov/compliance/provider-compliance-training

Office of Inspector General's (OIG's) Provider Self-Disclosure Protocol

https://oig.hhs.gov/compliance/self-disclosure-info/protocol.asp

Part C and Part D Compliance and Audits – Overview

https://www.cms.gov/medicare/compliance-and-audits/part-c-and-part-d-compliance-and-audits

Physician Self-Referral

https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral

Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1254524.html

Safe Harbor Regulations

https://oig.hhs.gov/compliance/safe-harbor-regulations

Network Medical Management Medicare Parts C and D General Compliance Training

Section 27
Standards of Conduct

2021 Standards of Conduct

I. Mission

Network Medical Management (NMM) is committed to conducting its business operations with the highest ethical standards and in full compliance with all applicable Federal and State laws, rules and regulations. NMM expects its employees and first-tier, downstream, and related entities (FDRs) to perform their job duties and represent the organization in a manner that reflects and upholds this commitment. The NMM Standards of Conduct is designed to clearly communicate the organization's expectations and provide guidance to its employees and FDRs in carrying out their daily activities within appropriate ethical and legal standards.

II. Purpose and Scope

All NMM employees and FDRs must comply fully with the standards set forth in the NMM Standards of Conduct as well as any additional parameters documented in department-specific policies and procedures. Employees and FDRs who violate the Standards of Conduct will be subject to disciplinary action.

The standards and requirements in these Standards of Conduct apply to all NMM employees, including directors, officers, managers, and staff at all levels, and all NMM FDRs, including but not limited to providers, brokers, agents and enrollers.

These Standards of Conduct are not intended to and shall not be deemed or construed to provide any rights, contractual or otherwise, to any employees of NMM or to any third parties.

III. Standards of Conduct

General Principles

All NMM employees and FDRs shall conduct their daily activities in accordance with the following general principles of conduct:

1. Job duties must be performed in full compliance with both the letter and the spirit of Federal and State law. No employee shall take any action that he or she believes is in violation of any statute, rule or regulation. All employees are expected to have a practical working knowledge of Federal and State laws and regulations affecting their job responsibilities, and to inquire of their immediate supervisor when related questions arise.

2. Conduct activities with integrity and honesty. NMM employees shall strive for excellence in performing their duties.

3. Avoid any conduct that could reasonably be expected to reflect adversely upon the integrity of the company, its officers, directors or other employees.

4. Be a positive influence and good corporate citizens in the communities where the company provides services. Treat members, providers, vendors, and fellow employees fairly and with respect.

5. Report to their supervisors or to the NMM Compliance Officer any illegal or unethical practices of NMM employees, FDRs or agents.

6. Abide by the NMM Compliance Program, Anti-Fraud Plan, Conflict of Interest Policy, and all other applicable Policies and Procedures.

Avoiding Conflicts of Interest

NMM employees and FDRs shall:

1. Understand and abide by NMM's Conflict of Interest policy.
2. Avoid situations that could create, or appear to create, a conflict of interest unless such a situation has been reported to management, approved and properly disclosed as required by the Conflict of Interest policy.
3. Avoid any financial, business, or other activity that competes with NMM's business interests, interferes or appears to interfere with the performance of their duties,

involves the use of NMM property, facilities, or resources, except to the extent consistent with the Conflict of Interest policy.

4. Not have a financial or other personal interest, other than compensation provided by
NMM, in a transaction between NMM or any of its business units and vendors, suppliers, providers, or customers.

Business and Financial Practices

NMM employees and FDRs shall:

1. Conduct all NMM business transactions in accordance with management's general or specific directives, as specified by applicable NMM policies and procedures, and in full compliance with governing Federal and State laws, rules and regulations.
2. Avoid offering or accepting any form of bribe, payment, gift, or item of more than a nominal value to or from any person or entity with which NMM has or is seeking a business or regulatory relationship.
3. Avoid unfair competition or deceptive trade practices, including misrepresentation of NMM's products or operations. NMM employees and FDRs shall not make false or disparaging statements about competitors or their products.
4. Comply with applicable antitrust laws. There shall be no discussions or agreements with competitors regarding price or other terms for products, prices paid to suppliers or providers, dividing up customers or geographic markets, or joint action to boycott or coerce certain customers, suppliers, or providers.

Preventing, Detecting and Correcting Fraud, Waste and Abuse

NMM is strongly committed to the detection and prevention of FWA. NMM maintains ultimate responsibility for adhering to and fully complying with all applicable State and Federal statutory and regulatory requirements. NMM will work in an ongoing manner with the appropriate entities to detect and prevent FWA as required by the CMS Compliance Program Guidelines.

NMM employees and FDRs shall:

1. Comply with applicable laws, regulations, guidelines and NMM policy, including NMM's Anti-Fraud Plan.
2. Immediately report suspected FWA conduct to the NMM Compliance Department.
3. Cooperate fully with, and disclose all pertinent information with regard to any NMM investigation of suspected FWA conduct.

Marketing and Sales / Enrollment Activities

NMM will take all appropriate steps to ensure that its marketing personnel present clear, complete and accurate information to potential enrollees. This includes ensuring that the marketing information has been approved by, and complies with all requirements of, the Department of Managed Health Care, in the case of commercial business, or the Centers for Medicare and Medicaid Services, in the case of Medicare business.

NMM employees and FDRs shall:

1. Comply with applicable Federal and State laws, regulations, guidelines and NMM policy, including the Medicare Marketing Guidelines, with respect to all marketing, sales and enrollment activities.
2. Always place the best interests of potential enrollees and NMM above personal financial interests.
3. Present clear, complete, accurate information, and ensure that potential enrollees have the opportunity to make a well informed enrollment decision. This includes utilizing only marketing materials and information that have been approved by, and comply with all requirements of, NMM and CMS.
4. Avoid providing any information or engaging in conduct that might in any way misrepresent NMM or its programs, or mislead, confuse, coerce or pressure potential enrollees. An example of misrepresentation by an agent would be to tell potential enrollees that the agent works for or is contracted with Social Security Administration or CMS.
5. Never offer cash payments, gifts, bribes or kickbacks to any person or entity to induce enrollment in NMM plans or programs.
6. Never engage in door-to-door solicitation of Medicare contracted products or

programs. **Quality and Accessibility of Health Care**

NMM employees and FDRs shall:

1. Comply with applicable Federal and State laws, regulations, guidelines and NMM policy with respect to provision of quality health care to NMM members.
2. Make every effort to ensure that all covered services are available, accessible, and appropriately delivered to NMM members, and that NMM:
    a. Contracts with providers in sufficient number and geographic location to service all NMM members;
    b. Maintains reasonable, understandable utilization review procedures that facilitate rather than discourage access to covered services; and

cProvides access to emergently needed services (according to the reasonable person standard) without prior authorization, and timely coordination of appropriate maintenance and post-stabilization stabilization care.

3. Make all decisions regarding provision of care or payment for services in a timely manner and in accordance with professionally recognized standards, without regard for fiscal concerns. Inappropriate delay or withholding of services is a violation of NMM policy and will not be tolerated.
4. Never create or contribute to situations, either through action or failure to act, that could promote underutilization or poor quality of care, and immediately report any such situation or circumstance to the appropriate manager.
5. Ensure that contracts with providers meet all NMM and regulatory requirements, and that incentives to promote efficient utilization of services do not include payments to reduce or limit medically necessary services to any particular enrollee.
6. Ensure at all times that providers are properly licensed and credentialed prior to providing services to NMM members.
7. Avoid interference with health care providers' advice to their patients, including advice regarding health status, care and treatment options, risks, benefits and consequences of treatment vs. non-treatment, or the opportunity for the patient to refuse treatment and express a preference for future treatment options.
8. Ensure that NMM members who are high utilizers of care continue to receive appropriate access to services are not in any way encouraged to disenroll from NMM.

Confidentiality, Privacy, and Maintenance of

Records NMM employees and FDRs

shall:

1. Ensure timely and appropriate creation, distribution, retention, storage, retrieval and destruction of records and documents, in any form (paper or electronic), in accordance with generally accepted accounting standards and other applicable Federal and State laws, regulations and policies, including but not limited to the Health Insurance Portability & Accountability Act (HIPAA) and the Confidentiality of Medical Information Act (CMIA).
2. Maintain the confidentiality and security of financial, medical, personnel, and other sensitive or proprietary information belonging to NMM, and/or information belonging or related to NMM's suppliers, FDRs, regulators, or customers.
3. Maintain the privacy and security of protected health information covered by HIPAA or other applicable patient/consumer privacy laws and regulations.

Workplace Conduct and Safety

NMM employees and FDRs shall, at all times while on the job or otherwise representing NMM:

1. Conduct themselves professionally and treat all fellow employees, members, FDRs, or other individuals they encounter in the course of their duties, with appropriate courtesy, dignity, and respect.
2. Avoid any type of behavior or conduct that could be construed as discrimination or harassment due to age, ethnicity, gender, religion, national origin, disability, sexual orientation, or covered veteran status. Any form of harassment, sexual or otherwise, including the creation of a hostile working environment, is completely prohibited.
3. Follow safe work practices and comply with all applicable safety standards and health regulations.

Department-Specific Compliance Standards and Operational Policies and Procedures

In addition to the standards and requirements described in these Standards of Conduct, compliance standards and operational policies and procedures specific to each NMM department will continue to be incorporated into department-specific manuals (and/or other appropriate media), and kept current with applicable Federal and State laws and regulations. The department-specific policies and procedures are a resource for the employees of each department, designed to enhance their ability to perform their duties in accordance with NMM's policies and applicable Federal and State laws and other requirements. Each department has defined and assigned responsibility for (i) the timely updating of the policies and procedures, (ii) the necessary training and education of affected personnel, and (iii) the completion of monitoring and audit work plans as designated by the Compliance Officer to ensure ongoing compliance.

IV. Reporting and Investigation

NMM considers adherence to these Standards of Conduct to be of paramount importance, because establishing and maintaining a reputation for honest, ethical business practices is a key NMM corporate value. Furthermore, engaging in illegal activity or improper conduct may subject NMM to severe civil and criminal penalties, including large fines and exclusion from certain types of business. It is therefore crucial that any suspected illegal activity or improper conduct, including violation of these Standards or any other NMM policy, be promptly reported and thoroughly investigated.

Duty to Report

1. NMM employees and FDRs who become aware of any suspected illegal activity or improper conduct are required to immediately report the illegal activity or improper conduct through appropriate channels.
2. NMM employees should report suspected illegal activity or improper conduct to their supervisor, or directly to the NMM Compliance Department.
3. NMM FDRs should report suspected illegal activity or improper conduct directly to the NMM Compliance Department.
4. Suspected illegal activity or improper conduct may be reported to the NMM Compliance Department by sending an email to FWA@nmm.cc calling the Compliance Hotline at 626-943 6286.
5. Failure to report suspected illegal activity or improper conduct is a violation of these Standards, and may be a violation of Federal and/or State law.
6. NMM has developed detailed reporting and investigation policies: Compliance Policy #5 – Reporting Possible Misconduct, Compliance Policy #7 – Internal Investigations of Alleged Violations, Compliance Policy #15 – Reporting Marketing Misrepresentation, and Compliance Policy #17 – Reporting FWA. All NMM employees and FDRs are expected to be aware of and abide by the requirements of these reporting and investigation policies.

Anonymous Reporting

NMM employees and FDRs may report suspected illegal activity or improper conduct anonymously.

1. To the extent permitted by Federal and State law, NMM will take reasonable precautions to maintain the confidentiality of those individuals who report illegal activity or improper conduct, and of those individuals involved in the alleged violation, whether or not it turns out that improper acts occurred.
2. Failure to abide by this confidentiality obligation is a violation of these Standards.

Investigations and Duty to Cooperate

It is NMM's policy to promptly and thoroughly investigate all reports of illegal activity or improper conduct. Detection of potential or actual issues related to compliance, ethical conduct, or other measurable areas of performance shall result in the initiation of appropriate corrective action. Any action, or lack of action, that prevents, hinders, or delays discovery and full investigation of suspected illegal activity or improper conduct is a violation of these Standards, and may be a violation of Federal and/or State law.

1. Internal investigations will include interviews and review of relevant documents. NMM employees and FDRs are required to cooperate fully with, and disclose all pertinent information with regard to any NMM investigation of suspected illegal activity or improper conduct.
2. NMM, its employees and FDRs shall cooperate with appropriate government investigations into possible civil and criminal violations of Federal and/or State law. It is important, however, that in this process NMM is able to protect the legal rights of the Company and its personnel. **To accomplish these objectives, any governmental inquiries or requests for information, documents, or interviews must be promptly referred to the NMM Compliance Officer.**

Protection from Retaliation

NMM ensures that employees and FDRs may report or assist investigation of suspected illegal acts or improper conduct without threat of negative consequences.

1. No retaliation, reprisals or disciplinary action will be taken or permitted against NMM employees or FDRs for good faith participation in the Compliance Program, including but not limited to reporting potential issues to appropriate authorities, cooperating in the investigation of suspected illegal activities or improper conduct, and conducting self-evaluations, audits and remedial actions.
2. Failure to abide by this prohibition against retaliation or reprisals is a violation of these Standards, and may be a violation of Federal and/or State law.

V. Disciplinary Action

NMM employees and FDRs who engage in illegal activity or improper conduct, including violation of these Standards or any other NMM policy, are subject to disciplinary action including oral or written warnings or reprimands, suspensions, termination, financial penalties and potential reporting of the conduct to law enforcement. If employees or FDRs self-report their own illegal actions or improper conduct, NMM will take such self-reporting into account in determining appropriate disciplinary action.

Section 28
Forms and Additional Attachments

Eligibility Request Form

Please fill in this form for eligibility inquiry. Photocopies of the member's insurance card, health plans web site eligibility print out or any other supporting information will help expedite the process.

Please fax to: (626) 943-6352

Date: ______________________________ Provider's Name: ______________________________

Provider's Office Contact Person: ______________________ Provider's Office Contact Number: ______________________

Provider Fax number: ______________________________ Email: ______________________________

*Member's eligibility status will be verified and returned through fax or email

Last Name	First Name	DOB	Member ID #	Health Plan	Line of Business:	Gender	Address: (Must input for correct authorization)	Phone #	Membership Effect Date
					☐ MCAL ☐ POS ☐ Commercial ☐ Senior/Medicare				
					☐ MCAL ☐ POS ☐ Commercial ☐ Senior/Medicare				

Web Portal New Account Registration Form

*Please fill out all required entries and fax completed form to: **(626) 943-6350**

*Vendor/Group Name:	*Tax ID:
*Office Contact/Manager:	Group NPI (if applicable):
*Best Contact Phone Number and Extension:	Office E-Mail Address:
*Best Time to Contact:	Current Web Portal User ID (if applicable):

*Please list all providers (physicians) affiliated under this vendor/group (attach additional sheets if required)			
Provider Name	NPI	Provider Name	NPI
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

What areas of the Web Portal will your office need access to? (Please circle all that apply)

- Eligibility
- Authorization (view)
- Authorization (submit)
- Claims (view)
- Claims (submit)

Will your office be authorizing an outside biller to access the data noted aabove? Yes No

If yes, please note the outside billing company's information below:

Billing Company:	Billing Contact Person:
Biller Phone Number:	Best Time to Contact:

Authorized Signature:____________________Print Name:____________________Date: ______________

Provider Signature:____________________Print Name:____________________Date: ______________

Direct Deposit Authorization Form

I. PAYEE INFORMATION

Payee Name_______________________________
Tax ID ___________________________________
EMANATE HEALTH IPA

II. ACCOUNT INFORMATION

Bank Name	Type of Account
	Check box:
Routing # ______________________________ Account # ______________________________	☐ Checking ☐ Savings

*Please provide a copy of a voided check

I hereby authorize Network Medical Management on behalf of LaSalle Medical Associates to initiate credit and, if necessary, debit entries* to the account listed on this form. My signature below indicates that I am either the accountholder or have the authority of the accountholder to authorize Network Medical Management to make deposits into the named account.

Signature_______________________________ Date_____________________________

Contact Person__________________________ Phone____________________________

E-Mail Address____

* "Debit entries" applies to previous agreements, if any, between NMM and the provider in the case of fund transmission errors. No debit entries will occur without prior notification.

PLEASE COMPLETE AND FAX THIS FORM TO:

Fax: 626-943-6379

Attention Accounting Department

ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT FORM

Electronic Remittance Advice (ERA/835) files are electronic transactions that contain the same information as your paper remittances. **Please complete the sections below in its entirety and send to the following: FAX (626) 943-6309, via email, ProviderNetworkOperations.Dept@nmm.cc**

- ☐ Advantage Health Network (ADV)
- ☐ Adventist Health Physicians Network (GAMC / WMMC)
- ☐ Greater San Gabriel Valley Physicians (GSGP)
- ☐ Access Primary Care Medical Group (APCMG)
- ☐ Arroyo Vista Family Health Center (AVISTA)
- ☐ LaSalle Medical Associates (LSMA)
- ☐ Accountable Health Care (AHCIPA)
- ☐ Citrus Valley IPA (CVIPA)
- ☐ Greater Orange Medical Group (GOM)
- ☐ Other ____________________

PROVIDER INFORMATION	
Contracted Provider Group Name:	
Provider Main Office Address:	
Authorized Contact Person:	
Authorized Contact Person Phone:	
Authorized Contact Person Email:	
PROVIDER IDENTIFICATION INFORMATION	
Federal Tax ID:	
Group NPI:	
Individual Provider NPI(s):	

ELECTRONIC REMITTANCE ADVICE INFORMATION (ONLY CHECK ONE BOX)

Preference for Agrregation of Remittance Data: (i.e., Account number linkage to Provider identifier). Please note, preference for grouping claim payment advice, must match preference for EFT payment (i.e., Billing Provider). Please fill in only one below:

☐	Provider Federal Tax Identification Number: ____________________
OR	
☐	National Provider Identifier (NPI): ____________________

I ______________________________, hereby authorize Network Medical Management to

Practice Owner/CEO

provide ______________________________ with the Electronic Remittance Advice for our organization.

Authorized Party

Practice/Owner Name: ______________________________

Practice/Owner Signature: ______________________________ **Date:**______________

Please complete all sections. Incomplete submissions will not be processed.

Material Needs Form

If your office is in need of Health Education Materials, please fill out this assessment form and fax response to (626) 943-6383.

Provider Name: ____________________
Provider Address: ____________________
Provider Telephone: ____________________
Provider Fax Number: ____________________
Provider Health Plan Contracts: ____________________

5. Would you like more information about health education classes?

   ________Yes ________No

6. Do you have health education materials in your office?
   ________Yes ________No

7. What sources have you used to obtain health materials?

   ____

8. Please circle Health Education Materials needed in your office and specify languages

Advance Directive	Hypertension	Medi-Cal Materials
Asthma	Men's Health	Healthy Family
Breastfeeding	Nutrition	Staying Healthy
Cholesterol	Pregnancy	WIC Services
Congestive Heart Failure	STD's	Parenting
Depression	Stress Management	Other:________
Diabetes Mellitus	Smoking Cessation	________
Family Planning	Weight Management	
Gyn. Disorders	Women's Health	

English Spanish Chinese Other: ________
Completed by:
____________________Sent:____________________

NETWORK MEDICAL MANAGEMENT USE ONLY

Date Health Education Materials sent to Provider: ____________________ By:____________________

Request/Refusal for Interpretive Services Form

Patient Name: ____

Primary Language: ____

- ☐ Yes, I am requesting interpretive services.
  Language: ____________________________________

- ☐ I prefer to use my family or friend as an interpreter. (Interpreters must be over 18 years of age)
- ☐ No, I do not require interpretive services.
- ☐ N/A

  Please explain:
  ____
  ____
  ____

________________________ ____________________
Patient Signature Date

- Please place in patient's medical record.

Other languages are available upon request. (Spanish, Chinese, Vietnamese, Armenian, Russian, Khmer)

Patient's Rights and Responsibilities

It is the Patient's Right to:

1. Exercise these rights without regards to sex or cultural, economic, educational or religious background or the source of payment for the member's care.
2. Considerate and respectful care.
3. Knowledge of the name of the provider who has primary responsibility for coordinating the member's care and the professional relationships of other providers who see the member
4. Receive information from the member's provider about the member, the course of treatment and the member's prospects for recovery in terms that the member can understand.
5. Receive as much information about any proposed treatment/procedure the member may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include the procedure/treatment, the significant medical risks involved, alternate course of treatment or non-treatment and the risks involved in each, and to know the name of the person who will carry out the procedure or treatment.
6. Participate actively in decisions regarding the member's medical care to the extent permitted by law; this includes the right to refuse treatment.
7. Full consideration of privacy concerning his/her medical program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The member has the right to be advised as to the reason for the presence of any individual.
8. Confidential treatment of all communications and records pertaining to their care. Member's written permission shall be obtained before medical records can be made available to anyone not directly concerned with their care.
9. Receive timely response to requests for services, including evaluations and referrals.
10. Leave the facility even against the advice of the member's provider.
11. Continuity of care, advance notice of time and location of appointment and provider providing medical care.
12. Be advised if facility/personal provider proposes to engage in or perform human experimentation affecting his/her care or treatment and the right to refuse to participate in such research projects.
13. Be informed by their provider or a delegate of their provider of his continuing health care requirements following the member's discharge from the facility.
14. Examine and receive an explanation of the member's bill regardless of source of payment.
15. Have all member's rights apply to the person legally responsibility to make decisions regarding medical care.
16. Acquire information desired about a member's Health Plan, including a clear explanation of benefits and services and how to receive them.
17. Obtain medically necessary health services, including preventive care.
18. Voice a complaint about a health plan or the care a member receives through their plan's grievance and appeal procedures, and to receive a timely response to any complaints or inquiries regarding benefits or care.
19. Discuss (and complete) an advance directive, living will or other health care directive with a provider.
20. Receive a second opinion when deemed necessary by the contracting medical group.
21. Receive emergency service when the members, as a prudent layperson, believe that a life-threatening emergency occurred. Payment will not be withheld in such cases.
22. Receive urgently needed services when traveling outside of the service area.
23. Not be discouraged to enroll in, or be directed to enroll in, any particular Medicare Choice plans.

It is the Patient's Responsibility to:

1. Follow the plans and instruction for care agreed upon with their provider(s).
2. Provide, to the extent possible, information that the medical group and its providers need in order to care for the member.
3. Contact their provider or health plan with any questions or concerns about health benefits or health care services.
4. Understand health benefits; follow proper procedures to obtain services, and to abide by health plan rules.

Be informed

If you are being treated for any form of ***breast cancer***, or prior to performance of a biopsy for breast cancer, your provider or surgeon is required to provide you a written summary of alternative efficacious methods of treatment, pursuant to section 1704.5 of the California Health & Safety Code.

The information about methods of treatment was developed by the state department of health services to inform members of the advantages, disadvantages, risks and descriptions of procedures.

Be informed

If you are being tested for any form of ***prostate cancer***, or prior to performance of a biopsy for prostate cancer, your provider or surgeon is urged to provide you a written summary of alternative efficacious methods of treatment pursuant to section 1704.1 of the California Health & Safety Code.

The information about methods of treatment was developed by the state department of health services to inform members of the advantages, disadvantages, risks and descriptions of procedures.

Emergency Services

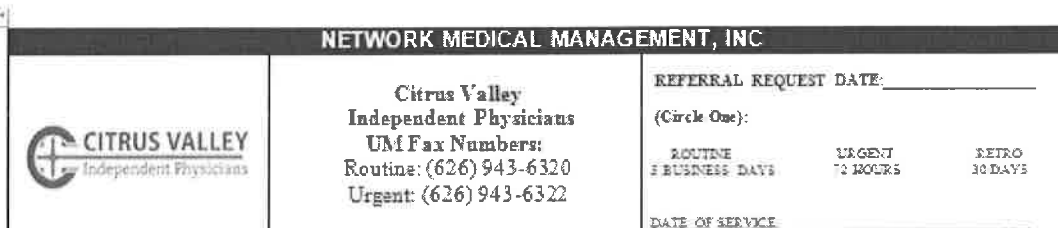
If a practice receives a call from a EMANATE HEALTH IPA member, they should determine whether the member should call 9-1-1, go to the nearest emergency room, urgent care center, or to the practice. Only licensed personnel should handle triage of members.

- If it is determined that the member is in a life-threatening emergency, they should be instructed to hang up the phone and dial 9-1-1 immediately.
- If it is determined that the member is stable enough to go to the nearest emergency room, urgent care center, or to their primary care provider's practice to be evaluated, the practice should instruct the member to be transported by another person. A member should never be instructed to drive himself/herself in the event of a life-threatening situation.

To seek care coordination for non-life threatening situations after 5:00pm or on weekends, the provider and/or the member can call Network Medical Management at (877) 282-8272 and speak to an on-call provider or Case Manager.

Treatment Authorization Form

NETWORK MEDICAL MANAGEMENT, INC



CITRUS VALLEY Independent Physicians

Citrus Valley
Independent Physicians
UM Fax Numbers:
Routine: (626) 943-6320
Urgent: (626) 943-6322

REFERRAL REQUEST DATE:______________

(Circle One):

ROUTINE 5 BUSINESS DAYS | URGENT 72 HOURS | RETRO 30 DAYS

DATE OF SERVICE ______________

FORM WILL BE RETURNED IF MEMBER'S NAME, ID#, HEALTH PLAN or/and CLINICAL INFORMATION ARE NOT COMPLETE OR NOT LEGIBLE

PATIENT INFORMATION

Patient Name: Last ______________ First ______________ Middle ______________ DOB ____/____/____ AGE ____ Sex (M) (F)

Address: ______________ City: ______________ Zip ______________ Phone # ( ) ______-______

Health Plan ______________ Member ID # ______________ Member Effective Date ____/____/____

PCP ______________ Phone # ( ) ______-______ Fax ( ) ______-______

Referring Provider Name: ______________

M.D. Office Contact Name: ______________

Phone: (____)______-______ Fax: (____)______-______

Referred to Specialty: ______________

Provider Name: ______________

Phone: (____)______-______ Fax: (____)______-______

Services to be provided at: Office – 11, Inpatient Stay – 21, Outpatient Hospital – 22 REQUESTED FACILITY: ______________

DIRECT REFERRALS ONLY: (CHECK ONE) ANY FOLLOW VISITS OR PROCEDURES MUST BE PRE –AUTHORIZED BY NMM

Well Woman Exam (New Patient) - ☐ 99385 (age 18-39) ☐ 99386 (age 40-64) ☐ 99387 (age 65 and over)

Established Patient: ☐ 99395 (age 18-39) ☐ 99396 (age 40-64) ☐ 99397 (age 65 and over) ☐ Pregnant OB Care (full term) - 59400

☐ Mammography – G0202 (40 and older eligible every 2 years) ☐ Chest, Long Bone or KUB X-Rays

☐ PATIENT REQUEST ☐ M.D. REQUEST

Diagnosis: ______________ ICD-10 code(s) ______________

Requested Services/Treatments

Procedure description: ______________ CPT CODE ______________

Procedure description: ______________ CPT CODE ______________

Clinical Problem & Duration: ______________

____

Pertinent Clinical History / Lab / X-Ray: ______________

____

Treatment tried/failed: ______________

Why is this referral or test (s) necessary? ______________

PHYSICIAN SIGNATURE: ______________ DATE: ______________

FOR USE BY NETWORK MEDICAL MANAGEMENT ONLY

☐ Authorized/Modified UM Signature: ______________ Date: ____/____/____ AUTH # ______________

☐ Pended Date: ____/____/____ Pended Reason: ______________ Response Date: ____/____/____ Signature ______________

☐ Denied Reason: ______________ Date: ____/____/____ UM Signature: ______________

Date PCP Notified: ____/____/____ Date Specialist Notified: ____/____/____ Member Notification: ____/____/____ by United States Mail

Phoned PCP of Denial: ____/____/____ Time: ____:____ Phoned Specialist of Denial: ____/____/____ Time: ____:____

STATEMENT FOR PROVIDER: **Further care must be authorized before it is rendered.** If additional treatment is required contact the referring physician. Additionally, consultant's findings and recommendations must be sent to the referring physician. ALL LABORATORY WORK MUST BE PERFORMED AT QUEST DIAGNOSTICS. Authorization does not guarantee payment. All claims are subject to Eligibility, Contracted provisions and Exclusions. This certificate is good for 60 days from approval day. All lab work and imaging studies should be done at a Network Medical Management contracted facility.

UM decisions are based on standardized criteria. Provider may view criteria upon request. Call [illegible] for more information.

Effective Date: 01/01/2018

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/Medical Group Name: ______________________ Plan/Medical Group Phone#: (______)______________
Plan/Medical Group Fax#: (______)______________ Non-Urgent ☐ Exigent Circumstances ☐

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request. **Information contained in this form is Protected Health Information under HIPAA.**

Patient Information

First Name:	Last Name:	MI:	Phone Number:

Address:	City:	State:	Zip Code:

Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm): ______ Weight (lb/kg):______	Allergies:

Patient's Authorized Representative (if applicable):	Authorized Representative Phone Number:

Insurance Information

Primary Insurance Name:	Patient ID Number:
Secondary Insurance Name:	Patient ID Number:

Prescriber Information

First Name:	Last Name:	Specialty:

Address:	City:	State:	Zip Code:

Requestor (if different than prescriber):	Office Contact Person:
NPI Number (individual):	Phone Number:
DEA Number (if required):	Fax Number (in HIPAA compliant area):
Email Address:	

Medication / Medical and Dispensing Information

Medication Name:

☐ New Therapy ☐ Renewal ☐ Step Therapy Exception Request
If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?
☐ Paid under Insurance Name:______________________ Prior Auth Number (if known):______________
☐ Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:
☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location:
☐ Physician's Office
☐ Ambulatory Infusion Center
☐ Patient's Home
☐ Home Care Agency
☐ Outpatient Hospital Care
☐ Long Term Care
☐ Other (explain):______________________

Revised 12/2016 Form 61-211

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Patient Name:	ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step therapy exception request.

1. Has the patient tried any other medications for this condition? ☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	Duration of Therapy (Specify Dates)	Response/Reason for Failure/Allergy

2. List Diagnoses:	ICD-10:

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification:________________ **Date:**________________

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

Plan/Insurer Use Only: Date/Time Request Received by Plan/Insurer:__________ Date/Time of Decision__________

Fax Number (______)______________

☐ Approved ☐ Denied Comments/Information Requested:____________________

Revised 12/2016 Form 61-211

NEW PHYSICIAN IN-SERVICE

Name of Physician Office: ______________________________________ Date: __________
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- Your title/position:
  ☐ Physician
  ☐ Office Manager
  ☐ Other ______________________

- Please note Physician's area of specialty:
  ☐ Family Practice ☐ General Practice ☐ Pediatrics ☐ Internal Medicine ☐ OB/GYN
  ☐ Other: ____________________________

Evaluation

	Excellent	Good	Fair	Poor
Overall evaluation of the in-service				
Do you feel this in- service met your expectations and needs				
Content of information received				
Did you understand the requirements and responsibilities indicated during the in-service				
Rate presentation of material provided				

Comments

Please send in evaluation to: Rafael.Zepada@nmm.cc

NEW PROVIDER IN-SERVICE ACKNOWLEDGEMENT

By signing below, ________________________________ (Physician/Provider Office Name) acknowledges that my office staff has received a formal in-service regarding the administrative and operational policies, procedures, forms, and protocols required to provide services to all members with members affiliated with EMANATE HEALTH IPA.

In addition to the in-service, I acknowledge receipt of the following materials:

- ☐ **Provider Manual**
- ☐ **HEDIS Reference Guide**
- ☐ **IPA Memorandums**
- ☐ **Utilization Management Guidelines**
- ☐ **Specialist Reporting Responsibilities**

I also attest that all staff has completed the 2020 trainings for the following:

- ☐ **Model of Care**
- ☐ **Fraud Waste and Abuse**
- ☐ **Code of Conduct & General Compliance**

Provider Training Acknowledgement (person who received training):

________________________________ ____________________
(Name & Title) (Date)

________________________________ ____________________
(Name & Title) (Date)

In-Service Presented By: ________________________________ ____________
(Name & Title) (Date)