2020

HCLA PROVIDER MANUAL

Health Care LA, IPA

Table of Contents

Welcome

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

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

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

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

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

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

Important Information About the Use of This Manual

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

This manual will be amended as policies change.

Please visit Health Care LA, IPA website at https://healthcarela.org/ for more information

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

Health Care LA, IPA

Quick Reference Guide

Need to contact us? This reference guide provides you with quick access to a variety of resources.
Dial: 818-702-0100. For **English Press 1**, For **Spanish Press 2**, **select Option 1** for Provider access then make your Department selection below.

Provider Network Operations

Phone: 818-702-0100, Option 5
HCLA_Provider_Updates@medpointmanagem

Provider Network Operations is responsible for the oversight of all its contracted providers. Our responsibilities include education and training for your staff, updating facility data, and resolution of provider issues and complaints.

Provider Network Operations is available 9 a.m. –5p.m., weekdays Pacific Time (PT) except major holidays.

MedPOINTManagement.com

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

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

For technical questions and to resolve issues with the portal, please contact IT at
818-702-0100, Option 6.

Eligibility

Phone: 818-702-0100, Option 1

Verify Eligibility through the MPM Web Portal. The MPM Eligibility is updated on a weekly, bi-monthly or monthly basis, depending on the health plan file availability. To obtain real-time eligibility information, check directly on the Health plan website.

Referrals and Authorizations

Phone: 818-702-0100, Option 2

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

Claims Inquiry

Phone: 818-702-0100, Option 3

Claims history and status can be viewed through the MPM Web Portal. Providers are encouraged to submit claims electronically through Office Ally, our preferred method, or make special arrangements to use another clearinghouse.

Claims Submission Electronic

Office Ally
Payer ID: MPM06

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

Provider Dispute Resolution

Phone: 818-702-0100, Option 3

For appeals or requests for reconsideration of a claim that has been denied, adjusted, or contested, please mail the Provider Dispute Resolution to the mailing address below.
For more information and to obtain the PDR form, visit the Provider Resources tab at MedPOINTManagement.com.

Please mail Provider Dispute to:

Health Care, LA IPA
Attn: PDRs
P.O. Box 570590
Tarzana, CA 91357

HCLA HEALTH CENTER SFTP ACCESS

MedPOINT Management (MPM) provides a secure and convenient way to transfer data and files to HCLA Health Center Leadership via the MPM sFTP (Secure File Transfer Protocol). Each HCAL Health Center has a private folder, which can only be accessed when permissions are granted.

To access your Health Center's folder, please email ITSupport@medpointmanagement.com

MPM IT Support will respond within 24 hours to complete sFTP set up. Once set up is complete, your Health Center sFTP can be accessed at https://ftp.medpointmanagement.com/

Credentialing

Phone: 818-702-0100, Option 4

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

Quality Management

qualitymeasures@medpointmanagement.com

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

Contracting

Phone: 818-702-0100, Option 5
HCLA_Provider_Updates@medpointmanagement.com

Please contact the Contracting Team at MedPOINT Management for all contracting inquiries.

Compliance Hotline

Phone: 818-702-0100, x1531
ComplianceConcerns@medpointmanagement.com

Please mail Compliance concerns to:

Health Care LA, IPA
Attn: Compliance Officer
P.O. Box 570590
Tarzana, CA 91357

Section 1: Introduction

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

How to Join Our Network

For instructions on joining the Health Care LA, IPA provider network, contact MedPOINT Management at HCLA_Provider_Updates@medpointmanagement.com

SECURE PROVIDER WEB PORTAL

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

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

The secure MPM Provider Web Portal allows you to:

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

PROVIDER NETWORK OPERATIONS

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

Section 2: Network and Affiliates

CONTRACTED HEALTH PLANS

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

HEALTH PLANS	MEDI-CAL	MEDICARE ADVANTAGE	MEDI- MEDI	COVERED CALIFORNIA	CAL MEDICONNECT	COMMERCIAL	POS
Alignment		✓	✓				
Anthem Blue Cross	✓			✓		✓	✓
Blue Shield						✓	✓
Blue Shield Promise	✓	✓	✓		✓		
Brand New Day		✓	✓				
Cigna						✓	✓
Health Net	✓	✓	✓	✓	✓	✓	✓
Imperial Health Plan		✓	✓				
L. A. Care	✓			✓	✓		
Molina	✓	✓		✓	✓		

Section 2: Network and Affiliates

CONTRACTED HEALTH PLANS

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

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

Section 2: Network and Affiliates

HEALTH PLAN AFFILIATIONS

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

Section 2: Network and Affiliates

HEALTH PLAN AFFILIATIONS

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

Section 2: Network and Affiliates

AFFILIATED HOSPITALS

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

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

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

AFFILIATED HOSPITAL LISTING BY HEALTH PLAN/PRODUCTLINE

	MEDI-CAL					MEDICARE						COMMERCIAL				COVERED CALIFORNIA			CAL MEDICONNECT				
HEALTH CARE LA	BLUE CROSS MEDI-CAL	BLUE SHIELD PROMISE MEDI-CAL	HEALTH NET MEDI-CAL	L A CARE MEDI-CAL	MOLINA MEDI-CAL	ALIGNMENT MEDICARE	BLUE SHIELD PROMISE MEDICARE	BRAND NEW DAY MEDICARE	HEALTH NET MEDICARE	IMPERIAL HEALTH PLAN MEDICARE	MOLINA MEDICARE	BLUE CROSS COMMERCIAL	BLUE SHIELD COMMERCIAL	CIGNA COMMERCIAL	HEALTH NET COMMERCIAL	HEALTH NET (HNCC)	L A CARE (LACC)	MOLINA (MOCC)	BLUE SHIELD PROMISE (CCMC)	HEALTH NET (HCMC)	L A CARE (LCMC)	MOLINA (MCMC)	IPA ANCILLARY AGREEMENT
CALIFORNIA HOSPITAL MEDICAL CENTER	Y-FR	Y-SR	Y-FR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	N	N	Y-SR
CENTINELA HOSPITAL MEDICAL CENTER (PRIME)	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	N	N	N	Y-SR	N	N	Y-SR	Y-SR	Y-SR	N	Y-SR	N	Y-SR	N	N
EMANATE HEALTH - FOOTHILL PRESBYTERIAN	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR
EMANATE HEALTH - INTERCOMMUNITY	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR
EMANATE HEALTH - QUEEN OF THE VALLEY	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR
GLENDALE MEMORIAL HOSPITAL	Y-SR	Y-SR	N	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	N	N	Y-SR
HOLLYWOOD PRESBYTERIAN MEDICAL CENTER	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR
LONG BEACH MEMORIAL MEDICAL CENTER	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR
LOS ANGELES COMMUNITY HOSPITAL - LOS ANGELES (ALTA)	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	N	N	Y-SR	N
LOS ANGELES COMMUNITY HOSPITAL - NORWALK (ALTA)	N	Y-SR	N	Y-SR	Y-SR	N	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	N
MARTIN LUTHER KING , JR. COMMUNITY HOSPITAL	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	N
MEMORIAL HOSPITAL OF GARDENA (AVANTI)	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR
MILLER CHILDREN'S HOSPITAL	Y-SR	Y-SR	Y-SR	N	Y-SR	N	Y-SR	N	N	N	Y-SR	Y-SR	N	N	Y-SR	N	N	Y-SR	N	N	N	N	N
POMONA VALLEY HOSPITAL MEDICAL CENTER	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	N	N	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	N	N	N	N
PROVIDENCE HOLY CROSS MEDICAL CENTER	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	N
PROVIDENCE LITTLE COMPANY OF MARY (SAN PEDRO)	Y-SR	Y-SR	N	Y-SR	Y-SR	N	Y-SR	N	N	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	Y-SR	N	Y-SR	Y-SR	Y-SR
PROVIDENCE LITTLE COMPANY OF MARY (TORRANCE)	N	N	N	Y-SR	N	N	N	N	Y-SR	N	N	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	N	Y-SR	Y-SR	N	N
PROVIDENCE SAINT JOHN'S MEDICAL CENTER	N	N	Y-SR	Y-SR	N	N	N	N	N	N	N	Y-SR	Y-SR	Y-SR	N	N	Y-SR	N	N	N	Y-SR	N	N
PROVIDENCE SAINT JOSEPH MEDICAL CENTER	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	N	Y-SR	N	Y-SR	Y-SR	Y-SR
PROVIDENCE TARZANA MEDICAL CENTER	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	Y-SR	Y-SR
SAN GABRIEL VALLEY MEDICAL CENTER (AHMC)	N	Y-SR	N	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N
SOUTHERN CA HOSP AT CULVER CITY	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N
SOUTHERN CA HOSP AT HOLLYWOOD	N	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	N
ST FRANCIS MEDICAL CENTER	Y-FR	Y-SR	Y-FR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR
ST MARY MEDICAL CENTER	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	N	Y-SR	N	N	N
VALLEY PRESBYTERIAN HOSPITAL	Y-FR	Y-SR	Y-FR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	N	Y-SR
WHITE MEMORIAL MEDICAL CENTER	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N
LIMITED AFFILIATION																							
ALHAMBRA HOSPITAL (AHMC)	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	
ANTELOPE VALLEY HOSPITAL	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	N	N	N	N	Y-SR	Y-SR	N	N	Y-SR	N	Y-SR	N	Y-SR	N	
BEVERLY HOSPITAL	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	N
CEDARS-SINAI MEDICAL CENTER - TERTIARY	N	N	N	N	N	N	N	N	N	N	N	Y-SR	Y-SR	Y-SR	N	N	N	N	N	N	Y-SR	N	N
CHILDRENS HOSPITAL LA-TERTIARY	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	N	N	N	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	N	N	N	N	N	N
COLLEGE MEDICAL CENTER- LONG BEACH	N	N	N	N	N	N	N	N	N	N	N	Y-SR	N	N	N	N	N	N	N	N	N	N	N
GARFIELD MEDICAL CENTER (AHMC)	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	N
GLENDALE ADVENTIST MEDICAL CENTER	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N
GOOD SAMARITAN HOSPITAL	Y-SR	Y-SR	N	Y-SR	N	N	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	N	Y-SR	Y-SR	Y-SR	N	N
GREATER EL MONTE MEDICAL CENTER (AHMC)	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	N
HENRY MAYO NEWHALL	Y-SR	N	N	N	N	N	N	N	Y-SR	N	N	Y-SR	Y-SR	Y-SR	N	N	N	N	N	Y-SR	N	N	Y-SR
HUNTINGTON MEMORIAL HOSPITAL	Y-SR	N	N	Y-SR	N	N	N	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	N	N	Y-SR	N	N	N	Y-SR	N	N
KECK HOSPITAL OF USC - TERTIARY	Y-SR	Y-SR	N	N	N	N	Y-SR	N	N	Y-SR	N	Y-SR	Y-SR	Y-SR	N	N	N	N	Y-SR	N	N	N	N
LOMA LINDA-TERTIARY	N	N	N	N	N	N	N	N	N	N	N	Y-SR	Y-SR	Y-SR	N	N	N	N	N	N	N	N	Y-SR
METHODIST HOSPITAL	N	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	N	Y-SR	N	N	Y-SR	Y-SR	N	N	Y-SR	Y-SR	
MISSION COMMUNITY HOSPITAL	Y-SR	Y-SR	N	N	N	N	Y-SR	Y-SR	Y-SR	N	N	Y-SR	N	N	N	N	N	N	N	N	N	N	Y-SR
MONTEREY PARK HOSPITAL (AHMC)	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N

AFFILIATED HOSPITAL LISTING BY HEALTH PLAN/PRODUCTLINE

	MEDI-CAL					MEDICARE						COMMERCIAL				COVERED CALIFORNIA			CAL MEDICONNECT				
HEALTH CARE LA	**BLUE CROSS MEDI-CAL**	**BLUE SHIELD PROMISE MEDI-CAL**	**HEALTH NET MEDI-CAL**	**L A CARE MEDI-CAL**	**MOLINA MEDI-CAL**	**ALIGNMENT MEDICARE**	**BLUE SHIELD PROMISE MEDICARE**	**BRAND NEW DAY MEDICARE**	**HEALTH NET MEDICARE**	**IMPERIAL HEALTH PLAN MEDICARE**	**MOLINA MEDICARE**	**BLUE CROSS COMMERCIAL**	**BLUE SHIELD COMMERCIAL**	**CIGNA COMMERCIAL**	**HEALTH NET COMMERCIAL**	**HEALTH NET (HNCC)**	**L A CARE (LACC)**	**MOLINA (MOCC)**	**BLUE SHIELD PROMISE (CCMC)**	**HEALTH NET (HCMC)**	**L A CARE (LCMC)**	**MOLINA (MCMC)**	**IPA ANCILLARY AGREEMENT**
NORTHRIDGE HOSPITAL MEDICAL CENTER	Y-SR	Y-SR	N	Y-SR	N	Y-SR	Y-SR	Y-SR	Y-SR	N	N	Y-SR	Y-SR	Y-SR	N	N	Y-SR	N	Y-SR	N	Y-SR	N	N
OLIVE VIEW MEDICAL CENTER	Y-SR	Y-SR	Y-SR	Y-SR	Y-SR	N	Y-SR	N	N	N	Y-SR	Y-SR	N	N	N	N	Y-SR	Y-SR	Y-SR	N	Y-SR	Y-SR	
PALMDALE REGIONAL MEDICAL CENTER	N	N	Y-SR	Y-SR	Y-SR	Y-SR	N	N	N	N	Y-SR	N	Y-SR	Y-SR	N	N	Y-SR	N	N	N	Y-SR	N	
SHRINERS HOSPITALS FOR CHILDREN	N	N	N	N	N	N	N	N	N	N	N	N	N	Y-SR	N	N	N	N	N	N	N	N	N
UCLA MEDICAL CENTER, RONALD REGAN	Y-SR	N	N	Y-SR	N	N	N	N	N	N	N	Y-SR	Y-SR	Y-SR	N	N	N	N	N	N	N	N	N
UCLA MEDICAL CENTER, SANTA MONICA	N	N	N	N	N	N	N	N	N	N	N	Y-SR	Y-SR	Y-SR	N	N	N	N	N	N	N	N	N

Y-FR	Contracted, Full Risk (FR) = Capitated Hospital based on PCP POD
Y-SR	Contracted, Shared Risk (SR) = Not a Capitated Hospital
N	Non-Contracted

Updated 04/30/2020

Section 2: Network and Affiliates

HOSPITALISTS

HCLA is contracted with Hospitalists that supervise care from admission through discharge at HEALTH CARE L.A., IPA affiliated hospitals.

THE CONTRACTED HOSPITALISTS WILL BE RESPONSIBLE FOR THE FOLLOWING

- All urgent and emergent admissions
- Provision of internal medicine, pulmonary disease and critical care medical services to all hospitalized adult patients
- Newborn Care
- Medical coordination and inpatient utilization management for surgical patients
- Provide consultation on complicated Surgical and Obstetric cases
- Coordination of all ancillary services related to the inpatient episode of care inclusive of durable medical equipment, home health and infusion services, etc.
- Coordination, in conjunction with the discharge planner, of discharge planning needs with the patient and the patient's family
- Feedback to the Primary Care Physician, as required, inclusive of a discharge summary within 24 hours of discharge
- Coordination of transfer of out-of-network patients to an in-network hospital
- MPM Inpatient Team can be reached during regular business hours, Monday – Friday, 9 am – 5 pm at (818) 702-0100 ext. 449
- MPM On-Call Nurses are available after hours, Monday – Friday, 5 pm – 9 am and Weekends and Holidays, 24 hours at (818) 702-0100

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

Section 2: Network and Affiliates

PHARMACY INFORMATION

For a listing of participating pharmacies, along with corresponding Formulary Information, please reference applicable Health Plan Web site:

Alignment Health https://www.alignmenthealthplan.com/
Look under "For Members" then click link, "Find a Pharmacy"

Anthem Blue Cross https://www.anthem.com/ca/
Search under "Providers" then "Pharmacy"

Blue Shield https://www.blueshieldca.com/
Search under "Be well" then "Pharmacy"

Blue Shield Promise
Only for formulary services at this time.
Search under "For members" then Pharmacy Formulary Search"

Brand New Day https://bndhmo.com/
Search under: "Providers" then "Pharmacy – more info"

Cigna http://www.cignaforhcp.com

Health Net https://healthnet.com/
Search under "Providers" then "Pharmacy Information"

LA. Care http://lacare.org/ Search under "Providers"

Molina https://www.molinahealthcare.com/en-US/Pages/home.aspx Search under "Providers"

Section 2: Network and Affiliates

CONTRACTED ANCILLARY PROVIDERS

LABORATORY

ALL MEMBERS MUST BE REFERRED TO: QUEST DIAGNOSTICS - (866) 697-8378

Lab work does not require prior authorization (except genetic testing). If you are not presently doing business with Quest, contact them at the number above to obtain requisition forms, etc.

QUEST IS ALSO THE EXCLUSIVE CONTRACTED PROVIDER FOR BRCA GENE TESTING

Lab costs for services associated with patient referrals to non-contracted lab, i.e., labs other than Quest, without formal prior authorization from the IPA, will be deducted from PCP Capitation.

DURABLE MEDICAL EQUIPMENT (DME)

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

CONTRACTED RADIOLOGY

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

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

Section 2: Network and Affiliates

URGENT CARE FACILITIES

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

Section 2: Network and Affiliates

URGENT CARE FACILITIES

PROVIDER NAME	ADDRESS	TELEPHONE & FAX NUMBER	HOURS OF OPERATION
RELIANT IMMEDIATE CARE MEDICAL GROUP (HUNTINGTON PARK)	5900 PACIFIC BLVD. HUNTINGTON PARK, CA 90255	PHONE: (310) 491-7080 FAX: (310) 491-7081	24 HOURS / 7 DAYS A WEEK
RELIANT IMMEDIATE CARE MEDICAL GROUP (LOS ANGELES)	5901 W CENTURY BLVD LOS ANGELES, CA 90045	PHONE: (310) 215-6020 FAX: (310) 491-7077	24 HOURS / 7 DAYS A WEEK
RELIANT IMMEDIATE CARE MEDICAL GROUP (LOS ANGELES)	814 FRANCISCO ST. LOS ANGELES, CA 90017	PHONE: (310) 491-7070 FAX: (310) 491-7071	24 HOURS / 7 DAYS A WEEK
RELIANT IMMEDIATE CARE MEDICAL GROUP (MONTEBELLO)	2300 W BEVERLY BLVD. #100 MONTEBELLO, CA 90640	PHONE: (626) 467-0202 FAX: (310) 491-7076	24 HOURS / 7 DAYS A WEEK
RELIANT IMMEDIATE CARE MEDICAL GROUP (SANTA FE SPRINGS)	11460 TELEGRAPH RD SANTA FE SPRINGS, CA 90670	PHONE: (310) 491-7060 FAX: (310) 491-7059	M-F: 8:00 AM – 10:00 PM SAT-SUN: 10:00 AM-5:00 PM
RESEDA FAMILY MEDICINE & URGENT CARE	6830 RESEDA BLVD. RESEDA, CA 91335	PHONE: (818) 996-4888 FAX: (818) 996-5888	M–F: 9:00 AM – 8:00 PM SAT–SUN: 9:00AM–5:00PM
SMART CLINIC URGENT CARE (SANTA CLARITA)	19231 SOLEDAD CANYON RD. SANTA CLARITA, CA 91351	PHONE: (661) 430-9040 FAX: (661) 673-7296	MONDAY – SATURDAY: 9:00 AM – 9:00 PM
SMART CLINIC URGENT CARE (WEST COVINA)	2707 E VALLEY BLVD. #116 WEST COVINA, CA 91792	PHONE: (626) 581-1000 FAX: (626) 581-1007	MONDAY – SUNDAY: 9:00 AM – 9:00 PM
SYLMAR URGENT CARE	13711 FOOTHILL BLVD # B SYLMAR, CA 91342	PHONE: (818) 408-8008 FAX: (818) 408-8011	MONDAY-SUNDAY: 9:00 AM–9:00 PM
URGENT CARE ONE	8337 LAUREL CANYON BLVD SUN VALLEY, CA 91352	PHONE: (818) 504-8499 FAX: (818) 504-8487	M-F: 9:00 AM – 9:00 PM SAT: 10:00 AM–6:00 PM SUN: CLOSED
VALLEY URGENT CARE	9335 RESEDA BLVD #100 NORTHRIDGE, CA 91324	PHONE: (818) 349-9966 FAX: (818) 349-5615	M–F: 8:00 AM – 8:00 PM SAT: 9:00AM–3:00PM
WILMINGTON URGENT CARE & FAMILY CLINIC INC.	714 N AVALON BLVD. WILMINGTON, CA 90744	PHONE: (310) 522-4200 FAX: (310) 878-0230	M–F: 9:00 AM – 7:00 PM SAT–SUN: 9:00AM–5:00PM

Visit https://www.medpointmanagement.com/ or https://healthcarela.org/
for the most up to date urgent care information

Section 2: Network and Affiliates

EMERGENCY ROOM – PATIENT EDUCATION TOOL

ATTENTION

SIGNS TO GET TO THE ER IN A HURRY

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

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

When should I call the Doctor for advice? Always! For example, conditions such as, fevers over 102.0, abdominal pain, headaches, heartburn, indigestion, constipation, hemorrhoids, back pain. If you call your doctor's office after working hours, you may ask to speak with the doctor on call.

What should I do if my Doctor's office can't help me?

Contact your health plan's 24-hour nurse advice line Click here for a list of nurse advice lines by health plan

To obtain card stock supply, please contact Melody Shahbazian or Varduhi Voskanyan via e-mail:
mshahbazian@medpointmanagement.com **or** vvoskanyan@medpointmanagement.com

Call 911 if your condition is life threating

Section 2: Network and Affiliates

EMERGENCY ROOM – PATIENT EDUCATION TOOL

ATENCIÓN

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

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

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

Si su condición es de vida o muerte, llame al 911

¿Cuándo debo pedir consejo a mi doctor?

¡Siempre! Para condiciones, por ejemplo, fiebres que pasan de 102.0, dolores de estómago, dolores de cabeza, acidez estomacal, indigestión, estreñimiento, hemorroides, dolor de espalda. Si llama después de las horas de trabajo a la oficina de su doctor, puede preguntar por el doctor que atiende las llamadas a esas horas.

¿Qué debo hacer si llamo a la oficina de mi doctor y no me pueden ayudar?

Puede llamar a su a seguranza y pedir consejo con enfermeras que están disponibles las 24 horas del día Fara más información haga clic aquí

Para obtener el suministro de cartulina, comuníquese con Melody Shahbazian o Varduhi Voskanyan vía correo electrónico:
mshahbazian@medpointmanagement.com
vvoskanyan@medpointmanagement.com

Section 3: Utilization Management

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

VERIFYING MEMBER ELIGIBILITY

It is the provider's responsibility to confirm the member's eligibility at the time of service.

When a Health Care LA, IPA patient arrives for an appointment, please verify eligibility.

Eligibility verification can be accomplished by doing the following:

1) Request the patient's Health Plan identification card.
2) Run eligibility on the Health Plan portal to verify status.
3) If the health plan or MPM portals cannot verify eligibility and the member still states that he/she is eligible, please call the MedPOINT Management Eligibility Department at **818-702-0100, Option 1**

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

1) Check Health Plan eligibility portal as instructed above.

2) Contact the health plan. If the member is still not identified, providers should contact the health plan before services are rendered. If the Health Plan is unable to verify eligibility, please do not turn away patient from medically necessary services.

HEALTH PLAN WEBSITE AND INTERACTIVE VOICE RESPONSE (IVR)

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

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

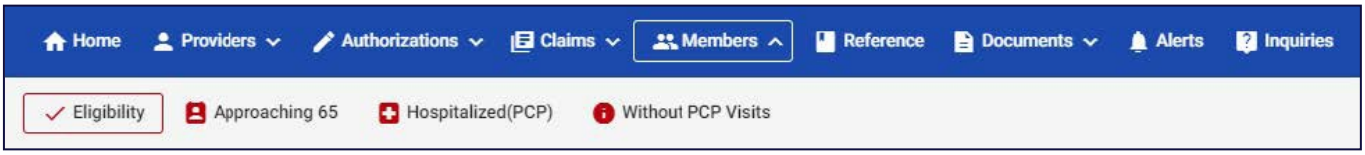
Please refer to the list below for each contracted Health Plan IVR line:

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

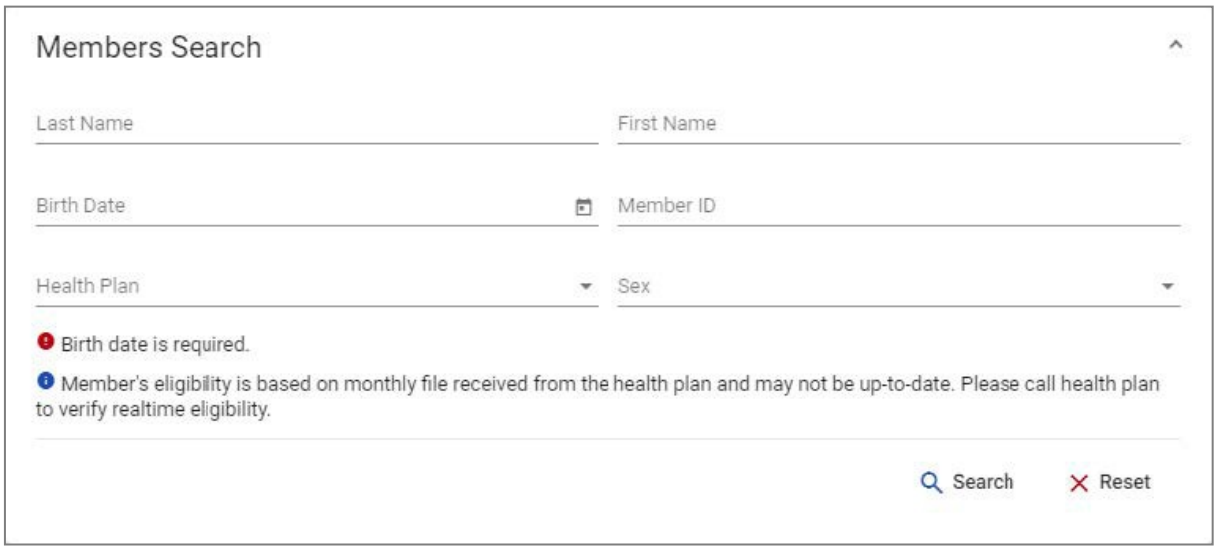
VERIFIYING ELIGIBILITY VIA THE WEB PORTAL

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

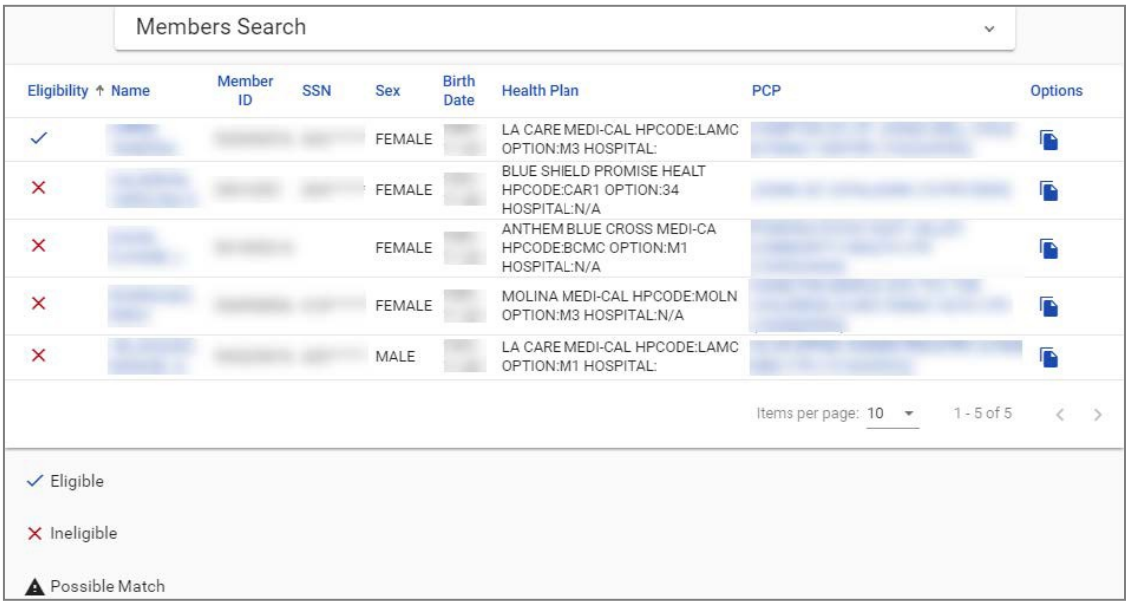
To access the Eligibility search feature, go to the Main Menu, click on Members then Eligibility:



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



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



When the system returns the Member record, you will have a clear visual indication whether the Member is Eligible, Possible Match or Ineligible.

By clicking on the Member Name, you will pull up the Member Detail Page.

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

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

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

SYSTEM REQUIREMENTS:

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

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

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

REFERRAL AND PRIOR AUTHORIZATION GUIDELINES

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

1) Submit all authorization requests via the Health Care LA, IPA/MPM Portal at: https://portal.medpointmanagement.com/sign - in. Always provide clear and concise notes stating the medically necessary/clinical reason for the referral.

2) All authorization requests are to be submitted under the actual referring provider, even if referring provider is a physician extender. In this way, we will have data to better track and trend referral patterns and care delivery.

3) Refer members to a contracted provider or facility. There is a current participating provider roster to choose from or if you have any questions about a provider's participation, feel free to contact the Provider Network Operations at MedPOINT Management.

4) Referral to non-contracted/out of network providers cannot be submitted to UM as an Urgent referral. Place in note that this is a non- contracted provider and needs immediate attention.

5) Upon approval or denial of authorizations, alerts will be sent to the Provider via the MPM Web Portal. Authorizations generally expire ninety (90) days after the date of the assignment and will be documented on the authorizations. Unused authorizations may be extended for a maximum of thirty (30) days. After this extended period, unused authorizations must be resubmitted with current progress notes to be approved for a new authorization.

6) Upon approval or denial of authorizations, alerts will be sent to the Provider via the MPM Web Portal. Authorizations generally expire ninety (90) days after the date of the assignment and will be documented on the authorizations. Unused authorizations may be extended for a maximum of thirty (30) days. After this extended period, unused authorizations must be resubmitted with current progress notes to be approved for a new authorization.

7) The requesting provider must file a copy of the approval or denial letter printed from MPM in the member's chart.

8) The Utilization Management Committee will review all redirected referrals or denials. If in disagreement with a redirect or denial, access to the Utilization Management or the Medical Director is available to discuss any concerns regarding the decision and/or alternate treatment options.

9) For appeals process and procedures, please refer to the Provider Dispute Resolution section.

10) Do not provide the member with a copy of an authorization that is in requested status. An approved routine referral will be mailed to the patient within seven (7) days.

11) PCP must have a way of tracking both Specialty Referrals and missed appointments, avoiding care fragmentation. Consult notes and follow up must be documented.

12) **Standing Referral:** If you have a member who requires continuing Specialty care over a prolonged period of time or specialist coordination of primary care, please contact the UM Department for a Standing Referral. The Standing Referral eliminates the need to return to the PCP on a repeated basis when Specialty care is required on an on-going basis.

13) **Utilization Management decisions** are made based on nationally recognized objective standards, criteria and guidelines that are based on sound medical evidence. Providers may contact MedPOINT Management for copies of all policies and procedures as well as Clinical Criteria used in the decision-making process. Providers are encouraged to discuss UM decisions with our Physician Reviewers. Please contact 818-702-0100 x 1779 to have a Medical Director answer your questions. No physician reviewer receives financial incentives to limit, restrict or deny services.

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

Type of Request	Description	Decision TAT
URGENT 	Urgent requests are for emergent referrals. The patient cannot wait for an appointment and may suffer loss of life or limb within 24 hours if not treated. Requests that do not meet this criterion will be downgraded to routine.	24 to 72 hours See SUBMITTING AUTHORIZATIONS VIA THE WEB PORTAL for instructions on submitting urgent requests. Please call the Utilization Management department at **818-702-0100 ext. 1449** (Inpatient) or **ext. 1579** (Outpatient) to follow up on urgent requests.
ROUTINE 	Routine requests are for non-urgent/non emergent referrals. The patient can wait for the appointment. Do not make an appointment for the member without an approved prior authorization.	Five (5) working days
RETROSPECTIVE 	Retrospective (Retro) refers to a process that occurs after a treatment has been completed or when a discharge from services has been accomplished.	See the RESTROSPECTIVE REVIEW POLICY for complete details. Submit Retro Auth Requests via the MPM Portal as Routine and enter "Retro Auth Request" in Notes.

Making a Referral?

Before your patient leaves, discuss…

Turnaround Time

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

Specialist Information

If you know the Specialist the patient will see,
Provide the contact information (Name & Phone), reason for referral, and referral authorization number (if available).

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

Setting an Appointment

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

Setting an Appointment

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

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

COMMON ERRORS AND SOLUTIONS

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

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

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

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

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

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

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

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

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

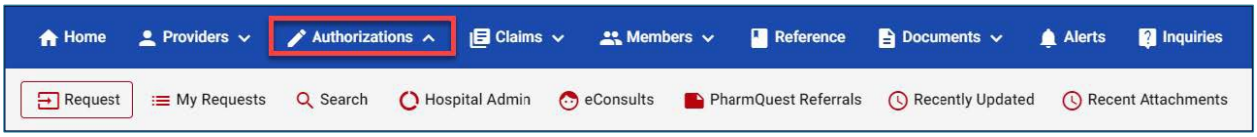
Error- Submitting comments with additional information on a denied request.
Solution- Once an authorization request has been denied that request cannot be changed. If the request was denied due to a lack of medical information, you may resubmit a new request with the additional clinical information.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

Section 3: Utilization Management

SUBMITTING AUTHORIZATIONS VIA THE WEB PORTAL

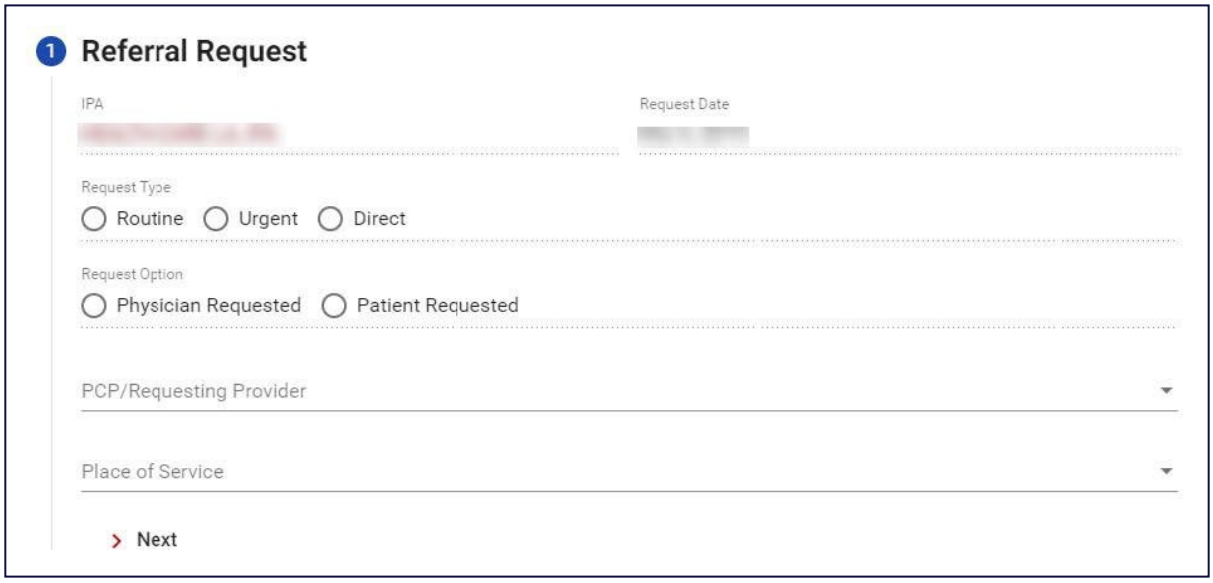
The Authorizations tab is where you can request an Authorization, view your requests, search Authorizations, and view Auth related reports.

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



The Request tab is where you can submit a Referral Request

Step 1: Referral Request



In this section, your selected IPA and request date are automatically populated

Request Type: **The timeliness of the request types per line of business is as follows:**

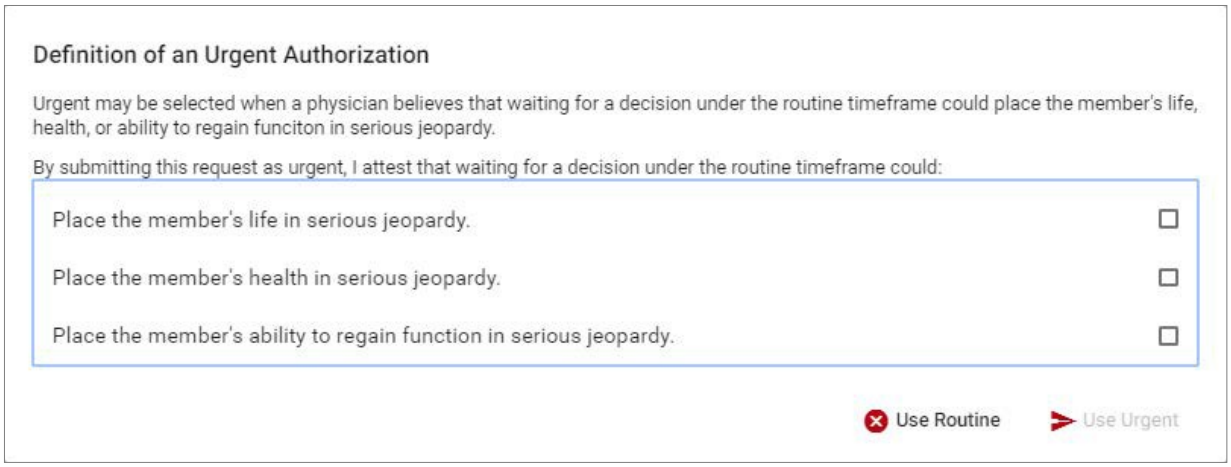
Request Turnaround Times

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

Close

Urgent Requests

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



Definition of an Urgent Authorization

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

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

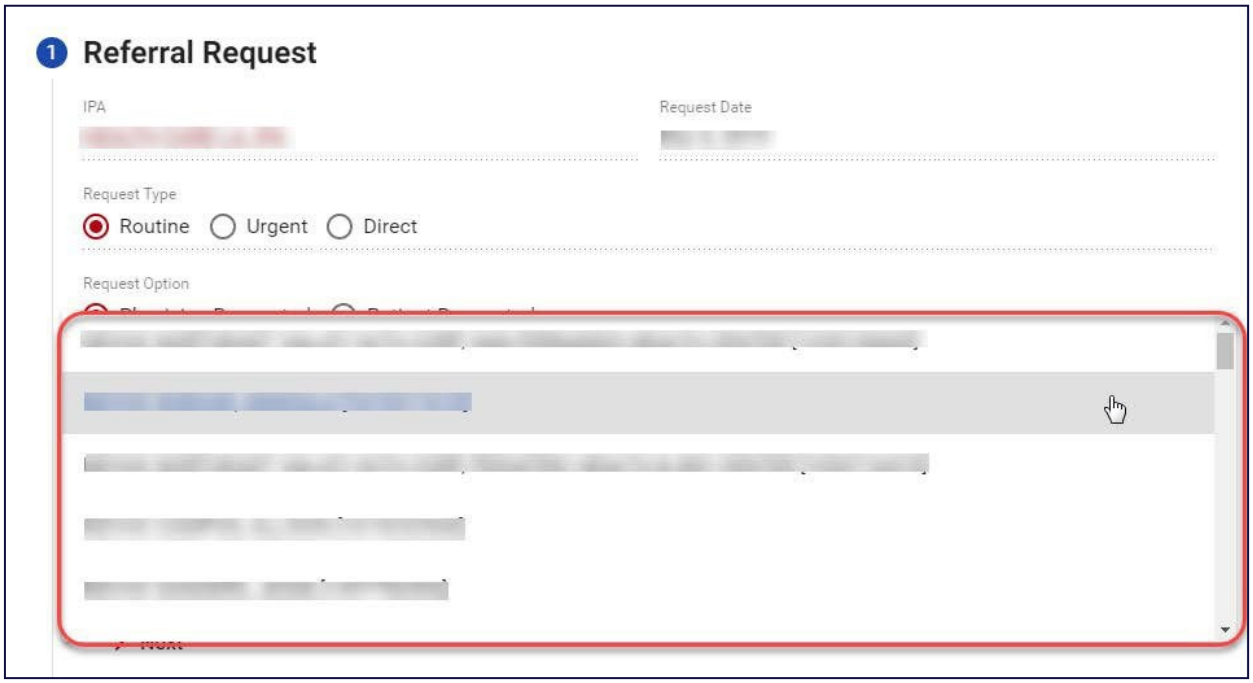
- Place the member's life in serious jeopardy. ☐
- Place the member's health in serious jeopardy. ☐
- Place the member's ability to regain function in serious jeopardy. ☐

Use Routine Use Urgent

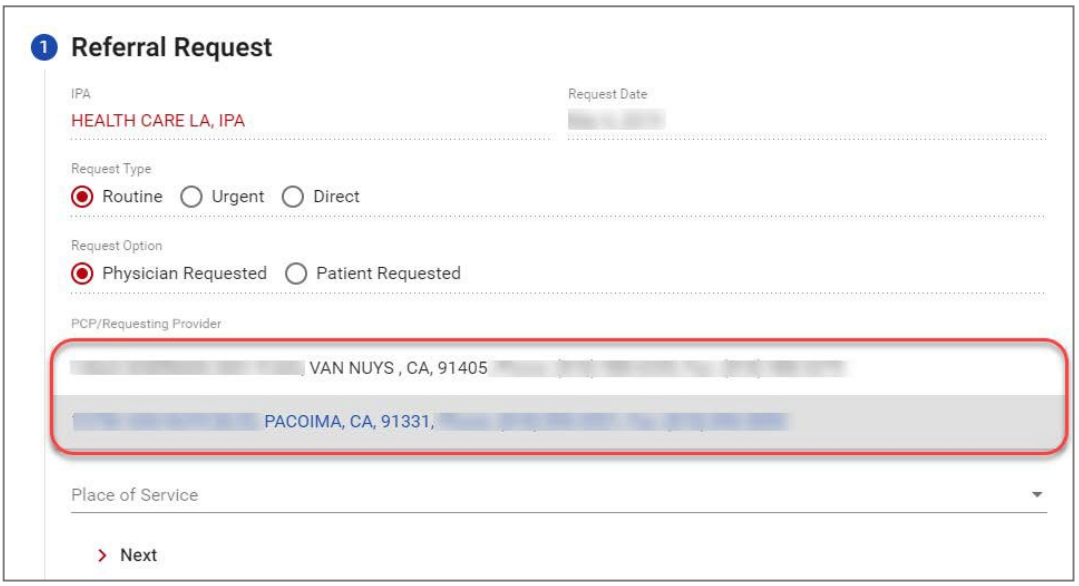
Select a PCP/Requesting Provider

Request Option: Physician Requested or Patient Requested

PCP/Requesting Provider: Clicking on the drop down will provide you with a list of all Providers within your network

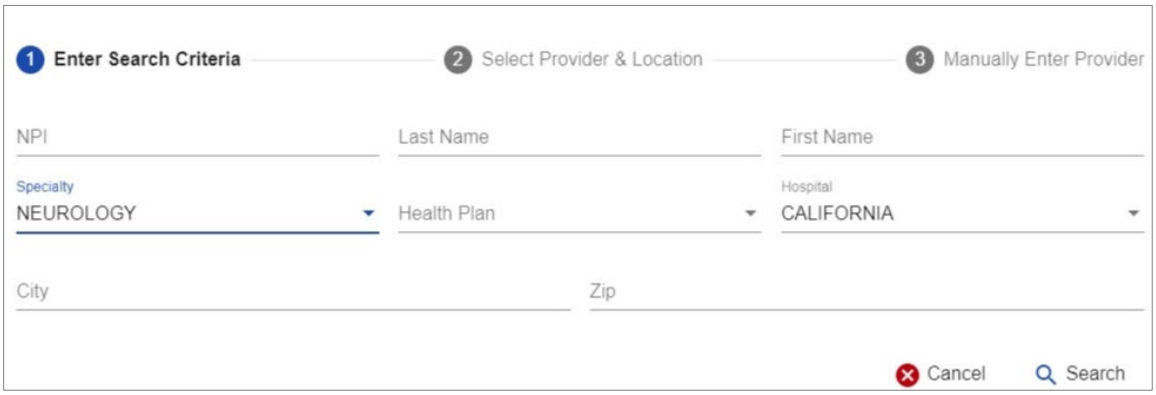


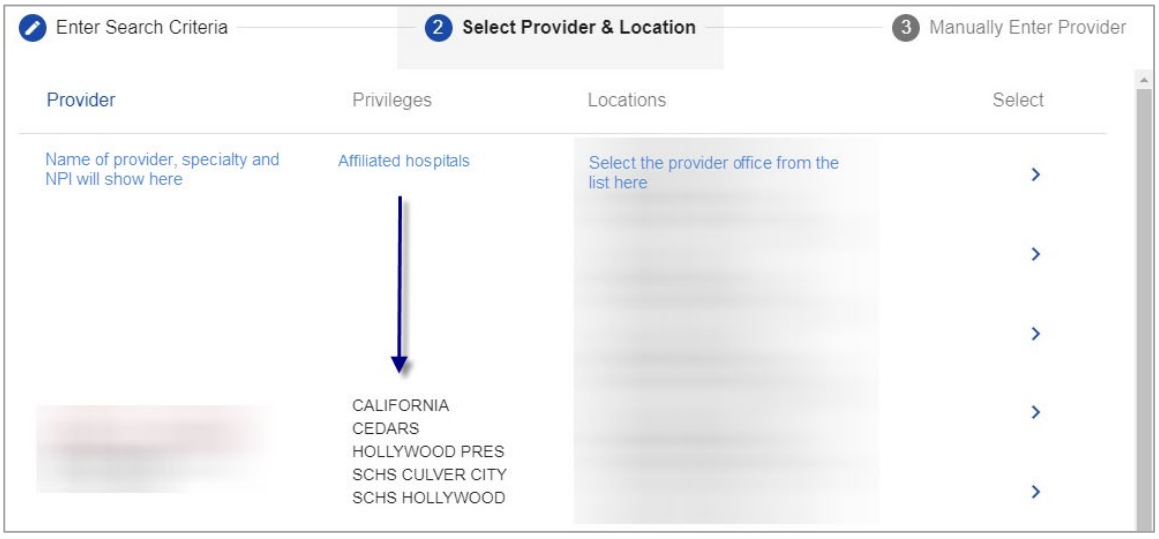
After selecting a PCP/Requesting Provider, an additional line will appear asking for the provider location. If the provider has multiple office locations, all locations will appear.



Place of Service: A drop down of all the available place of services will be available. You can type the code or description to populate the POS in the field.

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



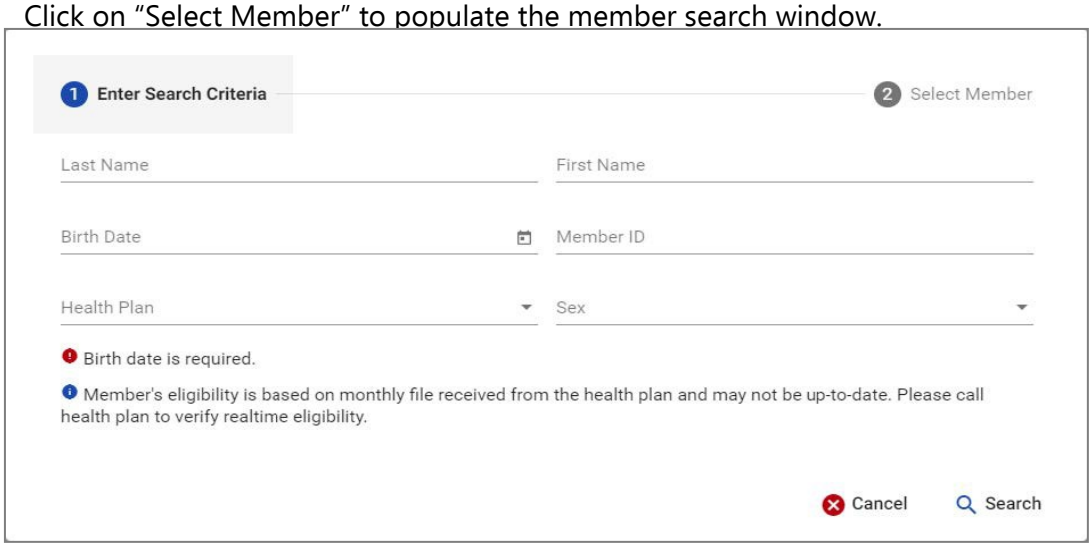


Click on Next or click on Step 2 to proceed

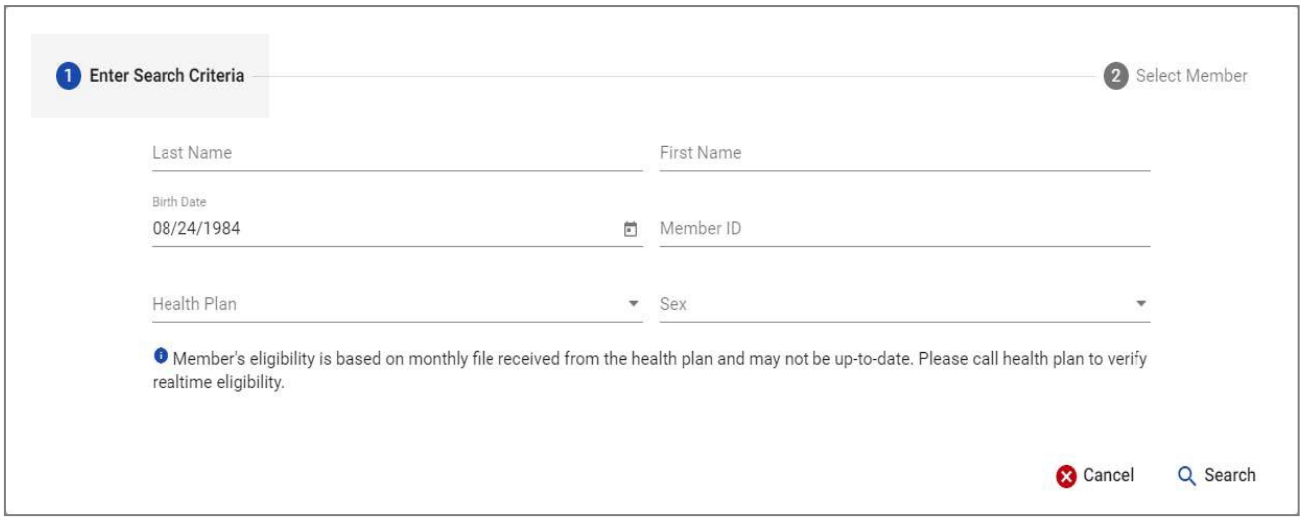
Step 2: Requesting Member

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

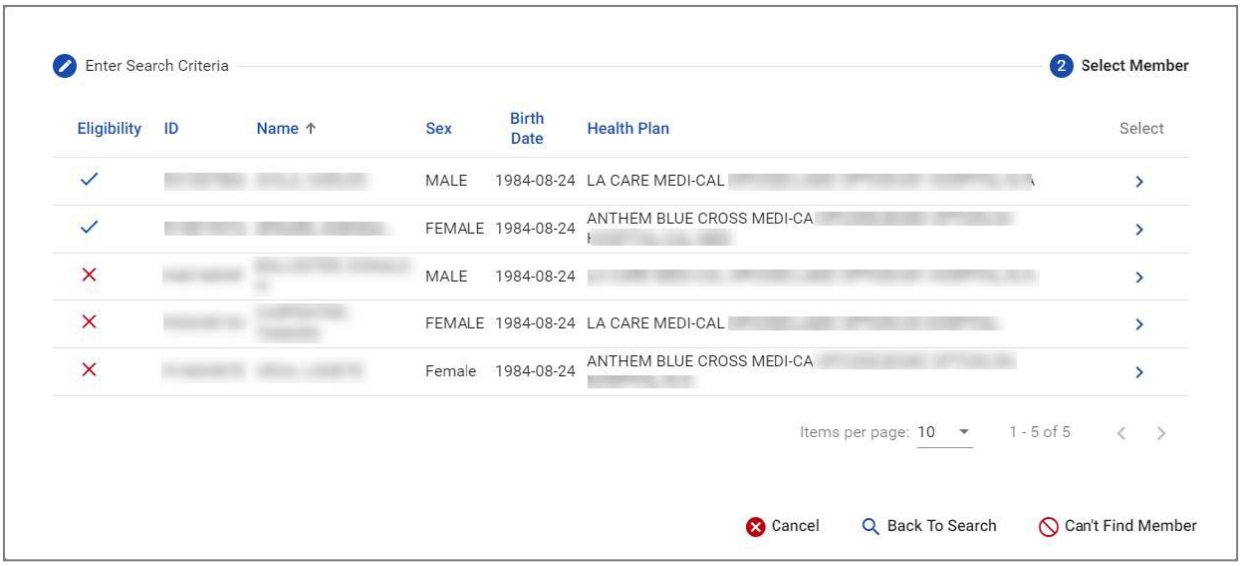
Click on "Select Member" to populate the member search window.



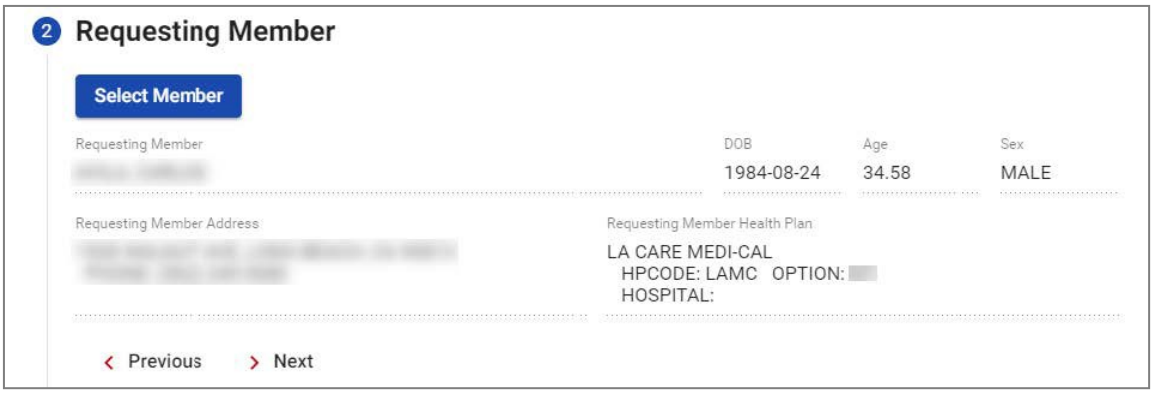
Enter the member's information. The birth date is the minimum requirement to search for a member.



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



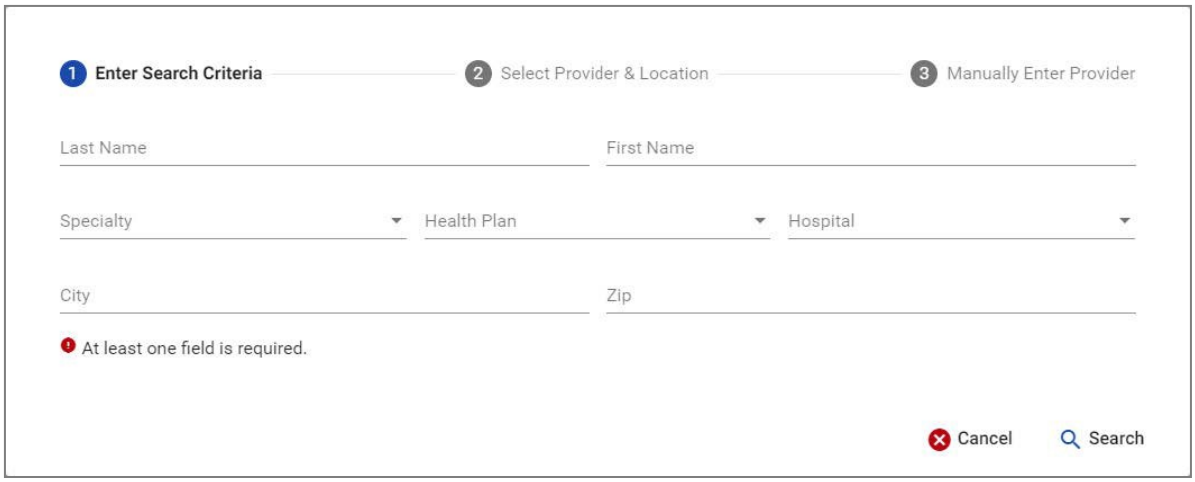
Click on the arrow under Select to add the member to the Authorization request.



Step 3: Requested Provider

Select the Requested Provider in this section.

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

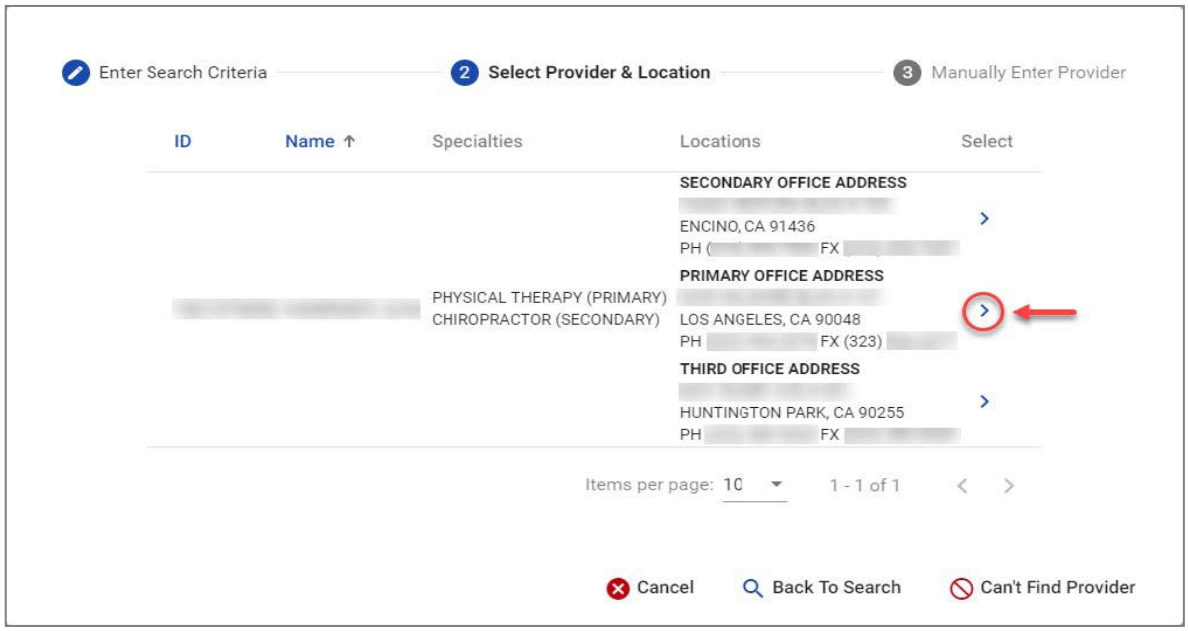


Enter the information for the Provider and click on the search icon.

Requested Provider Location

If a provider has multiple addresses, all of them will appear. Click on the icon to select the desired location to continue.

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



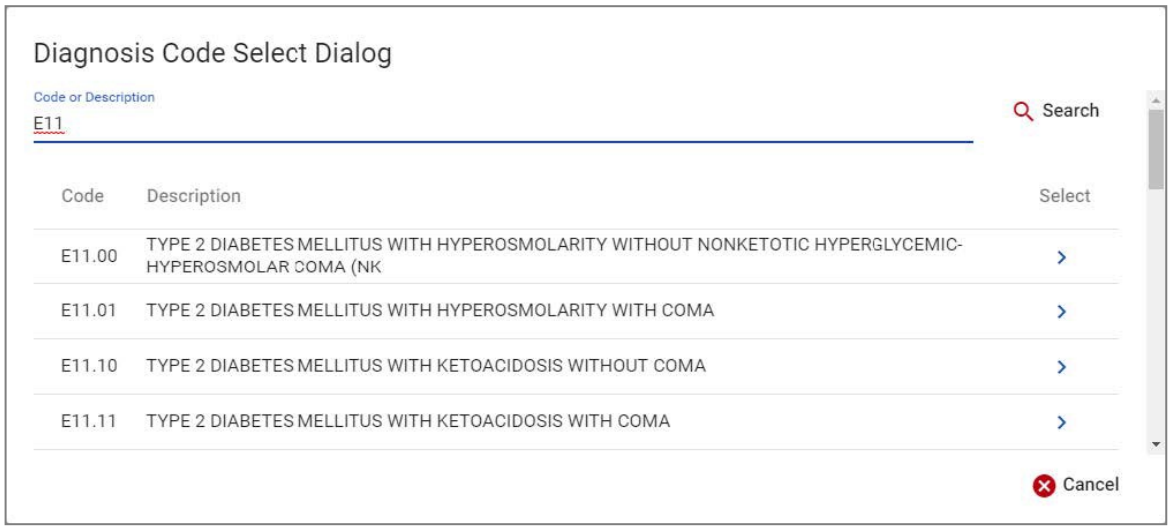
The Provider's information will now appear under Step 3.

Click on Next or click on Step 4 to proceed.

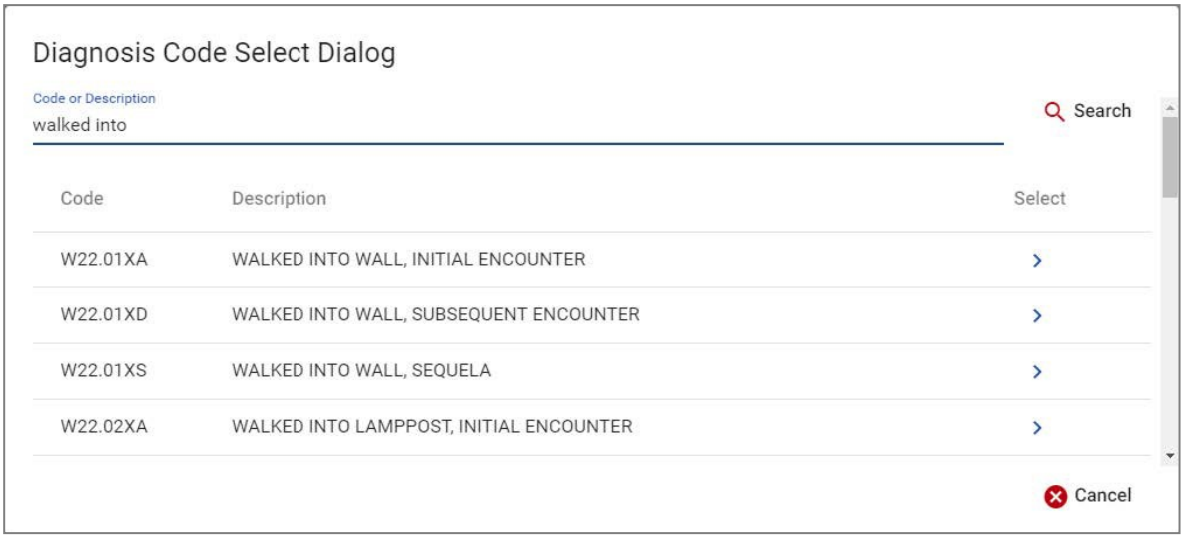
Step 4: Diagnosis

Enter the diagnosis code(s) in this section.

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



Enter in a description to pull up the possible diagnosis codes



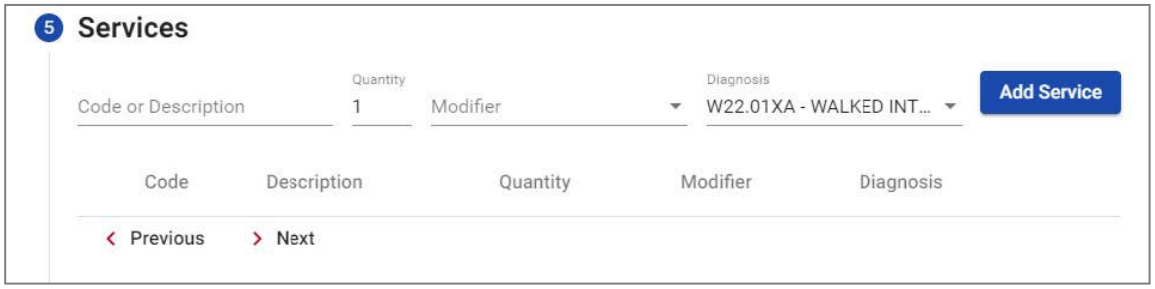
Once the codes are selected, they will appear on the Authorization Request page.

Click on the up and down arrows to move the diagnosis codes in sequence; primary, secondary, etc.

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

Step 5: Services

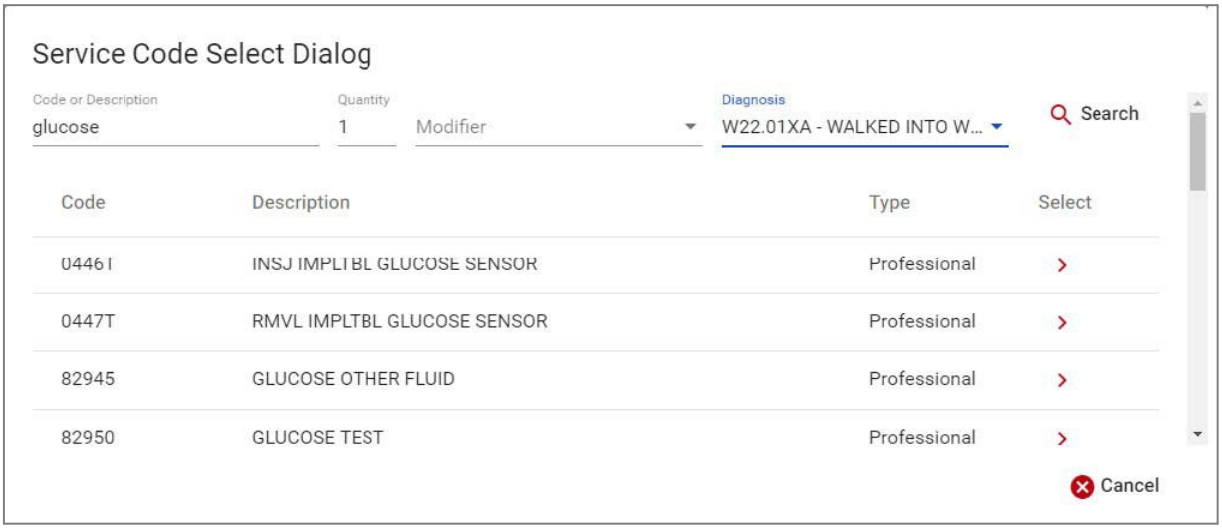
Enter the procedure code(s) in this section.



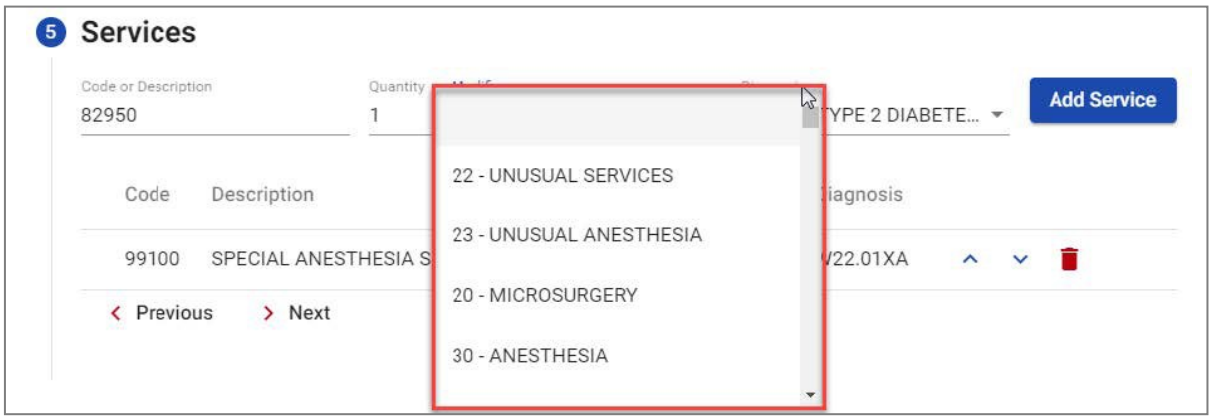
Code or Description: Enter in the procedure code.

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

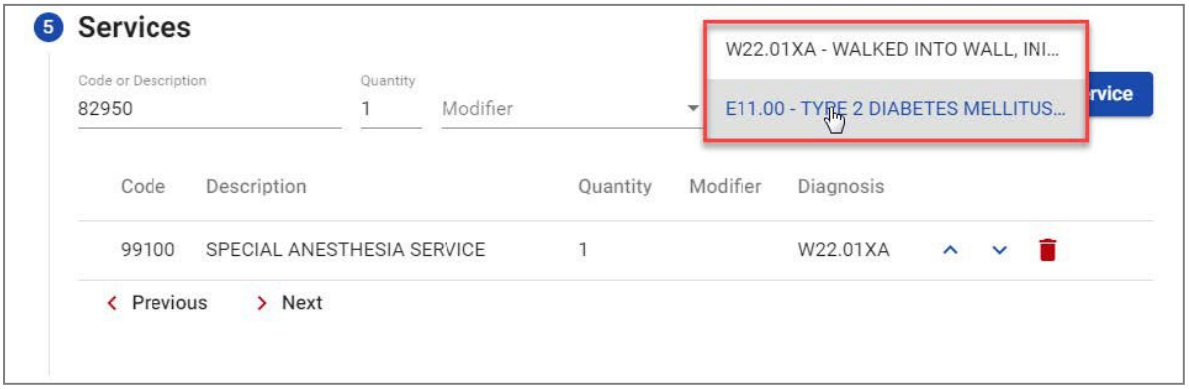
Entering a description will bring up related codes



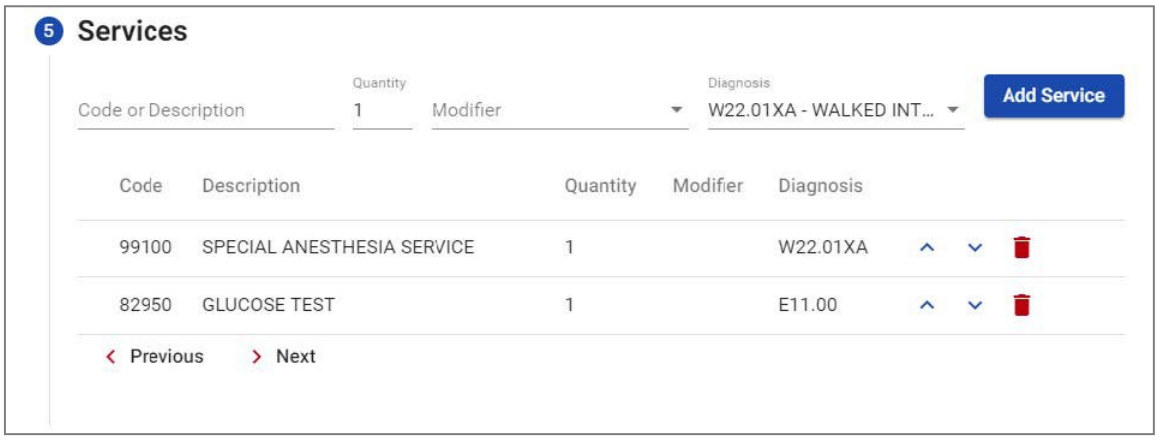
Select a modifier from the drop down (ifapplicable)



Select which diagnosis the procedure will be tied to



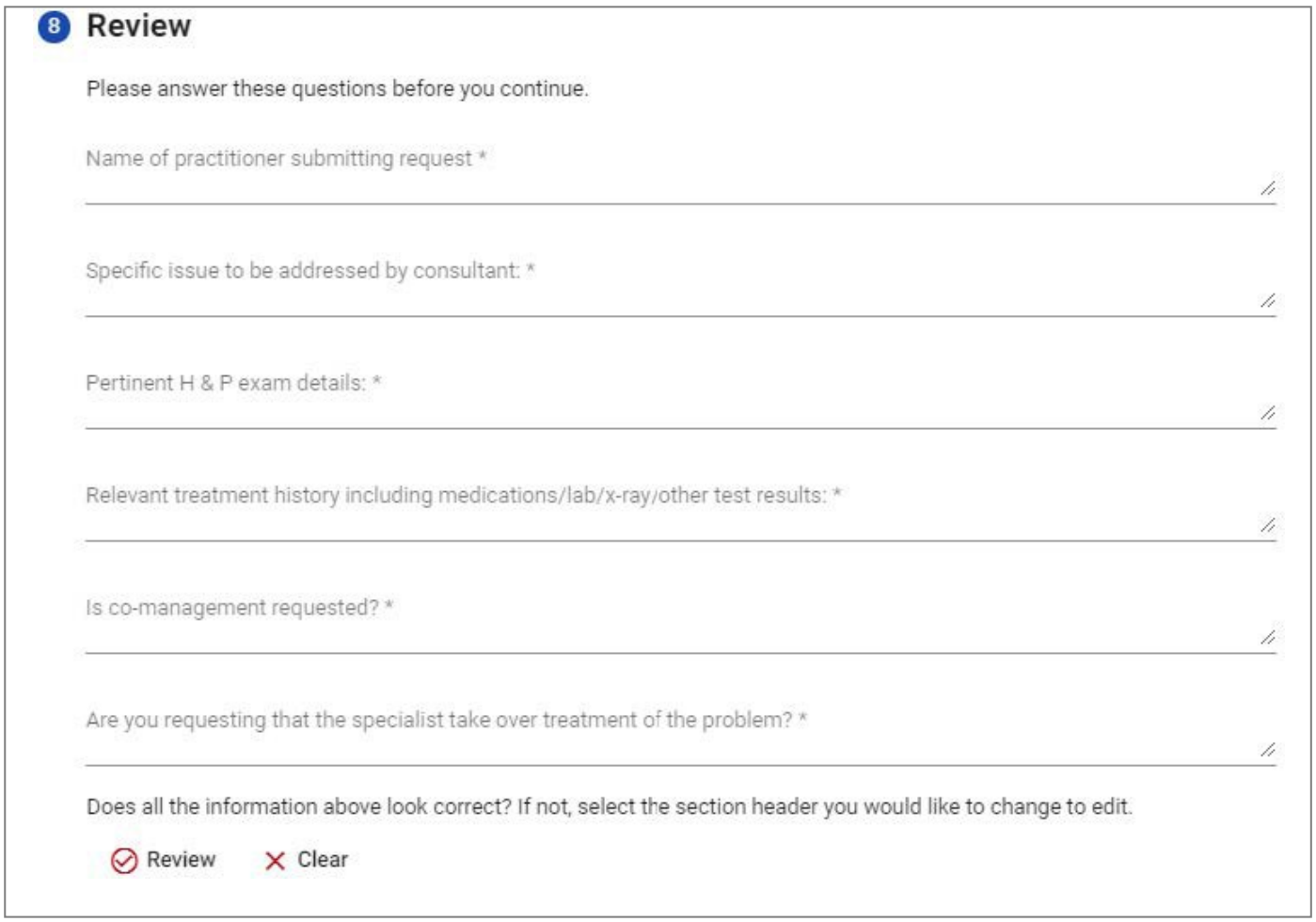
Click on the diagnosis to add the code to the Authorization request



Referral Clinical Questions

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

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



Click on Next or click on Step 6 to proceed.

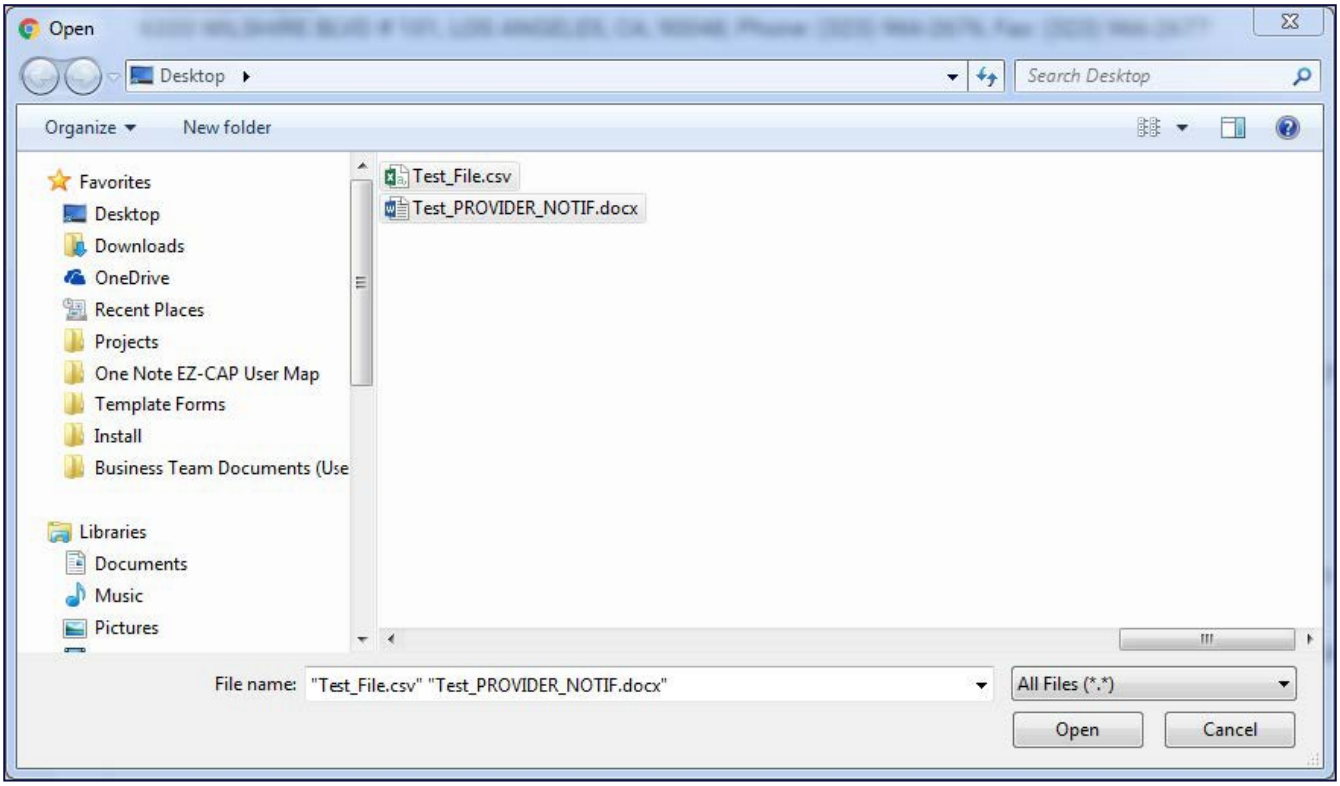
Step 6: Attachments

Add any supporting documents to the Authorization request.

Click on to select files to upload.

Select the files to be uploaded.

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



Click on Open.

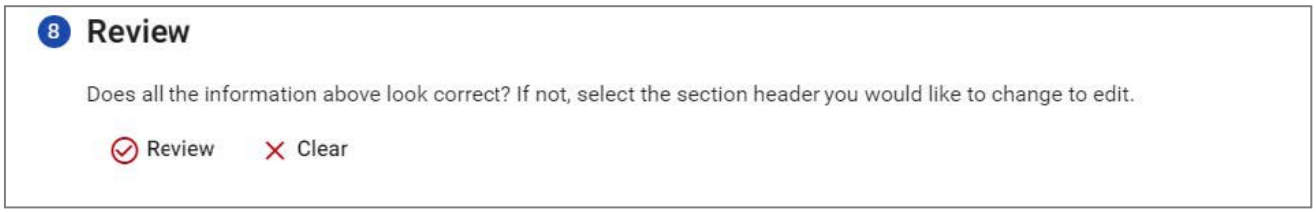
Click on Next or click on Step 7 to proceed.

Step 7: Notes

Enter notes regarding the referral in this section.

Click on Next or click on Step 8 to proceed.

Step 8: Review

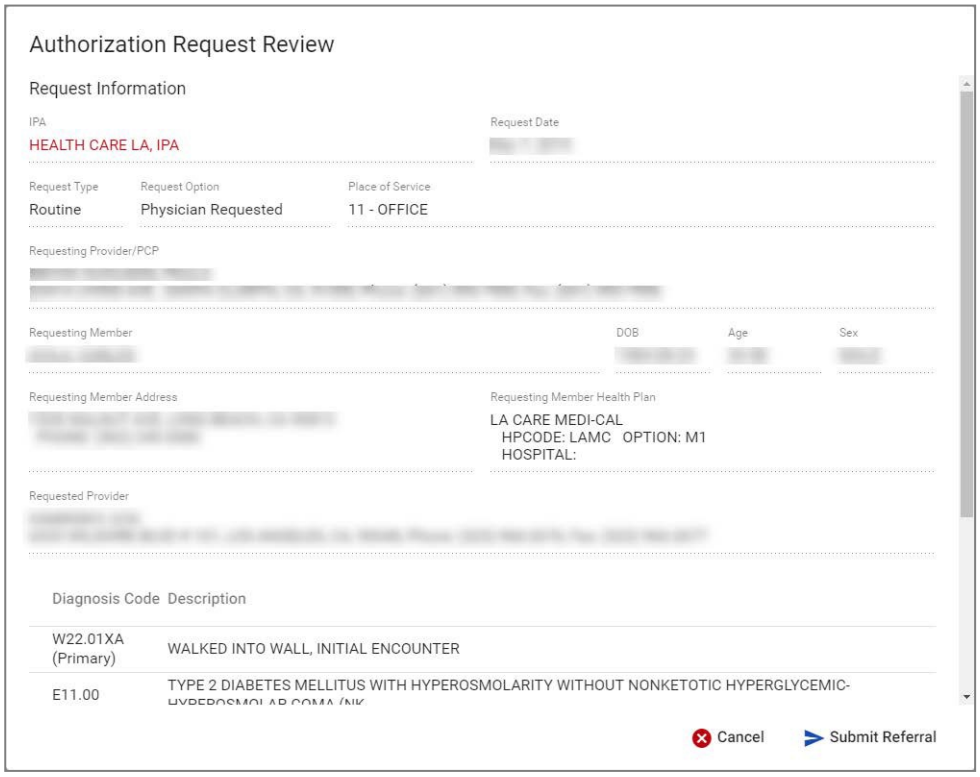


Review the Authorization request, and if no changes need to be made click on "Review."

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

Make any necessary corrections and click on "Review."

A preview of the Authorization will populate.



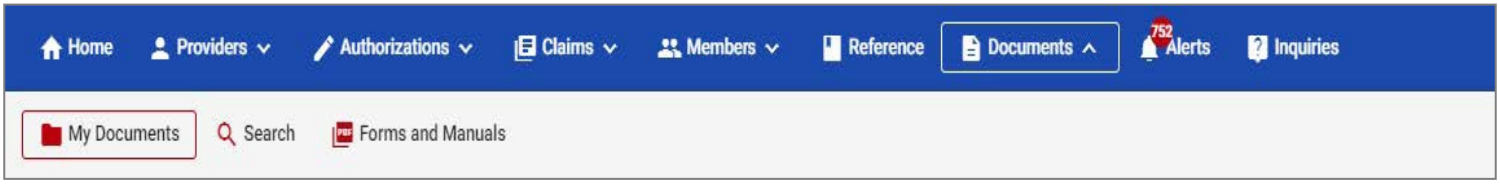
Review the Authorization and if no changes need to be made click on "Submit Referral"

ACCESSING REPORTS

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

The documents found in the My Documents section include:

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



RETROSPECTIVE REVIEW POLICY

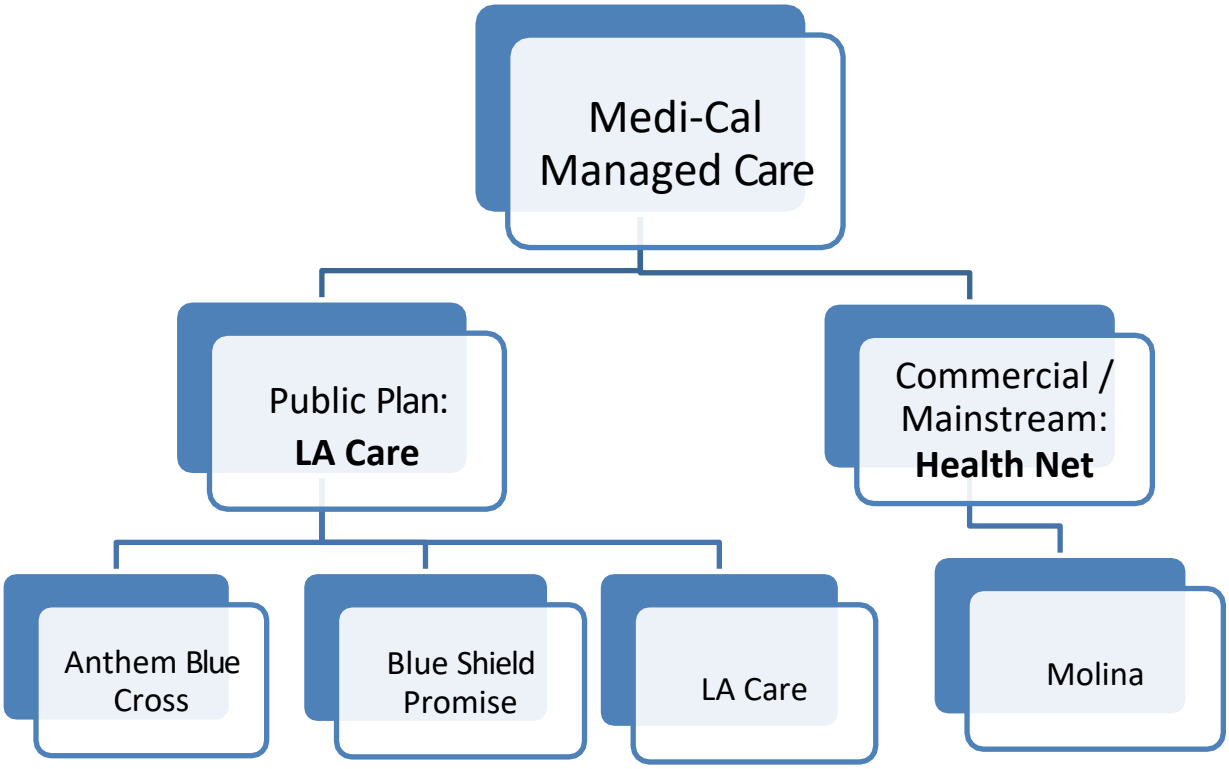
Purpose: The Utilization Management Committee, Medical Director or physician designee conducts retrospective review of cases, which were not previously authorized and of claims, which require authorization for payment. A senior physician has substantial involvement in the retrospective review process.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

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

1) Qualified health professionals assess the clinical information used to support UM decisions and appropriately apply to all requests for service.
2) Relevant clinical information will be obtained, and the treating physician will be consulted as appropriate. Approved practice guidelines and criteria will be appropriately applied to all requests for service.
3) All determinations will be clearly documented and made available to providers.
4) Complex cases will be evaluated by the Medical Director/Utilization Management Committee, Board-certified physicians from appropriate specialty areas also will assist in making determinations of medical appropriateness for retrospective authorizations.
5) Case management and revenue recovery cases will be submitted to the appropriate staff for follow-up.
6) Approved requests will be paid according to the specific services authorized.
7) Determinations for the denial of requests based on medical appropriateness will be made only by licensed physicians.
8) Retrospective service denials are followed by notification to the providers of the determination.
9) Denials for requested services will include a clearly documented letter to the provider explaining the reason for the denial, suggesting an alternative treatment plan, and informing them of HCLA's and the member 's health plan appeals process within five days of receipt.
10) Utilization statistics will be tracked, trended and analyzed by the UM Committee and reports will be presented to the Board of Directors at least on a quarterly basis.
11) Retrospective review decisions are made according to Regulatory Standards and Health Plan Policies.
12) Within thirty (30) calendar days in accordance with Health and Safety Code 1367.01, or any future amendments thereto.
13) Notification will take place within the thirty (30) calendar day timeframe. Providers will be notified in writing with two (2) working days of the decision.
14) **Utilization Management decisions** are made based on nationally recognized objective standards, criteria and guidelines that are based on sound medical evidence. Providers may contact MedPOINT Management for copies of all policies and procedures as well as Clinical Criteria used in the decision-making process. Providers are encouraged to discuss UM decisions with our Physician Reviewers. Please contact 818-702-0100 x 1779 to have a Medical Director answer your questions. No physician reviewer receives financial incentives to limit, restrict or deny services.

Section 3: Utilization Management

MEDI-CAL 2 PLAN MODEL



- For member transfers between Health Net and L.A. Care, contact HCO
- For member transfers between L.A. Care's Health Plan Partners, contact L.A. Care:(888)4LA-CARE
- For member transfers between Molina & Health Net, contact Health Net: (800)675-6110

Section 3: Utilization Management

MEDI-CAL MANAGED CARE REQUIREMENTS & SPECIFICATIONS

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

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

TDD Line for Hearing Impaired:
Telephone #: 1-800-430-7077

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

For member transfers between Health Net and LA Care contact HCO at the numbers listed above

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

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

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

Section 3: Utilization Management

LINKED AND CARVED OUT SERVICES

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

WIC NUTRITIONAL SERVICES

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

VISION SERVICES

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

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

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

Blue Shield Promise: IPA contracted Optometrist.

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

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

Molina Medical Centers: Vision Services to be provided by March Vision Care Group. Members may self-refer by calling (888) 493-4070.

DENTAL SERVICES

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

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

HIV and AIDS

The treatment and management of members with HIV and AIDs is complex and should not be undertaken by physicians without clinical expertise in this area.
Children and adolescents with HIV will receive HIV related services through California Children's Services (CCS). Adults will receive HIV related services through an IPA contracted specialist.

Section 3: Utilization Management

LINKED AND CARVED OUT SERVICES

CALIFORNIA CHILDREN'S SERVICES (CCS)

CCS eligible conditions are reimbursed directly through the CCS program.

EARLY INTERVENTION

Members who are children in need of early intervention services are to be referred to an Early Start Program in Los Angeles County. These include children with an established condition leading to developmental delay, those in whom a significant developmental delay is suspected, or those whose early health history places them at risk for delay.
Infants and children with the following conditions have a potential for being at risk for developmental disabilities and requiring Early Start Program services include those with:

HIV\AIDS, cancer, blindness, hearing impairments, retardation, heart conditions, epilepsy, juvenile diabetes, cleft palate, lung disorders (such as asthma and cystic fibrosis), downs syndrome, physical handicaps due to extensive orthopedic problems, neurological impairments, spinal cord injuries, and sickle cell anemia.

ARRANGEMENTS FOR REFERRAL

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

REGIONAL CENTERS

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

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

To be eligible, a person must have developmental disability before the age of 18, which includes mental retardation or similar conditions, cerebral palsy, epilepsy, and autism. Preventive services may also be provided to anyone determined to be at high risk of parenting a child with a developmental disability, and at the request of the parent or guardian, to any infant at high risk of becoming developmentally disabled.

There are no financial eligibility requirements for Regional Center services, however, parents are required to pay based on a sliding fee scale for out-of-home placement for children under age 18. Families are responsible for primary medical and health care for their children as well as those services normally provided to a child without disabilities. All persons receiving services must be California residents and must apply to the Regional Center for the area in which they reside.

Referrals from the PCP are directed to the intake coordinator at the regional center and must include the reason for referral, complete history and physical examination, including developmental screens, the results of developmental assessments and psychological evaluations, and diagnostic tests.

A list of Regional Centers and other relevant information is available upon request, or see the following Website: www.dds.ca.gov

Section 3: Utilization Management

LINKED AND CARVED OUT SERVICES

ALCOHOL AND DRUG TREATMENT SERVICES

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

SHORT DOYLE DRUG MEDI-CAL (SD/MC)

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

OUTPATIENT DRUG FREE TREATMENT SERVICES

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

PERINATAL RESIDENTIAL DRUG ABUSE SERVICES

include intake, assessment, admission physical examinations and laboratory tests, diagnosis, medical direction, individual and group counseling services, education on alcohol and other drug problems, parenting education, urine drug screens, medication services, collateral services, and crisis intervention services. Does not include room and board and must be provided by a licensed residential facility with 16 or less adult beds.

DAY CARE HABILITATIVE SERVICES

provided only to pregnant and postpartum women and EPSDT- eligible beneficiaries and include intake, assessment, diagnosis, evaluation, admission, physical examinations, treatment planning, individual and group counseling, urine drug screens, medication services, collateral services, and crisis intervention.

Naltrexone Treatment Services (for Opiate addiction): include intake, assessment, diagnosis, evaluation, admission, physical examinations, treatment planning, individual and group counseling, urine drug screens, medication services, collateral services, and crisis intervention services.

Fee-for-Service Medi-Cal: Fee-for-service Medi-Cal covers outpatient heroin detoxification services.

COMPREHENSIVE PERINATAL SERVICES PROGRAM

Comprehensive Perinatal Services Program (CPSP) provides enhanced perinatal services, nutrition, psychosocial and health education for Medi-Cal eligible women from pregnancy through the end of the second month after delivery

Section 3: Utilization Management

LINKED AND CARVED OUT SERVICES

SPECIALTY MENTAL HEALTH SERVICES

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

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

BEHAVIORAL HEALTH PROGRAM ACCESS
Telephone #: (800) 854-7771

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

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

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

HCBS Waiver Program services include home health aide services, respite care, rehabilitation services, skilled nursing, adult day health care, and personal care and other non-medical services.

Referral: Providers do not directly make HCBS Waiver referrals. When indicated by clinical evaluation or requested by a member or the member's family, physicians, IPAs, Medical Groups, assist the member by providing information on California Department of Developmental Services (DDS) Regional Center contacts and potential services.

Section 3: Utilization Management

LINKED AND CARVED OUT SERVICES

LANGUAGE ASSISTANCE PROGRAMS

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

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

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

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

Available languages for each Health Plan will vary in accordance with the Plan's required Threshold Languages set by the Department of Health Care Services (DHCS).
Threshold Languages are established by determining the primary languages spoken by at least 3,000 LEP members or 5% of LEP membership population (whichever is lower) associated with a given Health Plan.

Section 3: Utilization Management

LINKED AND CARVED OUT SERVICES

LANGUAGE ASSISTANCE

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

Section 3: Utilization Management

LINKED AND CARVED OUT SERVICES

LANGUAGE ASSISTANCE

HEALTH PLAN	PRODUCT LINE	PHONE NUMBER	HOURS	LANGUAGES	FACE-TO-FACE PRIOR NOTICE
Cigna	All	1-800-806-2059 Face-to-face: 1-800-997-1654 TTY: 711	Mon-Fri 8:00am-5:00pm	Spanish, Chinese (Traditional), other threshold available on request	10 days
Health Net	Medi-Cal	1-800-675-6110	24/7	150+ languages	5 days
	Medicare	1-800-929-9224	Mon-Fri 8:00am-5:00pm		
	Covered CA	Business hours: 1-888-926-2164 After hours: 1-800-546-4570	24/7		
	TTY (All)	711	24/7		
LA Care	All	1-855-322-4034 TTY: 711	24/7	Spanish, Chinese (Cantonese & Mandarin), Arabic, Armenian, Khmer, Korean, Farsi, Tagalog, Vietnamese, Russian	10 days
Molina	Medi-Cal	1-888-665-4621	Mon-Fri 7:00am-7:00pm	Spanish, Chinese (Cantonese & Mandarin), Arabic, Armenian, Khmer, Korean, Farsi, Tagalog, Vietnamese, Russian	5 days
	Medicare	1-800-665-0898	Mon-Fri 8:00am-8:00pm		
	Covered CA	1-888-858-2150	Mon-Fri 8:00am-6:00pm		
	Duals	1-855-665-4627	Mon-Fri 8:00am-8:00pm		
	TTY (All)	711	24/7		

Section 3: Utilization Management

EXPANDED MENTAL HEALTH BENEFITS

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

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

PCP RESPONSIBILITY

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

SPECIALTY MENTAL HEALTH SERVICES (SMHS)

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

- For referrals to DMH send the written consent (or documentation for a verbal consent via phone) with the screen form to the provider referral center via encrypted email to screener@dmh.lacounty.gov or via eFax (562) 863-3971. DMH referral line (855) 425- 8141
- Services provided by LA County Department of Mental Health:
  - > Inpatient services
  - > Residential services
  - > Outpatient services

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

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

Section 3: Utilization Management

EXPANDED MENTAL HEALTH BENEFITS

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

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

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

MENTAL HEALTH NETWORK CONTACTS BY PLAN		
HEALTH PLAN	**CONTRACT NAME**	**PHONE**
ANTHEM BLUE CROSS	Direct Behavioral Health Network	(888) 831-2246 Option 1
BLUE SHIELD PROMISE	Beacon Health Strategies	(855) 765-9701
HEALTH NET	MHN	(888) 426-0030
LA CARE	Beacon Health Strategies	(877) 344-2858
MOLINA	Direct Behavioral Health Network	(800) 675-6110 Option 2, Option 2

Section 3: Utilization Management

EXPANDED SUBSTANCE ABUSE SERVICES

DEPARTMENT OF PUBLIC HEALTH (DPH)

SERVICES PROVIDED BY PCPs:

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

NEW SERVICES PROVIDED BY DPH

- Outpatient Services:
  - > Outpatient drug free treatment
  - > Intensive outpatient treatment (newly expanded to all populations)
  - > Narcotic treatment services - methadone maintenance
  - > Naltrexone for opioid dependence (a Medi-Cal benefit through fee-for-service, outside of Drug Medi-Cal)
- Residential Services (newly expanded to all populations)

- Inpatient Services

- Voluntary Inpatient Detoxification Services (newly expanded with NO restriction of physical medical necessity)

REFERRALS

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

SBIRT TRAINING

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

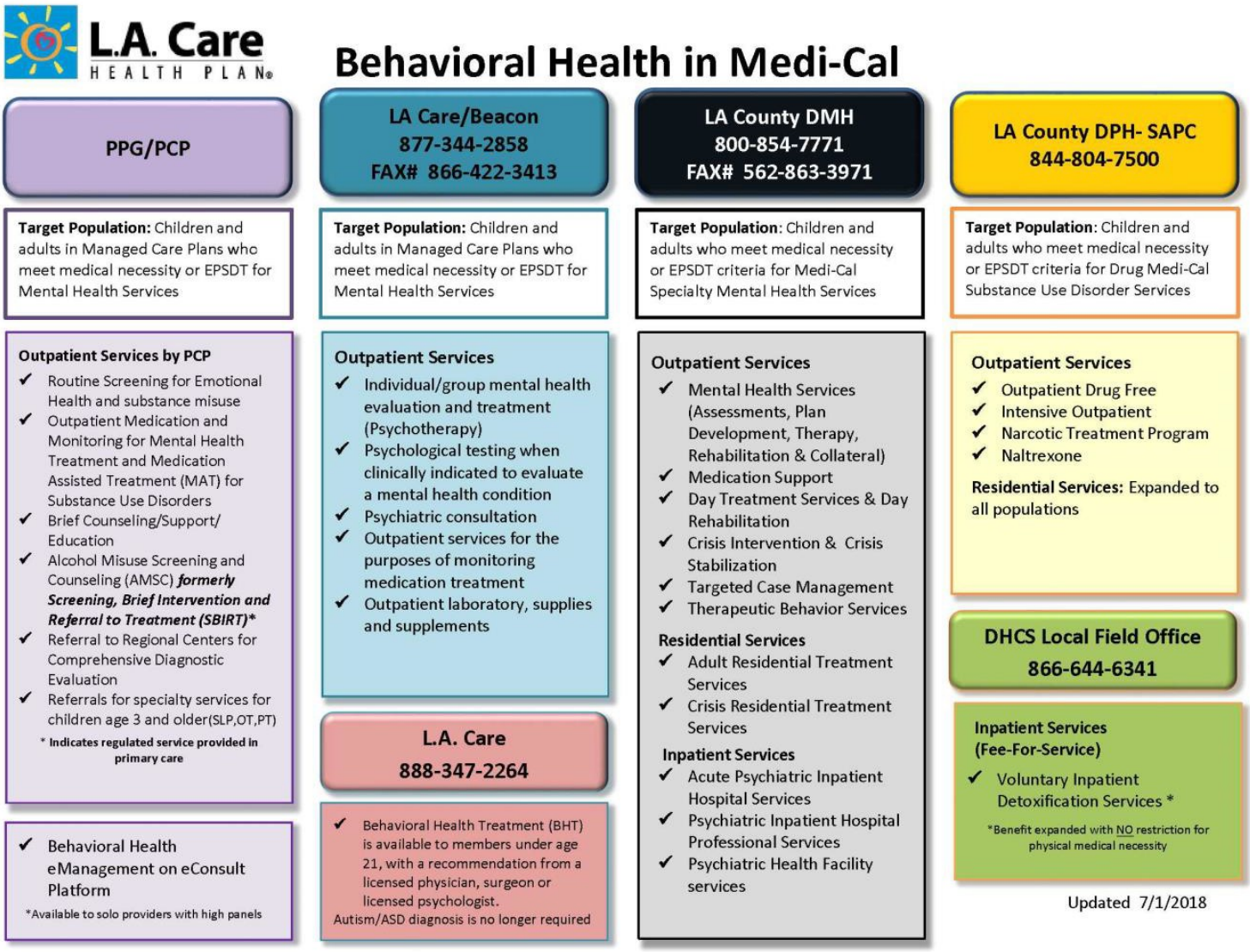
*Other trainings resources can be found on DHCS website at www.dhcs.ca.gov

Section 3: Utilization Management

BEHAVIORAL HEALTH

LA CARE HEALTH PLAN - BEHAVIORAL HEALTH IN MEDI-CAL

Behavioral Health Contact:
Phone – (866) LACARE6 or (866) 522-2736
Website: https://www.lacare.org/providers/provider-resources/tools-toolkits/behavioral-health-services



Section 3: Utilization Management

BEHAVIORAL HEALTH SCREENING FORM

MH731

Behavioral Health Screening Form to Obtain Behavioral Health Assessment

Please complete and follow algorithm

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

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

REFERRING PROVIDER INFORMATION

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

Fax number: ( ) To the attention of:

MEMBER INFORMATION

Patient Name: Date of Birth: / / ☐ M ☐ F

(Last) (First)

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

Address: City: Zip: Phone: ( )

Caregiver/Guardian: Phone: ( )

Referring Clinician: Phone: ( )

Primary Care Provider Phone: ( ) Health Plan:

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

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

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

List A - check all that apply:

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

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

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

Referral algorithm based on checked boxes:

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

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

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

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

Pertinent Current/Past Information

Current symptoms and impairments:

Brief MH/SUD history:

Brief medical history/diagnosis:

Current Medication(s) & Dosage:

For Receiving Clinician Use ONLY

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

*Referring provider to follow up with individual

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

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

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

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

Section 3: Utilization Management

BEHAVIORAL HEALTH SCREENING FORM - INSTRUCTIONS

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

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

Abbreviations: **H&P**: History and Physical Exam **SBI:** Screening and Brief Intervention
MH/SUD: Mental Health and Substance Use Disorder

Explanations:

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

Referring provider:

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

Section 3: Utilization Management

BEHAVIORAL HEALTH SCREENING FORM – INSTRUCTIONS

Receiving clinician:

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

Section 3: Utilization Management

HEALTH PLAN BEHAVIORAL HEALTH NETWORK CONTACT INFORMATION

Health Plan Behavioral Health Network Contact Information

Medi-Cal Only Beneficiaries

Medi-Cal Managed Care Health Plan	Non-Specialty Behavioral Health Services Provider	Contact Information
Health Net	MHN	Fax: (855) 703-3268 Phone: (800) 675-6110 (Follow member prompts)
Health Net – Molina	Molina	Fax: (562) 499-6105 Phone: (888) 665-4621
L.A. Care	Beacon	Fax: (866) 422-3413 Phone: (877) 344-2858
L.A. Care – Anthem	Anthem	Fax: (855) 473-7902 (Attn: Medi-Cal BH) Email: Medi-CalBHUM@wellpoint.com Phone: (888) 831-2246 (Option 1 for BH, 2 for BH Intake)
L.A. Care – BSC Promise	Beacon	Fax: (866) 422-3413 Phone: (855) 765-9701

L.A. Care –Kaiser	Kaiser		See below for Regional Offices:		
Bellflower Area – Downey/Norwalk	Fax: Phone:	(562) 657-2497 (562) 807-6200	San Fernando Valley – Woodland Hills	Fax: Phone:	(818) 592-3015 (855) 701-7955
Lancaster	Fax: Phone:	(661) 951-2999 (661) 951-0070	San Gabriel Valley – Baldwin Park/West Covina	Fax: Phone:	(626) 856-3010 (626) 960-4844
Los Angeles – Sunset	Fax: Phone:	(323) 783-4299 (323) 783-2600	South Bay	Fax: Phone:	(310) 517-3499 (310) 325-6543
Panorama City – Santa Clarita/Reseda	Fax: Phone:	(800) 700-8705 (818) 758-1200	West L.A.	Fax: Phone:	(323) 298-3119 (323) 298-3100

Cal MediConnect Beneficiaries

Cal MediConnect Health Plan	Non-Specialty Behavioral Health Services Provider	Contact Information
Blue Shield of California Promise	Beacon	Fax: (866) 422-3413 Email: Phone: (855) 765-9701
Anthem Blue Cross CMC	Beacon	Fax: (866) 422-3413 Email: Phone: (855) 371-8092
Health Net	MHN	Fax: (855) 703-3268 Email: MHN.CMC@MHN.COM Phone: (855) 464-3571
L.A. Care	Beacon	Fax: (866) 422-3413 Email: Phone: (877) 344-2858
Molina	Molina	Fax: (562) 499-6105 Phone: (855) 665-4627

Section 3: Utilization Management

DIRECT REFERRAL PROGRAM

The Direct Referral program was developed to expedite member access to specialists for consultation, eliminating administrative barriers and facilitate PCP's role by coordinating patient's medical care.

If the service is a covered benefit, Primary Care Physicians may directly authorize referrals for initial consultations to IPA In-Network participating specialists, in the categories referenced below when medically necessary (do not wait for IPA Utilization Review Department approval).

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

Copy of Form must be given to patient. PCP will enter authorization via MPM Web as Direct Referral and fax authorization to Health Care, L.A. IPA on the same day the referral is generated.

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

Authorization expires in sixty (60) days. Direct Referral Authorization is not valid for providers not participating on the IPA Panel. All follow-up care must be prior authorized by the utilization review department.

This protocol applies even when additional services are provided in conjunction with the initial consultation.

Services related to CCS eligible conditions must be authorized by CCS. Health Care, L.A., IPA is not responsible for payment of services related to CCS eligible conditions.

All other services including inpatient and outpatient care continue to require precertification.

All radiology providers require prescription order form in addition to IPA referral.

Member eligibility must be verified at encounter.

Member may self-refer for sensitive services such as family planning, abortions, sexually transmitted infections STIs, sterilization, HIV/AIDS testing.

Members may self-refer to Participating OBGYN providers. Obstetricians/ Gynecologists can directly refer members for the following services: pelvic ultrasounds, mammograms, DEXA scans, breast ultrasounds, Maternal AFIs and NSTs.

INITIAL CONSULTATION AND CODES			
CPT Code 99243: Medi-Cal		CPT Code 99203: Commercial and Medicare	
Cardiology	Maternal AFI	Ophthalmology	TAB (Medi-Cal only)
EKG (93000)	Maternal NST	Optometry (Blue Shield Promise 92004, Z2930, V2020)	
Gynecology	Obstetrics	Orthopedics	Urology
Radiology	Abdominal Ultrasound (76700)	Dexa Scan (77080)	OB Ultrasound
	X-Ray Extremity, Flat Plate, Chest	Pelvic Ultrasound (76856)	Venous Doppler

Section 3: Utilization Management

DIRECT REFERRAL PROGRAM

BREAST CANCER AND CERVICAL CANCER SCREENING

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

CPT CODE	DESCRIPTION
19102	Percutaneous image guided core breast biopsy
19103	Percutaneous vacuum assisted breast biopsy
19499	Unlisted breast procedure
77031	Stereotactic guidance
76942	Ultrasound guidance
77021	MR guidance
77032	Mammographic guidance
19295	Marker wire placement (clip)
76098	Radiological exam, surgical specimen
19290	Breast hookwire localization, initial state
19291	Breast hookwire localization, each additional site
38792	Injection procedure for sentinel node ID
38900	Intraoperative ID of sentinel node, includes dye when performed
G0202	Screening mammography, producing direct digital image, bilateral, all views
G0204	Diagnostic mammography, producing direct digital image, bilateral, all views
G0206	Diagnostic mammography, producing direct digital image, unilateral, all views
76645	Breast Ultrasound
77051 & 77052	Computer Aided Detection
19081	Breast biopsy w/local, specimen imaging, percutaneous, 1st lesion including stereo guidance
19083	Breast biopsy w/local, specimen imaging, percutaneous, 1st lesion including ultrasound guidance

Section 3: Utilization Management

TRANSITION OF CARE (TOC) PROCESS FOR POST DISCHARGED PATIENTS

NOTIFICATION OF ADMISSION

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

Notification includes members/patients with recent admissions from hospitals or skilled nursing facilities.

**This process should apply to all of Health Center service locations

NOTIFICATION OF DISCHARGE

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

Admission and Discharge Process:

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

Obtaining PCP Appointments can be made by phone, email or fax:

a) **Phone Call:** TOC Coordinator calls the DHC individual to schedule appointments of discharged members (preferably while in-house) by the PCP/provider

b) **Email**: A list of discharged members and demographic information is sent via secured email to the DHC individual and is emailed back to the TOC Coordinator within 2 business days with the appointment information

c) **Fax**: A list of discharged members and demographic information is sent via fax to DHC individual and is faxed back to the TOC Coordinator within 2 business days with the appointment information

**Available Medical Records/TOC Packets are sent 1- 2 days prior to the scheduled visit unless the Health Center has EHR access to hospital medical records

**TOC Coordinators notify the members (preferably while in-house) of the scheduled PCP visit

**DHC individual and/or staff member of Health Center confirms/reminds members of the scheduled visit

Section 3: Utilization Management

CASE MANAGEMENT

Case Management employs a team-based model formed by many health care professionals- to deliver quality care and help individuals gain access to needed medical, social and educational services. Widely accepted as a compass to optimize health performance by enhancing patient experience, improving population health, reducing costs and improving the continuum between health care providers and patients. The overall goal of case management is to help members regain optimum health or improve functional capability by ensuring efficient communication and coordination between the member and their medical network.

MedPOINT Management's Case Management team is made up of nurses, care coordinators, social workers and other healthcare professionals. Together, the team configures ways to help members and the member's health care providers better manage the member's health. It is a multidisciplinary approach to ensure integration of service. The process involves comprehensive assessments of the member's condition(s), determination of available benefits and resources, development and implementation of patient prioritized goals: what is important to the patient and for the patient, monitoring and follow up

Who can submit referrals?

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

Process

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

SUPPORT **SAFEGUARDS UNDERSTANDING** **PERSON CENTERED COORDINATION**

For more details about our services, please call the Case Management Department at (818) 702-0100 ext. 1834, Monday through Friday from 8:00 a.m. to 5:00 p.m.
Referrals may be submitted via fax or e-mail.
E-mail: cm_notification@medpointmanagement.com
Fax: (818) 444-1203

Section 4: Provider Standards And Policies

TIMELY ACCESS TO CARE STANDARD

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

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

For more information please visit the Department of Managed Healthcare (DMHC) website

Urgent Appointments

- Services that do not require prior authorization
  Wait Time: 48 hours

- Services that do require prior authorization
  Wait Time: 96 hours Non-Urgent

Appointments

- Primary Care, Regular/Routine
  Wait Time: 10 business days

- Specialist
  Wait Time: 15 business days

- Other Services to diagnose or treat a health condition
  Wait Time: 15 business days

AFTER HOURS ACCESS REQUIREMENTS

After Hours Access audits are routinely conducted to ensure that physician offices have appropriate after- hours telephone recordings that direct patients to an emergency room or urgent care facility to access immediate care. An on-call phone number or nurse's line must be provided during the message.

Primary Care Physicians are to be available by telephone 24 hours per day, 7 days per week within 30 minutes of member call.

An effective telephone service after normal business hours provides for callers to reach a live voice within 30 seconds. All calls must be returned within 30 minutes to meet DMHC Access Requirements.

One of the following scripts, on the next page, may be used by your office or medical group as an example for ensuring members have access to timely medical care after normal business hours.

Section 4: Provider Standards And Policies

AFTER HOURS SAMPLE SCRIPT

CALLS ANSWERED BY A LIVE VOICE (e.g. answering service or centralized triage)

If the caller believes the situation is an emergency or urgent in nature, advise the caller to call 911 immediately or proceed to the nearest Urgent Care Center or Emergency Room.

If the member indicates a need to speak with a physician, facilitate the contact by:

a) Putting the caller on hold momentarily and then connecting the caller to the on-call physician or providing a pager number and advising them to call back if they have not heard from the physician within one hour.

b) Get the member's number and advise a physician will call them back within the 30 Minutes Or
c) If a member indicates a need for interpreter services, facilitate the contact by accessing interpreter services.

CALLS ANSWERED BY AN ANSWERING MACHINE

If this is an emergency, please call 911 immediately.

Hello, you have reached (Name of Doctor/Office/Medical Group). If you wish to speak to the physician on-call,

a) Please hold and you will be connected to (Dr. Name)

b) You may reach the on-call doctor directly by calling (give number)

c) Please call (give number). The doctor will be paged, and you may expect a return call within 30 minutes. If you do not hear from the doctor within 30 minutes, please go to the nearest Emergency Room.

d) Our Urgent Care Center is located at (give address/phone number)

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

ACCESS TO RECORDS

Providers must provide access to any medical, financial or administrative records related to services you provide to Health Care LA, IPA members. Maintain these records for at least 10 years.

Providers must establish policies that safeguard privacy and maintain accurate medical records that abide by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information.

ADMINISTRATION OF HEALTH ASSESSMENTS

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

Initial Health Assessment (IHA) Components and Requirements

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

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

The IHA consists of:

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

- History of present illness
- Past medical history
- Prior major illnesses and injuries
- Prior operations
- Prior hospitalizations
- Current medications
- Allergies
- Age appropriate immunization status
- Age appropriate feeding and dietary status
- Social history
- Marital status and living arrangements
- Current employment
- Occupational history
- Use of alcohol, drugs and tobacco
- Level of education
- Sexual history
- Any other relevant social factors
- Review of organ systems

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

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

B. Preventive services

Asymptomatic healthy adults – must adhere to the current edition of the Guide to Clinical Preventive Services of the U.S. Preventive Services Task Force (USPSTF), specifically USPSTF "A" and "B" recommendations for providing preventive screening, testing and counseling services. Document status of current recommended services.

- Members younger than 21 years of age – provide preventive services by

- the most recent American Academy of Pediatrics age specific guidelines and periodicity schedule

- Perinatal services for pregnant members must be provided according to the most current standards of guidelines of the American College of Obstetrics and Gynecology (ACOG). A DHCS approved comprehensive risk assessment tool must be used for all pregnant members. This must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. Risks identified must be followed up and documented in the medical record.

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

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

E. Individual Health Education Behavioral Assessment (IHEBA)

- IHEBA requirement – administer an age specific

- IHEBA as part of the IHA. Assessment tools used to complete the IHEBA must be approved by the Medi-Cal Managed Care Division (MMCD) prior to use

- Exceptions for transferring members - the IHEBA requirement for members transferring from an outside group may be met if the medical record indicates in the IHEBA tool or a behavioral risk assessment has been completed within the last 12 months

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

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

Who Can Perform the IHA?

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

Staying Healthy Assessment (SHA) Periodicity Schedule

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

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

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

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

  Adolescents (12–17 years) should complete the SHA without parental/guardian assistance beginning at 12 years of age, or at the earliest age possible. This helps to get accurate responses to sensitive questions. You should determine the most appropriate age, based on discussion with the parent/guardian and the family's ethnic/cultural background.

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

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

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

SHA DOCUMENTATION BY PCP

A. Sign, print your name, and date the "Clinic Use Only" section of a newly administered SHA to verify you reviewed and discussed it with the member.

B. Document specific behavioral-risk topics and patient counseling, referral, anticipatory guidance, and follow-up provided, by checking the appropriate boxes in the "Clinical Use Only" section.

C. Sign, print your name, and date the "SHA Annual Review" section of the questionnaire to document that an annual review was completed and discussed with the member.

D. If a member refuses the service:

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

Section 5: Encounter Data, Claims and Billing

ENCOUNTER DATA REPORTING IS REQUIRED TO ENSURE SERVICES ARE PROVIDED IN COMPLIANCE WITH STATE GUIDELINES.

We encourage you to submit Encounters electronically through Office Ally. Health Care, LA, IPA's Office Ally Payer ID is MPM06. If you are not registered and would like to utilize this free service option, please call (866) 575-4120 or e-mail to Info@OfficeAlly.com.

ENCOUNTER SUBMISSION

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

ENCOUNTER CLAIM REQUIRED DATA ELEMENTS

Effective April 1, 2014, the CMS-1500 is the required format for Encounter billing submission and Superbills or Encounter Forms will be rejected. The use of current, applicable CPT/HCPCS Codes and other applicable codes are needed for Payor to determine services provided and accuracy of payment on each encounter for services rendered to each IPA Enrollee. The following information, in a typed or system generated format, needs to be included:

1) Insured's I.D. # (Box1a.)
2) Patient's Name (Box 2)
3) Patients Birth Date (Box3)
4) Sex (Box 3)
5) Patient's Address (Box 5)
6) Claim Codes (Designated by NUCC) (Box 10d.)
7) Prior Authorization Number (Box23)
8) Date(s) of service (Box 24. A.)
9) Place of service (Box 24. B.)
10) Procedures, Services or Supplies (Box 24.D.)
11) Rendering Provider ID# (Box 24.J)
12) Rendering Provider NPI (Box 24J.)
13) Federal Tax I.D. Number "TIN" (Box25)
14) Signature of Physician or Supplier (Box31)
15) Service Facility Location Information (Box32)
16) Service Facility Location NPI Number (Box 32.a)
17) Billing Provider Info and PH # (Box33)
18) Billing Provider NPI (Box33a)

120 DAY HEALTH ASSESSMENT

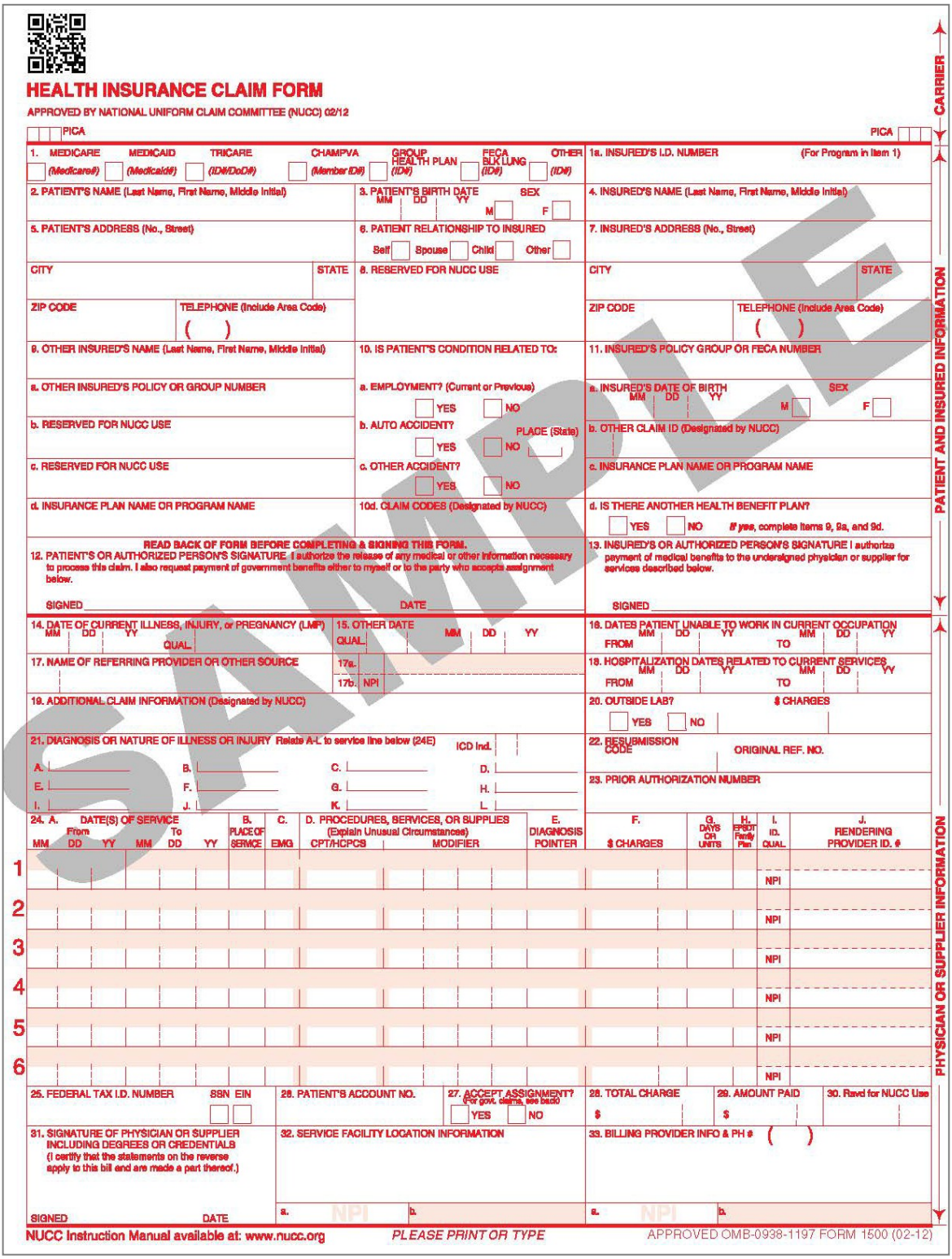
Follow up attempts for 120 Day Health Assessment are the responsibility of the PCP.

CHILD HEALTH AND DISABILITY PREVENTION PROGRAM (CHDP)

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

Section 5: Encounter Data, Claims and Billing

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



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Section 5: Encounter Data, Claims and Billing

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

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

Section 5: Encounter Data, Claims and Billing

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

HEALTH PLAN	IMMUNIZATIONS	CHDP	CONTRACEPTIVE DEVICE	DEPO-PROVERA
Blue Shield Promise (Medicare)	Submit CMS 1500 to HCLA, Paid Fee-for-Service	NA	Oral: Bill Blue Shield Promise Device: Submit CMS 1500 to HCLA, included in IPA Capitation	Bill Blue Shield Promise
Cigna	Submit CMS 1500 to HCLA, included in IPA Capitation	NA	Oral: Bill Cigna Device: Submit CMS 1500 to HCLA, included in IPA Capitation	Submit CMS 1500 to HCLA, included in IPA Capitation
Health Net (Cal MediConnect)	Submit via the Health Net portal Submit CMS 1500 to HCLA, included in IPA Capitation	NA	NA	NA
Health Net (Commercial)	Submit via the Health Net portal Submit CMS 1500 to HCLA, included in IPA Capitation	NA	Submit via the Health Net portal Submit CMS 1500 to HCLA, included in IPA Capitation	Submit via the Health Net portal Submit CMS 1500 to HCLA, included in IPA Capitation
Health Net (Covered CA)	Submit via the Health Net portal Submit CMS 1500 to HCLA, Paid Fee-for-Service	NA	Submit via the Health Net portal Submit CMS 1500 to HCLA, Paid Fee-for-Service	Submit via the Health Net portal Submit CMS 1500 to HCLA, Paid Fee-for-Service
Health Net (Medi-Cal)	Adult Vaccines & Non CHDP Submit via the Health Net portal Submit CMS 1500 to HCLA, included in IPA Capitation	IPA Risk	Submit via the Health Net portal Submit CMS 1500 to HCLA, included in IPA Capitation	Submit via the Health Net portal Submit CMS 1500 to HCLA, included in IPA Capitation

Section 5: Encounter Data, Claims and Billing

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

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

Section 5: Encounter Data, Claims and Billing

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

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

HEALTH PLAN	HEALTH PLAN CMS 1500	IPA CMS 1500	Vaccines: VFC	NOTES
ANTHEM/ BLUE CROSS	√	√	√	Submit Plan CMS 1500: P.O. Box 60007 Los Angeles, CA 90060-0007 In addition, CMS 1500 encounter must be submitted to the IPA. CHDP is Plan financial responsibility.
Blue Shield Promise		√	√	CHDP is IPA financial responsibility included in capitation. No additional Blue Shield Promise incentive.
Health Net	√	√	√	Submit CMS 1500 electronically via the Health Net web portal. In addition, CMS 1500 encounter must be submitted to the IPA.
L.A. CARE	√	√	√	Submit CMS 1500 to Plan: PO Box 811580 Los Angeles, CA 90081 CHDP is Plan financial responsibility.
MOLINA *You must preregister for the program.* **Contact Molina: (562) 435-3666**	√	√	√	CHDP is IPA financial responsibility. Molina offers additional incentive based on electronic encounter to IPA. Member enrollment must be over 200. PCP must be enrolled in the program.

Section 5: Encounter Data, Claims and Billing

CLAIMS AND ENCOUNTER DATA SUBMISSIONS

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

Office Ally
Payer ID: MPM 06
Officeally.com
866-575-4120

Office Ally
New enrollments, please contact at
(866) 575-4120 or
Email: info@officeally.com
Submitter # MPM06

Via mail: P.O. BOX 570590, Tarzana CA 91357

The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required:

CLAIM TIMELINESS

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

COMPLETE CLAIMS

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

CLAIM RECEIPT VERIFICATION

For verification of claim receipt, contact:

Via Phone: (818) 702-0100
Website: Access through MPM Web (preregistration required; to be set up, contact IT Department at (818) 702-0100 ext. 299 or request login through via MedPOINT Management web site.)

CLAIM REJECTION

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

NATIONAL DRUG CODES (NDC)

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

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

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

Section 5: Encounter Data, Claims and Billing

PROVIDER DISPUTE RESOLUTION (PDR)

DISPUTE RESOLUTION PROCESS FOR CONTRACTED PROVIDERS

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

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

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

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

SENDING A CONTRACTED PROVIDER DISPUTE

Contracted provider disputes submitted to IPA must include the information listed in section 2 above, for each contracted provider dispute. All contracted provider disputes must be sent to the attention of Claims Appeals at the following:

Via Mail: P.O. Box 570790, Tarzana, CA 91357

Section 5: Encounter Data, Claims and Billing

PROVIDER DISPUTE RESOLUTION (PDR)

TIME PERIOD FOR SUBMISSION OF PROVIDER DISPUTES

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

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

ACKNOWLEDGMENT OF CONTRACTED PROVIDER DISPUTES

All incoming disputes will be acknowledged upon receipt of the dispute regardless of whether or not the dispute is complete within 15 working days of receipt. A letter of acknowledgement will be sent to the provider.

CONTACT IPA REGARDING CONTRACTED PROVIDER DISPUTES

All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to IPA at: (818) 702-0100, option 3.

INSTRUCTIONS FOR FILING SUBSTANTIALLY SIMILAR CONTRACTED PROVIDER DISPUTES

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

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

TIME PERIOD FOR RESOLUTION AND WRITTEN DETERMINATION OF CONTRACTED PROVIDER DISPUTE

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

Section 5: Encounter Data, Claims and Billing

PAST DUE PAYMENTS

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

CLAIM OVERPAYMENTS

1. NOTICE OF OVERPAYMENT OF A CLAIM

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

2. CONTESTED NOTICE

If the provider contests IPA's notice of overpayment of a claim, the provider, within
30 Working Days of the receipt of the notice of overpayment of a claim, must send written notice to IPA stating the basis upon which the provider believes that the claim was not overpaid. IPA will process the contested notice in accordance with IPA's contracted provider dispute resolution process described in Section II above.

3. NO CONTEST

If the provider does not contest IPA's notice of overpayment of a claim, the provider must reimburse IPA within thirty (30) Working Days of the provider's receipt of the notice of overpayment of a claim.

4. OFFSETS TO PAYMENTS

IPA may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when; (I) the provider fails to reimburse IPA within the time frame set forth above, and (ii) IPA's contract with the provider specifically authorizes IPA to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, IPA will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

DISPUTES FOR RETROSPECTIVE CLAIMS

IPA will follow Health Plan guidelines for hearing appeals. In all cases of denials, IPA will explicitly describe process of appeal rights for retrospective medical necessity and claims denials. IPA may be delegated to handle First Level Appeal; exact mechanism will be noted on letter, depending on Health Plan.

For Medicare Members: Under Part C (Medicare Advantage) rules, once a service has been rendered without obtaining prior authorization, it is considered to be post-service even if we have not received a claim. Post-services, you may be required to submit a claim for payment.

BILLING GUIDELINES

CO-PAYMENTS, CO-INSURANCE, AND DEDUCTIBLES

Providers may only bill and collect the member's applicable co-payments, co-insurance and deductibles which are specifically permitted in the member's health plan contract. A member's co-pay for an office visit can often be found on the member's health plan card or via th plan website.

The provider shall bill and collect all charges from a member for non-covered services provided to the member. Non-Covered Services are defined as follows:

1. **NOT** authorized but requested by patients, regardless of authorization.

2. **NOT** a covered benefit as determined by member's benefit plan.

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

NO BILLING OF PATIENTS

According to the Knox-Keene Health Care Service Plan Act of 1975;

No bills or statements of any kind shall be sent to Plan members, except for copayment amounts, unauthorized services, or non-covered benefits.

Members are responsbile only for co-payment amounts and services determined as exclusions and limitations to the health plan explanation of benefits.

Section 5: Encounter Data, Claims and Billing

COVERED CALIFORNIA

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

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

ELIGIBILITY AND BENEFITS		
HEALTH PLAN	**WEBSITE**	**PHONE NO.**
ANTHEM BLUE CROSS	https://www.anthem.com/ca/	(866) 755-2680
HEALTH NET	www.healthnet.com/provider	(800) 675-6110
L.A. CARE	www.lacarecovered.org	(855) 222-4239
MOLINA	www.molinahealthcare.com/providers/ca/marketplace/pages/home.aspx	(855) 322-4075

WHAT IF MEMBER DOES NOT SHOW AS ELIGIBLE VIA WEBSITE OR THROUGH PLAN CUSTOMER SERVICE?

- Direct the member to contact the Health Plan Member Services Department

MEMBER SERVICES DEPARTMENT	
HEALTH PLAN	**PHONE NO.**
ANTHEM BLUE CROSS	(800) 331-1476
HEALTH NET	(888) 926-4988
L.A. CARE	(855) 270-2327
MOLINA	(888) 858-2150

Section 5: Encounter Data, Claims and Billing

COVERED CALIFORNIA

CO-PAYMENTS

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

Verify if copayments are applicable via Health Plan website or Members Services Department.

- If all services are rendered within your clinic multiple copay(s) apply.

Example:

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

LAB DRAW AND X-RAY COPAYS

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

SPECIALIST OFFICE VISIT COPAYS

- Specialty office visit copay(s) may apply for services rendered by a specialist within your clinic. This applies even though HCLA does not reimburse separately for these services.

  Examples include Allergy, Cardiology, OB/GYN, Podiatry, etc.

HEALTH PLAN, PCP OR IPA CHANGES

HOW AND WHEN CAN A MEMBER CHANGE PLANS?

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

BILLING

WHO DO WE BILL FOR SERVICES?

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

Section 5: Encounter Data, Claims and Billing

COVERED CALIFORNIA

FINANCIAL RESPONSIBILITY FORM (ENGLISH VERSION)

Health Care LA, IPA

FINANCIAL RESPONSIBILITY FORM

Member Acknowledgement of Financial Responsibility

Provider, Please check one of the following:

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

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

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

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

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

Service Description:

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

_____

_____

_____ _____

Patient's Signature | Date of Service

_____ _____

Patient's Printed Name | Permanent Address

_____ _____

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

_____ _____

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

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

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

Section 5: Encounter Data, Claims and Billing

COVERED CALIFORNIA

FINANCIAL RESPONSIBILITY FORM (SPANISH VERSION)

Health Care LA, IPA

FORMULARIO DE RESPONSABILIDAD FINANCIERA

Aceptación de responsabilidad financiera por parte del miembro

Proveedor, por favor marque una de las siguientes:

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

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

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

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

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

Descripción del servicio:

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

_____

_____

_____ Firma del paciente

_____ Fecha del servicio

_____ Nombre del paciente en letra de molde

_____ Dirección permanente

_____ Firma de la parte responsable (en nombre del dependiente)

_____ Ciudad, estado, código postal

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

_____ Número telefónico

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

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

Section 5: Encounter Data, Claims and Billing

COVERED CALIFORNIA

CALIFORNIA CHILDREN'S SERVICES (CCS)

Children needing specialized medical care may be eligible for the California Children's Services (CCS) program.

CCS is a California medical program that treats children with certain physical conditions and who need specialized medical care. This program is available to all children in California whose families meet certain medical, financial and residential eligibility requirements. Services provided through the CCS program are coordinated by the local county CCS office.

If a member's PCP suspects or identifies a possible CCS eligible condition, he/she may refer the member to the local county CCS program. The CCS program (local or the CCS Regional Office) will determine if the member's condition is eligible for CCS services.

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

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

Section 6: Quality Management

QUALITY MANAGEMENT PROGRAM

MedPOINT has a comprehensive and integrated Quality Management (QM) Program. It is designed to objectively and systematically monitor and evaluate quality, appropriateness and outcome of care and services along with the processes by which they are delivered to IPA members.

Specific activities in the QM program include but are not limited to the following areas:

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

MEDICARE FIVE STAR QUALITY RATING

What is a Five Star Plan Rating?

Medicare uses information from member satisfaction surveys, plan and healthcare providers to give overall performance star ratings to Medicare Health Plans. These ratings help you compare plans based on quality and performance. A plan can get a rating from one to five stars. A 5- star rating is considered excellent.

5- Star Quality Measures

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

How to Achieve a 5-Star Rating

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

What is Hierarchical Condition Categories (HCC)?

HCC is a category of medical conditions that map to a corresponding group of ICD-10 diagnosis codes.

What is Risk Adjustment Factor (RAF)?

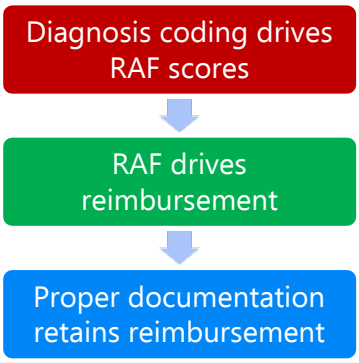
- Payment methodology used by Medicare Advantage Health Plan to adjust Health Plan payments
- Based on enrollee health status and demographic characteristics
- HCC
- Specific diagnostic coding to include chief complaint and all co- morbidities
- Status codes (V-codes)
- Documentation of underlying disease
- Documentation of manifestation of disease
- Specific coding regarding stages of disease (i.e. chronic kidney disease codes)
- Compliance to CMS documentation requirements
- To schedule training related to HEDIS and HCC, email qualitymeasures@medpointmanagement.com

PROPER CODING VERSUS NO CODING

Components for Success

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

DOCUMENTATION



CULTURAL COMPETENCY PROGRAM

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

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

Who is responsible for arranging interpreters' services?

The provider conducting the consultation or treatment plan is to schedule interpreter services.

How far in advance should I call the Health Plan to arrange interpreter services?

For a phone interpreter, call at least 1 hour before the patient's appointment. For a face-to face interpreter, please contact the Health Plan for guidelines on prior notice.

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

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

Incentives for Clinics/Health Centers – Annual Wellness Visits (AWV)

Incentives for Clinics/Health Centers - ANNUAL WELLNESS VISITS (AWV)			
Health Plan	**LOB**	**Program**	**Details**
Anthem Blue Cross	Commercial	Annual Wellness Visit (AWV)	Due to COVID19, the Anthem routine programs for preventive care are on hold (3/19/20). For questions, please email anisha.dua@anthem.com.
Blue Shield Promise	Medicare, Cal MediConnect Applies only to IPAs: HCLA, CCIPA and IHP	Annual Wellness Exam (AWE) Provider Incentive Program 2020	Complete the In-Office Assessment (IOA) form accurately within 60 days of visit for maximum payment of up to $200 for Medicare, $300 for CMC. After 60 days, payment is $25 for Medicare and $75 for CMC. Forms are provided by Optum. Payment is made through the IPA. Document verification included in incentive and must pass. For questions about distribution and return of forms, please email klitzsey@medpointmanagement.com. For questions about IOA, email: Sandra.Jaureguibaza@optum.com.
Brand New Day	Medicare	STARs Annual Wellness Exam (AWE)	$150 per AWE form in 2020. Use a blank form or EHR template until the populated form is available. Please return form to klitzsey@medpointmanagement.com. For more details, contact provider_services@universalcare.com. (Members receive $50 for completed annual exam.)
Health Net	Medicare	Annual Wellness Program	Unconfirmed for MY2020: $100 incentive for each comprehensive health assessment performed at a qualifying visit (CPT codes G0438/G0439/G0402/99396/99397). Besides the encounter submission, the corresponding medical chart must also be available to earn the incentive.
IEHP	Cal Medi-Connect	Annual Wellness Visit	For any member, receive $200 for completing the IEHP DualChoice Annual Visit form online at www.iehp.org. Forms must be submitted within two months from the date of service and must meet IEHP submission standards to qualify for incentive. For questions email: ProviderServices@iehp.org.
LA Care	Cal MediConnect	CMC Annual Wellness Exam (AWE) Program 2020	$350 if submitted less than 90 days from date of service (DOS), $175 if after 90 days DOS. Complete information required including AWE Form and PHQ-9 section. Contact RiskAdjustment@lacare.org or call 213-694-1250, x4664, for more information.
Molina	Commercial, Medicare, Medi-Medi	Annual Comprehensive Exam (ACE)	The ACE Program is being finalized for 2020 and this grid will be updated as soon as information becomes available. For questions about completing AWV's for Molina members, email klitzsey@medpointmanagement.com.

Incentives for Clinics/Health Centers - PROGRAMS			
Health Plan	**LOB**	**Program**	**Details**
Blue Shield Promise	Medi-Cal	Align Measure Perform (AMP) 2020	A score is calculated based on six domains: • Clinical Quality • Data Quality (Encounters) • Patient Experience • Advancing Care Information • Appropriate Resource Use • Total Cost of Care For details of the AMP program for Medi-Cal see https://IHA.org. For questions email: ProviderIncentives@blueshieldca.com.
Blue Shield Promise	Medi-Cal	CHDP Incentive	In addition to capitation, CHDP services will be paid at CHDP rates when submitted accurately within 30 days from the date of service.
Blue Shield Promise	Medi-Cal	Patient Centered Medical Home (PCMH) Certification	Primary care practices will be incentivized to continue ongoing PCMH certification through NCQA or the Joint Commission with two annual incentive payments payable once in April and once in October. The payments will be based on PCMH certification status and practice size ($1.50 PMPM). For questions, please email: ProviderIncentives@blueshieldca.com.
Central Health Plan	Medicare	STARs PCP Incentive Program Applies to FCS IPA only	The 2020 program has not been released but will be similar to 2019, which included the following measures: Mental Health Screening, Monitor Physical Activity, Improve Bladder Control, Fall Prevention, BMI, Colorectal Cancer, Mammogram, Medication Reconciliation, Blood Pressure </= 139/89, Eye Exam, HbA1c <8%, Nephropathy, Medication list and review, Care for Older Adults and Statin Treatment, plus 3 adherence measures. A minimum of 35 members are required to qualify.
Health Net	Medi-Cal	Clinic HEDIS Improvement Program (C-HIP) 2019 - FQHC	The C-HIP FQHC Clinic incentive has not been released yet for 2020. The eligibility for 2019 C-HIP bonus payment depended on 0.5% year over year improvement or exceeding the following benchmarks in these HEDIS measures: BCS (60%), CCS (67%), CDC HbA1c Test (93%), CIS Combo 10 (TBD), IMA Combo 2 (40%) and W34 (81%).
Health Net	Medi-Cal	HEDIS Improvement Program (HIP) 2020 – PCP	The HIP Program rewards PCP's efforts to improve quality in the following 18 measures through encounter data: AMM acute ($75) and continuation ($75), AWC ($22.50), BCS ($75), CBP ($50), CCS ($75), CDC A1c > 9 ($50) , CDC A1c Test ($12.50), CHL ($25), CIS 10 ($200), IMA 2 ($50), PPC Postpartum ($100) and Prenatal ($100), W15 ($75 6+ visits), W34 ($25), WCC BMI ($5), WCC Nutrition ($5) and WCC Physical Activity ($5). Minimum of 50 members required. For more information, please contact HEDIS@healthnet.com.

Incentives for Clinics/Health Centers – PROGRAMS (continued)			
IEHP	Medi-Cal	Global Quality Pay for Performance (GQP4P) 2020 PCP Program Program Applies to IHP only	A score is calculated based on five domains: • Access • Clinical Quality • Behavioral Health Integration • Patient Experience • Encounter Data The 2020 incentive pool is $67 million for the PCP Program. Incentive dollars for the 2020 performance period will be distributed via a monthly Per Member Per Month (PMPM) Quality Payment beginning in July 2021 and continuing through June 2022. For program details see: https://www.iehp.org/en/providers/pay-for-performance?target=global-quality-program For questions email: QualityPrograms@IEHP.org
IEHP	Medi-Cal	OB/GYN P4P Program 2020 Applies to IHP only	There are eight maternity care measures, including postpartum care measures, for which OB/GYN Providers are eligible to receive a financial incentive: 1. Initial Prenatal Visit $90 2. Perinatal Chlamydia Screening $75 3. Perinatal Depression Screening $75 4. Postpartum Blood Pressure Screening $75 5. Postpartum Diabetes Screening $75 6. Early Postpartum Visit (1 - 21 days postpartum) $75 7. Later Postpartum Visit (22 - 84 days postpartum) $75 8. Tdap Vaccine $90 For program details see: https://www.iehp.org/en/providers/pay-for-performance?target=ob-p4p-program For questions email: QualityPrograms@IEHP.org
LA Care Includes: Anthem Blue Cross and Blue Shield Promise	Medi-Cal	HEDIS Physician P4P Program (Pay for Performance)	The 2020 program is similar to last year but with additional measures. Each performance measure includes attainment and improvement scores. **HEDIS (30%) -** The 16 HEDIS measures include: **AWC, AMM** (Antidepressant Medication Mgmt.), **AMR** (Asthma Medication Ratio), BCS, CCS*, CIS10*, CHL, CDC A1c Control <8%*, CDC Eye Exam, **CBP*,** IMA2, PPC Postpartum and Prenatal*, **WCC Physical Activity,** W34* and **W15.** Three additional Test Measures include Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD and SMD), and Metabolic Monitoring for Children and Adolescents on Antipsychotics (AMD). * Indicates double-weighted measures. Bolded measures are in new in 2020. Complete, timely and accurate encounter data is also key. Contact Incentive_Ops@lacare.org for P4P and reporting questions.
LA Care	Medi-Cal	HEDIS Behavioral Health - eManagement Physician Incentive Program 2020	LA Care solo and/or small group Medi-Cal providers who submit completed screenings for anxiety, depression, and/or alcohol use receive $15 (once a year per member). For patients who score mild to moderate for anxiety and/or depression and engage in an online consultation directly with a psychiatrist, the PCP receives $50 for every completed consult. Please contact emanagement@lacare.org or (213) 694-1250 x 5635 for further information.

Incentives for Clinics/Health Centers – PROGRAMS (continued)			
Molina	Covered CA	Marketplace Quality Partner Bonus Program	The Marketplace Bonus payments are as follows: $25 – HbA1c <8 $300 – PPC Prenatal Program is not applicable to Sacramento. Call or email your Provider Services liaison as needed.
Molina	Medi-Cal	CHDP Wellness Incentives Does not apply to FQHCs outside of LA County.	PCPs and LA County FQHCs with minimum of 200 members (minimum only applies to LA County) receive CHDP incentive bonus payments for complete, accurate and timely wellness services submitted via the encounter process within 60 days from the date of service. Counties included: LA, Inland, Sacramento, San Diego, Imperial. Payment for CHDP services include: $20 for well visits for infants (99381, 99391), $35 for well visits for children and adolescents (99382-99385, 99392-99395), $20 for lead screening (83655) for members age 0-23 months, $5 per Pap smear (88150), and $7.50 (LA) or $9 (other counties) for targeted immunizations (MCV4, Tdap, HPV must be administered between 9 years and 12 years 11 months). See JTF CHDP 01-18-2019 and JTF CHDP Update 09-27-2019 for details. Contact Molina Provider Services liaison at (855) 322-4075 or MHCQuality@MolinaHealthCare.com for questions.
Molina	Medi-Cal	HEDIS P4P Program (Pay-for-Performance) for **PCPs/OBGYNs** 2020	The PCP Program requires a minimum of 200 Medi-Cal members to qualify for Well Child Visits (W34), Cervical Cancer Screening (CCS) and A1c Control performance bonus. No minimum on other measures below. P4P Bonus measures include: CCS ($25), A1c < 8.0 ($75), Prenatal ($200), Postpartum ($150), CIS combo 10 ($100), IMA combo 2 ($25) (only in Imperial and Inland Empire) and W34 ($25). <u>IHA/SHA Bonus:</u> MHC requires that New/Extended/Routine History of Physicals must be submitted with an Initial Health Assessment (IHA) and Staying Health Assessment (SHA). Effective 10/1/2019, $50 will be paid through the P4P Program for members age 0-18 years who had a timely, accurate and complete Initial Health Assessment (CPT codes 99381-99385) <u>and</u> Staying Health Assessment (CPT code 96156) within 120 days of enrollment with Molina. Please refer to Molina "Just the Fax" (JTF) "Revision" notice dated 3/17/2020 and JTF CHDP Update 09-2-2019 for further details. Contact Provider Services liaison at (855) 322-4075 or email MHCQuality@MolinaHealthCare.com for questions.

Incentives for Clinics/Health Centers – PROGRAMS (continued)			
Molina	Medi-Cal	HEDIS P4P Program (Pay-for-Performance) for **FQHC/RHCs** 2020 Applies to FQHCs outside of LA County only	Announcement of the redesigned Molina Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) program is delayed until March or April 2020. To qualify for any payment, all goals for "NCQA 2020 Threshold" for each measure must be met. This will trigger a $1.25 PMPM payment. Additional payment is then based on how many of the stretch goals are met and if the Member Satisfaction component is met. Payments will be paid annually after final HEDIS rates are announced. Measures include AWC, ABA, AMM-Acute, AMM-Cont, AMR, BCS, CCS CHL, CIS-10, CDC>9%, CBP, SSD, IMA-2, PPC Prenatal, PPC Postpartum, WCC-BMI, WCC-N, WCC-PA, W34 and W15. For questions, please email: MHCQuality@MolinaHealthCare.com. Please refer to JTF notice dated 1/31/2020. MCAS measures are listed here: https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEAS.aspx.
Molina	Medi-Cal	Value Based Payment (VBP) Program 2020	For FY 2019-2020, the Governor's Budget proposed a VBP through Medi-Cal managed care health plans (MCPs) that will provide incentive payments to providers for meeting specific measures aimed at improving care for certain high-cost or high-need populations. These risk-based incentive payments will be targeted at physicians that meet specific achievement on metrics targeting areas such as behavioral health integration, chronic disease management, prenatal/post-partum care and early childhood prevention. Dental Fluoride Varnish: Molina's CHDP Dental Fluoride Varnish Program has been folded into the VBP program and will provide a $25 incentive for Dental Fluoride Varnish (CPT 99188 or CDT D1206) for members age 6 months through less than age 6. FQHCs are no longer eligible for this program. To request a detailed PowerPoint on the measures, requirements and payment amounts, please call 818-702-0100, x1353.
Scan Health Plan	Medicare	Provider Incentive Program (PIP)	Unconfirmed for MY2020: The 2019 PIP Program included the following components: • Eligibility – Full encounter data eligibility with an error rate of ≤ 3.5%. • Office Staff and Physician Training – Participate in at least 3 unique courses for a bonus of $3.00 per member x total members. • 15 Measures included – BCS, COL, CDC Eye, CDC Blood Sugar Controlled, Chronic Condition Recapture Rate, Statin Use in persons with Cardiovascular Disease, Medication Adherence for Diabetes Medications, Hypertension and Cholesterol, Statin Use in Persons with Diabetes, Medication Reconciliation Post-Discharge, Flu (admin. Data), Care Coordination and Falls, plus Improvement Measure. Year over year membership improvement is required. Thresholds are set by Scan and are not from CMS. Achievement and improvement rewards are weighted. Minimum membership for program is 1 member. For details, contact NetworkQuality@scanhealthplan.com.

Incentives for MEMBERS

Incentives for MEMBERS			
Health Plan	**LOB**	**Program**	**Details**
Alignment	Medicare	Jump Start Assessment (JSA)	Eligible members who complete the Jump Start Assessment receive $20 on their Concierge Card. Patients receive initial assessment within the first 30-90 days of membership and annual wellness visits at Care Centers in Los Angeles, Stockton and Modesto. See https://www.alignmenthealthplan.com/members/find-a-care-center for details.
Alignment	Medicare	Member Rewards Program - Access on Demand Concierge Card 2020	Eligible members are automatically enrolled in the Concierge program and earn rewards for completing select wellness behaviors and preventive screenings between 1/1/20 and 11/30/20: Colorectal Cancer Screening ($5-$20), Diabetic/Retinal Eye Exam ($10), DEXA Scan ($50), Mammogram ($30) and Flu Shot ($5). There may be additional rewards available to members throughout the year. For certain plans, the card also may also provide a monthly grocery benefit ($10 to $20) and a monthly benefit for over-the-counter (OTC) medicine and health aid benefit items such as cold and allergy medicine, denture products and diabetes care accessories at participating drug stores. Contact 833-242-2223 for further information.
Anthem Blue Cross	Commercial	Member Incentive Program – Preventive Care 2020	Adult and pediatric members who receive a mailing from Anthem with screenings due receive a $25 Visa gift card for each preventive screening completed for the following HEDIS measures: CDC A1c Test, CDC Eye Exam, CDC Nephropathy, BCS, CCS, AWC and W34.
Anthem Blue Cross	Commercial	Member Incentive Program – Hypertension	Members with a diagnosis of hypertension with high blood pressure readings will be offered to come to the clinic and be offered lifestyle and diet modification education materials (provided by Anthem) and a free BP monitor and $25 visa gift card at the time of the visit.
Blue Shield Promise	Medicare	Member Incentive Program 2020	Gift card to members for completing healthcare activities for 10 measures through self-attestation: (1) $50 for Colorectal Cancer Screening; (2) $25 for Annual Wellness Visit, (3) $25 for Diabetes Eye Exam, (4) $25 for Diabetes Blood-Sugar Controlled, (5) $25 for Breast Cancer Screening; (6) $10 for Annual Flu Vaccine; (7) $25 for Bone Density Test; and (8) $25 Bonus for completing all three: Colorectal Cancer Screening, Diabetes Eye Exam and Breast Cancer Screening. For questions email: MedicareStarRating@blueshieldca.com.
Brand New Day	Medicare	Rewards Plus Program 2020	Gift cards for completing preventive screening: $50 for Annual Wellness Exam, (2) $10 for Health Risk Assessment, (3) $10 for annual exercise plan, (4) $25 for mammogram, (5) $25 for colonoscopy or $10 for stool test, (6) $25 for diabetic members who have A1c, eye exam and nephropathy, and (7) $25 for weight management program for members with a BMI greater than 30. Rewards are loaded on a Rewards Plus Card to use at selected retailers for health related and personal care items. Call 866-255-4795 for questions.

Incentives for Members (continued)			
Health Net	Medi-Cal	Medi-Cal Reward Cards Program	Members receives information from Novu Health vendor by print communication, email and online. Member attests to completion of screening and gift cards are mailed by Health Net. Rewards include: $25 for Adolescent Well Care, $10 x 6 for Well Child in first 15 months of life, $25 for Asthma Medication Ratio and $15 for Flu. For questions, email: HEDIS@healthnet.com.
Health Net	Medi-Cal Medicare	Point-of-Care Reward Card Program	Select health centers receive $20 gift cards for the measures below and give them to the member after the visit is completed at the clinic. A log of cards distributed to members is required. Measures: Flu Vaccine, Mammography, Bone Mineral Density, HRA or Personal Wellness Assessment (SNPs only), Colorectal Cancer Screening, CDC Eye, CDC A1c and Annual Wellness Visit. *Health Centers who use this program will opt out of the Novu incentives and mailings above for 2020.*
Health Net	Medicare	My Health Pays and Health Net Care Cards Program	Health Net has same Visa prepaid card rewards for 2 different processes. (1) My Health Pays is a vendor who will mail a letter to Amber and Sapphire Medicare members and process the gift card after the screening claim is processed (does not include annual wellness visits). (2) Health Net Care Cards Program includes a letter mailed to other Medicare members (except Amber and Sapphire) and gift card will be processed after member attests by phone, mail or online. $20 rewards are paid for each of the following: Flu Vaccine, Mammography, Bone Mineral Density, HRA or Personal Wellness Assessment (SNPs only), Colorectal Cancer Screening, CDC Eye, CDC A1c and Annual Wellness Visit. For questions, email: HEDIS@healthnet.com.
Molina	Medi-Cal, Covered CA	Moms of Molina (MOM) POS Postpartum Program	All members who are in the Prenatal and Postpartum Care (PPC) measure that completes a postpartum visit will receive a voucher for a free package of diapers. Vouchers are issued based on eligibility and encounter data. For questions, please email: MHCQuality@MolinaHealthCare.com.
WellCare of CA (Centene)	Medicare	NOVU Healthy Rewards Program FCS IPA only	Member receives reward amounts in a reloadable Visa prepaid card as follows: Annual wellness ($25), BCS ($30), COL ($15-$30), flu vaccine ($10), physical health ($25), mental health ($10), osteoporosis (bone health) ($50), Diabetic Eye ($20), Diabetic Kidney ($20), blood sugar control (eye exam and kidney test) ($50, 2-$25), Controlling blood pressure (including high blood sugar test A1c) ($50, 2-$25). https://wellcare.com/california.

Incentives for IPA (PPG)

Incentives for IPA (PPG)			
Health Plan	**Category**	**Program**	**Details**
Adventist Health Plan	Medi-Cal	HEDIS Quality Performance Program	2020 Incentive is based on improvement of 17 HEDIS measures: HEDIS components include: ABA, AMM acute, AMM continuation, AWC, BCS, CBP, CCS, CDC A1c > 9, CDC A1c Test, CHL, CIS 10, IMA 2, PPC Postpartum and Prenatal, W15, W34, WCC BMI.
Blue Shield of CA and Blue Shield Promise	Medicare	Medicare Star Provider Incentive (MSPI) Program 2020	PPG Incentive is based on achievement of an overall Star score of 3.5 (BSC – Blue Shield of California)/3.0 (BSP – Blue Shield Promise) or higher. Payment is a "per member per year" (PMPY) payment based on claims, encounters, Pharmacy Playbook, monthly meeting attendance and supplemental data. Bonus amounts are tiered and vary by plan. • Measures - BCS, COL, OMW, CDC Eye, CDC A1c <8, CDC Blood Pressure Control, CBP (Controlling High Blood Pressure), ART (Rheumatoid Arthritis Management), MRP (Medication Reconciliation Post-Discharge), SPC (Statin Therapy for Patients with CV), PCR (Plan All-Cause Readmission), Medication Adherence for Hypertension, Medication Adherence for Cholesterol, Medication Adherence for Oral Diabetes Medication, and SUPD (Statin Use in persons with Diabetes). • Pharmacy – includes percent of 90-day supply prescriptions for diabetes agents, RAS antagonists and statins. Incentive ranges from $5 to $15 PMPM. • CAHPS – Possible $20,000 bonus based on Access to Care PCP member experience (>100 members and minimum 30 surveys per PCP annually), PCP survey results and Specialist member experience. • Improvement bonus is included. A Blue Shield Incentive PowerPoint with additional details is available upon request.
Blue Shield Promise	Commercial, Medi-Cal	HEDIS IPA Incentive Program	Blue Shield of California Promise Health Plan has aligned their Medi-Cal and Commercial lines of business with the Integrated Healthcare Association (IHA) statewide quality performance and payment incentive model called "Align. Measure. Perform." (AMP). The IHA incentive is based on scores calculated as part of the Integrated Health Association's (IHA) Value Based Pay for Performance Program (PVP4P.)
Blue Shield Promise	Medi-Cal	Value Initiative Program LA (VIP) 2020	A score is calculated based on five domains: • Access and Availability (25%) • HEDIS (25%) • Member Satisfaction (20%) • Utilization (15%) • Encounter Timeliness (15%) The score for each measure in a domain is based on how the IPA's result compares to its peers. 90th percentile + = full points. 50th and 89th percentile = 50% of the points. Below 50th percentile = 0 points for that measure. The Encounter gate incentivizes IPAs to increase their encounter data submission. Higher encounter data levels are eligible for a larger percentage of their total possible incentive payment. Focus measures for MY2020 have not yet been announced. For questions email: ProviderIncentives@blueshieldca.com

Incentives for IPA (PPG) (continued)			
Health Net (includes CalViva)	Medi-Cal	PPG HQIP (HEDIS Quality Incentive Program) This program excludes Adventist (AHP).	2020 Incentive is based on 18 HEDIS and 4 Access to Care components. HEDIS components include: AMM acute and continuation, AWC, BCS, CBP, CCS, CDC A1c > 9, CDC A1c Test, CHL, CIS 10, IMA 2, PPC Postpartum and Prenatal, W15, W34, WCC BMI, WCC Nutrition and WCC Physical Activity. Access measures (must be at 90%) are (1) Urgent appointments with PCP within 48 hours, (2) Non-urgent appointments with PCP within 10 business days, (3) Urgent appointments with specialist within 96 hours and (4) Non-urgent appointment with specialist within 15 business days. A minimum of 1,000 Medi-Cal members (MCE, SPD and OTLIC) is required. For further details, contact HEDIS@healthnet.com.
IEHP	Medi-Cal	Global Quality Pay for Performance (GQP4P) 2020 IPA Program Applies to IHP only	A score is calculated based on five domains: • Access • Clinical Quality • Behavioral Health Integration • Patient Experience • Encounter Data The 2020 incentive pool is $20 million for the IPA Program. For program details see: https://www.iehp.org/en/providers/pay-for-performance?target=global-quality-program For questions email: QualityPrograms@IEHP.org
LA Care Includes: Anthem Blue Cross and Blue Shield Promise	Medi-Cal	LA VIIP (Value Initiative for IPA Performance) + P4P (Pay-for-Performance Program) 2020	The 2020 program is similar to last year but with additional measures. Each performance measure includes attainment and improvement scores. **HEDIS (30%) -** The 16 HEDIS measures include: **AWC, AMM** (Antidepressant Medication Mgmt.), **AMR** (Asthma Medication Ratio), BCS, CCS*, CIS10*, CHL, CDC A1c Control <8%*, CDC Eye Exam, **CBP*,** IMA2, PPC Postpartum and Prenatal*, **WCC Physical Activity,** W34* and **W15.** Three additional Test Measures include: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD and SMD), and Metabolic Monitoring for Children and Adolescents on Antipsychotics (AMD). * Indicates double-weighted measures. Bolded measures are in new in 2020. **Member Experience (30%)** - for both Adult and Child includes: (1) **Getting Needed Care*,** (2) Timely Care and Service*, (3) Rating of all Health Care and (4) Rating of PCP. * Indicates double-weighted measures. New domain is bolded. **Utilization Management (20%)** – Includes (1) Acute Hospitalization Admission Rate (AHU), (2) Emergency Dept. Utilization, and (3) Plan All-Cause Readmissions (PCR). **Encounters (20%)** – Includes (1) Timeliness within 60 days of service and (2) Volume per member per year. NOTE: Ranking data is unblinded to groups. Contact VIIP@lacare.org if you have questions.

Incentives for IPA (PPG) (continued)			
LA Care	Covered CA	L.A. Care Covered VIIP (Value Initiative for IPA Performance) Program	The Commercial incentive is through the Integrated Healthcare Association (IHA) program called Align. Measure. Perform (AMP), with payout in 2021 for 2020 data. Measures are being finalized for 2020. The 2019 program is below. **HEDIS (30%)** – Total of 24 HEDIS measures include: CDC (A1c Control <8%, Nephropathy, Eye Exam, Blood Pressure Control, A1c Poor Control >8%), SPD & SPC (Statin Therapy for Patients with Diabetes and Cardiovascular Disease), Proportion on days covered by medications (for Oral Diabetes Medications and RAS Antagonists and Statins), CBP, AAB, BCS, CCS, COL, CHL, CIS10, CWP, IMA2, AMR, Concurrent Use of Opioids and Benzodiazepines and Use of Opioids at High Dosage. **Member Experience (30%)** – Includes Care Coordination, Office Staff, Overall Ratings of Care, Provider Communication and Access. Prenatal is a test measure for 2019. **Utilization Management (20%)** – Includes ER utilization, All-Cause Readmission, Inpatient utilization, Acute hospital utilization, Ambulatory care, Outpatient procedures, Generic prescribing and Frequency of Selected Procedures. **Encounters (20%)** – Includes (1) Timeliness within 60 days of service and (2) Volume by professional and facility and by per member per year. Contact VIIP@lacare.org if you have questions.
LA Care	Cal MediConnect	VIIP (Value Initiative for IPA Performance) Program	Medi-Medi incentive, with payout in 2021 for 2021 data. Measures are being finalized for 2020. The 2019 program is below. **HEDIS (25%)** – HEDIS measures include: BCS, COL COA, CDC (A1c<8%, Eye Exam, Blood Pressure Control), AMM (Antidepressant Med. Mgmt.) and DAE (Use of High-Risk Medications in the Elderly). **Care Management (20%)** – Includes Annual Wellness Exam, care coordinator and care team contact, timely ICP completion and log accuracy and completeness. **Member Experience (20%)** – Includes disenrollment (TRR), retention over 90 days (TRR) and Member Satisfaction for getting care quickly, getting needed care, rating of PCP and rating of health care quality. **Utilization Management (15%)** – Includes All-Cause Readmission (PCR), ED utilization (EDU) and reduction in ED use for seriously mentally ill and substance use disorder members. **Encounters (10%)** – Includes (1) Timeliness within 180 days of service and (2) Volume by per member per year. **Pharmacy (10%)** - Includes Part D Medication Adherence for Oral Diabetes, Hypertension and Cholesterol (Statins). Contact VIIP@lacare.org if you have questions.

Section 6: Quality Management

ACTIONABLE MONTHLY REPORT

Ambulatory Care Sensitive Conditions (ACSC) Report

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

Re-Admission Report

- Four recommended strategies for improving transition of care are:

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

Emergency Room Visits

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

Member Aging into Medicare Coverage 64+ years of age

- Use this report to outreach to these members to anchor them to your practice through one of HCLA's Medicare Advantage plans: Blue Shield Promise and Molina. Note that while the open enrollment period for Medicare Advantage is once a year October 15 through December 7 for enrollment the following January, members aging into the program may enroll within the initial enrollment period which is 3 months before turning 65 and up to 3 months after turning 65. Medi-Medi patients may enroll or dis-enroll at any time into a Medicare Advantage plan. Now is the time to anchor these members before your competition goes after them.

Medi-Cal Members Identified as Dual Eligible (Med-Medi)

- Use this list to outreach to these patients to encourage them to enroll with you under a Medi-Medi plan. For example: Blue Shield Promise, Health Net, L.A. Care and Molina.

Eligibility Report

- Enrollment Strategies:

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

HCC Scores

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

Section 6: Quality Management

ACTIONABLE QUARTERLY REPORT

Ambulatory Care Sensitive Conditions (ACSC) Report

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

Re-Admission Report

- Four recommended strategies for improving transition of care are:

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

Emergency Room Visits

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

Member Aging into Medicare Coverage 64+ years of age

- Use this report to outreach to these members to anchor them to your practice through one of HCLA's Medicare Advantage plans: Blue Shield Promise and Molina. Note that while the open enrollment period for Medicare Advantage is once a year October 15 through December 7 for enrollment the following January, members aging into the program may enroll within the initial enrollment period which is 3 months before turning 65 and up to 3 months after turning 65. Medi-Medi patients may enroll or dis-enroll at any time into a Medicare Advantage plan. Now is the time to anchor these members before your competition goes after them.

Medi-Cal Members Identified as Dual Eligible (Med-Medi)

- Use this list to outreach to these patients to encourage them to enroll with you under a Medi-Medi plan. For example: Blue Shield Promise, Health Net, L.A. Care and Molina.

Eligibility Report

- Enrollment Strategies:

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

HCC Scores

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

Clinic Report Card – Medi-Cal Line of Business (Adult Combined)

- This report is used to monitor performance against IPA average

Clinic Report Card – Medi-Cal of Business (Pediatric)

- This report is used to monitor performance against IPA average

HEDIS Report Card

STARs Report Card

Section 7: Compliance

COMPLIANCE PROGRAM

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 aims to improve the efficiency and effectiveness of the United States health care system. While the Act's core goals were to maintain insurance coverage for workers and fight health care fraud and abuse, its Administrative Implication provisions have had the greatest impact on how the health care industry works.

COMPLIANCE TIPS

The Five Things You Need to Know About Compliance

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

Suspect a Compliance Issue? Utilize the following options:

Call the Compliance Hotline at **818-702-0100, x1531**

Email the Compliance Department at ComplianceConcerns@medpointmanagement.com

Submit a report via surveymonkey.com/r/ComplianceConcern

ETHICS AND INTEGRITY

Health Care LA, IPA is dedicated to conducting business honestly and ethically with you and our members. Making sound decisions as we interact with you, other health care providers, regulators and others is necessary for our continued success and that of our business associates.

FRAUD, WASTE, ABUSE

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

REPORTING

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

EXCLUSION CHECKS

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

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

Health and Human Services- Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE) at oig.hhs.gov.

General Services Administration (GSA) System for Award Management at SAM.gov.

VOLUNTARY STERILIZATION

You must comply with the procedures below prior to obtaining an authorization and performing a sterilization service. A completed Consent Form (PM330) must be submitted with claims for all sterilization procedures. Claims submitted without the PM330 will not be processed for payment.
The PM330 form is available for download from https://files.medi-cal.ca.gov/pubsdoco/forms/PM-330_Eng-SP.pdf

Voluntary sterilization consent requires:

- The member to be at least 21 years of age at the time consent assigned
- The recipient to be mentally competent
- It to be voluntary and obtained without duress.
- 30 days, but not more than 180 days, to pass between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery
- At least 72 hours must have passed since the recipient gave informed consent for the sterilization if the recipient is to be sterilized at the time of a premature delivery or emergency abdominal surgery
- The informed consent must be given at least 30 days before the expected date of delivery in the case of premature delivery
- The person securing the informed consent and the care provider performing the sterilization procedure are required to sign and date the consent form
- Copy of the signed Federal Consent Form must be submitted by each provider involved with the hospitalization and/or the sterilization procedure
- Providers must indicate in the record that the recipients already receive the sterilization booklet
- That sterilization consents may not be obtained when an eligible recipient:
  - is in labor or childbirth
  - is seeking to obtain or obtaining an abortion
  - is under the influence of alcohol or other substance that affect that recipient's state of awareness.

ACCESS TO CARE SURVEYS

Health Care LA, IPA conducts quarterly Access to Care compliance audits by telephone to assess appointment availability and afterhours access to healthcare providers as required by DHCS, DMHC, CMS and NCQA.

Appointment Availability calls will be made during the Provider's normal operating hours. After Hours calls will be conducted during early mornings, evenings, weekends and holidays to meet the requirement for 24/7 coverage.

Respondents who refuse to participate in the survey will be scored as noncompliant.

You will find Timely Access and Availability Standards in Section 4**.**

REFERRAL, MISSED APPOINTMENT AND ABNORMAL TEST RESULTS TRACKING LOG

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

Tracking Log of Specialty Referrals must include the following:

- Date of Referral
- Reason for referral and clearly documented in the medical record
- Date of appointment
- Confirmation that patient went to appointment
- Copy of Specialty visit notes with the provider's signature

Tracking Log of all Missed Appointments must include the following:

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

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

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

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

□ No action required

□ Abnormal Results

- Labs
- X-rays
- Other

□ Discussed recommendation with patient

GLOSSARY

ACA	(Patient Protection and) Affordable Care Act
ACO	Accountable Care Organization
ALOS	average length of stay
AMA	American Medical Association
AMCRA	American Managed Care and Review Association
APT	admissions per thousand
ASO	administrative services only
ASR	age/sex rate
AUR	ambulatory utilization review
AWP	average wholesale price
CAP	capitation or Corrective Action Plan
CAPG	California Association of Physician Groups
CCLAC	California Association of Los Angeles County
CDHS	California Department of Health Services
CDPH	California Department of Public Health
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHIP	Children's Health Insurance Program
CHP	Community Health Plan
CMP	competitive medical plan
CMS	Centers for Medicare and Medicaid Services
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985
CPCA	California Primary Care Association
CPT	Physician’s Current Procedural Terminology
CQI	Continuous Quality Improvement
DHCS	Department of Health Care Services
DME	durable medical equipment
DMHC	Department of Managed Health Care
DOS	date of service
DPT	days per thousand
DRG	diagnosis related group
DX	diagnosis code
EAP	employee assistance program
EOB	explanation of benefits
EOM	end of month
EOY	exclusive provider organization
EPO	exclusive provider organization
ER	Emergency Room

GLOSSARY

ERISA	Employee Retirement Income Security Act of 1974
FFS	fee for service
FMTB	Federal Means Tested Benefit
FQHC	Federally Qualified Health Center
GHAA	Group Health Association of America
HCC	Hierarchical Condition Category
HCCN	Health Center Controlled Network
HCFA	Health Care Financing Administration
HCLA	Health Care LA IPA
HCPCS	HCFA Common Procedural Coding System
HEDIS 2.5	Health Plan Employer Data and Information Set
HHS	Department of Health and Human Services
HMO	Health Maintenance Organization
HRA	Health Risk Assessment
IBNR	incurred but not reported
ICD-9-CM	International Classification of Diseases, 9th Ed. (Clinical Modification)
IHA	Initial Health Assessment
IPA	Independent Physician Association
JCAHO	Joint Commission of Accredited Hospitals
LOS	length of stay
LPR	Legal Permanent Resident
MAC	maximum allowable cost
MCE	Medi-Cal Expansion
MCR	modified community rating
MD	Medical Doctor
MESH	medical staff hospital joint venture
MH/CD	mental health/ chemical dependency
MPM	MedPOINT Management
NCQA	National Committee on Quality Assurance
NON-PAR	non- participating provider
NPN	non-par not approved
OOA	out of area
OOPS	out of pocket expenses
P&T	pharmacy and therapeutics committee
PAC	preadmission certification
PAR	participating provider

GLOSSARY

PCP	Primary Care Physician
PCPM	per contract per month
PCR	physician contingency reserve
PEC	preexisting condition
PMG	primary medical group
PMPM	per member per month
PMPY	per member per year
POS	point of sale or point of service
PPACA	Patient Protection and Affordable Care Act
PPO	preferred provider organization
PRO	professional (or peer) review organization
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act
PSRO	professional standards review organization
QA	quality assurance
QM	quality management
QMB	qualified Medicare beneficiary
R&C	reasonable and customary
RAF	Risk Adjustment Factor
RBRVS	resource based relative value scale
RFP	request for proposal
RPI	Registered Provisional Immigrant
SIC	standard industry code
SNAP	Supplemental Nutrition Assistance Program
SPD	Seniors and People with Disabilities
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TPA	third party administrator
U&C	usual and customary
UCR	usual, customary and reasonable
UM	utilization management
UR	utilization review
UR/QA	utilization review/quality assurance
YTD	year to date

MANAGED CARE DEFINITIONS

Helpful Definitions

Acute refers to a health effect that is brief and/or of high intensity.

Advance Premium Tax Credits is the payment of the tax credits authorized by 26 U.S.C. 26B and its implementing regulations, which are provided on an advance basis, to an individual enrolled in a Qualified Health Plan (QHP) through Covered California in accordance with Section 1412 of the Affordable Care Act.

Affordable Care Act (ACA) is a law that provides the framework, policies, regulations and guidelines for implementation of comprehensive health care reform by the states. 'The Affordable Care Act will expand access to high-quality affordable insurance and health care.

Allowable Charges refers to charges in the fee schedule negotiated by the health plan and each participating provider.

Ambulatory Patient Services is medical care provided without need of admission to a health care facility. This includes a range of medical procedures and treatments such as blood tests, X-rays, vaccinations, nebulizing and even monthly well-baby checkups by pediatricians.

Americans with Disabilities Act (ADA) of 1990 is law that protects people with disabilities from discrimination and ensures equal opportunity for persons with disabilities in employment, state and local government services. For more information, call the U.S. Department of Justice at 1-800-514-0301 (voice) or 1-800-514-0383 (TTY/TDD).

Anesthesia is the loss of sensation due to pharmacological depression of nerve function.

Applicant is a person who applies for coverage on his/her own behalf. An applicant is also a person who applies on behalf of a child for whom he or she is responsible. The child or children are called the Enrolled Dependents.

Assisters are those individuals who have been certified by Covered California to help eligible individuals and families apply for and enroll in qualified health plans through Covered California.

Authorize/Authorization is the requirement that Covered Services be approved.

Behavioral Health Treatment is professional services and treatment programs that are prescribed by a physician, surgeon or is developed by a licensed psychologist and provided under a treatment plan prescribed by qualified autism service provider, and administered by a qualified autism service provider, professional or paraprofessional, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the

MANAGED CARE DEFINITIONS

maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

Benefits, Plan Benefits, or Covered Services are those services, supplies, and drugs a Member is entitled to receive according to the QHP.

Benefit Year is the l2-month calendar year, as defined by Covered California.

California Health Eligibility Enrollment and Retention System (CalHEERS) is a project jointly sponsored by the California Exchange and the Department of Health Care Services, with the assistance of the Office of Systems Integration to maintain processes to make the eligibility determinations regarding the Exchange and other State health care programs and assist Enrollees in the selection of a health plan.

California Children's Services (CCS) is a statewide health care program open to persons under the age of 19 with a handicapping condition. Call the Los Angeles County CCS program at (626) 858-2100 for more information.

Cancer Clinical Trial is a research study with cancer patients, to find out if a new cancer treatment or drug is safe and works with the type of cancer that you have.

Capitation is a set flat rate paid each month to providers for covered services provided to assigned Members.

Cardiology is the medical specialty of the diagnosis and treatment of heart disease.

Chemotherapy is the treatment of a disease using chemical substances or drugs.

Chiropractic is the practice of locating, detecting and assisting in correcting vertebral subluxation. This is done by hand only with an adjustment.

Civil Rights Act of 1964 (Title 6) is a law that protects limited English speaking members by requiring health care providers who receive federal government money to offer language services that include interpreting and translations. For more information, call the U.S. Department of Hea.lth and Human Services, Office of Human Rights at 1-800-368-1019 (voice) 1-800-537-7697 (TTY/TDD).

Co-insurance refers to a percentage of allowable charges that you must pay when you receive covered services from a participating provider.

Continuity of Care is your right to continue seeing your doctor or using a hospital in certain cases, even if your doctor or hospital leaves your health plan or medical group.

MANAGED CARE DEFINITIONS

Contraindicated is the showing that a method of treatment that would normally be used is not advisable due to the special circumstances of an individual case.

Co-payment is the amount a Member is required to pay for certain covered services after meeting any applicable deductible.

Cost-Sharing Subsidies (also called Cost-Sharing Reductions) are the reductions in cost-sharing for an eligible individual enrolled in a silver level plan through Covered California or for certain Native American Indians or Alaskan Natives enrolled in a through Covered California.

Covered California is the California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State of California. Beginning January 20 14, Covered California will selectively contract with health plans to make available to enrollees of the Exchange health care coverage choices that seek to provide the optimal combination of choice, value, access, quality and service.

Covered Services, Plan Benefits, or Benefits are those services, supplies, and drugs a Member is entitled to receive according to the QHP.

Credential is a certificate showing that a person is entitled to treat a member.

Custodial Care is a long-term care that does not require skilled nursing.

Deductible is the amount a member must pay in a calendar year directly to health care service providers for health care services the health plan covers before the health plan begins to pay. For example, if your deductible is $ 1,000, your health plan will not pay for any of the services that are subject to the deductible until the $ 1,000 deductible is met. The deductible does not apply to all covered services.

Diagnosis is the decision of the nature of a disease.

Diagnostic testing is the use of tests to reach a diagnosis.

Dialysis is a form of filtration to separate smaller molecules from larger ones in a solution. 'This is achieved by placing a semi permeable membrane between the solution and water.

Disability is a physical or mental problem that completely or seriously limits one or more of your major life activities.

Disenrollment is when a member leaves a Health Plan for any reason.

Drug Formulary (formulary) is a list of drugs approved by the Health Plan. A formulary is a

MANAGED CARE DEFINITIONS

list of drugs that are generally accepted in the medical community as safe and effective.

Durable Medical Equipment (DME) is medical equipment, like hospital beds and wheelchairs, which can be used over and over again.

Eligible/Eligibility means to meet certain requirements, in order to take part in or receive program benefits.

Emergency Care/Services are medically necessary covered services, including ambulance and mental health services, which a prudent layperson would have considered necessary to stop or relieve a serious illness or symptom, injury, severe pain, active labor, or conditions requiring immediate diagnosis and treatment.

Emergency Contraceptive Drugs contain the same medication as regular birth control drugs and help prevent pregnancy.

Enrolled Dependent is a member of an Enrollee's family who meets the applicable eligibility requirements set forth by Covered California for Dependent coverage and enrollment.

Enrollee is a person who is enrolled in the QHP for Individuals and Families and is responsible for payment of premiums. An Enrollee is also called a "Member."

Essential Health Benefits (EHB) are health care service categories that must be covered by certain plans and all Medicaid state plans starting in 2014. Health Plans must cover these benefits in order to be certified and offered in the Exchange under contract with Covered California.

Evidence of Coverage (also called "Subscriber Agreement & Member Handbook). It tells what services are covered or not covered and how to use Health Plan services.

Experimental or Investigational in Nature are medical services that are used on humans in testing and trial centers and will require special authorization from government agencies, like the Federal Food and Drug Administration (FDA).

Family Premium is the monthly family payment.

Federal Poverty Level (FPL) is a measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used by both government and private organizations to determine eligibility for certain programs and benefits. Covered California uses this measure to determine if you and your Enrolled Dependent(s), if any, qualify for a federal tax credit (which reduces your monthly premium) or for a federal cost-sharing subsidy (which reduces your cost-sharing out-of-pocket costs).

MANAGED CARE DEFINITIONS

Federally Qualified Health Centers (FQHCS) are health centers that receive a Public Health Services (PHS) grant. FQHCS are located in areas without a lot of health care services.

Formulary is a list of drugs approved by L.A. Care. A formulary is a list of drugs that are generally accepted in the medical community as safe and effective.

Generally medically accepted is a term used for tests or treatments that are commonly used by doctors for the treatment of a specific disease or diagnosis.

Grievance is the term used when a Member is not happy with the health care service received. A grievance may be administrative or clinical. A grievance may be filed over the phone or in writing.

Habilitation Services means medically necessary health care services and health care devices that assist an individual in (partially or fully) acquiring or improving in skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Examples of health care services that are not habilitative services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to vocational training. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

Health Benefits Exchange in California is another name for Covered California. Each state in the country name and will have an Exchange by 2014, either a State-based Exchange or a Federally Facilitated Exchange. Covered California is a State-Based Exchange.

Hemodialysis is the dialysis of soluble substances and water from the blood by diffusion through a semi permeable membrane.

Health Insurance Portability and Accountability Act (HIPAA) is a law that protects rights to get health insurance and to keep medical records and other personal health information private.

Hospice is care and services provided in a home or facility, by a licensed or certified professional, to relive pain and provide support to persons who have received a diagnosis for a terminal illness.

Immunizations help the immune system attack organisms that can cause disease. Some immunizations are given in a single shot or oral dose. Others require several shots over a length of time.

Independent Medical Review (IMR) is a review of a health plan's denial of a request for a

MANAGED CARE DEFINITIONS

certain service or treatment. (The review is provided by the Department of Managed Health Care and conducted by independent medical experts, and the health plan must pay for the service if an IMR decides you need the service.)

Infertility is a diminished or absent ability to conceive, and produce off' spring after unprotected sexual relations on a regular basis for more than twelve months.

Inpatient care services are services provided to a patient admitted to a hospital.

Integrated Deductible refers to the combined amount you must pay (directly to health care service providers) for health care services in a calendar year for two distinct service categories such as medical and pharmacy services, before your health plan begins to pay. For example, if your integrated deductible for medical and pharmacy is $5,000, your health plan will not pay for any covered medical services or drugs that are subject to the deductible until the $5,000 integrated deductible is met. The integrated deductible does not apply to all covered services.

Interpreter is a person who expresses a message spoken or signed in one language into a second language and who abides by a code of professional ethics.

IPA stands for Independent Physician Association. It is a Network of doctors that contract with a Health Plan to provide medical services. See also Medical Group or Participating Provider Group.

Laboratory is the place equipped for the running of tests, experiments, and investigative procedures.

Liable/liability is the responsibility of the party; or obligation one is bound by law or justice to perform.

Lien is a claim or charge on property which a creditor (one who is owed money) has as security for a debt or charge that is owed to him/her.

Life-threatening tells about a disease or condition that may put a person's life in high danger if the course of the disease is not stopped.

Maintenance Drug is any drug taken continuously for a chronic medical problem.

Medical Group is a physician group your doctor or PCP is a part of. Also see "Participating Provider Group."

Medically Necessary is a term for those services provided to treat an illness or injury according to established and accepted medical practice standards.

MANAGED CARE DEFINITIONS

Member is a person who is enrolled in a Health Plan. A Member is also called an Enrollee.

Member Services Department is the department in a Health Plan or IPA that can help Members with questions and concerns.

Mental Health Care is the diagnosis or treatment of mental or emotional disorders or the mental or emotional problems associated with an illness, injury, or any other condition.

Negligence is the doing of some act which a person of ordinary prudence would not have done under similar circumstances, or failure to act which a person of ordinary prudence would have done under similar circumstances.

Network is the doctors, hospitals, pharmacies, and mental health services contracted with aa Health Plan to provide covered health care services for Members.

Occupational Therapy is the treatment provided by licensed professional, using arts, crafts, or other training in daily living skills, to improve and maintain a patient's ability to function after an illness or injury.

Office of Civil Rights handles complaints about discrimination against minorities or the disabled.

Open Enrollment Period is a designated period of time each year - usually a. few months - during which insured individuals and their Enrolled Dependents) can make changes in health insurance coverage.

Out-of-pocket Limit is the most you pay during the Benefit Year before your health plan begins paying 100% of the allowed amount for covered services. Any amounts paid for covered services subject to the deductible apply towards the annual out-of-pocket limit. Co-payments and no-insurance payments that count towards the limit are listed under the section "Payments that count toward the maximum."

Orthotics is a device used to support, align, prevent, correct, or improve the function of movable body parts.

Outpatient is the medical treatment in a hospital or clinic but you do not have to stay overnight.

Participating Hospital is a hospital approved by a Health Plan to provide covered services to its Members.

Participating Physician is a doctor of medicine, who is also a participating primary care physician (PCP) or a participating specialist approved by the IPA to provide covered services to

MANAGED CARE DEFINITIONS

its Members.

Participating Provider is a doctor, hospital, pharmacy or other health care professional approved by the IPA to provide covered services to its Members.

Participating Provider Group is a physician group your doctor or PCP is a part of. Also see "medical group or IPA."

Participating Specialist is a doctor with specialized training, who has been approved by IPA to provide covered services to its Members.

Pharmacy is a licensed retail drugstore. It is a place where you can get your prescription filled.

Phenylketonuria (PKU) is a rare disease. PKU can cause mental retardation and other neurological problems if treatment is not started within the first few creeks of life.

Physical Therapy is the treatment provided by a licensed professional, using physical agents, such as ultrasound, heat and massage, and exercise to improve and maintain a patient's ability to function, after an illness or injury.

Physician is a doctor of medicine.

Plan Benefits, Benefits, or Covered Services are those services, supplies, and drugs a Member is entitled to receive according to the QHP.

Premium is monthly fee that an Enrollee (Member) must pay for health coverage.

Prescription is a written order issued by a licensed prescriber.

Primary Care Physician (PCP) is a doctor who acts as your family doctor and manages your health care needs.

Prosthetic is an artificial device, used to replace a missing art of the body.

Provider(s) are the medical professionals and organizations that are contracted to provide covered health care services for Members. Health care providers include:

- Doctors
- Hospitals
- Skilled nursing facilities
- Home health agencies
- Pharmacies
- Medical transportation companies
- Laboratories

MANAGED CARE DEFINITIONS

- X-ray facilities
- Durable medical equipment suppliers
- Others

Provider Directory is a list of doctors, hospitals, pharmacies, and mental health services contracted to provide covered health care services for Members.

Prudent Layperson is an individual who does not belong to a particular profession or specialty; but has awareness or information to make a good decision.

Qualified Health Plan (QHP) is a health service plan insurance product that is certified by a Health Benefit Exchange, such as Covered California, provides the Essential Health Benefits, and is offered by a health plan that 1) is licensed and in good standing; 2) agrees to offer at least one silver and one gold plan; and 3) complies with the requirements of the Secretary of Health and Human Services and the Exchange (such as L.A. Care).

Qualified Health Care Professional is a PCP, specialist, or other licensed health care provider who is acting within his/her scope of practice. A qualified healthcare professional also has a clinical background in the illness, disease, or condition(s). Clinical background includes training, and expertise or a high degree of skill and knowledge.

Radiology is the use of radiation to diagnosis and treat a disease.

Reconstructive Surgery repairs abnormal body parts, improves body function, or brings back a normal look.

Referral is the process by which your PCP directs you to other providers to seek and obtain covered services, which require prior authorization.

Rehabilitative Services are the services used to restore the ability to function in a normal or near normal way, after a disease, illness, or injury.

Respiratory Therapy is the treatment provided by a licensed professional, to improve a patient's breathing function.

Routine Patient Care Costs are ordinary or normal costs for patient care services.

Screenings protect your health by detecting disease early and when it may be easier to treat.

Second Opinion is a visit with another doctor when you:
- Question a diagnosis,
- Do not agree with your PCP'S treatment plan,
- Would like to confirm your treatment plan

MANAGED CARE DEFINITIONS

Seriously Debilitating tells about a disease or condition that may not be possible to stop or change and may cause death.

Serious Emotional Disturbance (SED) is a mental condition in children under the age of 19 years. As said by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, children with this disorder have serious problems in at least two of the following areas: self-care, school functioning, family relationships, ability to function in the community; and meets other requirements; and either of the following occur:

a. The child is at risk of being removed or has been removed from the home; or
b. The mental disorder and problems have been present for more than six months or are likely to continue for more than one year without treatment.

Service Area is the geographic area in which Health Plan is licensed to provide services.

Severe Mental Illnesses (SMI) include, but are not limited to: Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

Skilled Nursing Facility is a facility licensed by the California State Department of Health Services (SDHS) to provide specialized nursing services.

Specialist is a doctor with specialized training, who has been approved by IPA to provide covered services for Members.

Speech Therapy is the treatment provided by a licensed professional, to treat speech problems. 'This definition is not intended to limit or exclude services provided as part of a Behavioral Health Treatment plan by a Qualified Autism Service Professional or Qualified Autism Service Paraprofessional for the treatment of pervasive developmental disorders or autism.

Standing Referral is a referral approved by your PCP for more than one visit to a specialist or specialty care center for continued or long-term treatment of a medical condition.

State Department of Health Services (SDHS) is a California state agent with the purpose to protect and improve the health status of all Californians.

Subscriber Agreement (also called "Subscriber Agreement & Member Handbook") tells what services are covered or not covered and how to use Health Plan services.

Therapeutic Services are the services for the treatment, reradiating, or curing of a disorder or disease.

MANAGED CARE DEFINITIONS

Third Party includes insurance companies, individuals, or government agencies.

Third Party Liability is the liability of a party other than the State of California, Health Plan, or a Member.

Triage or Screening is the evaluation of a member's health by a doctor or nurse who is trained to screen for the purpose of determining the urgent of the Member's need for care.

Triage or Screening Waiting Time is the time waiting to speak by telephone with a doctor or nurse who is trained to screen a Member who may need care.

TTY/TDD is a communication device for the deaf, using a telephone system.

Urgent Services are health services needed to prevent an illness or injury from becoming worse with delay of treatment.

Urgent Grievance is when you are not happy with the health care service and feel that any delay with decision could lead to a life-threatening or debilitating condition. Urgent grievances include, but are not limited to:

- severe pain
- potential loss of life, limb, or major bodily function

Vision Impaired is when the ability to see is reduced.