Provider Training Manual

PO Box 4939
Oceanside, CA 92052

Phone: (855) 498-2633
www.cvpg.org

PHYSICIANS DATATRUST

INTEROFFICE MEMORANDUM

TO: PCP, SCP, Clinical Services and Administrative Staff

FROM: Lisa Serratore, Chief Executive Officer

CC: Evelyn Jimenez, IPA Manager, CVPG
Clarissa Lomeli, IPA Manager, GPMG
Kailah Burton, IPA Manager, GTC IPA
Mary Beltran, IPA Administrator, Noble AMA IPA; Exec. Dir. IPA Administration
Michael Gella, IPA Manager, St. Vincent IPA

DATE: January 8, 2025

RE: Affirmative and Impartiality Statements

AFFIRMATIVE STATEMENT

As a utilization management organization, Physicians DataTrust on behalf of Citrus Valley Physicians Group, Golden Physicians Medical Group, Greater Tri Cities IPA, Noble AMA IPA, and St. Vincent IPA, ensures that all decisions are made based on the available medical information at the time of the request. Should a member ask to see the criteria utilized to make a medical decision; the statement below is attached to that guideline, as required by the National Committee for Quality Assurance (NCQA):

Decisions regarding requests for medical care are based on the medical necessity of the request, the appropriateness of care and service and existence of coverage. There is no monetary reward for non-approval of services. Compensation for individuals who provide utilization review services does not contain incentives, direct or indirect, for these individuals to make inappropriate review decisions.

Utilization review criteria, based on reasonable medical evidence and acceptable medical standards of practice (i.e. MCG and/or applicable health plan guidelines) are used to make decisions pertaining to the utilization of services. Review Criteria are used in conjunction with the application of professional medical judgment, which considers the needs of the individual patient and characteristics of the local delivery system.

IMPARTIALITY STATEMENT

All participating practitioners are ensured independence and impartiality in making referral decisions which will not influence hiring, compensation, termination, promotion or any other similar matters.

These statements are also on our websites: www.cvpg.org, www.gpmedicalgroup.com, www.gtcipa.com, , www.nobleamaipa.com, and www.stvincentipa.com, along with other valuable information for our contracted providers and our members, and can be printed, if needed. Our business hours are Monday through Friday, 9:00a.m. to 5:00p.m. and Administrative staff can be reached at (760) 941-7309 or (800) 458-2307 during business hours. Should you have a question for the Utilization Management Department after hours, you may call (760) 941-7309 or (800) 458-2307 and leave a message for someone to call you back the next business day.

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Dear Citrus Valley Physicians Group Provider,

Thank you for selecting Citrus Valley Physicians Group (CVPG) and I would like to welcome you to Citrus Valley Physicians Group (CVPG). We would like to briefly review with you many functions that the IPA is responsible for and your role in this important process. The IPA holds contracts with several HMOs or "Health Plans." The Health Plans give the IPA a portion of the monthly premium they collect for each member assigned to the IPA. The IPA is then responsible to provide health care services to these members. In order to do that, the IPA must contract with a network of PCPs, specialists, and other ancillary providers such as outpatient surgery centers, home health, physical therapy, radiology, pathology, and many others. The IPA is also delegated by the Health Plans for credentialing, case management, utilization management, quality improvement, claims as well as other functions.

The responsible use of healthcare resources is maintained by authorizing services according to current medical necessity guidelines, and since we only have access to the information you provide us with your authorization request, your active participation in this process is crucial. It is very important that you provide complete information when submitting a request so it can be reviewed appropriately.

Both authorizations and claims payment are subject to the patient's eligibility at the time of service. A patient has the right to change their IPA at any time, so it is important that you check the patient's eligibility before each visit. You may obtain current eligibility by contacting the patient's health plan directly. We use an online portal, https://aerial.carecoordination.medecision.com/login.html
for authorization request and tracking in addition to claims submission and tracking. A user name and password can be requested by completing the Aerial Care Physician Data Trust Physician Access Request Form enclosed in your Provider Training Manual. Aerial Care can be contacted directly at 800-864-8160 for any technical assistance. We also accept electronic claims through Aerial Care or Office Ally 866-575-4120. When calling one of those providers, give them our Payor ID of **PDT01** to get set up.

As a reminder, Citrus Valley Physicians Group primary hospital is Emanate Medical Center- Queen of the Valley. If you have an IPA patient that is requiring hospital emergency or in-patient services, you must contact the appropriate Hospitalist to admit your patient. The Hospitalist will manage all aspects of inpatient care and if necessary, will call in a Citrus Valley Physicians Group contracted specialists to consult.

We are excited to have you as a participating provider. We look forward to a long and mutually beneficial relationship. Our objective is to manage the use of healthcare resources responsibly without impeding our provider's ability to deliver appropriate, quality healthcare.
Should you have any questions regarding the information enclosed or need further assistance, please do not hesitate to contact me at 562.860.8771 ext. 182.

Sincerely,
Evelyn Jimenez
IPA Manager

All new and existing Primary Care Physicians, Specialists and Ancillary Providers will receive initial orientation and training. **The health plans require that the initial orientation be conducted within 10 business days of the contract effective date**. Provider Relations will conduct ongoing on-site and/or telephonic education and training as needed. Providers will be instructed to access the IPA website to receive the most up to date information on the IPA's policies, tools and training materials.

Distribution of this Manual

This Manual is delivered by Citrus Valley Physicians Group, Provider Relations Department to the Physicians' office when a Physician joins the IPA. An electronic version is also available on our website, www.cvpg.org

Updates to this Manual

Updates to this manual will be available to all contracted providers on CVPG website. Additional communications related to health plan information, customer service, operations, or community information will be faxed out.

PCP Provider Listings

Our PCP Directory is available on-line and is updated on a monthly and ad-hoc basis. The website is available to both physicians and members with Internet access.

To access the Physician listings:

- Connect to the Internet and go to www.cvpg.org
- Our home page will appear. Click "Directory" at the top of the page.

If your office does not have Internet access, please contact Provider Relations department at **(562) 860-8771 ext. 113 or 101** to receive a listing.

Provider Directory Changes

The Provider Directory data is what is current in our systems. If you have a change of address, phone number, fax number, etc. please notify our Provider Relations Department of any changes, so that our directories and listings reflect your current information. Prompt notification is required to ensure checks, important announcements, reports, and communications are delivered to you in a timely manner.

CVPG IMPORTANT CONTACTS

Network Management	Phone	Fax	Email
Evelyn Jimenez, IPA Manager	(562) 860-8771 ext. 182	(562) 269-5829	ejimenez@pdtrust.com
Gitzel Lopez, Provider Relations Specialist	(562) 860-8771, ext. 113	(562) 269-5829	glopez@pdtrust.com
Brandon De La Torre, Provider Relations Specialist	(562) 860-8771 ext. 101	(562) 269-5829	bdelatorre@pdtrust.com
Fredy Espino, PR Coordinator	(562) 860-8771 ext. 163	(562) 269-5829	fespino@pdtrust.com
Claims	Phone	Fax	Mailing Address
Claims Hours of operation 9:00am- 3:00pm	(855) 498-2633, option 2.	(760) 631-7614	CVPG PO Box 4939 Oceanside, CA 92052 Payor ID (PDT01)
For Appeals, please fax to (760) 631-7614			
Clinical Services	Phone	Fax	
Authorizations	(562) 860-8771, option 2	(760)477-2925	
Inpatient Case Manager	**Phone**	**Fax**	**Email**
Colleen Guenther RN Najaha Wolfe, LVN	(562) 884-2604 (562) 484-1493	Fax: (760) 477-2925 Fax: (562- 207-3528	cguenther@pdtrust.com nwolfe@pdtrust.com
	Phone		Email
Lupe Castro *Credentialing Coordinator*	(714) 941-7309 ext. 127		lcastro@pdtrust.com
Quality	Phone	Fax	Email
Caroline Begins *Quality Coordinator*	(760) 941-7309 x227	(760) 630-3676	cbegins@pdtrust.com
Risk Adjustment	Phone	Fax	Email
April Goularte, *Manager, Risk Adjustment*	(562) 860-8771, ext.. 116	(562) 207-6579	agoularte@pdtrust.com
Cesar Delgado, CRC *Risk Adjustment Specialist*	(562) 860-8771, ext. 144	(760) 477-2921	cdelgado@pdtrust.com

Contracted Health Plans

Commercial Plans	Telephone	Website
Anthem Blue Cross	(800) 999-3643	www.anthem.com/ca
Blue Shield Of California	(800) 200-3242	www.blueshield.com
CIGNA	(800) 244-6224	www.cigna.com
Health Net	(800) 522-0088	www.healthnet.com
L.A. Care Health Plan	(888) 522-1298	www.lacare.org
Senior Plans	**Telephone**	**Website**
Anthem Blue Cross Senior		
Blue Shield of California 65+	(800) 541-6652	www.blueshieldca.com
Central Health Plan	(866) 314-2427	www.centralhealthplan.com
Wellcare	(866) 999-3945	www.easychoicehealthplan.com
Cal MediConnect Plans	**Telephone**	**Website**
L.A. Care Health Plan	(888) 522-1298	www.lacare.org
Medi-Cal Plans	**Telephone**	**Website**
L.A. Care Health Plan	(888) 522-1298	www.lacare.org
Anthem Blue Cross	(800) 999-3643	www.anthem.com/ca
Health Net	(800) 641-7761	www.healthnet.com

Access to Care Standards:

We have adopted access guidelines using both the California Managed Health Care Quality Coalition as well as the National Committee on Quality Assurance (NCQA). A copy of the access standards is located on the next page.
Compliance to these Guidelines will be monitored and coordinated with other activities throughout the organization. Ways this is monitored may include member surveys and complaints.
The IPA will conduct Member and Provider Surveys on a yearly basis focusing on appointment scheduling, waiting times and after hours care.

The health plans will conduct annual Provider Appointment Availability and After-Hours Access Surveys through the survey vendor, the Center for the Study of Services.
In order for the health plans to accurately measure Access &Availability for CVPG network, it is imperative that you respond to this survey in a timely manner. Please note that all Health Plans in the state of California are required to administer an identical survey. L.A. Care does not receive the results of other Plan surveys; therefore, in order to receive credit, each provider must complete the Survey.

A summary sheet illustrating the access standards is provided on the following page.

Primary Care Physician (PCP)	Standard
Emergency (Serious condition requiring immediate intervention)	Immediately (office, UCC, ER)
Urgent (Condition that could lead to a potentially harmful outcome if not treated)	*Within 48 hours (office, UCC)
Non-Urgent (routine) *(visit for symptomatic but not requiring immediate diagnosis and/or treatment)	*Within 10 business days
Adult or Pediatric Health Assessment / Physical *(Physical: periodic health evaluation with no acute medical problem) *(Preventive: for prevention and early detection of disease, illness, condition)	Within 30 calendar days, unless more prompt exam is warranted
**IHA (18 months and older) **IHA (under 18 months)	Within 120 days of enrollment Within 60 days of enrollment
Waiting Time in physician office	Less than 30 minutes
After hours Access	Answering Service or service w/ option to page Provider

- Enrollee with life threatening medical problem must have access to health care twenty-four (24) hours per day and 7 days per week.
- After hours answering system or voice mail should instruct members that if they feel they have a serious acute medical condition, to seek immediate care by calling 911 or going to the nearest Emergency Room.
- **Member must be assured that a Health Care Professional (Dr., Advice Nurse, PA, NP) will communicate with them within 30 minutes.

**Telephone Triage and Screening (urgent and routine) • Telephone triage is available 24 hours a day and 7 days a week	**Within 30 minutes

Specialty Care Provider (SCP)	Standard
**Urgent referral (includes Behavioral Health)	Within 96 hours
*Non-Urgent / routine (includes Behavioral Health)	*Within 15 business days from time of PCP request

Behavioral Health Provider (based on Plan contracts)	Standard
Urgent	*Within 96 hours
Routine	*Within 15 business days
**Non-physician BH	** 10 business days

**Ancillary Services	Standard
Urgent (for diagnosis and treatment)	Within 96 hours
Routine (for diagnosis and treatment)	Within 15 business days

*Revised Standard 2011 ** New Standard 2011 Compliance = 80%

Access to Care Standards: Medi-Cal, Dual Eligible (Medi-Medi) and Special Needs Plan (SNP) Members

Service	Access Standard
Appointment making systems	A written or computerized appointment making system, which includes following up on missed appointments
Appointments for routine primary care services for a member who is symptomatic but does not require immediate diagnosis and/or treatment	30 calendar days maximum
Appointments for routine prenatal care	• Within two weeks from request during the 1st and 2nd trimester • Within three working days from request during 3rd trimester
Appointments for routine preventative care	Physical exam/preventative services – four (4) weeks maximum for appointment
Appointments for urgent care	Within 24 hours
Routine specialty referral appointment	Within 10 working days
Availability of interpreter service	24 hours/7 days a week
Availability of primary care physician – time requirements	24 hours/7 days a week
Preventative Exams A periodic health evaluation for a member with no acute medical problem, including: • Initial Health Assessments and Behavioral Risk Assessments	Children under the age of 18 months – within 60 calendar days of enrollment or within the AAP periodicity timelines for ages two and younger, whichever is less 18 months of age and older – within 120 calendar days of enrollment EPSDT/CHDP or preventative health examination within four weeks from request
AAP periodic screenings	As prescribed by AAP Periodicity guidelines

Access to Care Standards: Medi-Cal, Dual Eligible (Medi-Medi) and Special Needs Plan (SNP) Members

Service	Access Standard
Emergency appointment: Services for a potentially life threatening condition requiring immediate medical intervention to avoid disability or serious detriment to health	Immediate, 24 hours a day/7 days a week
Non-emergent telephone appointment responsiveness	45 minutes
Office waiting time: The time a member with a scheduled medical appointment is waiting to see a doctor once in the office	5 – 45 minutes
Telephone waiting time: The maximum length of time for office staff to answer the phone	30 seconds
Call Return Time (After Hours): The maximum length for PCP or on-call provider to return a call	30 minutes
Services for members with disabilities	Compliance with all provisions of the Americans with Disabilities Act: • At least one designated handicapped parking space • A handicapped bathroomor alternative access which is equipped with handrails in the bathroom • A wheelchair access ramp • A handicapped water fountain or alternative provisions • An elevator
Availability of ancillary services	Available within a reasonable distance from the primary care physician
Availability of hospitals	Travel time and distance standards of 15 miles travel distance or 30 minutes travel time from their residence or workplace
Availability of primary care physician distance requirements (PCP Geo Access Reports)	Travel time and distance standards of 10 miles travel distance or 30 minutes travel time from their residence or workplace

Primary Care Physician Responsibilities

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PRIMARY CARE PHYSICIAN RESPONSIBILITIES

1. **Basic PCP Responsibilities**
   - Provide outpatient clinic care during normal business hours (Monday-Friday from 9a.m to 5p.m.)
   - Twenty-four hour On-call coverage
   - Provide cross coverage with an IPA contracted physician
   - Recommend and coordinate the care of consulting specialists
   - Telephone consultation to members contracted to the primary care physician's service

2. **Routine Office visits**
   - Well baby care (Family Practice/Pediatrics), including developmental assessment and patient/parent education
   - Complete physicals as outlined in Health Plan guidelines
   - T.B. Skin Test/Mantou
   - Preventive medical care including health risk identification, education, reduction, and periodic screening

3. **State Mandated Referrals**
   - Well Woman Exam
   - Mammography
   - Family Planning*
   - Vision Care*

4. **Injections**
   - Antibiotics, vitamins, hormones, flu vaccine, etc.
   - Allergy treatment (in conjunction with treatment plan from Allergist if appropriate); not including sensitivity testing or antigen preparation
   - Authorized injectables (Betaseron, neupogen, etc.)

5. **Ophthalmology**
   - Basic vision test
   - Removal of foreign body, external eye
   - Removal of foreign body, corneal, w/o slit lamp

6. **ENT**
   - Routine audiometry
   - Drainage external ear, abscess or hematoma; simple
   - Removal foreign body from external auditory canal
   - Removal impacted cerumen, one or both ears
   - Control of nasal hemorrhage, anterior simple

7. **Digestive System**
   - Proctosigmoidoscopy; diagnostic; rigid or flexible up to 25 cm**
   - Anoscopy; diagnostic
   - Colon cancer screening; age >50 yearly hemoccult testing with patient off ASA/NSAID; Refer for flexible sigmoidoscopy every 3-5 years.

8. **Musculoskeletal System**
   - Arthrocentesis aspiration or injection; small joint bursa, or ganglion cyst
   - Injection of tendon, ligament, trigger points, or ganglion cysts**
   - Care of routine and uncomplicated rheumatic and orthopedic conditions

9. **Localized burns**
   - Initial treatment first degree burns

10. **Surgical Procedures**
   - Simple repair of scalp, trunk and /or extremities lacerations <2.5 cm.
   - Simple repair of lacerations 2.6-7.5 cm**
   - Incision and drainage of abscesses
   - Incision and drainage of pilonidal cyst
   - Removal of foreign body
   - Drainage of hematoma
   - Puncture aspiration
   - Debridement
   - Excision of benign lesions
   - Incision of thromboses hemorrhoid, external**
   - Destruction of lesion(s) anus (condyloma, papilloma, molluscum contagiosum)
   - Suture removal

11. Reproductive System

- Destruction of lesions penis, simple, with chemicals
- Destruction of lesions of vulva
- Diaphragm fitting**
- Treatment of uncomplicated venereal diseases
- Other gynecologic procedures

12. Dermatologic Procedures

- Acne care
- Excision of benign lesions
- Excision of malignant lesions
- Biopsy of skin, subcutaneous tissue and /or mucous membrane
- Destruction of pre-malignant lesions
- Wart removal
  - Cryotherapy
  - Electrosurgical
- Avulsion of nail plate**
  - Partial
  - Complete
- Matricectomy**
- Evacuation of subungual hematoma**

13. Other Office Procedures

- Venipuncture
- EKG
- Diagnosis of alcohol/chemical dependency
- Recognition of psychological problems, including routine outpatient management of anxiety and depression
- Treatment and follow-up of uncomplicated hypertension
- Management and follow-up of uncomplicated, controlled diabetes mellitus

14. Advanced procedures

- Flexible Sigmoidoscopy**

* Check benefits prior to referral

** If PCP feels that the procedure is complex, or has required excessive time to treat, a referral to self may be submitted to Utilization Management for authorization and reimbursement. An explanation or report may be necessary.

Office Update Request Form

Citrus Valley Physicians Group must maintain accurate information in the provider database. This updated information will be forwarded to health plans affiliated with Citrus Valley Physicians Group. Please complete, provide any changes, and fax this form to:

Provider Relations Fax #: (562) 269-5829

Physician /Group Name: _____

Additional Physicians: _____
(*In same office & contracted with IPA*)

_____

Address _____

City, State, Zip _____

Phone ( ) _____ Fax ( ) _____

Office Hours: M _____ T _____ W _____ Th _____ F _____ Sat _____ Sun _____

2nd Address _____

2nd City, State, Zip _____

2nd Phone ( ) _____ Fax ( ) _____

Email: _____

2nd Office Hours: M _____ T _____ W _____ Th _____ F _____ Sat _____ Sun _____

Languages Spoken _____

Age Restrictions (*check one*) All Ages _____ Newborn - 18 _____ 18 & up _____ Other: _____

Office Manager/Contact: _____

Referral Coordinator: _____

Effective Date for Changes/Updates: _____

Comments: _____

_____

_____

****

Authorized Signature _____ Title _____
Office Manager/Supervisor or Physician

Date _____ Phone Number: _____

(Please make sure to also complete W-9 Form for any changes of address, even if the Tax ID number has not changed)

Communication of Provider Address and Data Changes

Providers shall provider 90 days notice to the IPA in writing (preferably on office letterhead) along with any required supporting documentation (e.g. a TIN change requires copies of the W-9 forms.). Requests may be sent to the Provider Relations Specialists by mail or fax.

Important: Delay in notifying us with address and data changes may affect your claims payments.

The following table illustrates some common data changes and the corresponding document(s) we require before each change can be made. Please call the Provider Relations department at **(562) 860-8771 ext. 113 or ext. 101** if you have any questions.

Change Documentation

Type of Change Document Needed	Document Needed
Adding a new practice location, change of address, phone, fax, etc.	Letter, effective date
Change practice location, change of address, phone, fax, etc.	Letter, effective date
Billing address change Letter, effective date	Letter, effective date, W-9
Closing of panel; eliminating services Letter, effective date	Letter, effective date
TIN Change Letter	Letter, W-9

OR submit changes by mail to: Citrus Valley Physicians Group
Provider Services
17215 Studebaker Road
Suite 320
Cerritos, CA 90703

OR by email to: CVPG_Provider_Relations@pdtrust.com

OR by fax to: **(562) 269-5829**

Termination of Contract/Business Associate Agreement

Advanced notice must be given in writing when electing to discontinue as an IPA provider. Refer to your IPA contract for specifics. If you have any questions, please contact Provider Relations at **(562) 860-8771 ext. 113 or ext. 101**.

Operations: Claims, Referrals, and Eligibility

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PHYSICIANS DATATRUST

PROVIDER CLAIMS DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.

Mail the completed form to: **The appropriate IPA address listed on the attached sheet.**

*PROVIDER NAME:	*PROVIDER TAX ID # / Medicare ID #:
PROVIDER ADDRESS:	

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

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

* Patient Name:		Date of Birth:
* Health Plan ID Number:	Patient Account Number:	Original Claim ID Number: (If multiple claims, use attached spreadsheet)

Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	Original Claim Amount Billed:	Original Claim Amount Paid:

DISPUTE TYPE

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

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print) | **Title** | **( ) Phone Number**

Signature | **Date** | **( ) Fax Number**

[ ] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED

For Health Plan Use Only
TRACKING NUMBER
PROVIDER ID#

PHYSICIANS DATATRUST

PROVIDER DISPUTE RESOLUTION REQUEST
(For use with multiple "LIKE" claims)

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

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

Page _____ of _____

[ ] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED

PHYSICIANS DATATRUST

PROVIDER DISPUTE RESOLUTION REQUEST

Tracking Form

INSTRUCTIONS

- This optional form may be used to track the status, time-frames and disposition of the Provider Dispute Resolution.
- The entity processing the Provider Dispute Resolution should track the following information internally for ensuring compliance with regulations and for later reporting to the appropriate entity.

TRACKING NUMBER:	**PROVIDER ID#:**
a. PROVIDER NAME:	**b. CONTRACTED PROVIDER: _____ YES _____ NO**
c. DATE DISPUTE RECEIVED (Date Stamped):	**d. DATE OF INITIAL PAYMENT OR ACTION:**
e. WAS DISPUTE RECEIVED WITHIN TIMEFRAME? (c – d) _____YES _____ NO (If NO, should be returned to provider without action)	
f. DISPUTE TYPE: ☐ CLAIM ISSUE ☐ OVERPAYMENT REIMBURSEMENT REQUEST ☐ BILLING ISSUE ☐ CONTRACT ISSUE ☐ UM/MEDICAL NECESSITY ISSUE ☐ OTHER _____ (Please specify type of "other")	
g. DATE DISPUTE ACKNOWLEDGED:	**h. TURNAROUND TIME (g – c):**

TYPE OF LETTER SENT: **(List the various ICE letters as applicable)**

IF NO ADDITIONAL INFORMATION REQUESTED:

j. DATE OF ACTION:	**k. ACTION TURNAROUND TIME (j – c):**	**l. TYPE OF ACTION (Upheld, Denied, Partially Upheld):**

IF ADDITIONAL INFORMATION REQUESTED:

m. DATE ADDITIONAL INFO REQUESTED:	**n. TURNAROUND TIME (m – c):**	
o. DATE ADDITIONAL INFO RECEIVED:	**p. RECEIPT TURNAROUND TIME (o – m):**	
q. DATE OF ACTION:	**r. ACTION TURNAROUND TIME (q – o):**	**s. TYPE OF ACTION (Upheld, Denied, Partially Upheld):**

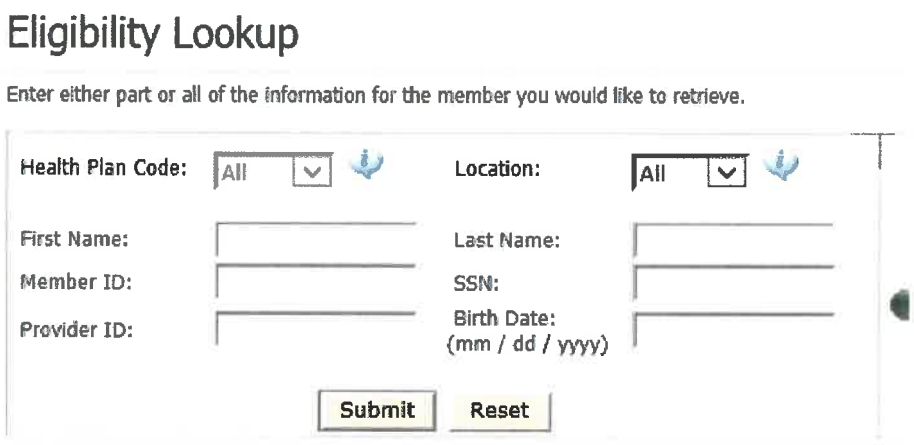
COMPLETE DESCRIPTION OF DETERMINATION RATIONALE:

Aerial Care
Member's Eligibility

Retrieve your member

Enter a members DOB (preferably)

Providing more than one search criteria can overload the search engine and not provide and result.



Your member's eligibility

Once a search criteria is entered a member name will be generated. The following icon will appear:

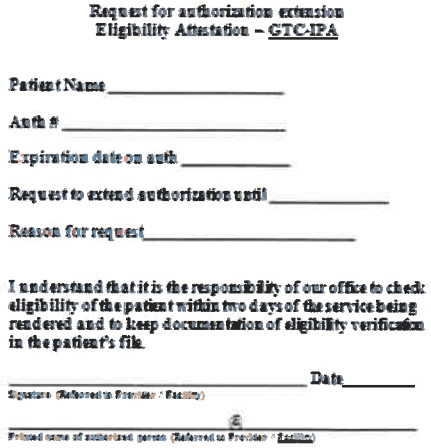
Red indicates the member is ineligible

Blue indicates member is eligible

If you have trouble finding the member look at their ID card to check if the health plan knows them by a different name or DOB: (Note: If the health plan has the patient information incorrectly, member must contact the health plan directly and make corrections. If you do not find your member and all the information is correct, contact the health plan directly and verify the member's eligibility.

Adding a New Member

Once the member's eligibility has been verified with the health plan, please fax an eligibility attestation form to **(562) 207-6511** in order to have the new member added to our database. Please allow 24 hours for the member to appear on the on-line portal.



Request for authorization extension
Eligibility Attestation – GTC-IPA

Patient Name _____

Auth # _____

Expiration date on auth _____

Request to extend authorization until _____

Reason for request _____

I understand that it is the responsibility of our office to check eligibility of the patient within two days of the service being rendered and to keep documentation of eligibility verification in the patient's file.

_____ Date _____

Signature (Referred to Provider / Facility)

_____

Printed name of authorized person (Referred to Provider / Facility)

Sample Eligibility List

MEMBER ID	LAST NAME	FIRST NAME	BIRTH DATE	SEX	EFFECTIVE DATE	Health Plan	ADDRESS
123456-01	Doe	John	1/1/1960	M	1/1/2012	Blue Shield	123 Main St.
654321-01	Smith	Jane	1/1/1940	F	1/1/2011	SCAN	111 Clark St.

Referral Process

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REFERRAL TURNAROUND TIME STANDARDS

Citrus Valley Physicians Group follows or exceeds the national standards for referral turnaround times.

- **Routine Referrals** - have a 5 business day decision time frame from the time a completed and signed referral has been received in IPA office. The IPA must notify the PCP office within 24 hours of that decision via FAX, email or telephone.

- **Urgent Referrals** - have a 72 hour turnaround.

- **Emergent Referrals** - must have a **24 hour turnaround time** during business hours (9:00 am – 5:00 pm).

- Referrals received at the end of a business day (after 5:00 pm) will be processed as received on the next business day.

- Pended **Routine** referrals – can remain pending for 45 days for commercial members or 14 days for senior members. Once we receive the requested information, we have five (5) business days to make a decision.

- Pended **Urgent** referrals – can remain pending for 48 hours; then a decision must be made within 24 hours.

Unused Referral is the Providers Responsibility

Dear Provider,

In an effort to ensure our current referral/authorization process is as efficient and streamlined as possible, LA Care Health Plan is requesting that we emphasize the importance of tracking and documenting all information pertaining to **unused referrals**.

Please ensure your office is following the below documentation guidelines for all unused referrals for CVPG patients.

- **Keep a copy of the referral authorization**
- **Document in the member chart the date/time of the specialty appointment**
- **Obtain and keep a copy of the visit note from the specialist**
- **Document your follow up on the recommendation from the specialist**
- **Document your follow up on any missed or broken appointments**

Thank you for continuing to provide excellent service to our members.

PO Box 4939
Oceanside, CA 92052

Phone: (855) 498-2633
www.cvpg.org

New User Reference Guide

The Aerial Care system allows our providers to submit Referral Requests and Claims as well as the ability to check on their status and verify a patient's eligibility. Below are steps to help you log-in and get started using Aerial Care.

If you do not have an Aerial Care Log-in for Citrus Valley Physicians Group, please call us at (562) 860-8771 x163.

Aerial Care Log-in Steps

1. Go to https://aerial.carecoordination.medecision.com/cvp/physician/LoginDefault.aspx

3. Type in your **Username** and **Password**.
   New Users: Enter your Temporary Password. You will then be asked to change the password to one of your choice. Then enter your ***New*** Password to log-in.

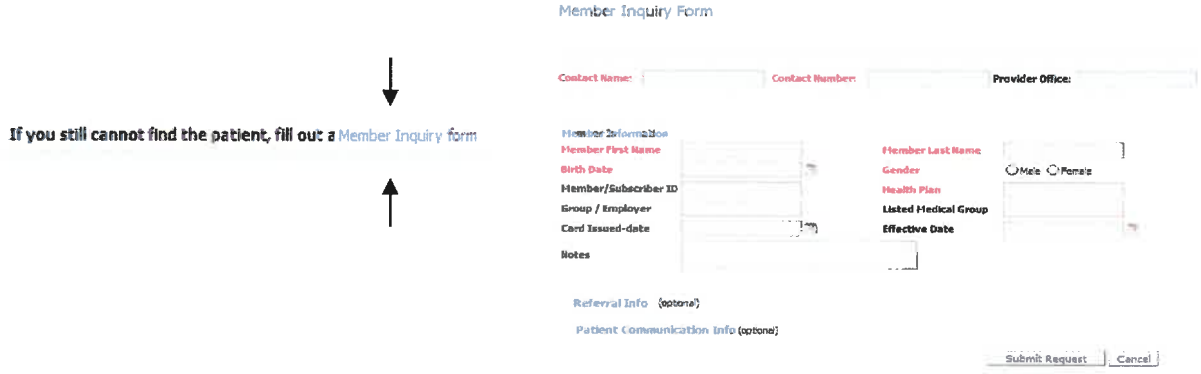
4. To submit a Referral Request or check status click on one of the on of the following:

5. To submit/Upload a Claim or Claim Batches click one the following:

6. To download your e-list click on the **Eligibility** Tab at the top of the page

7. Then Click the **Download to Excel** button

- If you cannot find a member listed in Aerial Care, Click on the Member Inquiry Form and complete all the required information. It will be submitted directly to our Eligibility Department. The member will be loaded in Aerial Care once eligibility is confirmed.



- If you are not able to scan and attach notes and/or additional information to your online Referral Request, please fax those to (760) 477-2925. Please note in the online Referral Notes that additional information will be submitted via fax.

- If you have any technical issues with Aerial Care, or forget your username and/or password, you may contact Aerial Care at (800) 864-8160.

- Online training is available 24/7. You can watch live videos, print out "quick reference" documents and instructions anytime just login and click on the Training Tab at the top of the page

If you have any questions or would like additional training on Aerial Care, please contact the Provider Relations Department at (562) 860-8771 Ext. 163.

Aerial Care
On-line Referral Submission

Referral Submission

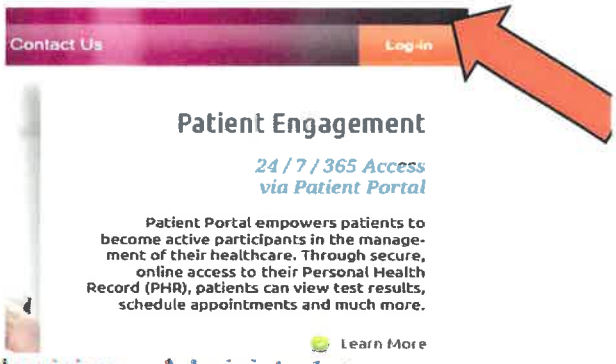
Citrus Valley Physicians Group (CVPG) provides a Web Portal for on-line referral submissions. Internet access must be available in order to view and submit referrals. Simply follow the steps below to easily set up your own on-line referral process for your CVPG members.

Contact Aerial Care at **1-800-864-8160, Option#1** to obtain a user name and password.

Web Portal Address

Once a username and password have been set up; go to www.aerial.carecoordination.medecision.com

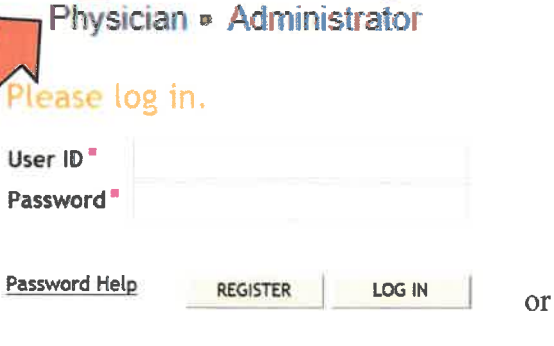
Click on the Log- in button on the right upper hand.



Login instructions

Look for the CVPG logo and click on the Physician option

- Enter your login user ID and password.
- First time log-in will promote a change of password



Please note; you will be promoted to change your password every 30 days. You may reuse the same password every time.

Aerial Care Dashboard

Once in the portal, a main screen will appear named the "dash board." You will see recent referral comments and clinical alerts.

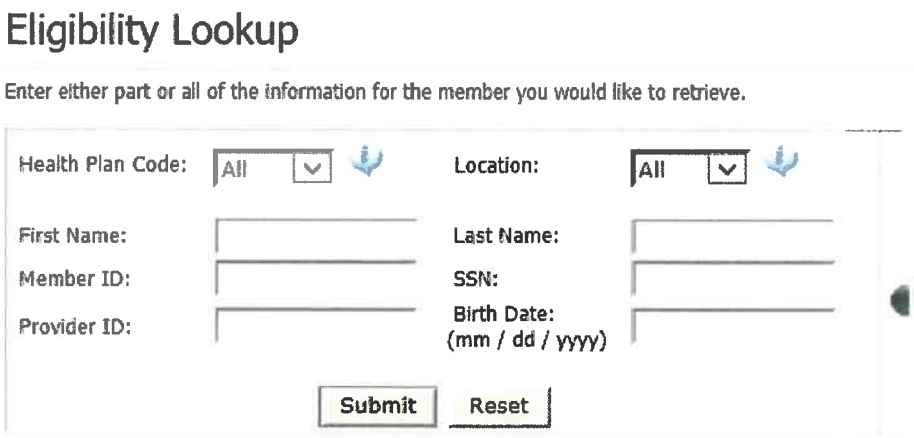
Entering a referral

Click on the eligibility tab on the dash board

Retrieve your member

Enter a members DOB (preferably)

Providing more than one search criteria can overload the search engine and not provide and result.



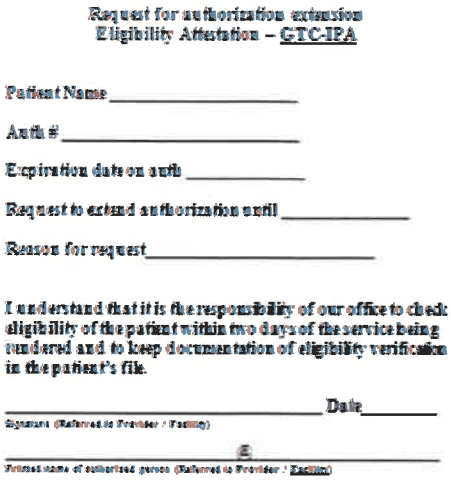
Your member's eligibility

Once a search criteria is entered a member name will be generated. The following icon will appear:
Red indicates the member is ineligible
Blue indicates member is eligible

If you have trouble finding the member look at their ID card to check if the health plan knows them by a different name or DOB: (Note: If the health plan has the patient information incorrectly, member must contact the health plan directly and make corrections. If you do not find your member and all the information is correct, contact the health plan directly and verify the member's eligibility.

Adding a New Member

Once the member's eligibility has been verified with the health plan, please fax an eligibility attestation form to **(562) 207-6511** in order to have the new member added to our database. Please allow 24 hours for the member to appear on the on- line portal.
If you are unable to find your member after confirmation with the health plan, please fill out the Member Add Request Form. You can submit to prsvipa@pdtrust.com or fax to (562) 924-1603.



Request for authorization extension
Eligibility Attestation – GTC-IPA

Patient Name _____

Auth # _____

Expiration date on auth _____

Request to extend authorization until _____

Reason for request _____

I understand that it is the responsibility of our office to check eligibility of the patient within two days of the service being rendered and to keep documentation of eligibility verification in the patient's file.

_____ Date _____
Signature (Referred to Provider / Facility)

_____
Printed name of authorized person (Referred to Provider / Facility)

Member Add Request Form

Complete all fields below and fax this form to (562) 924-1603.

Please note that this form is for non-urgent Member Adds only. If you have a patient who requires a medically urgent referral, please fax the referral directly to the UM Department for expedited processing. Requests will be processed within 3 business days. You may submit Member Add requests electronically, by logging into Aerial Care and selecting "Create a New Member Inquiry" under the Eligibility Tab.

**** All fields must be completed for your request to be processed.**

Provider Name:			
Contact Name		Contact Phone#	
Contact Fax#			
Purpose for this Request:	☐ New Member ☐ Health Plan Change ☐ Update Member information (Member information is received from the Health Plan. Member must notify their Plan of any necessary updates.) ☐ Date of Birth ☐ Address ☐ Sex ☐ Other :		
Health Plan		Health Plan Member ID	
Member First Name		Member Last Name	
Member Date of Birth		Effective Date	
Comments			
To Be Completed by IPA:			
Response: ☐ Member has been added or updated; Changes will be reflected in next month's capitation report. ☐ Member is not eligible with IPA Name / PCP ☐ Form Incomplete / Information Submitted can not be verified with Health Plan ☐ Other:			

Refer your member

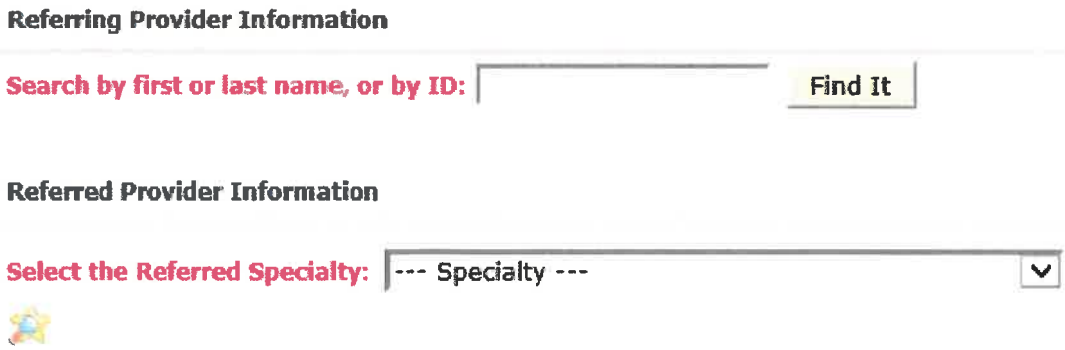
1. Click the blue icon on the left or the eye icon on the right to begin.

2. Member information will appear, on the bottom of the page a "**Refer Patient**" button will appear, click to enter the actual referral.

3. A referral form will come up on the screen. **All** fields must be completed in a dropdown option or typing format

Referring Physician

Referring physician (PCP, NP, PA , Specialist)



Referring to (Self, imaging facility, another specialist, physical therapy, surgery center etc…)

Referring Priority

Indicate the Priority of the referral:

- **Routine**
  Referrals processed within 5-7 business day
  (commercial health plans)
  Referrals processed within 14 days (Senior health plans)

- **Urgent**
  48 hour turn around time
  (medical necessity must be indicated)

- **STAT**
  24 hour turn around
  (medical necessity must be indicated)

- **Retro**
  Not to exceed more than 30 days from DOS

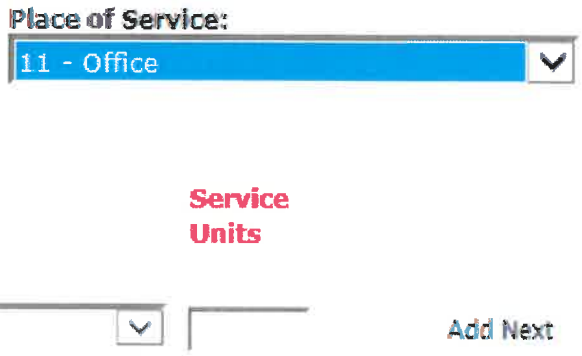
***Please note; urgent or STAT referrals entered due to administrative purposes will be downgraded from urgent/ STAT to routine. Please enter referrals in a timely manner.
*** Do not schedule appointments or procedures prior to obtaining authorization to ensure the member does not need to be rescheduled.

Indicate Services

- **Indicate Place of Service:**

Office, outpatient includes (surgery center,
outpatient hospital procedures less than 24hrs.) Inpatient, or Home (are a few of the most common)

Indicate Services & Quantity: CPT CODES



Please use appropriate modifiers as indicated.

CPT Codes

CVPG uses a *claims editing software* which contains commercially available coding rules and guidelines to monitor internal claims processing and identify unclean claims which may require reduced payment for improper or erroneous coding.
When referrals with multiple CPT codes are received, it is processed through *claims editing software*, for appropriate claims processing. *Claims editing software* unbundles compounded codes and identifies compounded procedures. During the UM process, bundled CPT codes are removed from the referral. Please note; if CPT codes are taken off the request, look under the comment section and rational will be provided. If further clarification is needed please present provided information to your billing department.

Global Periods

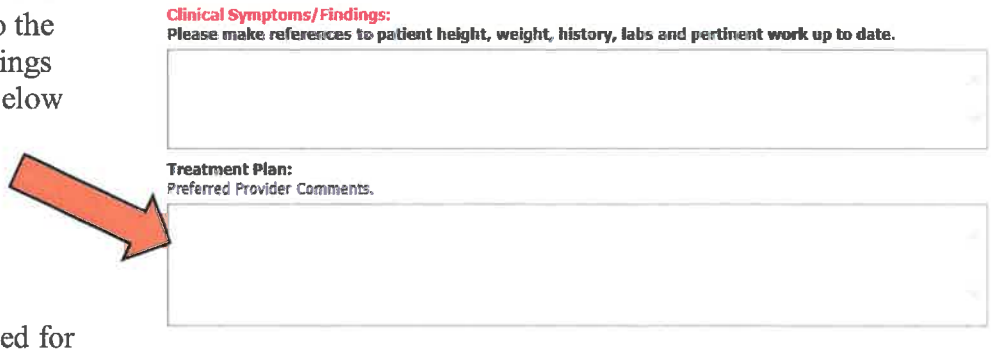
Post-op global periods

- **10**- Day Post- Operative Period, (minor procedures)
- **90**- Day Post- Operative Period, (major procedures)
- Follow up referrals may often be canceled due to members being under a post op period. During this post op period all office physician based visits are covered under a global procedural authorization and no authorization is warranted.
- Modifier **-25-** may be used to bill a separately identifiable evaluation and management (E/M) service by the same physician. If, the member presents with separate issue/ condition non related to the surgical procedure, the physician may evaluate, treat and bill the new condition with a 25 modifier.

Your member's diagnosis

- Enter the most accurate **ICD-10Code (s)** provided by the physician

Every referral requires supporting documentation. It may either be faxed to (562) 207-6511, attached and or copied or pasted into the clinical symptoms/findings section of the request below (preferred).



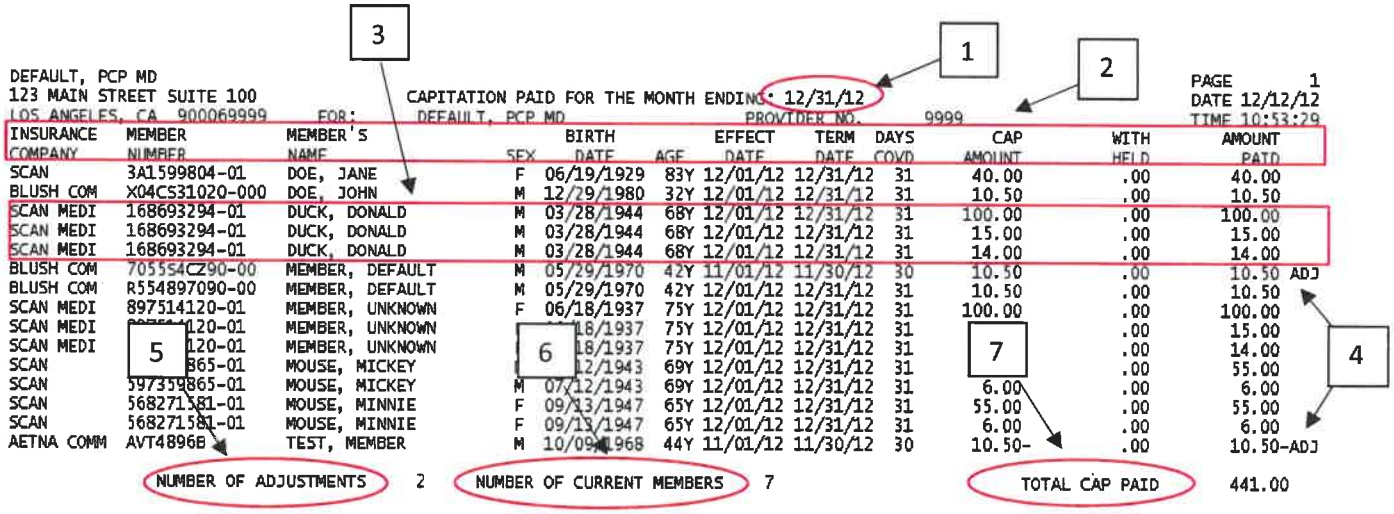
Documentation is needed for review and to establish medical necessity.

Submit your members referral

- Lastly, once the referral is all set, click submit referral button.

How to Read your Capitation Report

Detail Capitation Report



DEFAULT, PCP MD
123 MAIN STREET SUITE 100
LOS ANGELES, CA 900069999 FOR: DEFAULT, PCP MD

CAPITATION PAID FOR THE MONTH ENDING: 12/31/12

PROVIDER NO. 9999

PAGE 1
DATE 12/12/12
TIME 10:53:29

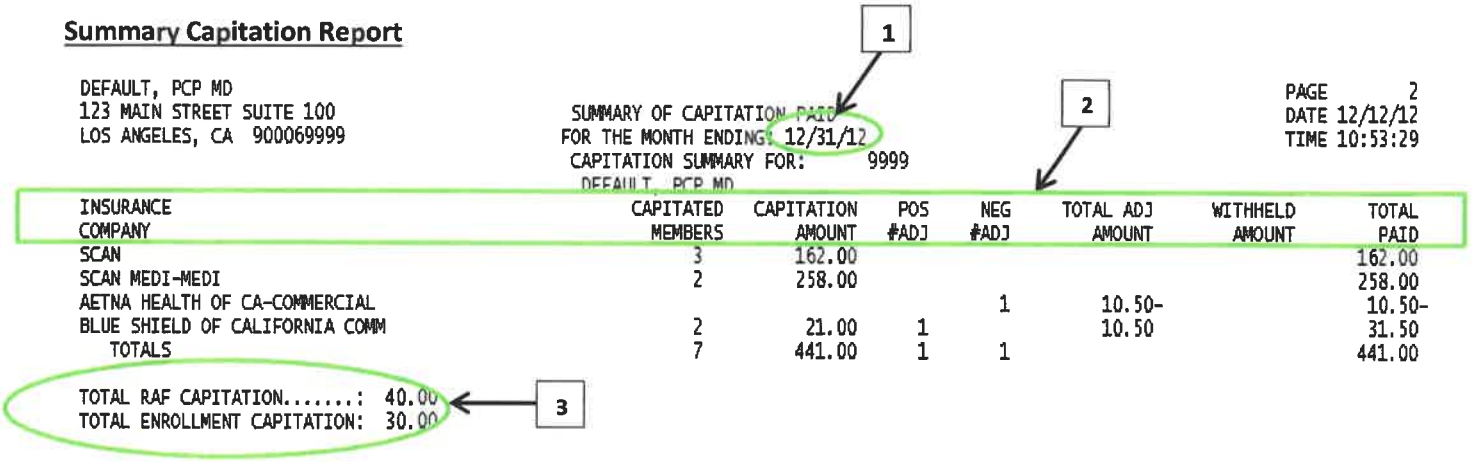
INSURANCE COMPANY	MEMBER NUMBER	MEMBER'S NAME	SEX	BIRTH DATE	AGE	EFFECT DATE	TERM DATE	DAYS COVD	CAP AMOUNT	WITH HELD	AMOUNT PAID	
SCAN	3A1599804-01	DOE, JANE	F	06/19/1929	83Y	12/01/12	12/31/12	31	40.00	.00	40.00	
BLUSH COM	X04CS31020-000	DOE, JOHN	M	12/29/1980	32Y	12/01/12	12/31/12	31	10.50	.00	10.50	
SCAN MEDI	168693294-01	DUCK, DONALD	M	03/28/1944	68Y	12/01/12	12/31/12	31	100.00	.00	100.00	
SCAN MEDI	168693294-01	DUCK, DONALD	M	03/28/1944	68Y	12/01/12	12/31/12	31	15.00	.00	15.00	
SCAN MEDI	168693294-01	DUCK, DONALD	M	03/28/1944	68Y	12/01/12	12/31/12	31	14.00	.00	14.00	
BLUSH COM	7055S4CZ90-00	MEMBER, DEFAULT	M	05/29/1970	42Y	11/01/12	11/30/12	30	10.50	.00	10.50	ADJ
BLUSH COM	R554897090-00	MEMBER, DEFAULT	M	05/29/1970	42Y	12/01/12	12/31/12	31	10.50	.00	10.50	
SCAN MEDI	897514120-01	MEMBER, UNKNOWN	F	06/18/1937	75Y	12/01/12	12/31/12	31	100.00	.00	100.00	
SCAN MEDI	[illegible]120-01	MEMBER, UNKNOWN		[illegible]18/1937	75Y	12/01/12	12/31/12	31		.00	15.00	
SCAN MEDI	[illegible]120-01	MEMBER, UNKNOWN		[illegible]18/1937	75Y	12/01/12	12/31/12	31		.00	14.00	
SCAN	[illegible]865-01	MOUSE, MICKEY		[illegible]12/1943	69Y	12/01/12	12/31/12	31		.00	55.00	
SCAN	597359865-01	MOUSE, MICKEY	M	07/12/1943	69Y	12/01/12	12/31/12	31	6.00	.00	6.00	
SCAN	568271581-01	MOUSE, MINNIE	F	09/13/1947	65Y	12/01/12	12/31/12	31	55.00	.00	55.00	
SCAN	568271581-01	MOUSE, MINNIE	F	09/13/1947	65Y	12/01/12	12/31/12	31	6.00	.00	6.00	
AETNA COMM	AVT48968	TEST, MEMBER	M	10/09/1968	44Y	11/01/12	11/30/12	30	10.50-	.00	10.50-ADJ	

NUMBER OF ADJUSTMENTS 2 NUMBER OF CURRENT MEMBERS 7 TOTAL CAP PAID 441.00

1. Capitation Paid for the Month Ending: This date represents the last day of the month that capitation is being paid for.
2. a. Insurance Company: An abbreviation of the Health Plan Name that the member is assigned to.
   b. Member Number: The Health Plan assigned Member Number for the member.
   c. Member's Name: The name of the member.
   d. Sex: The sex of the member as noted by the Health Plan.
   e. Birth Date: The member's date of birth.
   f. Age: The current age of the member for the capitation month. If the value ends with a Y the number of years is being displayed. If the value ends in M the number of months is being displayed.
   g. Effect Date & Term Date: The first and last date of eligibility for which capitation is being paid.
   i. Days Covd: The number of days that the member was eligible for the applicable capitation month.
   j. Cap Amount: The amount of capitation that is being paid or deducted. Deductions will end with a "-".
   k. With Held: The amount of capitation being withheld.
   l. Amount Paid: The amount of capitation being paid.
3. If your contract includes multiple capitation programs, (RAF adjusted Capitation and/or Membership adjusted Capitation) there will be one record for each capitation program for each eligible member.
4. Adj: Any capitation adjustments (Retro Capitation) records include "ADJ". Adjustments are changes in the eligibility status of a member as notified by the Health Plan requiring an adjustment to capitation.
5. Number of Adjustments: The Total number of capitation adjustments for this month.
6. Number of Current Members: The total number of currently active members for this month.
7. Total Cap Paid: The total capitation being paid for the month.

How to Read your Capitation Report

Summary Capitation Report



DEFAULT, PCP MD
123 MAIN STREET SUITE 100
LOS ANGELES, CA 900069999

SUMMARY OF CAPITATION PAID
FOR THE MONTH ENDING: 12/31/12
CAPITATION SUMMARY FOR: 9999
DEFAULT, PCP MD

PAGE 2
DATE 12/12/12
TIME 10:53:29

INSURANCE COMPANY	CAPITATED MEMBERS	CAPITATION AMOUNT	POS #ADJ	NEG #ADJ	TOTAL ADJ AMOUNT	WITHHELD AMOUNT	TOTAL PAID
SCAN	3	162.00					162.00
SCAN MEDI-MEDI	2	258.00					258.00
AETNA HEALTH OF CA-COMMERCIAL				1	10.50-		10.50-
BLUE SHIELD OF CALIFORNIA COMM	2	21.00	1		10.50		31.50
TOTALS	7	441.00	1	1			441.00

TOTAL RAF CAPITATION.....: 40.00
TOTAL ENROLLMENT CAPITATION: 30.00

1. Capitation Paid for the Month Ending: This date represents the last day of the month that capitation is being paid for.
2. a. Insurance Company: An abbreviation of the Health Plan Name.
   b. Capitated Members: The number of capitated members that are included in this month's capitation for the listed Insurance Company.
   c. Capitation Amount: The total capitation being paid for the listed Insurance Company, excluding any adjustments.
   d. Pos #Adj: The positive number of adjustments included in this month's capitation. For the listed Insurance Company.
   e. Neg #Adj: The negative number of adjustments included in this month's capitation, for the listed Insurance Company.
   f. Total Adj Amount: The total amount of capitation adjustments included in this month's capitation, for the listed Insurance Company.
   g. Withheld Amount: The total amount of capitation withheld from this month's capitation, for the listed Insurance Company.
   h. Total Paid: The total amount of capitation paid for the listed Insurance Company.
3. a. Total RAF Capitation: The total amount of capitation being paid as part of the RAF Adjusted Capitation Program.
   b. Total Enrollment Capitation: The total amount of capitation being paid as part of the Enrollment Adjusted Capitation program.

Re-Credentialing

PO Box 4939
Oceanside, CA 92052

Phone: (855) 498-2633
www.cvpg.org

PO Box 4939
Oceanside, CA 92052

Phone: (855) 498-2633
www.cvpg.org

Physician Re-Credentialing Sample Letter

Dear Provider:

As you may be aware, our contracted health plans require that providers be re-credentialed every three (3) years. Our records indicate that you are due for re-credentialing with **Citrus Valley Physicians Group**. It is imperative we receive your re-credentialing application without delay in order to meet health plan deadlines. Please note that failure to comply with the re-credentialing process may result in the closure of your office to new members or termination from **Citrus Valley Physicians Group**.

Enclosed is your reappointment application for **«Specialty name»**, which needs to be completed and returned in the enclosed self-addressed envelope **IMMEDIATELY.**

Directions for completing application:

- Complete Re-Application with all current information
- Complete and sign Addendums A, B, C, & W-9 taxpayer form **(Please be sure to sign all addendum's whether they pertain to you or not).**
- Please include copies of your current DEA, & Professional Liability Insurance.

In accordance with Citrus Valley Physicians Group standards, Providers have the right to review information submitted in support of their credentialing and/or recredentialing application. This includes information received from any outside primary source verification entities.

We kindly request your prompt attention to this very important request. If you should have any questions regarding your application, please contact me directly at (562) 860-8771 ext 186.

Sincerely,

Credentialing Department

Enclosures

cc: Evelyn Jimenez, IPA Manager for Citrus Valley Physicians Group

Re: Outsourcing Credentialing to Gemini (logo referenced below)

Dear Valued Provider,

Thank you so much for your application and/or continued participation with **Citrus Valley Physicians Group IPA. Citrus Valley Physicians Group IPA** has partnered with Gemini Diversified Services, Inc. (GDS) to assist in the administration and execution of our credentialing verification process.

We are reaching out to inform you of this change as you may be receiving correspondence from this entity and want to assure you of the credibility and reasoning behind the outreach to you. Any credentialing elements can be sent directly to Gemini at mc@servicesbygemini.com. If you have any questions, please contact Gemini at (866)437-6968 or Citrus Valley Physicians Group Provider Relations at (562)860-8771 ext.163

We look forward to a long-term, mutually beneficial relationship with you and your staff. If you should have any questions regarding this letter or any contracting related matters, please do not hesitate to contact Citrus Valley Physicians Group at (562) 860-8771.

Sincerely,

Duncan O'Toole

Duncan O'Toole
Credentialing Coordinator
Phone (760) 941-7309 X124
Email: dotoole@pdtrust.com

cc IPA Administrator
Provider Credentialing file

Compliance

PO Box 4939
Oceanside, CA 92052

Phone: (855) 498-2633
www.cvpg.org

Who must comply?

Organizations providing healthcare services or certain administrative services must uphold an individual's right to privacy. This means adhering to requirements set forth by the Centers for Medicare & Medicaid Services (CMS), HIPAA and the HITECH Act, the Gramm-Leach-Bliley Act, the IPA, and the IPA's affiliated health plans.

Under HIPAA, health plans, health care clearinghouses, and health care providers are considered **covered entities**.

Subcontractors that perform activities involving the use or disclosure of protected health information (PHI) are considered **business associates**. These activities include creating, receiving, maintaining, transmitting, processing, accessing, or storing PHI.

A covered entity may be a business associate of another covered entity.

Workforce members are employees, volunteers, trainees, and any other persons under the direct control of a covered entity or business associate, regardless of payment.

Your Responsibilities

As a business associate, the IPA is responsible to fulfill the terms and conditions in our contracts with covered entities, and to meet regulatory requirements for patient privacy and information security. As a subcontractor to the IPA, you are responsible to adhere to these requirements as well. This includes:

- Upholding the Business Associate Agreement (BAA) provisions set forth by the IPA,
- Ensuring your subcontractors also uphold these privacy and security standards.

You must keep evidence of your compliance with these requirements for at least 6 years. This may include employee training records, policies, risk assessments, documentation of privacy/security incidents, or proof of the way you oversee your subcontractors. You may be asked to complete an attestation or audit to verify your adherence to these requirements.

If you or your subcontractors fail to meet privacy and security requirements, it may lead to retraining, corrective actions, or other sanctions. If you discover a privacy or security issue, you must take quick action to fix and report the issue. And, you need to prevent it from happening again.

Privacy/Security Requirements

Offshore Operations

Offshore operations refers to operations conducted outside of the United States or United States Territories. An offshore subcontractor provides services performed by workers located offshore. This includes:

- American-owned companies with operations performed outside of the United States
- Foreign-owned companies with operations performed outside of the United States

If any of your employees or subcontractors perform work offshore, and that offshore work includes receiving, processing, transferring, handling, storing, or accessing PHI on the IPA's behalf, you must notify Physicians DataTrust at compliance@pdtrust.com, or by phone at (562) 860-8771, ext. 114.

Physicians DataTrust may be required to report these operations to the IPA's affiliated health plans. And, Physicians DataTrust may require your organization to develop additional controls to ensure PHI is protected in the course of offshore business.

More information about offshore operations is available at https://pdtrust.com/compliance.

Privacy & Security Training

As a subcontractor to the IPA, your organization must maintain policies and procedures to uphold privacy and security requirements. And, you must train your workforce and business associate subcontractors on these policies and procedures, as necessary and appropriate for them to carry out their assigned duties in compliance with privacy and security requirements.

The policies, procedures, and training materials must include the requirement and the method(s) for workforce members and business associates to report privacy and security concerns. And, your policies and procedures must include a provision to report privacy and security concerns (that impact the IPA) to Physicians DataTrust without delay.

You must conduct this training prior to granting access to PHI, annually thereafter, and when there are changes to privacy and security policies. You must also save proof that you conducted the training. If you use training logs, reports, or sign-in sheets as evidence of completion, they must include names, dates, and training topics.

PDT Privacy/Security Training is available at https://pdtrust.com/compliance. You are not required to use these materials.

Subcontractor Oversight

As a subcontractor to the IPA, you must monitor the compliance of your business associate subcontractors. If you choose to subcontract with other parties for IPA business, you must make sure they abide by all requirements that apply to you as a subcontractor of the IPA. This includes ensuring:

- A written service agreement and BAA are in place prior to involvement with IPA business
- The business associate subcontractor complies with the requirements described in this guide
- The business associate subcontractor complies with all applicable privacy and security standards

PDT's BAA template is available at https://pdtrust.com/compliance. You are not required to use this BAA template.

Not every subcontractor is a business associate. Only subcontractors that create, receive, maintain, transmit, process, store, or access PHI are considered business associates. The following types of subcontractors are not business associates:

- Housekeeping/custodial
- Grounds and maintenance
- Machine repair or servicing

For help identifying which of your subcontractors are business associates, please contact Physicians DataTrust at compliance@pdtrust.com, or by phone at (562) 860-8771, ext. 114.

L.A. Care Requirements

PO Box 4939
Oceanside, CA 92052

Phone: (855) 498-2633
www.cvpg.org

Accreditation of Medi-Cal, Healthy Kids and Healthy Families Program.

The New Provider Orientation Handbook

L.A. Care HEALTH PLAN®

Revised: 10/14/15

LA1456 10/15

Dear L.A. Care Contracted Provider,

L.A. Care Health Plan (L.A. Care) has created this provider orientation handbook to ensure that your L.A. Care contracted Participating Provider Group (PPG) or Management Services Organization (MSO) has the necessary tools to train you, the Primary Care Physicians and/or Specialists, on the Medi-Cal Managed Care program and L.A. Care's policies and procedures.

According to L.A. Care's contract with the State of California's Department of Health Care Services, new contracted providers MUST be trained within 10 business days of active status.

The information provided will allow you and your staff to gain a broad understanding of L.A. Care's mission, the importance of positive customer service experiences, member benefits, and member rights and responsibilities. If you would like more information, please reference the L.A. Care Provider Manual by visiting **www.lacare.org**.

Additionally, if you need clarification on any of the information provided, please contact your PPG or MSO for further guidance.

Welcome to the L.A. Care Health Plan Network!

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L.A. Care's History

Established in 1997, L.A. Care is an independent local public agency created by the state of California to provide health coverage to low-income Los Angeles County residents. L.A. Care is the nation's largest publicly operated health plan. Serving more than 1.8 million members, our mission is to ensure our members get the right care at the right place at the right time. For more history and information on L.A. Care, please visit **www.lacare.org**.

L.A. Care's Delegated Model

L.A. Care delegates certain authorization and claims processing to some of its contracted Participating Provider Groups (PPGs) and Management Services Organizations (MSOs). Delegation is when an entity gives another entity the authority to carry out a function that it would otherwise perform, such as operating within the parameters agreed upon between the health plan and PPG/MSO.

The National Committee on Quality Assurance (NCQA) holds L.A. Care to the following requirements:

- Delegation Agreement - A mutual agreement between L.A. Care and its PPG/MSO outlining specific delegated functions that meet NCQA standards.
- Oversight and Monitoring – L.A. Care must oversee the delegates to ensure that the delegate is properly performing all delegated functions.

For more information on NQCA standards and functions, please visit their website at **http://www.ncqa.org/AboutNCQA.aspx**.

Medi-Cal Managed Care provides high quality, accessible, and cost-effective health care through managed care delivery systems. Medi-Cal Managed Care contracts for health care services through established networks of organized systems of care which emphasize primary and preventive care. Managed care plans like L.A. Care, have been proven to be a cost-effective use of health care resources that improve health care access and assure quality of care.

In order to determine who is responsible for paying a claim, please contact the members assigned PPG/MSO or reference your PPG/MSO contract for more information.

Timely Filing Deadline

L.A. Care cannot impose a timeframe for receipt of an 'initial claim' submission less than 90 days for contracted providers or 180 days for non-contracted providers after the date of service for timely filing for a new claim.

Billing

All paper claims must be submitted on CMS 1500 form for professional services and UB-04 form for facility services. L.A. Care accepts EDI submissions, please reference **http://www.lacare.org/providers/provider-resources/provider-forms**.

Claims Adjudication

Each claim is subject to a comprehensive series of quality checks called "edits" and "audits." Quality checks verify and validate all claim information to determine if the claim should be paid, denied or suspended for manual review. Edit and audit checks include verification of:

- Data validity
- Procedure and diagnosis compatibility
- Provider eligibility on date of service
- Recipient eligibility on date of service
- Medicare or other insurance coverage
- Claim duplication
- Authorization requirements

Provider Portal Claims Verification

- The L.A. Care Provider Portal is the preferred method for contracted providers to check claims status. Please see information on how to access the L.A. Care Provider Portal in the Provider Portal section of this handbook.
- The secondary method to check claims status is by calling 1-866-LA-CARE6.

Balanced Billing

Balance billing L.A. Care members is prohibited by law. Contracted providers cannot collect reimbursement from a L.A. Care member or persons acting on behalf of a member for any services provided, except to collect any authorized share of cost.

Provider Disputes

When the claim is the responsibility of the PPG/MSO, a provider dispute can be filed in writing with the PPG/MSO. Contact the PPG/MSO for more information on how to file a claims dispute. If the provider is dissatisfied with the resolution of the initial dispute filed with the PPG/MSO, a second level dispute may be filed with L.A. Care's Claims Provider Disputes unit. A copy of the PPG/MSO denial or Notice of Decision letter must fully describe the dispute and the PPGs/MSOs decision. The second level dispute must include a description of timelines as well as information to support the description of the dispute along with the claim.

Provider disputes must be submitted to:
L.A. Care Health Plan
Attention: Provider Disputes
P.O. Box 811610
Los Angeles, CA 90081

Authorizations

In order to determine who is responsible for authorization of services, please contact the members' assigned PPG/MSO or reference your contract with the PPG/MSO for more information.

Professional authorizations and payment of claims for those services are usually the responsibility of the PPG. For all other services, PPGs/MSOs and L.A. Care have a contractual document that defines which entity is responsible for a service (e.g., Division of Financial Responsibility and a Delegation Agreement). For additional information on what services are paid for by the PPG or L.A. Care, please call your PPG/MSO.

You can access the *Delegation Matrix* tool to identify which PPG is at risk for authorizing services by visiting **http://www.lacare.org/sites/default/files/Provider%20Authorization%20and%20Billing%20Guidance%2006%2017%2015.pdf**

A copy of L.A. Care's Authorization Request Form is available at: **http://www.lacare.org/sites/default/files/PL0022c_Updated_Auth_Req_Form_10%2001%202015_FINAL.pdf**

Services That Do Not Require Prior Authorization

- Emergency Services, whether in or out of L.A. County but within the continental USA (except for care provided outside of the United States which is subject to retrospective review)
- Emergency Care provided in Canada or Mexico is covered
- Urgent care, whether in or out of network
- Mental health care and substance use treatment
- Routine Women's health services – a woman can go directly to any network provider for women's health care such as breast or pelvic exams
  - This includes care provided by a Certified Nurse Midwife/OB-GYN and Certified Nurse Practitioners
- Basic prenatal care – a woman can go directly to any network provider for basic pre-natal care
- Family planning services, including: counseling, pregnancy tests and procedures for the termination of pregnancy (abortion)
- Treatment for Sexually Transmitted Diseases, includes: testing, counseling, treatment and prevention
- Emergency medical transportation

Services That May Require Prior Authorization

Note: As the Prior Authorization process may vary between PPGs/MSOs, verify with your contracted PPG/MSO that these services are correct.

- Non-emergency out of area care (outside of L.A. County)
- Out of network care, services not provided by a contracted network doctor
- Inpatient admissions, post-stabilization/non-emergency/elective
- Inpatient admission to skilled nursing facility or nursing home
- Outpatient hospital services/surgery
- Outpatient, non-hospital , such as surgeries or sleep studies
- Outpatient diagnostic services, minimally invasive or invasive such as CT Scans, MRIs, colonoscopy, endoscopy, flexible sigmoidoscopy, and cardiac catheterization

- Durable Medical Equipment, standard or customized; rented or purchased
- Medical Supplies
- Prosthetics and Orthotics
- Home Health Care, including: nurse aide, therapies, and social worker
- Hospice
- Transportation (excluding emergency medical transportation)
- Experimental or Investigation Services
- Cancer Clinical Trials

Hospital and Ancillary Provider Network

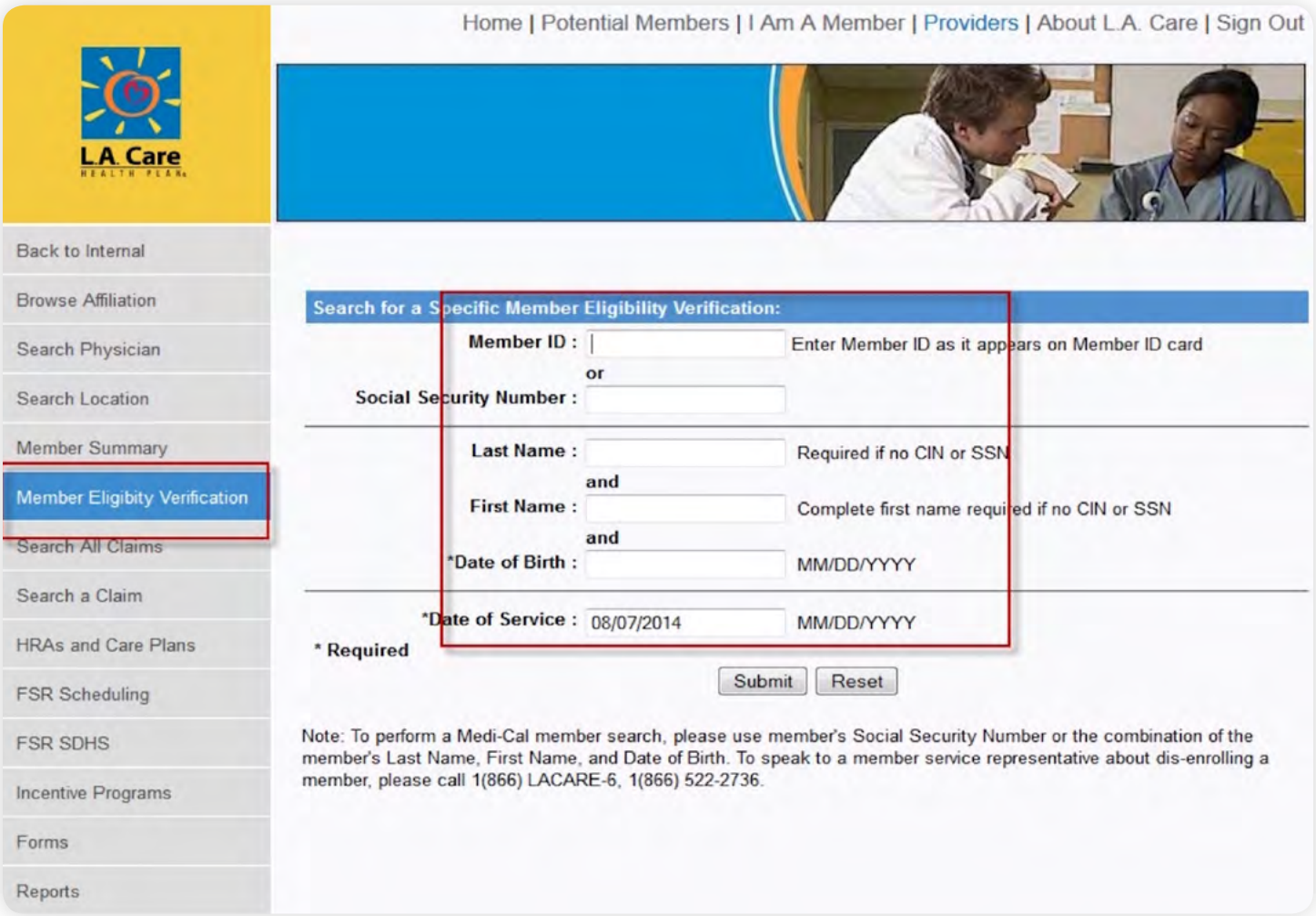
L.A. Care maintains a network of contracted hospitals and ancillary providers. Please contact your PPG/ MSO for the most recent list to be utilized for services provided to L.A. Care Direct members.

Checking Member Eligibility

A. Log on to the Provider Portal then select "Member Eligibility Verification."

B. Please fill out all fields with as much information as possible to get the best results. Click "submit" when finished. See Figure 1.

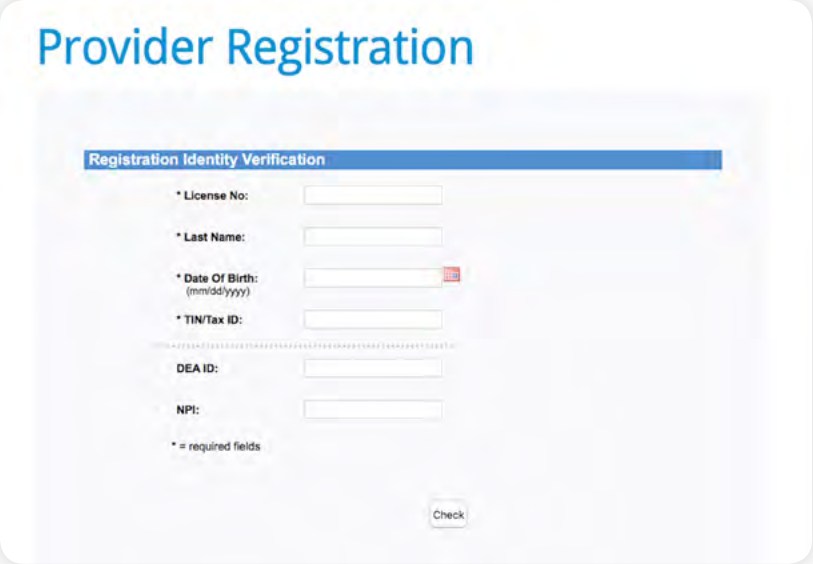
Figure 1.



Provider Portal: Registering a New Provider
All contracted physicians and specialist may self-register at
http://www.lacare.org/providers/provider-sign-in/provider-registration.

All information marked with an asterisk is required in order for your request to be processed. See Figure 2.

Figure 2.



All other medical and administrative staff have to submit a request for registration for the Provider Portal. This request can be submitted via email to **providerrelations@lacare.org** or by phone at 1-213-694-1250 x 4719. The required information that needs to be specified is listed below:

- Name of organization (as listed in the contract)
- Organization address
- Full name of person(s) that need access
- Job title
- Phone number
- Email address
- Purpose/reason why access is needed

Please note all Provider Portal registration requests will be processed within 3 - 5 business days.

Once you receive access to the Provider Portal you will be notified via email to confirm your registration. You will have 24 hours to activate your account with the link provided to you by email. If you do not activate your account within the 24-hour period you will have to contact the Provider Relations department at **PPO@lacare.org** or by phone at 1-213-694-1250 x5200 to receive a new activation email for your account.

Under federal and state law, medical care providers must provide individuals with disabilities:

- Full and equal access to their health care services and facilities
- Reasonable modifications to policies, practices, and procedures when necessary to make health care services accessible and,
- Effective communication, including auxiliary aids and services, such as the provision of sign language interpreters or written materials in alternative formats.

Physical Access

Providers must make their facilities, as well as their medical equipment and exam rooms accessible. The law requires the development and maintenance of accessible paths of travel to elevators, ramps, doors that open easily, reachable light switches, accessible bathrooms, accessible parking and signage that can assist individuals who are blind or have low vision.

Additionally, health care providers must provide accessible equipment, such as exam tables, diagnostic equipment and the use of a lift or trained staff who can ensure equal access to medical testing.

Reasonable Modifications

The Americans with Disabilities Act (ADA) provides protection from discrimination for people with all types of disabilities, including people with physical, cognitive, communication and mental health disabilities. Health care providers must make reasonable modifications in policies, practices and procedures when necessary to avoid discrimination on the basis of disability, unless the provider can demonstrate that making the modification would fundamentally alter the nature of the service, program or activity.

Examples of reasonable modifications health care providers may need to make for individuals with disabilities are:

- Spend additional time explaining individualized member care plans to ensure understanding
- Scheduling an appointment to accommodate a member with an anxiety disorder who has difficulty waiting in a crowded waiting room
- Allowing members to be accompanied by service dogs

Note: A health care provider cannot require individuals who are visually impaired or hard of hearing to bring someone with them to interpret or facilitate communication. Health care providers cannot charge members for providing any form of interpreter services.

Procedures for Providing Accommodations

Health care providers must:

- Ensure that individuals are informed of their right to request accommodations
- Provide individuals with information about the process for requesting accommodations
- Provide individuals with information about filing complaints about accommodations with L.A. Care if the provider is in the L.A. Care network, and filing complaints with other entities that oversee disability access laws in the health care context.

Health Assessments and Provider Toolkits

Initial Health Assessments

Primary Care Providers (PCP) are responsible for conducting a health assessment screening. All new members must have an initial health assessment (IHA) within:

- Medi-Cal members - 120 calendar days from the date of enrollment with L.A. Care. L.A. Care does not mandate utilization of a standardized form for the IHA. L.A Care does require the documentation of specific elements of the assessment. L.A. Care does provide samples of Well Child Assessment forms. A full description of the IHA process is available in the L.A. Care Provider Manual. Copies of the assessment forms are available at: **http://www.lacare.org/providers/provider-resources/provider-faqs/well-child-assessment-forms**.

Staying Healthy Assessments

For Medi-Cal enrollees, L.A. Care requires the completion of the Staying Healthy Assessments to be administered during the IHA and periodically thereafter as the patient enters a new age category. Forms are located at: **http://www.lacare.org/providers/provider-resources/staying-healthy-forms**.

Provider Toolkits

L.A Care maintains accessible toolkits and resources to assist providers in managing the care of our members. Currently toolkits include:

- Appropriate Use of Antibiotics
- Asthma
- Cardiovascular Care
- Childhood and Adolescent Wellness Flyers
- Chlamydia
- COPD
- Diabetes and Cardiovascular Care
- Obesity Toolkit for Adult and Children
- Pre/Post Bariatric Surgery Toolkit
- Perinatal Care
- Tobacco Control and Cessation
- Better Communication, Better Care: A Provider Toolkit for Serving Diverse Populations
- Behavior Health Provider Toolkit
- Behavioral Health Toolkit for PCPs
- Depression Provider Toolkit

The medical and mental health toolkits are available at **http://www.lacare.org/providers/provider-resources/provider-tool-kits**.

The CHDP program provides health assessments for the early detection and prevention of disease and disabilities for low-income children and youth.

CHDP health assessments screenings should consist of the following:

- health history
- physical examination
- developmental assessment
- nutritional assessment
- dental assessment
- vision and hearing tests
- a tuberculin test
- laboratory tests
- immunizations
- health education/anticipatory guidance
- referrals for any needed diagnosis and treatment

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

PCPs are required to follow-up with the components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal eligible children and youth.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) are a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. This benefit allows for periodic screenings to determine health care needs. Based upon the identified health care need and diagnosis; treatment services are provided. EPSDT services include all services covered by Medi-Cal. A beneficiary under the age of 21 may receive additional medically necessary services.

EPSDT Screening Services

Screening services provided at intervals that meet standards of medical and dental practice, and at such other medically necessary intervals to determine the existence of physical or mental illnesses or conditions. Screening services must at a minimum include:

- a comprehensive health and developmental history (including assessment of both physical and mental health development)
- a comprehensive physical exam
- appropriate immunizations
- laboratory tests (including blood lead level taking into account age and risk factors)
- health education (including anticipatory guidance)

EPSDT Diagnostic Services

EPSDT covers medically necessary diagnostic services. When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis without delay.

ESPDT Treatment Services

Mental Health and Substance Use Services:

- Treatment for mental health and substance use issues and conditions is available under a number of Medi-Cal service categories, including hospital and clinic services, physician services, and services provided by a licensed professional such as a psychologist.

Medically Necessary Personal Care Services

- Are furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility, or institution for mental disease, that are:

  (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State), otherwise authorized for the individual in accordance with a service plan approved by the State

  (B) provided by an individual who is qualified to provide such services and is not a member of the individual's family

  (C) furnished in a home or in another location

Oral Health and Dental Services:

- Dental care needed for relief of pain, infection and maintenance of dental health (provided as early an age as necessary).
- Emergency, preventive, and therapeutic services for dental disease that, if left untreated, may become acute dental problems or cause irreversible damage to the teeth or supporting structures.
- Medi-Cal Dental Care and Treatment Services are a carved out benefit for Medi-Cal members through the Medi-Cal Denti-Cal Program. Primary Care Providers are expected to perform dental screenings on all Medi-Cal members as part of the IHA, periodic, and other preventive health care visits and provide referrals to the Medi-Cal Denti-Cal Program for treatment. For children, Denti-Cal uses the periodicity schedule recommended by American Academy of Pediatric Dentistry (AAPD). Also some Dental benefits for adults 21 and older have been recently restored. To find a dentist, Medi-Cal members should be advised to call Denti-Cal at 1-800-322-6384 or visit **http://www.denti-cal.ca.gov**.

Vision and Hearing Services

- EPSDT requires that vision services be provided at intervals that meet reasonable standards as determined in consultation with medical experts, and at other intervals as medically necessary to determine the existence of a suspected illness or condition.
- At a minimum, vision services must include diagnosis and treatment for defects in vision, including eyeglasses.
- Glasses to replace those that are lost, broken, or stolen also must be covered.
- Medi-Cal vision benefits are covered by L.A. Care.
- L.A. Care has contracted with Vision Service Plan (VSP) to coordinate Medi-Cal vision care and lenses.
- To find out more about eye exams or vision care coverage for Medi-Cal members, call VSP at 1-800-877-7195 [TTY/TDD 1-800-428-4833].
- To find out more about eye exams or vision care coverage, you can also call L.A. Care Member Services at the toll free number 1-888-839-9909 [TTY/TDD 1-866-522-2731].

- EPSDT requires that hearing services be provided at intervals that meet reasonable standards as determined in consultation with medical experts, and at other intervals as medically necessary to determine the existence of a suspected illness or condition.
- Hearing services must include, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids.

Vaccines for Children (VFC)

The Vaccines for Children Program, established by an act of Congress in 1993, helps families by providing free vaccines to doctors who serve eligible children 0 through 18 years of age. The VFC program is administered at the national level by the United States Centers for Disease Control and Prevention (CDC) through the National Center for Immunization and Respiratory Diseases. The CDC contracts with vaccine manufacturers to buy vaccines at reduced rates. Enrolled VFC providers are able to order vaccine through their state VFC program and receive routine vaccines at no cost. This allows routine immunizations to eligible children without high out-of-pocket costs.

Appropriate documentation shall be entered in the member's medical record. It should indicate all attempts to provide immunizations. A receipt of vaccines or proof of prior immunizations; or proof of voluntary refusal of vaccines in the form of a signed statements by the member (if an emancipated minor) or the parent(s), or guardian of the member, shall be entered in the member's medical record. Please contact your PPG or MSO for further details.

The Vaccines for Children (VFC) Program is managed by the California Department of Public Health, Immunization Branch. A full description of the program and potential conditions is located at:

- **https://www.cdph.ca.gov/programs/immunize/Pages/HealthProfessionals.aspx**
- **http://eziz.org/vfc/overview/**

California Children Services (CCS)

CCS is a statewide program that treats children under the age of 21 with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Services manages the CCS program. Providers are required to refer children with certain physical limitations and chronic health conditions or diseases to a CCS paneled provider or CCS Specialty Care Center for care. A full description of the program and potential CCS conditions is located at:

- **http://publichealth.lacounty.gov/cms**
- **http://www.lacare.org/providers/provider-resources/provider-faqs/ccs**

Services for the Developmentally Disabled

The term developmental disability refers to a severe and chronic disability that is attributable to a mental or physical impairment that begins before an individual reaches adulthood. These disabilities include mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions closely related to mental retardation or requiring similar treatment.

For an individual to be assessed in California as having a developmental disability, the disability must begin before the individual's 18th birthday, be expected to continue indefinitely and present a substantial disability. For additional information, please visit the L.A. Care website at: **http://www.lacare.org/dds-0**

Early Intervention/Early Start

A child with or at risk of developmental delay or disability can receive an "Early Start" in the State of California. Teams of service coordinators, health care providers, early intervention specialists, therapists, and parent resource specialists can evaluate and assess an infant or toddler. They can also provide appropriate early intervention services to children eligible for California Early Start. For more information, please refer to the section below; "Primary Care Responsibilities for Care Coordination with Linked and Carved out Services."

Eligibility Criteria

Infants and toddlers from birth to 36 months may be eligible for Early Intervention services through documented evaluation and assessment if they meet one of the criteria listed below:

- Have a developmental delay in either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing
- Have established risk conditions of known etiology, with a high probability resulting in delayed development
- Are at high risk of having a substantial developmental disability due to a combination of risk factors

For additional information on Early Intervention and Early Start, please see L.A. Care's website at: **http://www.lacare.org/dds-0**

Primary Care Responsibilities for Care Coordination with Linked and Carved out Services

PCPs are responsible for Coordination of Care for Linked and Carved out Services (i.e. CCS, DDS, Regional Centers, etc.).

Care Managers at L.A. Care or the PPG/MSO are available to assist members, who may need or who are receiving services from out of plan providers and/or programs. This service is available to ensure coordinated service delivery and effective joint case management. The coordination of care and services remains the responsibility of each member's PCP. PPG's and the member's PCP will monitor the following:

- Member referral to and/or utilization of special programs and services
- Member referral to and/or utilization of specialty care, including ensuring consultative notes and summaries are maintained in the medical home records
- Routine medical care, including providing the necessary preventive medical care and services
- Provision of Initial Health Assessments including the Staying Healthy Assessment (SHA)

PPGs/MSOs and PCPs are encouraged to make referrals to local health departments, mental health programs and regional centers.

Out-of-Plan Case Management and Coordination of Care for Linked and Carved out Services

L.A. Care maintains procedures to identify individuals, who may need or who are receiving services from out of plan providers and/or programs. These procedures are established in order to ensure coordinated service delivery and efficient and effective joint case management.

Medical Record Documentation

L.A. Care requires physician offices to maintain a certain level of medical record documentation. L.A. Care will assess records using the DHCS Medical Record Review Guidelines during the Facility Site Review process. A copy of the guidelines are available at: **http://www.lacare.org/providers/provider-resources/provider-faqs/well-child-assessment-forms**.

Behavioral Health

Beacon Health Options is L.A. Care's delegated vendor for non-specialty mental health services. All services listed below are provided to our members:

- 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 and treatment
- Outpatient laboratory, medications, supplies and supplements
- Psychiatric consultation
- For non-specialty mental health services, please contact:
  - Beacon Health Options
  - Phone Line: 1-877-344-2850

County Specialty Mental Health

There are no changes to County Specialty Mental Health services provided by Los Angeles County Department of Mental Health (DMH) or Substance Use Disorder Treatment by the Department of Public Health (DPH).

- For Specialty Mental Health services, please contact:
  - L.A. County Department of Mental Health (DMH)
  - Phone Line: 1-855-854-7771
- For Specialty Substance Use Disorder treatment, please contact:
  - L.A. County Department of Public Health (DPH)
  - Phone Line: 1-800-564-6600

L.A. Care's Behavioral Health Department

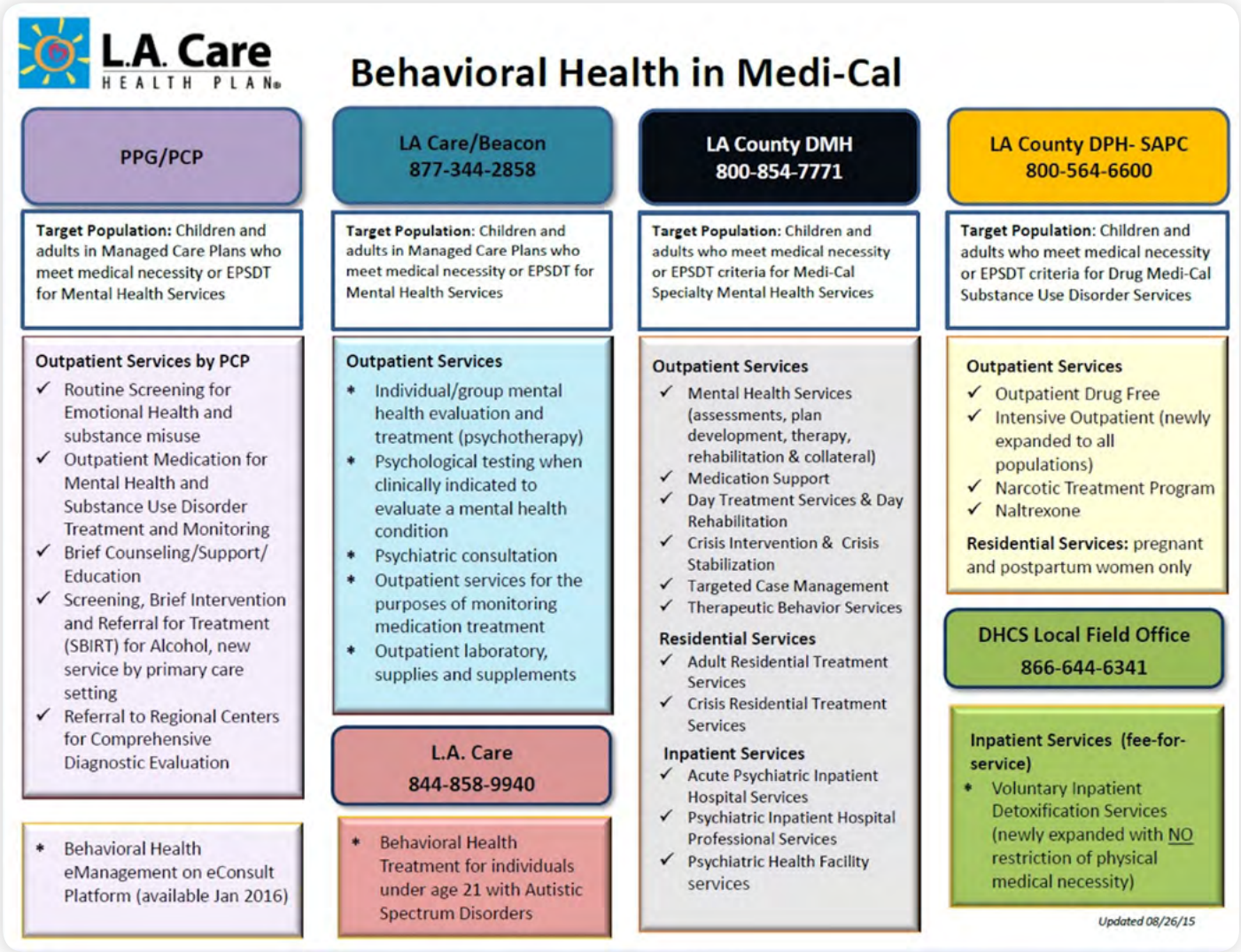
L.A. Care's Behavioral Health Department has licensed behavioral health staff dedicated to supporting you with the services listed below:

- Resolve behavioral health service access issues
- Ensure appropriate clinical transfer in behavioral health system of care
- Assist with service system coordination provided by the Beacon network
- Facilitate Care Coordination between Care Management and PPG Case Managers for behavioral health services
- Educate and train providers and the community
- Support members with behavioral health grievances, appeals and advocacy

This service is available Monday to Friday from 8 a.m. to 5 p.m. You can reach us by phone at 1-844-858-9940 or via email at **behavioralhealth@lacare.org**. Please note that protected health information (PHI) must be sent secured.

The following diagram illustrates services and correlating contact information for L.A. Care's Behavioral Health Medi-Cal program. See figure 3.

Figure 3.


L.A. Care HEALTH PLAN
Behavioral Health in Medi-Cal
PPG/PCP
Target Population: Children and adults in Managed Care Plans who meet medical necessity or EPSDT for Mental Health Services
Outpatient Services by PCP
✓ Routine Screening for Emotional Health and substance misuse
✓ Outpatient Medication for Mental Health and Substance Use Disorder Treatment and Monitoring
✓ Brief Counseling/Support/ Education
✓ Screening, Brief Intervention and Referral for Treatment (SBIRT) for Alcohol, new service by primary care setting
✓ Referral to Regional Centers for Comprehensive Diagnostic Evaluation
* Behavioral Health eManagement on eConsult Platform (available Jan 2016)
LA Care/Beacon
877-344-2858
Target Population: Children and adults in Managed Care Plans who meet medical necessity or EPSDT for Mental Health Services
Outpatient Services
* Individual/group mental health evaluation and treatment (psychotherapy)
* Psychological testing when clinically indicated to evaluate a mental health condition
* Psychiatric consultation
* Outpatient services for the purposes of monitoring medication treatment
* Outpatient laboratory, supplies and supplements
L.A. Care
844-858-9940
* Behavioral Health Treatment for individuals under age 21 with Autistic Spectrum Disorders
LA County DMH
800-854-7771
Target Population: Children and adults who meet medical necessity or EPSDT criteria for Medi-Cal Specialty Mental Health Services
Outpatient Services
✓ Mental Health Services (assessments, plan development, therapy, rehabilitation & collateral)
✓ Medication Support
✓ Day Treatment Services & Day Rehabilitation
✓ Crisis Intervention & Crisis Stabilization
✓ Targeted Case Management
✓ Therapeutic Behavior Services
Residential Services
✓ Adult Residential Treatment Services
✓ Crisis Residential Treatment Services
Inpatient Services
✓ Acute Psychiatric Inpatient Hospital Services
✓ Psychiatric Inpatient Hospital Professional Services
✓ Psychiatric Health Facility services
LA County DPH- SAPC
800-564-6600
Target Population: Children and adults who meet medical necessity or EPSDT criteria for Drug Medi-Cal Substance Use Disorder Services
Outpatient Services
✓ Outpatient Drug Free
✓ Intensive Outpatient (newly expanded to all populations)
✓ Narcotic Treatment Program
✓ Naltrexone
Residential Services: pregnant and postpartum women only
DHCS Local Field Office
866-644-6341
Inpatient Services (fee-for-service)
* Voluntary Inpatient Detoxification Services (newly expanded with NO restriction of physical medical necessity)
Updated 08/26/15

Case Management

L.A. Care has a Case Management department (also known as Care Management) with specially trained staff to help members with complex care needs or members at high risk for adverse outcomes. Examples of members with complex needs may include:

- Serious acute or chronic health condition (trauma, new cancer diagnosis)
- multiple uncontrolled health conditions
- complicated social issues (no social support)

Please refer members with complex needs to L.A. Care through the following ways:

- Complete the Care Management Referral Form which is available on the L.A. Care Provider Portal
- Simply call the Care Management department during regular business hours at: 1-844-200-0104

We will work with our members to develop an Individualized Care Plan (ICP) and provide you with updates to the plan after holding an Interdisciplinary Care Team (ICT) meeting with participants most appropriate to address individualized needs.

Managed Long-Term Services and Supports (MLTSS)

MLTSS is a wide range of services that provide support to seniors and individuals with disabilities so that they can remain living safely at home. Services available to L.A. Care members under MLTSS include:

- **In Home Supportive Services (IHSS):** Provides in home care for seniors and people with disabilities. Eligible members can hire anyone they wish to help them with their daily needs. This includes assistance with home chores, personal care assistance, basic medical needs, getting to provider appointments and providing supervision for people with dementia or other mental impairments.
- **Multipurpose Senior Services Program (MSSP):** Provides intensive care coordination services in the home for seniors age 65 and older. An MSSP nurse and social worker team will provide eligible members with a full assessment of their health and social support needs. Additionally the MSSP team will identify, arrange and provide help with accessing resources, monitor the member's wellbeing, and purchase other needed services that may not be available through L.A. Care or other community based programs.
- **Community Based Adult Services (CBAS):** Provides professional nursing services, physical, occupational and speech therapies, socialization, mental health services, therapeutic activities, social services, nutrition and nutritional counseling for people ages 18 and older. CBAS is a day program formerly known as adult day health care center.
- **Long Term Care (LTC):** Provides continuous skilled nursing care to eligible members with physical or mental conditions in a nursing home. The Medi-Cal LTC nursing facility benefit includes room and board and other medically necessary services.

L.A. Care members receiving MLTSS often have complex needs. They may be diagnosed with multiple chronic conditions (functional and cognitive) or may lack social, educational, and economic support. The MLTSS department can help support your patient's access to needed care by:

- Determining if they are IHSS, CBAS, MSSP and LTC eligible
- Coordinating and navigating IHSS, MSSP and CBAS assessment
- Resolving IHSS, MSSP, CBAS and LTC related issues and navigating the grievance and appeals process
- Applying for IHSS and MSSP services
- Coordinating requests for expedited assessments
- Providing temporary services to fill in coordination of care gaps
- Following up with IHSS, MSSP, CBAS, and LTC services to ensure services are being provided
- Referring to local CBAS centers and MSSP sites
- Accessing community based organizations for non-plan services

To find MLTSS Referral forms, go to the L.A. Care website: **http://www.lacare.org/providers/provider-resources/provider-forms**

MLTSS Contact Information

For Managed Long Term Services and Supports questions:

MLTSS Phone Line: 1-855-427-1223

MLTSS Fax Line: 1-213-438-4877

MLTSS Email: **mltss@lacare.org**

L.A. Care Website: **www.lacare.org**

Federal and State Statutes

Federal Statutes

The Centers for Medicare & Medicaid Services(CMS), is part of the Department of Health and Human Services (DHHS). They administer Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and parts of the Patient Protection and the Affordable Care Act (ACA).

The link below provides access to proposed and existing statutes and regulations relevant to CMS.

https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html

State Statutes

The Department of Health Care Services (DHCS) was created and is directly governed by California statutes passed by the California Legislature. These statutes grant DHCS the authority to establish programs and adopt regulations.

The link below provides access to proposed and existing statutes and regulations relevant to the DHCS.

http://www.dhcs.ca.gov/formsandpubs/laws/Pages/LawsandRegulations.aspx

L.A. Care requires primary care physicians, behavioral health providers, specialists and ancillary providers to be compliant with access and availability standards. The standards are provided below.

Access to Care Quick Tips

Standard[1]	Medi-Cal	L.A. Care Covered	Cal-MediConnect
Primary Care Provider (PCP) Accessibility Standards:			
Routine Primary Care Appointment (Non-Urgent) Services for a patient who is symptomatic but does not require immediate diagnosis and/or treatment.	≤ 10 business days of request		
Urgent Care Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.	≤ 48 hours of request if no authorization is required ≤ 96 hours if prior authorization is required		
Emergency Care Services for a potentially life threatening condition requiring immediate medical intervention to avoid disability or serious detriment to health.	Immediate, 24 hours a day, 7 days per week		
Preventative health examination (Routine)	≤ 10 business days of request		≤ 30 calendar days of request
First Prenatal Visit A periodic health evaluation for a member with no acute medical problem	• ≤ 14 calendar days of request • ≤ 7 calendar days of request for Healthy Kids	≤ 14 calendar days of request	
Staying Healthy Assessment Initial Health Assessment and Individual Health Assessment and Individual Health Education Behavioral Health Assessment (IHEBA)	≤ 120 calendar days from when the member becomes eligible. Members <18 months of age ≤60 calendar days of enrollment or within periodicity timelines as established by the American Academy of Pediatrics (AAP) for ages two and under, whichever is less.		≤ 90 calendar days from when the member becomes eligible.
In-Office Waiting Room Time The time after a scheduled medical appointment a patient is waiting to be taken to an exam room to be seen by the practitioner.	Within 30 minutes		
Specialty Care Provider (SCP) Accessibility Standards:			
Routine Specialty Care Physician Appointment	≤ 15 Business days of request		
Urgent Care Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.	• ≤ 48 hours of request if no authorization is required • ≤ 96 hours if prior authorization is required		
Ancillary Care Accessibility Standards:			
Non-Urgent Ancillary Appointment	≤ 15 business days of request		

[1] *Unless otherwise stated, the requirement is 100% compliance.*

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Standard[1]	Medi-Cal	L.A. Care Covered	Cal-MediConnect
Behavioral Health Care Accessibility Standards:			
Routine Appointment (includes non-physician behavioral health providers)	≤ 10 business days of request		
Urgent Care Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.	≤ 48 hours of request		
Life Threatening Emergency	Immediately		
Non-Life Threatening Emergency	≤ 6 hours of request		
Emergency Services	Immediate, 24 hours a day, 7 days per week		
After Hours Care Standards:			
After Hours Care Physicians (PCP, Behavioral Health Provider and Specialists, or covering physician) are required by contract to provide 24 hours a day, 7 days per week coverage to members. Physicians, or his/her on-call coverage or triage/screening clinician must return urgent calls to member, upon request within 30 minutes. *Clinical advice can only be provided by appropriately qualified staff, e.g., physician, physician assistant, nurse practitioner or RN.	• Automated systems must provide emergency 911 instructions; and • Automated system or live party (office or professional exchange service) answering the phone must offer a reasonable process to connect the caller to the PCP, Behavioral Health Provider, Specialist or covering practitioner, or offer a call-back from the PCP, Behavioral Health Provider, Specialist, covering practitioner or triage/screening clinician within 30 minutes If process does not enable the caller to contact the PCP, Behavioral Health Provider, Specialist or covering practitioner directly, the "live" party must have access to a practitioner or triage/screening clinician for both urgent and non-urgent calls.		
Call Return Time (Practitioner's Office) The maximum length of time for PCP, Behavioral Health Provider, Specialist offices, covering practitioner or triage/screening clinician to return a call after hours.	≤ 30 minutes *Clinical advice can only be provided by appropriately qualified staff, e.g., physician, physician assistant, nurse practitioner or RN.		
Practitioner Telephone Responsiveness:			
Speed of Telephone Answer (Practitioner's Office) The maximum length of time for practitioner office staff to answer the phone.	≤ 30 seconds		
Member Services Department Call Service Standards:			
Speed of Telephone Answer • The maximum length of time for Member Services Department staff to answer the telephone. • Call Abandonment Rate	• 90% of calls ≤ 30 seconds • NTE 5% in a calendar month		

[1] *Unless otherwise stated, the requirement is 100% compliance.*

1-866-LACARE6 (1-866-522-2736)
www.lacare.org

V. 10/5/2015

Members Rights and Responsibilities

L.A. Care Members have the right to the following:

- **Respectful and courteous treatment:** Members have the right to be treated with respect, dignity and courtesy by their provider and staff. Members have the right to be free from retaliation or force of any kind when making decisions about their care.
- **Privacy and confidentiality:** Members have the right to have their medical records kept confidential. Provider offices must implement and maintain procedures that protect against disclosure of confidential patient information to unauthorized persons. Members also have the right to receive a copy of and request corrections to their medical records. Physicians must abide by California State minor consent laws. Members have the right to be counseled on their rights to confidentiality and members consent is required prior to the release of confidential information, unless such consent is not required.
- **Choice and involvement in their care:** Members have the right to receive information about their health plan, services, and providers. Members have the right to choose their Primary Care Provider (PCP) from L.A. Care's provider directory. Members also have the right to obtain appointments within access standards. Members have the right to talk with their provider about any care provided or recommended. Members have the right to discuss all treatment options, and participate in making decisions about their care. Members have the right to a second opinion. Members have the right to speak candidly to their provider about appropriate or medically necessary treatment options for their condition. Members have the right to deny treatment. Members have the right to decide in advance how they want to be cared for in case of a life-threatening illness or injury. Members also have the right to assist with the formulation of their advanced directives. Written policies and procedures respecting advanced directives shall be developed in accordance.
- **Voice concerns:** Members have the right to grieve about L.A. Care and/or its affiliated providers. They also have the right to receive care without fear of losing their benefits. L.A. Care will help members with the grievance process. If members don't agree with a decision, they have the right to appeal. Members have the right to disenroll from their health plan whenever they want. As a Medi-Cal member, they have the right to request a State Fair Hearing, including information on the circumstances under which an expedited fair hearing is possible.
- **Service outside of L.A. Care's provider network:** Members have the right to receive emergency or urgent services as well as family planning and sexually transmitted disease services outside of their health plan's network. Members also have access to Federally Qualified Health Centers and Indian Health Services Facilities.
- **Service and information:** Members have the right to request an interpreter at no charge and not use a family member or a friend to translate for them. Members have the right to access the Member Handbook and other information in another language or format, including; braille, large size print, and audio format upon request.
- **Know their rights:** Members have the right to receive information about their rights and responsibilities. Members have the right to make recommendations about their rights and responsibilities. Members have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.

As a member of L.A. Care members have the responsibility to:

- **Act courteously and respectfully:** Members are responsible for treating providers and staff with courtesy and respect. Members are responsible for being on time for their visits or calling your office at least 24 hours before the visit to cancel or reschedule.
- **Give up-to-date, accurate and complete information:** Members are responsible for giving correct information and as much information as they can to all of their providers and L.A. Care. Members are responsible for getting regular check-ups and telling their provider about health problems before they become serious.
- **Members should follow their provider's advice and take part in their care:** Members are responsible for talking about their health care needs with their provider, developing and agreeing on goals, doing their best to understand their health problems following the treatment plans and instructions you both agree on.
- **Use the Emergency Room only in an emergency:** Members are responsible for using the emergency room in case of an emergency or as directed by their provider.
- **Report wrong doing:** Members are responsible for reporting health care fraud or wrong doing to L.A. Care. Members can do this without giving their name by calling the L.A. Care Fraud and Abuse Hotline toll-free at 1-800-400-4889.

To access the L.A. Care Member Rights section on the website go to **http://www.lacare.org/members/member-protection/member-rights**.

Cultural and Linguistic Services

L.A. Care provides an array of cultural and linguistic services and resources to assist you in delivering effective patient-centered care. The following is a quick guide to help you and your staff understand the state and federal regulatory requirements that guide cultural and linguistic services to ensure compliance.

Bilingual Staff

Effective communication though qualified interpreters improves quality of care, increases member satisfaction and minimizes the risk of liability and malpractice lawsuits. L.A. Care offers no cost qualified interpreting services to you and your members in an effort to discourage the use of bilingual staff as interpreters. If a member of your staff is bilingual and utilizes the second language to interact with members, it is important they are qualified and proficient in English and the other language with proper training and education.

Please maintain the following documentation for your qualified bilingual staff:

- Certification for medical interpreters
- Number of years of service employed as an interpreter (e.g. resume)
- Certificate of completion interpreter training program
- Bilingual skills self-assessment

Bilingual Language Skills Self-Assessment Tool

The self-assessment tool is a resource to assist you in identifying language skills and resources existing in your office. It can be used to document bilingual skills of your staff before the professional assessment. The self-assessment tool is included in Section 1 of "What you need to know" in the Provider Toolkit. The assessment should be conducted annually for office staff and every three years for physicians.

- To order the toolkits go to **https://external.lacare.org/HealtheForm/**
- To download the toolkits go to **http://www.lacare.org/providers/provider-resources/provider-tool-kits**

Interpreting Services

Qualified interpreting services are essential to communicating effectively with limited English proficient members. L.A. Care's face-to-face and telephonic interpreting services are available to you and your staff at no charge. Interpreting services also include American Sign Language (ASL). The following information describes how to access these services:

- Face-to-face Interpreting Services
  - Call 1-888-839-9909 to request an interpreter for medical appointments.
- Telephonic Interpreting Services
  - Call 1-888-930-3031 to be connected with an interpreter over the phone immediately.
- California Relay Services
  - Call 711 to communicate with the deaf and hard of hearing members over the phone.

Key Things to Remember

- Inform members of the availability of no-cost 24/7 interpreting services including ASL.
- Document the member's preferred language in the medical chart.
- Discourage use of friends, family members and minors as interpreters.
- Document member's request/refusal of interpreting services in the medical chart after no-cost interpreting services are offered to them.

Language Poster

The language poster is an effective way to let your staff and members know about availability of no cost interpreting services and how to access the services from L.A. Care. The poster is translated into 14 languages and should be posted at the key points of contact such as front office and exam rooms.

To order the posters, go to **https://external.lacare.org/HealtheForm/**

Telephonic Interpreting Card

Keep the card available for easy access to no cost telephonic interpreters.

To order the telephonic card, go to **https://external.lacare.org/HealtheForm/**

Cultural and Linguistic Training

The following workshops are a rapid way to learn how to deliver culturally and linguistically appropriate care to diverse member populations. The below instructor-led classroom or Learning Management System (LMS) trainings are available at no cost for your convenience:

- Interpreting Services
- Cultural Competency
- Disability Awareness

To schedule classroom training sessions at your facility, contact **CLStrainings@lacare.org**

To access online LMS, go to **https://lacareuniversity.torchlms.com**

Cultural and Linguistic Provider Toolkit

The provider toolkit is a comprehensive guide to culturally and linguistically appropriate services. It is organized in five sections which contain helpful information and tools that can be reproduced as needed.

- To order the toolkits, go to **https://external.lacare.org/HealtheForm/**.
- To download the toolkits, go to **http://www.lacare.org/providers/provider-resources/provider-tool-kits**.

Online Resource Directory

To refer the members to cultural and linguistic community services, go to **http://www.healthycity.org/**.

The following are suggested best practices. The information consists of useful reminders and tips providers and medical office staff can utilize to enhance a positive customer service experience.

Build rapport with the member

- Address members by their last name if the member's preference of greeting is not clear
- Focus your attention on members when addressing them
- Learn basic words in your member's primary language, like "hello" or "thank you"
- Explain the different roles performed by office staff

Make sure members know your role

- Take a few moments to prepare a handout that explains office hours, how to contact the office when it is closed and how the provider coordinates specialty care
- Have instructions professionally translated and available in the common language(s) spoken by your member panel
- It is not necessary to raise the volume of your voice if the issue is language comprehension and not hearing

Keep members' expectations realistic

- Inform members of delays or extended wait times

Work to build members trust

- Inform members of office procedures, such as when they can expect a call with lab results, how follow-up appointments are scheduled and routine wait times

Determine if the member needs an interpreter for the visit

- Document the member's preferred language in the member chart
- Have an interpreter access plan. Use of interpreters with a medical background is strongly encouraged, rather than family, minors or friends of the member
- Assess your bilingual clinical staff for interpreter abilities

Give members the information they need

- Have health education materials in languages that reflect your membership
- Offer handouts such as immunization guidelines for adults and children, screening guidelines and culturally relevant dietary guidelines for diabetes or weight loss

Make sure members know what to do

- Review any follow-up procedures with the member before they leave your office
- Verify call back numbers, the locations for follow-up services such as labs, X-ray or screening tests and whether or not a follow-up appointment is necessary

Develop pre-printed simple handouts of frequently used instructions and translate the handouts into the common language(s) spoken by your membership

Styles of Speech

People vary greatly in the length of time between comments and responses. The speed of their speech and their willingness to interrupt may vary.

- Tolerate gaps between questions and answers; impatience can be seen as a sign of disrespect
- Listen to the volume and speed of the member's speech as well as the content. Modify your own speech to more closely match that of the member to make them more comfortable
- Rapid exchanges and even interruptions are a part of some conversational styles
- Do not be offended if a member interrupts you
- Stay aware of your interruption patterns, especially if the member is older than you are

Eye Contact

The way people interpret various types of eye contact is tied to cultural background.

- Look people directly in the eyes to demonstrate communication engagement
- For other cultures, direct eye contact is considered rude or disrespectful. Never force a member to make eye contact with you.
- If a member seems uncomfortable with direct eye contact, try sitting next to them instead of across from them

Body Language

- Follow the member's lead on physical distance and contact
- Stay sensitive to those who do not feel comfortable
- Gestures can have different meanings
- Be conservative in your own use of gestures and body language
- Do not interpret member's feelings or level of pain solely from facial expressions

Gently Guide Member Conversation

English language predisposes us to a direct communication style however, other languages and cultures differ.

- Non English speaking members or individuals from diverse cultural backgrounds may be less likely to ask questions

Facilitate member-centered communication

- Avoid questions that can be answered with "yes" or "no"
- Steer the member back to the topic by asking a question that clearly demonstrates that you are listening
- Some members can tell you more about their health through story telling than by answering direct questions

Thank you for taking this training. Please make sure to sign and attest that you have read and understood this information and provide a copy to your PPG or MSO. If you would like more information, please refer to the L.A. Care Provider Manual. If you have additional questions, please contact your PPG or MSO.

Produced by the L.A. Care Provider Network Operations department.

DEVELOPMENTAL DISABILITIES SERVICES (DDS) – MEDI-CAL

L. A. Care and its PPGs must maintain policies, procedure, and processes in place to address the following: identification, diagnosis, referral, and tracking of members with potential and eligible DDS conditions for the provision of all screening, preventive, medically necessary, and therapeutic services. L. A. Care and its PPGs will utilize network providers for diagnosis and treatment of members with developmental disabilities. Members may access the Regional Centers if services are needed and not available within the L. A. Care network. L. A. Care and its PPGs will refer members with developmental disabilities to the Regional Centers for those nonmedical services such as respite, out of home placement, supportive living, etc. Identification L.A. Care will: For existing Medi-Cal members, L. A. Care obtains information in the referral matching Regional Center eligibility criteria.

PPGs must: Implement procedures to ensure confidential transfer of medical documentation to and from the PCP to Regional Centers in compliance with all federal and state regulations. Establish procedures to support the identification and management of problems with the PCP, Regional Centers, and L. A. Care. Ensure that the PCP maintains the role of the overall case manager for the member and assure appropriate referrals for members with potential and or eligible DDS conditions.

PCPs must: Maintain the role of the overall case manager for the member and assure appropriate referrals for members with potential and or eligible DDS conditions

MATERNAL AND CHILD HEALTH – COMPREHEHSIVE PRENATAL SERVICES PROGRAM (CPSP)

L. A. Care and its PPGs must complete a comprehensive risk assessment tool for all pregnant female Members that is comparable to the American College of Obstetrics and Gynecology standard and Comprehensive Perinatal Services Program (CPSP) standards. The results of this assessment shall be maintained as part of the obstetrical records and shall include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tools shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risks identified shall be followed up on by appropriate interventions, which must be documented in the medical record. Standard Obstetrical Record Elements Standard Obstetrical record elements shall be included in the obstetric, nutritional, psychosocial and educational examination of pregnant members in compliance with DHS and the most current guidelines of the American College of Obstetrics and Gynecology (ACOG), CPSP, and Title 22. Obstetrical records include the CPSP Patient Records - CPSP Documentation Forms and/or any obstetric record that applies with the CPSP standards for documentation.

Referral to Specialists L. A. Care and its PPGs are responsible for ensuring that appropriate hospitals are available within the provider network to provide necessary high-risk pregnancy services. Pregnant women that are at high risk of a poor pregnancy outcome are referred to appropriate specialists including perinatologists and have access to genetic screening with appropriate referrals. Specialists may include, but are not limited to:

- Cardiologists
- Psychiatrists
- Internists
- Infectious Disease

personnel. Participating obstetrical providers must ensure that health education, nutrition, psychosocial assessment, re-assessment and intervention are administered by qualified personnel. Training of Comprehensive Perinatal Services personnel will be provided by L. A. Care with technical assistance from the County of Los Angeles Comprehensive Perinatal Service Program.

Comprehensive Perinatal practitioners may include any of the following:

- General Practice physician
- Family Practice physician
- Pediatrician
- Obstetrician-Gynecologist
- Certified Nurse Mid-Wife
- Registered Nurse
- Nurse Practitioner

• Physician's Assistant

• Social Worker

• Health Educator

• Childbirth Educator

• Registered Dietitian

• Comprehensive Perinatal Health Worker

Ancillary Services/staff who may provide services within specific components of Comprehensive Perinatal services or services available within Linked/ Carved out Services include, but are not limited to:

• Geneticists • Other medical specialists • Public Health Services • Family Planning Services • Substance Abuse Prevention Service • Community-Based Organizations • Community Outreach Services • Agencies providing transportation • Domestic Violence Units • Child Protective Services • Local Diabetes and Pregnancy Programs • Dental Services • Specialty Mental Health Services • Translation Services • Women's Center • Respite Care Services

Other Referrals include, but are not limited to: • Supplemental Nutrition Program for Women, Infants, and Children (WIC) L. A. Care and its PPGs shall ensure that all pregnant, breastfeeding and postpartum women, and infants and children who are eligible for WIC services will be assessed, and if appropriate, referred to the Los Angeles County Public Health Services WIC Program. Family planning referral protocols may include assistance with birth control issues, STD information or control, procedure or counseling. A referral may be done, but is not required for this service, as members can self-refer to Family Planning Services. For instance, Social Work referrals due to:

• Family Abuse/Domestic Violence

• Financial Problems

• Other identified social needs

The CSPS Program must be offered to all Medi-Cal members. The program is voluntary and if member declines to participate in the CPSP program, the member must sign the Acknowledgement Form stating they were offered services and declined (form attached).

If your office is interested in additional training, the link below offers virtual training courses for CPSP providers.
Link: http://publichealth.lacounty.gov/mch/cpsp/CPSPwebpages/cpsp_training.htm
Resources: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx

Other Resources

PO Box 4939
Oceanside, CA 92052

Phone: (855) 498-2633
www.cvpg.org

END OF LIFE SERVICES (Carve Out)

Terminally ill members, age 18 or older with the capacity to make medical decisions are permitted to request & receive prescriptions for aid-in-dying medications if certain conditions are met. Provision of these services by health care providers is voluntary and refusal to provide these services will not place any physician at risk for civil, criminal or professional penalties.

End of Life Services include consultations and the prescription of an aid-in-dying drug. EOL services are a "carve out" for Medi-Cal Managed Care Health Plans (MCPs) and are covered by Medi-Cal FFS. Members are responsible for finding a Medi-Cal FFS Physician for all aspects of the EOL+benefit. Policy & Procedure describes:

1) During an unrelated visit with an MCP physician, a member may provide an oral request for EOL services. If the physician is also enrolled with the Department of Health Care Services (DHCS) as a Medi-Cal FFS provider, that physician may elect to become the member's attending physician as he or she proceeds through the steps in obtaining EOL services.

2) EOL services following the initial visit are no longer the responsibility of the MCP, and must be completed by a Medi-Cal FFS attending physician, or a Medi-Cal FFS consulting physician.

3) Alternatively, if the MCP physician is not a Medi-Cal FFS provider, the physician may document the oral request in his or her medical records as part of the visit.

4) MCP physician should advise the member that following the initial visit he or she must select a Medi-Cal FFS physician in order for all of the remaining requirements to be satisfied.

Evidence:

1) Must show that practitioner/staff are notified of Program components which may be in the form of sign in logs, agendas, newsletters, fax-blasts, website or mailings

BEHAVIORAL HEALTH TREATMENT (Carve-Out)

BHT is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement and functional analysis of the relations between environment and behavior. BHT services teach skills through the use of behavioral observation and reinforcement or through prompting to teach each step of targeted behavior. BHT services are designed to be delivered primarily in the home and in other community settings.

BHT services are a Medi-Cal covered benefit for members under 21 years of age when medically necessary, based upon the recommendation of a licensed physician, surgeon or a licensed psychologist after a diagnosis of autism spectrum disorder (ASD).

Policy and Procedure description includes:

o BHT services overview

o Eligibility criteria

o Referral information

o Anthem Resources

Evidence:

Must show that practitioner/staff are notified of Program components and may be in the form of sign in logs, agendas, newsletters, fax-blasts, website or mailings

PALLIATIVE CARE (Carve-Out)

Palliative care consists of patient-and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The provision of palliative care does not result in the elimination or reduction of any covered benefits or services under the MCP contracts and does not affect a member's eligibility to receive any services, including home health services, for which the member would have been eligible in the absence of receiving palliative care. Unlike hospice, palliative care does not require the member to have a life expectancy of six months or less, and palliative care may be provided concurrently with curative care. A member 21 years of age or older may not be concurrently enrolled in hospice care and palliative care. A member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care.

Policies and Procedures description includes:

i). Palliative Care Program Overview

ii). Referral Process information

Evidence:

Must show that practitioner/staff are notified of Program components which may be in the form of sign in logs, agendas, newsletters, fax-blasts, website or mailings

INFORMED CONSENT FOR STERILIZATION PROCEDURES

Please be advised that our members must be appropriately and adequately informed about human reproductive sterilization procedures. Informed consent must be obtained prior to performing a procedure that renders a person incapable of producing children. Sterilization performed because pregnancy would be life threatening to the mother is included in this requirement. When sterilization is the unavoidable secondary result of a medical procedure and the procedure is not being done in order to achieve that secondary result, the procedure is not included in this policy.

Required Member Information: The member requesting to be sterilized must be provided with the appropriate booklet on sterilization published by the Department of Health Care Services (DHCS) **BEFORE THE CONSENT IS OBTAINED**. These are the only information booklets approved by DHCS for distribution to individuals who are considering sterilization:

• "Understanding Sterilization for a Woman"/"Entendiendo La Esterilizacion Para La Mujer" • "Understanding Vasectomy"/"Entendiendo La Vasectomia"

Conditions for Sterilization: Sterilization may be performed only under the following conditions:

• The member is at least 21 years old at the time the consent is obtained.

• The member is not mentally incompetent or institutionalized, as defined by Title 22

• The member is able to understand the content and nature of the informed consent process.

• The member has voluntarily given informed consent in accordance with all of the prescribed requirements.

• At least thirty (30) days, but not more than one hundred eighty (180) days, have passed between the date of written informed consent and the date of the sterilization. Conditions When Informed Consent May Not Be Obtained Informed consent may not be obtained while the member to be sterilized is:

• In labor or within twenty four (24) hours postpartum or post-abortion.

• Seeking to obtain or obtaining an abortion. • Under the influence of alcohol or other substances that affect the member's state of awareness.

What You Can Do: The following must be met for compliance with the informed consent process:

• The informed consent process may be conducted either by Provider/ Practitioner or appropriate designee.

• Suitable arrangements must be made to ensure that the information specified above is effectively communicated to any individual who is deaf, blind, or people with disabilities.

• An interpreter must be provided if the member to be sterilized does not understand the language used on the consent form or the language used by the person obtaining the consent.

• The member to be sterilized must be • The sterilization procedure must be requested without fraud, duress, or undue influence.

The PM 330 must be fully and correctly completed, signed and dated by:

- The member to be sterilized.
- The interpreter, if utilized in the consent process.
- The person who obtained the consent.
- The Provider/Practitioner performing the sterilization procedure.

All of the following must be provided verbally to the member who is seeking sterilization:

- Advice that the member is free to withhold or withdraw consent to the procedure at any time
- A full description of available alternative methods of family planning and birth control.
- Advice that the sterilization procedure is considered irreversible.
- A thorough explanation of the specific sterilization procedure to be performed.
- A full description of discomforts and risks that may accompany or follow the procedure, including explanation of the type and possible side effects of any anesthetic to be used.
- A full description of the benefits or advantages that may be expected from sterilization.
- Approximate length of hospital stay and approximate length of time for recovery.
- Financial cost to the member. Information that the procedure is established or new.
- Advice that sterilization will not be performed for at least thirty (30) days, except in the case of emergency abdominal surgery or premature birth (when specific criteria are met).
- The name of the Provider/Practitioner performing the procedure.

Medical Record Documentation:

There must be documentation in the progress notes of the member's medical record that a discussion regarding sterilization has taken place, including the answers given to specific questions or concerns expressed by the member. It will be documented that the booklet and copy of the consent form were given to the member. The original signed consent form must be filed in the member's medical record. A copy of the signed consent form must be given to the member and a copy is placed in the member's hospital medical record at the facility where the procedure is performed.

If the procedure is a hysterectomy, a copy of the informed consent form for hysterectomy should be placed in the member's medical record. This form is supplied by the facility performing the procedure.

Exceptions to Time Limitations: Sterilization may be performed at the time of emergency abdominal surgery or premature delivery if the following requirements are met:

- A minimum of seventy-two (72) hours have passed after written consent to be sterilized, and
- A written informed consent for sterilization was given at least thirty (30) days before the member originally intended to be sterilized, or

- A written informed consent was given at least thirty (30) days before the expected date of delivery

Special Considerations, Hysterectomy: A hysterectomy will not be performed solely for the purpose of rendering an individual permanently sterile. If a hysterectomy is performed, a hysterectomy consent form must be completed in addition to other required forms.

Noncompliance: The contracted health plans with your IPA will monitor this during all audits conducted. Any corrective action plans for non-compliance will be reported to the IPA UM/QI and Board committees for potential further action or increased monitoring. The DHCS also performs audits for compliance with Title 22. Both MHC and DHCS are required to report non-complaint Providers/Practitioners to the Medical Board of California.

Initial Health Assessment (IHA) / Staying Healthy Assessment (SHA) Requirements for Members with Medicare and Medi-Cal (Medi-Medi)

Requirement

Per California Department of Healthcare Services (DHCS) Title 22, CCR, Section 53851 (b)(1), complete Initial Health Assessment (IHA)/Staying Healthy Assessment (SHA) within 90 days of enrollment and annually thereafter

Medical Group/Primary Care Physician Responsibilities

- Conduct a comprehensive Initial Health Assessment and Staying Healthy Assessment within 90 days of enrollment and annually which must include:
  - Present and past illness/injury/hospitalizations
  - Height, weight, BP
  - Social history, medications, immunizations
  - Preventative services (age-appropriate assessments including but not limited to TB screening, clinical breast exam, allergies, chlamydia, mammogram, pap smear, etc.) – refer to USPSTF A/B guidelines for adults age 65 and older
  - Physical review/assessment of all organ systems
  - Assessment of Risk Factors (i.e. use of alcohol/drugs/tobacco, falls)
  - Mental status exam
  - Plan of care
  - Must also include ***Staying Healthy Assessment***- a specific form with questions to identify health risks and behaviors, for PCP to determine interventions
    - Must be part of medical record (or note that member declined)

How do you know which patients need an IHA/SHA?

- Access IHA ASAP reports monthly from the SCAN Provider Portal
  - Go to SCAN Provider Portal
  - Click on SCAN Documents
  - Click on Network
  - Access the IHA_ASAP folder
  - Report includes list of all SCAN Medi-Medi members and whether they have had an IHA based on encounter data

- Primary Care Physicians receive faxed letter and copy of the SHA for each new Medi-Medi SCAN patient
  - Schedule IHA or annual comprehensive visit with patient
  - Put paper SHA in medical chart
  - Complete with patient and document in medical records

- Discuss any health risks identified and create risk reduction plan
- Patient can decline but that must be documented in medical record

Access to Medical Records

Providers must provide access to Medical records related to services provided to CVPG members. Providers must maintain these records for at least 10 years and 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. Medical records are frequently an important element in the investigation of identified concerns, grievances, appeals and potential quality of care issues. The IPA staff will make every effort to ensure that medical record requests will be as specific as possible to prevent an unnecessary burden to providers. The Health plans audit the IPA's on quarterly basis and the PCP will be required to provide medical records pertaining to the grievances, appeals, quality of care issues and/or proof of IHA, CCS, ACHA or CPSP. It is very important that your office respond timely to these time sensitive requests.

Request for Medical Record Form

Dates of Service < Range >

Type of Record	Description
☐ History and Physical	To include the following: • Present and past illness(es) • Hospitalizations, operations • Medications • Physical exam (including review of all systems) • Height, weight, BP • Identification of screening needs • Identification of preventative services (per the USPSTF A and B Guidelines for 65-year old) • Mental Health Exam Social history (i.e. Current living situation, Marital status, Work history, Education level • Assessment of Risk Factors (Staying Healthy Assessment) (i.e. Sexual history, Use of alcohol, tobacco and drugs) • Diagnosis and plan of care
☐ Member Information Form	Document that is filled out by the patient on the first visit to the physician's office and then updated as necessary, providing data that relates directly to the patient, including: last name, first name, gender, DOB, marital status, street address, city, state, zip code, telephone number, social security number, employment status, address and phone number of employer, name and contact information for the person who is responsible for the patient's bill, and vital information for the person who is responsible for the patient's bill, and vital information concerning who should be contacted in case of an emergency
☐ Admission Summary	Documentation of the patient's status (including history and physical examination findings), reasons why the patient is being admitted for inpatient care to a hospital or other facility, and the initial instructions for that patient's care.
☐ Admission Face Sheet	A one-page summary of important information about a patient. It may include patient identification, past medical history, medications, allergies, upcoming appointments, insurance status, or other pertinent information.
☐ Nursing Notes	Record of the patient's care that includes vital signs, particularly temperature (T), Pulse (P), Respiration (R), and blood pressure (BP). The procedures, and patient's responses to such care.
☐ Social Worker Notes	Documentation of Social Worker evaluation and coordination of services
☐ Ancillary Progress Notes	Documentation of procedures or therapies provided during a patient's care, such as physical therapy, respiratory therapy, or chemotherapy
☐ Discharge Summary	Outline summary of the patient's hospital care, including date of admission, diagnosis, course of treatment and patient's response(s), results of tests, final diagnosis, follow-up plans, and date of discharge
☐ Patient Discharge Instructions	Written discharge instructions or other documentation of educational material given to patient/caregiver including list and utilization of all discharge medications
☐ Emergency Room Notes	Documentation given by the emergency physician regarding the patient's condition, results of the physician's examination, summary of test results, plan of treatment, and updating of data as appropriate.

☐ Physician Orders	Record of the prescribed care, medications, tests, and treatments for a given patient
☐ Physician Progress Notes or Office Visit Notes	Documentation given by the physician regarding the patient's condition, results of the physician's examination, summary of test results, plan of treatment, and updating of data as appropriate.
☐ Consultation Summary	Documentation given by specialists whom the physician has asked to evaluate the patient; Designate physician or specialty
☐ Medication Administration Records	Documentation of medications administered in the hospital
☐ Treatment Records	Documentation of specific treatments (i.e. wound care, fall precautions)
☐ Medication List	List of patient medications
☐ Transfer Form(s)	Designate specific transfer information
☐ Consent Form(s)	Signed document by the patient or legal guardian giving permission for treatment -
☐ Informed Consent Form(s)	Signed document by the patient or legal guardian that explains the purpose, risks, and benefits of a procedure and serves as proof that the patient was properly informed before undergoing a procedure - designate procedure
☐ Diagnostic Tests/Laboratory Reports	Documents providing the results of all diagnostic and laboratory tests performed on the patient
☐ Operative Report	Documentation from the surgeon detailing the operation, including the preoperative and postoperative diagnosis, specific details of the surgical procedure, how well the patient tolerated the procedure, and any complications that occurred
☐ Pathology Report	Documentation from the pathologist regarding the findings or results of samples taken from the patient, such as bone marrow, blood, or tissue
☐ Anesthesia Record	Documentation from the attending anesthesiologist or anesthetist that includes a detailed account of anesthesia during surgery, which drugs were used, dose and time given, patient response, monitoring of vital signs, how well the patient tolerated the anesthesia, and any complications that occurred.
☐ Plan of Care/Care Plan	Documented Plan of Care/Care Plan
☐ MDS (Long Term Care ONLY)	Medical Data Set: a standardized, primary screening and assessment tool of health status which forms the foundation of the comprehensive assessment for all residents (regardless of payer) of long-term care facilities certified to participate in Medicare or Medicaid. The MDS contains items that measure: •physical •clinical •psychological •psycho-social functioning •life care wishes

Anthem BlueCross

Language Assistance Program Quick Reference Guide

Anthem Blue Cross (Anthem) is committed to providing culturally and linguistically appropriate healthcare services in a competent manner. This means all reasonable accommodations are provided to ensure equal access to communication resources for members. We achieve this through our Language Assistance Program.

We provide language assistance services to the following members with:

- Limited English proficiency (LEP).
- Hearing, speech, or visual impairments.
- Culturally and ethnically diverse backgrounds.

Language assistance services are not limited to the members identified above.

Language Assistance Program services and guidelines

Language assistance services are available to members at no cost for those enrolled in Medi-Cal Managed Care (Medi-Cal).

Service offered	Guidelines
Telephonic interpreter services provided at all points of contact	◦ Qualified interpreters are proficient in healthcare terminology. ◦ Qualified interpreters receive training regarding *HIPAA* and ethical standards. ◦ Points of contact include administrative, clinical, and related services.
Face-to-face and sign language interpreter services	◦ Interpreters are available to members, providers, and staff at key points of medical contact. ◦ Three days or more advance notice is needed for scheduling face-to-face and sign language interpreters. ◦ 24-hour advance notice is requested for cancellations.
TTY services for the hearing impaired	◦ Services are available for the hearing impaired during business hours via Medi-Cal TTY line: **800-735-2922**. ◦ After-hours services are available through the California Relay Line (**711**) or Anthem's 24/7 NurseLine (**800-224-0336, TTY: 800-368-4424**).
Vital documents provided in threshold languages	◦ Materials translated prospectively include enrollment, eligibility, and membership information; *Explanation of Coverage*; and notices of language assistance. ◦ Members must indicate their preferred written language to receive prospectively translated materials.
Additional materials translated upon request	◦ Materials that are member-specific (for example, denial, delay, or claims letters) are sent in English with the offer of translation upon request. ◦ We send translated materials to the member no later than 21 days from the request date. ◦ Oral translations will be provided for all languages. ◦ Translators are proficient in healthcare terminology. ◦ Translators receive training regarding *HIPAA* and ethical standards.

Threshold language translations available

We designed the Language Assistance Program to meet the growing needs of our state's population as well as our membership. Threshold language translations are available for Medi-Cal members and vary by county. Based on U.S. Census data released in December 2015, the top 18 non-English languages spoken by individuals with LEP in California are: Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Mien, Punjabi, Russian, Spanish, Tagalog, Thai, Ukrainian, and Vietnamese. These languages will remain in effect until the next U.S. Census Survey.

Accessing the Language Assistance Program

To access the Language Assistance Program for members with LEP, call our Customer Care Center at the appropriate phone number provided at the end of this guide and ask to speak to an interpreter.

Cultural sensitivity resources

In addition to language services, the Language Assistance Program offers web-based information regarding: cultural differences including communication styles; healthcare traditions; commonly held beliefs; alternative medicine; and healing disparities including quality of care and preventive care, pain management and treatment, and aging.

You will find more cultural and linguistic information on our website under Provider Support > Resources > Provider Training Academy:

- Cultural Competency Training — offers information and key components to the provision of culturally competent care
- Caring for Diverse Populations toolkit — offers comprehensive information on working with diverse patients, tools and resources to help mitigate barriers, including materials that can be printed and made available for patients in your office
- My Diverse Patients — resource-rich care provider website that covers topics relevant to providing culturally competent care and services for diverse individuals

Anthem offers additional information in our online provider manuals, also located on this site at *Provider Manuals, Policies & Guidelines*. On this page, choose from the latest manual for Medi-Cal.

Tips to optimize communications with your patients

Here are a few tips to optimize communications when working with telephonic interpreters:

- If possible, speak to the interpreter privately prior to the contact, providing relevant information regarding the member and the important information to convey.
- Interpreters are not allowed to rephrase or clarify. Encourage the interpreter to request clarification or to redirect explanations as needed.
- Direct the conversation to the member, not the interpreter.
- Use short sentences limited to a single concept, if possible.
- Allow adequate time for the interpreter to convey the information in the member's language.
- Avoid excessive medical terminology or technical explanations unless the member requests them.
- Avoid interrupting the interpreter.
- If the member's nonverbal cues indicate confusion, ask the member to summarize or restate what you have communicated.

Working effectively with members with LEP

Offer the Language Assistance Program to members who appear to be LEP, even if a member brings a family member or friend to their healthcare visit to act as an interpreter. The use of a qualified interpreter is preferred because relatives and friends are not usually proficient in healthcare terminology.

More communication tips

Here are a few more communication tips for your use when working with patients:

- Speak slowly, not loudly, with your patient.
- Organize information into short, simple sentences. Place important topics at the beginning and end of the conversation.
- Use open-ended questions to assess for understanding.
- If the member initially refused interpreter services and is not demonstrating full understanding, offer interpreter services again.
- Monitor nonverbal cues, such as facial expressions, positioning, and body language. These may indicate understanding or confusion.

Anthem hopes you will find this information useful in your everyday encounters with members with LEP.

If you have any questions or require assistance with the Language Assistance Program, contact our Customer Care Center at the appropriate phone number below:

- Medi-Cal (outside of Los Angeles County): **800-407-4627**
- Medi-Cal (inside Los Angeles County): **888-285-7801**

Best practices for providers

Hospitals, physicians, and other healthcare professionals should:

- Complete a language skills self-assessment, which is kept on file. The assessment provided by the Industry Collaboration Effort is a prescreening/self-assessment tool to be done before seeking interpreter credentialing. It does not qualify as appropriate documentation for staff to be considered a qualified interpreter that adheres to generally accepted interpreter ethics and principles.
  - The Employee Language Skills Self-Assessment Tool is available on our website under Resources > Forms > For Providers. Choose the correct form depending on the region.
- Document the member's preferred spoken and written language in their office chart or medical record.
- Document the communication aid used for the visit (for example, the person who provided interpretation services); any use or refusal of a professional interpreter; or the use of family, friend, office staff or the provider as the interpreter.
  - *Request/Refusal for Interpreter Services* forms are available on our website under Resources > Forms > Patient Care. Choose the appropriate form, available in a variety of threshold languages.
- Enhance their own knowledge and appreciation of the cultural differences that are inherent in their region by taking advantage of the opportunities listed on the Anthem website.
  - Post the Free Interpretation Services sign at key points of contact. The Free Interpretation Services sign is available on our website under > Resources > Provider Training Academy > Interpreter Services. Under *Free Interpreter Resources*, choose **Free Interpreter Services Poster**.

https://providers.anthem.com/ca

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Physicians DataTrust, and all contracted IPAs, comply with CMS requirements. The training herein is an overview of CMS guidelines. For comprehensive CMS Marketing Guidelines visit: www.cms.gov. Last update 08/06/2019.

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PHYSICIANS DATATRUST

Introduction

CMS Compliance Concerns and Limitations

- CMS has expressed concern with providers participating in marketing activities because
  - Providers may not be aware of all plan benefits and costs.
  - It may confuse beneficiaries if they perceive providers as acting as an agent or plan representative.
  - Providers may face conflicting incentives when acting on a Plan Sponsor's behalf.

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Definitions

- **Communications:** Activities and materials to provide information to current and prospective enrollees, including their caregivers and other decision makers.
- **Marketing:** A subset of communications. Includes activities and materials with the intent to draw a beneficiary's attention to a plan or plans and to influence a beneficiary's decision-making process when selecting a plan for enrollment or deciding to stay enrolled in a plan (that is, retention-based marketing). Additionally, marketing contains information about the plan's benefit structure, cost sharing, measuring, or ranking standards.

Definitions

- To identify marketing activities and materials, CMS will evaluate both the **intent and content** of the activities and materials to determine if the definition of marketing is met.
  - A flyer reads “Swell Health is now offering Medicare Advantage coverage in Nowhere County. Call us at 1-800-SWELL-ME for more information.” Marketing or Communication? Communication. While the intent is to draw a beneficiary’s attention to Swell Health, the information provided does not contain any marketing content.

Definitions

- A billboard reads “Swell Health Offers $0 Premium Plans in Nowhere County” Marketing or Communication? Marketing. The advertisement includes both the intent to draw the viewer’s attention to the plan and has content that mentions zero-dollar premiums being available.
- A letter is sent to enrollees to remind them to get their flu shot. The body of the letter says, “Swell Health enrollees can get their flu shot for $0 copay at a network pharmacy…” Marketing or Communication? Communication. While the letter mentions cost sharing, the intent is not to steer the reader into making a plan selection or to stay with the plan, but rather to encourage existing enrollees to get a flu shot. The letter contains factual information about coverage and was provided only to current enrollees.

Providers Must

- Providers must remain neutral when assisting patients with information about their Medicare plan options.
- Any communications by providers to patients must come from the provider or medical group and not the agent or health plan in a misleading way.
- Be aware of agent or health plan engagement in marketing events and ensure they are within the scope of CMS guidelines.

Providers May

- If providers allow plan marketing materials to be available in their common areas, then:
  - Provider must allow **ALL** contracting plans to participate.
- Display posters or other materials announcing plan affiliations.
- Direct patient to plan materials in common areas.
- Refer patients to other sources for more information, such as:
  - CMS/Medicare.gov website, HICAP/SHIP office, etc.
- If **patient initiates** request, provider may refer to plan or plan marketing representatives (brokers or agents.)

Providers May

- Provide names and contact information of Health Plans they contract with and any factual, publicly available information about plan benefits and formularies.
  - Example: Information from *Medicare and You* or *Medicare Options Compare.*
- Provide information and assistance to patients applying for Low Income Subsidy (LIS/Extra Help.)
- Display plan marketing materials (but **not** enrollment forms) in waiting rooms.

Providers May NOT

- Provide an endorsement or testimonial for a health plan
- Mislead or pressure patients into participating in presentations.
- Use health screenings as a marketing activity.
- Offer anything of value to induce beneficiaries to enroll in a particular plan or set of plans.
- Provide list of Medicare eligible patients to an agent or health plan representative.
- Conduct marketing, sales, or enrollment activities in areas where patients receive or wait to receive care:
  - Example: Exam rooms, waiting rooms, etc.

Providers May NOT

- Distribute/display marketing materials in an exam room.
- Distribute sales agents' business cards to patients (unsolicited.)
- Make available/distribute, help complete, or accept completed enrollment applications.
- Offer or assist with Scope of Appointment Forms, lead cards and/or business reply cards.
- Make phone calls or distribute materials in an attempt to steer, direct, urge or persuade beneficiaries to enroll in a specific plan or set of plans.
- Mail marketing materials on behalf of a plan or agent.
- Accept compensation directly or indirectly from a plan for enrollment activities.

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Promotional Activities

Nominal Gifts, any items offered to attendees of promotional activities, must:

- Be of nominal value – no more than $15, with a maximum aggregate of $75/person, per year.
- Be offered to all people regardless of enrollment and without discrimination.
- Not be items considered to be a health benefit, covered item or service.
- If the nominal gift is one large gift (e.g., concert, raffle, drawing, etc.) the total value must not exceed the nominal per person value based on attendance.
    - Example) For 10 attendees, the gift may not be worth more than $150.

Promotional Activities

Nominal Gifts, any items offered to attendees of promotional activities, may not:

- Be in the form of cash or other monetary rebates, including gift cards or certificates that can be readily converted to cash, even if it is worth $15 or less.
- Be in the form of a meal, unless the event meets the CMS definition of an educational event and complies with the nominal gift value.

Marketing Unsolicited Contacts

Unless an individual has agreed to receive communications, providers may not initiate direct contact with non-patients for marketing purposes in the following forms:

- Telephonic outreaching including voice and text messaging.
- Electronic solicitation/electronic messaging via direct messaging on social media platforms.
- Approaching beneficiaries in common areas (e.g., parking lots, hallways, lobbies, etc.)
- Door-to-door solicitation including leaving flyers at residences or cars.

Marketing purposes pertains to health plan listings and benefit information. This does not extend to current patients, conventional mail, or other print medias.

Marketing Unsolicited Contacts

Providers may not make unsolicited telephone calls to prospective enrollees expect for the following specific telephonic activities:

- Call current enrollees, including those in non-Medicare products, to discuss plan business
  - Calls to enrollees aging into Medicare from commercial products offered by the same organization
  - Calls to existing Medicaid/MMP plan enrollees to talk about its Medicare products
- Call former enrollees to conduct disenrollment surveys for quality improvement purposes (may not include sales or marketing information)
  - Call to market plans or products to former enrollees who have disenrolled, or to current enrollees who are in the process of voluntarily disenrolling;

Marketing Unsolicited Contacts

Providers may not initiate Electronic Communication, including voicemail or direct messages, for marketing purposes unless an individual has agreed to receive those communications.

- If an individual likes or follows on social media, this does not constitute agreement to receive communication outside a public forum.
  - Providers may respond to questions or statements initiated by the beneficiary but only in the scope of the question.
- Providers may contact via email but must provide an opt-out process for recipients.

Thank You

For a comprehensive understanding of CMS Marketing Guidelines visit:
https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html

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