NORTH EAST MEDICAL SERVICES
東 北 醫 療 中 心

Management Services Organization
2171 Junipero Serra Boulevard, Suite 600
Daly City, CA 94014
(415) 352-5186
www.nems.org/mso

NEMS-MSO BULLETIN

The latest updates for NEMS Medical Group!

We hope everyone is staying well and healthy!

September 2020
TOPICS

UPDATE TO PRIOR AUTHORIZATION

During the COVID-19 pandemic, NEMS Management Services Organization (NEMS MSO) is making changes to simplify the authorization process. Effective immediately, NEMS MSO will not require prior authorization (PA) for initial consultation and follow-up visits at an in-network specialist's office. Primary Care Providers can refer NEMS members directly to an in-network specialist without an authorization. Please visit the NEMS MSO website at https://www.nems.org/mso/forms.html for the most updated list of in-network specialists.

While we are waiving the PA requirement for initial consultation and follow-up office visits for in-network specialists, we are still requiring PA for tests and procedures regardless if they are performed in office or at a facility. A list of services requiring PA is available at the NEMS MSO website at https://www.nems.org/mso/forms.html.

Specialists can obtain PA for tests and procedures directly from the NEMS MSO Utilization Management (UM) team without having to contact the PCP for a new referral. Specialists may submit a PA request via the NEMS MSO Provider Portal. If you would like access to the provider portal, please contact NEMS Provider Relations at (415) 352-5186, option 3. Alternatively, specialists can submit an authorization request via fax by filling out the Treatment Authorization Request (TAR) Form and fax to NEMS MSO at (415) 398-2895. A copy of the TAR form is enclosed and can be downloaded at: https://www.nems.org/mso/forms/NEMS_MSO_Treatment_Authorization_Form.pdf

If you have any questions, you may contact the NEMS MSO UM team at 415-352-5186, option 1.

2020 PROVIDER APPOINTMENT AVAILABILITY SURVEY (PAAS) – AUGUST ~ DECEMBER

On an annual basis, SFHP administers the PAAS to measure patient access to care against Department of Managed Health Care's (DMHC) requirements. A random sample of primary care providers, specialists, and ancillary providers such as physical therapy and imaging vendors will be selected for the survey.

- The survey will take place during August 17th to December 31, 2020.
- The survey will be delivered by either email and/or fax and surveys that are not responded to within five business days will be followed-up by a phone survey.

(*2020 PAAS continued next page)*

If you have any questions or would like to provide updates/news to future newsletters, please feel free to contact NEMS Provider Relations at provider.relations@nems.org.

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- Refusal or non-participation of the survey will be deemed non-compliant with the Timely Access Regulations.
- Please review the attached NEMS Timely Access Standard document, or visit the DHCS website at: http://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccesstoCare.aspx and ensure your frontline office staff and answering service are aware of the Timely Access Regulation

HEALTH NET INTERPRETATION SERVICES

For Health Net Medicare Advantage members requiring in-person or over-the-phone interpretation services, will need to call Health Net Member Services **at least 72 hours** in advance prior to their visit. Please note the following:

- Contact Member Services at **1-800-431-9007**.
- From October 1 – March 31 members may call 7 days a week from 8AM – 8PM. From April 1 – September 30 members may call Monday – Friday from 8AM – 8PM.
- Health Net Member Services will ask for member's ID number, care manager's contact information, appointment details (i.e. date, time, location, type of visit (video, phone, in person), and language needed.

NEMS-MSO INTERPRETATION SERVICES

NEMS-MSO has suspended in-person interpretation services until further notice. We encourage providers to utilize our over-the-phone (OTP) interpretation service. To request for OTP interpretation, please complete and return the form linked here: https://www.nems.org/mso/forms/Request%20for%20Interpretation%20Services%20-%20201712_fillable.pdf

MEMBER AND BALANCE BILLING

As a reminder, balance billing is strictly prohibited by state and federal law and the agreement between NEMS and network providers. Balance billing occurs when contracted providers bill a beneficiary for Medi-Cal and/or Medicare covered services for fees and surcharges above and beyond a member's copayment and coinsurance responsibilities for services covered under a member's benefit program, or for claims for such services denied by NEMS MSO. Participating providers are also prohibited from initiating or threatening to initiate a collection action for non-payment of a claim for covered services and agree to accept NEMS MSO's fee for these services as payment in full, except for beneficiaries with applicable copayments, coinsurance, or deductibles.

- It is a federal law and state law violation, health plan contracting violation, and NEMS' contracting violation to charge a managed care beneficiary for any part of a covered benefit.
- An example of a balance billing violation is charging a $5 administrative fee to complete medical forms. This is NOT an allowable fee for Medi-Cal and/or Medicare patients.

(Member and balance billing continued next page)

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- There are exceptions to balance billing. Allowed exceptions include: Medi-Cal Share of Cost, applicable copays for medications covered under Medicare Part D, or the cost for non-covered benefits.
- Balance billing may cause providers to be subject to sanctions by CMS, DHCS, and San Francisco Health Plan

MSO CORNER

UTILIZATION MANAGMENT (UM)

UM Affirmative Statement: Decision to approve or deny a service is based only on appropriateness of care, service, and existence of coverage. NEMS does not reward practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for decision makers do not encourage decisions that result in underutilization. Members and providers may request a copy of the policies, procedures, and criteria used to decide for a specific procedure or condition by contacting NEMS UM at 1(415) 352-5186, option 1.

UM Staff Availability: NEMS UM staff is available to members and providers during regular business hours (Monday through Friday, 8:00am - 5:30pm) to discuss UM issues, including denial decisions, request a copy of the policies, procedures and UM criteria, by calling 1(415) 352-5186, option 1. TTY services 1(800) 735-2929 is available for the hearing impaired. NEMS provides language assistance for members whose primary language is not English. After normal business hours, UM staff can receive secure voicemail, fax, and email. Our fax number is 1(415)-398-2895. Members and providers can email us at MSO-UM@nems.org for any UM questions. Messages received are returned within one business day. Our staff is identified by name, title and organization name when initiating or returning calls regarding UM issues.

UM Prior Authorizations: As a reminder, all requests for Prior Authorization (PA) must be sent to NEMS MSO either by fax to 1(415) 398-2895 to include all supporting clinical documentation/ medical records to assist NEMS MSO's clinical reviewers with determining whether the request meet NEMS MSO criteria coverage. Visit our NEMS MSO Provider Portal to submit Treatment Authorization Requests (TARs) online for faster determination. Visit the NEMS MSO website https://www.nems.org/mso/providerportal.html for additional information on how to create an account for the NEMS MSO Provider Portal. **An updated Treatment Authorization Form is attached with the newsletter.**

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TREATMENT AUTHORIZATION FORM

Type of Request:
☐ Routine ☐ Urgent ☐ Retro

Member Information	Name:_____ Date of Birth:_____ Member ID #:_____
Requesting Provider	Name:_____ Phone #:_____ Fax #:_____
Rendering Provider	Provider Name:_____ NPI: _____ Specialty:_____ Facility:_____ Contact Person:_____ Phone #:_____ Address:_____ Fax #:_____

Diagnosis Description 1:_____ **ICD-10**: _____
Diagnosis Description 2:_____ **ICD-10**: _____
Diagnosis Description 3:_____ **ICD-10**: _____

For Completion by Referring Provider

Specific Services Requested	Procedure Code (CPT code)	Units of Service	Specific Services Requested	Procedure Code (CPT code)	Units of Service
1.			4.		
2.			5.		
3.			6.		

Medical Justification: *(copy of related medical records/x-ray/lab reports - attach as necessary)*

I certify that the above requests are medically necessary in the care of this patient.

Referring Provider Signature:_____ **Date:**_____

Important Note: *Services which have not received an Authorization Number will not be paid. Payment is contingent upon eligibility at the time of service. Providers are responsible for checking patient eligibility prior to rendering services by verifying eligibility directly with member's health plan. Payment to non-contracted/out-of-network providers is based on the current CMS Medicare or DHCS Medi-Cal fee schedule according to member's eligibility at the time of service.*

For NEMS-MSO Use Only

☐ **Approved** ☐ **Modified** ☐ **Denied** ☐ **Deferred**

Comments:

By:_____ **Date:**_____ **By:**_____ **Date:**_____

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Access to Care Standards

The California Department of Managed Health Care's Timely Access Regulations became effective in January 2011. Appointments and triage for various types of medical care should be offered within specified timeframes as follows:

PRIMARY CARE

Topic	Standard
Initial Health Assessment	Must be completed within 120 calendar days of enrollment if over the age of 18 months Must be completed within 60 calendar days of enrollment if 18 months or younger
Routine (non-urgent) PCP appointment	Within 10 business days of request
Urgent Care	Within 48 hours of request if no authorization is required Within 96 hours of request if authorization is required
After Hours Care	Provide or arrange 24/7 coverage
Initial Prenatal Visit	Within 14 calendar days of request
In-Office Wait Time for Scheduled Appointments	Within 30 minutes
Telephone Access and Triage	Must provide 24 hour coverage with the ability to hear from a licensed clinician within 30 minutes of request when members have an urgent (non emergent) medical need. Triage must include emergency instructions to go to nearest hospital or call 911 if members experience an emergency.
Call Return Time	30 minutes
Time to Answer Call	10 minutes
Language Accessibility	Must provide 24 hour interpretive services through in-person interpretation or telephonic interpretation

SPECIALTY CARE & ANCILLARY CARE

Topic	Standard
Routine Appointment	Within 15 business days of request
Urgent Care	Within 48 hours of request if no authorization is required Within 96 hours of request if authorization is required
In-Office Wait Time	Within 30 minutes
Language Accessibility	Must provide 24 hour interpretive services through in-person or telephonic interpretation
Call Return Time	30 minutes
Time to Answer Call	10 minutes

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BEHAVIORAL HEALTH	
Topic	**Standard**
Routine Appointment (does not include MDs)	Within 10 business days of request
Urgent Care	Within 48 hours of request if no authorization is required Within 96 hours of request if authorization is required
In-Office Wait Time	Within 30 minutes
Language Accessibility	Must provide 24 hour interpretive services through in-person or telephonic interpretation
Call Return Time	30 minutes
Time to Answer Call	10 minutes

MEDICAL EMERGENCIES	
Topic	**Standard**
Emergency Care	Immediately

Exceptions to the Access to Care Standards

Preventive Care Services and Periodic Follow Up Care: Preventive care services and periodic follow up care are not subject to the appointment availability standards. These services may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice. Periodic follow-up care includes but is not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease.

Interpretation Services for Patients with Limited English Proficiency (LEP)

Language interpretation service is offered to patients with limited English proficiency, even when there is a family member or friend who can provide the interpretation. Use of family members or friends for interpretation is discouraged. Language interpretation service is offered at **NO COST** to members.

Reference(s):
Department of Managed Health Care (DMHC) Timely Access Regulations