NORTH EAST
MEDICAL SERVICES
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MANAGEMENT SERVICES ORGANIZATION (MSO)

Provider Manual

NEMS MSO Provider Relations 1(415) 352 - 5186 Option 3
www.nemsmso.org

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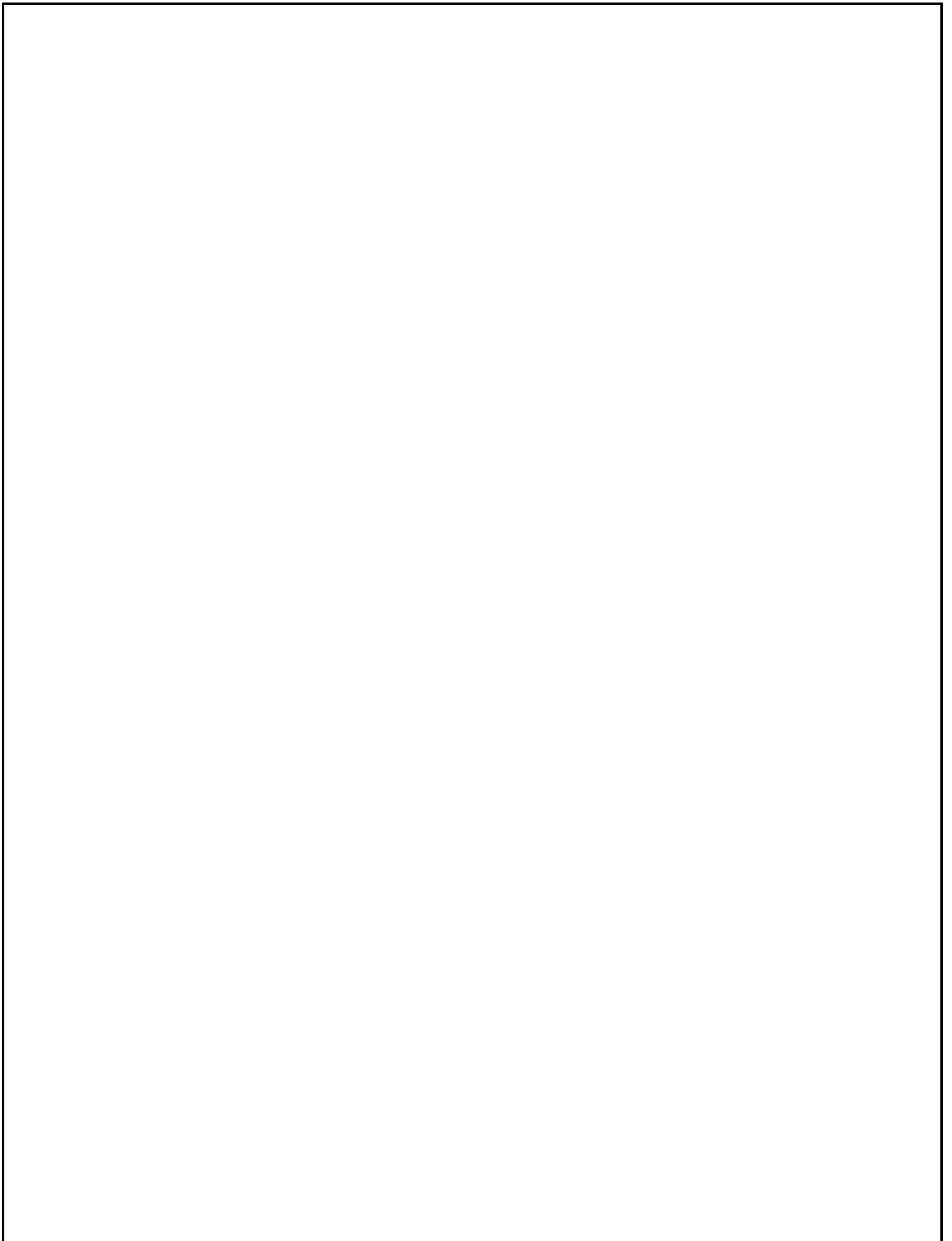

Our Mission:

To provider affordable comprehensive, compassionate, and quality health care services in a linguistically competent and culturally sensitive manner to improve the health and well-being of our community.

NEMS MSO PROVIDER MANUAL

NEMS MSO provides periodic updates to the provider network using provider bulletins, memorandums, and through the provider manual. The provider manual describes your responsibility as a provider to our members, and it is a resource for providers and staff to assist with providing our members with the best possible care. In this manual, the term "provider(s)" includes practitioners, medical groups, hospitals, ancillary providers, and other non-hospital facilities. All contracted providers are required to fulfill the relevant specified responsibilities explained in this provider manual. If you have any questions about our provider network, the provider manual, or our members, please contact Provider Relations at 1 (415)-352-5186 **Option 3.**

Welcome to the NEMS MSO Provider Network

NEMS MSO is North East Medical Services' (NEMS) internally developed Management Services Organization (MSO), which performs administrative services for the managed care members enrolled in Santa Clara Family Health Plan (SCFHP) and have selected NEMS as the primary care clinic/provider.

We are committed to providing affordable, comprehensive, compassionate, and quality health care services in a linguistically competent and culturally sensitive manner to improve the health and well-being of our community. For more than 50 years, NEMS has grown from a small primary care clinic to a large, comprehensive health care organization, serving over 250,000 people since our creation. We became a federally qualified health center (FQHC) in 1992 and have received federal funding through the Community Health Centers (CHC) program since inception.

In 2002, NEMS formed a MSO to provide medical management services for Medi-Cal and Medicare members enrolled in a managed care plan and selected a NEMS network. NEMS MSO has since grown to manage over 40,000 members in San Francisco County and over 7,000 members in Santa Clara County.

Through the NEMS MSO provider network, our members may access care from the Bay Area's highly skilled primary care and specialty care physicians. In Santa Clara County, our members may receive care at our NEMS community clinic located at 1870 Lundy Avenue in San Jose.

NEMS MSO Contact Information

General Inquiries

Hours of Operation: Monday through Friday, 8:00 a.m. to 5:30 p.m.
Telephone: (415) 352 - 5186 option 4
Email: mso-info@nems.org
Please contact our MSO representatives for any general questions or any other inquiries

Provider Relations Department

Hours of Operation: Monday through Friday, 8:00 a.m. to 5:30 p.m.
Telephone: (415) 352 - 5186 option 3
Email: provider.relations@nems.org
Please contact our Provider Relations Department for any questions or concerns pertaining to provider issues, network and contracting inquiries, and credentialing.

Utilization Management Department

Hours of Operation: Monday through Friday, 8:00 a.m. to 5:30 p.m.
Telephone: (415) 352 - 5186 option 1
Please contact our Utilization Management Department for any questions regarding authorizations and covered medical services.

Claims Department

Hours of Operation: Monday through Friday, 8:00 a.m. to 5:30 p.m.
Telephone: (415) 352 - 5186 option 2
Please contact our Claims Department for any questions related to claims and reimbursement.

Case Management Department

Hours of Operation: Monday through Friday, 8:00 a.m. to 5:30 p.m.
Telephone: (415) 352 - 5179
Email: casemanagement@nems.org
Please contact our Case Management Department for any questions related to case management and care coordination.

OUR PROGRAMS

Medi-Cal Managed Care Program

The State of California Medi-Cal Managed Care Program provides high quality, accessible, and cost-effective health care through managed care delivery systems.

The Department of Healthcare Services (DHCS) contracts for health care services through established networks of organized systems of care that emphasize primary and preventive care. Managed Care Plans (MCP) are a cost-effective use of health care resources that improve health care access and assure quality of care. Today, approximately 13 million Medi-Cal beneficiaries in California counties receive their health care services through three models of health care plans: Two-Plan, County Organized Health Systems (COHS), and Geographic Managed Care (GMC).

Providers who wish to provide services to our Medi-Cal managed care enrollees must participate in the NEMS MSO provider network.

VERIFYING MEMBER ELIGIBILITY

A member's eligibility and PCP/Medical Group assignment can change from month to month and beneficiaries will often not communicate or be aware of such changes. **Hence, it is important to verify eligibility:**

- To verify that the member is currently active
- To verify medical group or PCP affiliation
- To ensure that the member is assigned to you or that a referral is on file
- To ensure that you will be reimbursed for providing services to an eligible member

NOTE*: A referral or authorization does not guarantee member eligibility.*

Options to Check Eligibility with Santa Clara Family Health Plan (SCFHP)

1) **SCFHP Online Eligibility Verification**
   This is the easiest and most convenient method for checking eligibility. It is available 7-days a week, 24-hours a day. Please contact the SCFHP Provider Services Department at **(408) 874-1788** or providerservices@scfhp.com to obtain a password and instructions for obtaining online verification.

2) **SCFHP Automated Eligibility Verification**
   Using this system, which is also available 7-days a week, 24-hours a day, you may verify eligibility for the current month as well as the past three months. You must have a

touch-tone phone and call **1(800) 720-3455**. The system can accept up to 10 requests per call.

To use the automated eligibility system, you must enter the following information using the phone keypad:

- Member Name and SCFHP identification number
- Member date of birth
- Month of service

The automated eligibility system will:

- Confirm eligibility for the month requested
- Provide the name and phone number of the member's PCP
- Provide the phone number of the PCP's Medical Group authorization department
- Give you a confirmation number

3) **Member Identification (ID) Card**

All SCFHP members receive a Member ID card that allows physicians and other health-care providers to identify patients as members of the plan. The identification card includes:

- Member's name, sex and date of birth
- Member's SCFHP ID number
- The back of the card contains SCFHP contact numbers as well as the address for submitting claims

A new Member ID card will be issued in response to the report of a lost or stolen card. Possession of a Member ID card is not verification of eligibility to receive services—you should verify that the card is being submitted by the member him/herself, i.e., that someone else is not using the card.

PCP SELECTION AND RESPONSIBILITIES

New members under the SCFHP NEMS network are encouraged to select a Primary Care Physician (PCP) at the time of enrollment. When this does not happen, SCFHP will automatically assign a PCP following an assignment algorithm that considers the member's place of residence, primary spoken language, and other similar factors. SCFHP members who are auto assigned to a PCP may select another PCP at any time, and there is no limit to the number of times a member can request a new PCP. All members may change their current PCP to a PCP of their choosing that is accepting new patients. SCFHP will do its best to meet the member's request and if the PCP selected by the member is unavailable, SCFHP Customer Service will contact the member by phone or in writing.

In most cases, PCP changes will be effective on the first day of the following month and the changes are made directly through SCFHP's Customer Service Department.

To request a change of PCP, a member may call SCFHP Customer Services at **1(800) 260-2055** at any time and request a change. They may also login to the mySCFHP member portal to request the change. A new member ID card with the name and phone number of the new PCP will be mailed to the member. If the member wishes to see a PCP for routine care before receiving the new member ID card, the member may contact SCFHP Customer Services and a representative will assist in finding a PCP with an open panel.

Primary Care Physician (PCP) and Service Provider Responsibilities

The PCP's role is vital in the overall coordination of health care for each member and in providing routine and preventive health care services, including:

- Assessing each individual's health status
- Providing and documenting preventive services in accordance with established criteria including those from the American Academy of Pediatrics, the United States Preventive Services Task Force "A" and "B" recommended services, and the American College of Obstetricians and Gynecologists
- Providing quality care
- Coordinating referrals to specialists
- Facilitating patients' access to treatment
- Referring patients to health education classes
- Educating them on the use of their health education benefits
- Providing basic case management services in collaboration with NEMS MSO's Case Management Department including, at a minimum:
    - Assisting with the identification of patients in need of case management services
    - Completing patient's initial health assessment and reviewing responses related to potential needs for care coordination
    - Communicating directly with the member, family and/or NEMS MSO case management staff
    - Participating in initial and ongoing training and education related to NEMS MSO's case management and care coordination services
- Assuring that members are not discriminated against in the delivery of services, both clinical and non-clinical, based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability, disability, genetic information, or source of payment
- Assuring that no unnecessary or redundant medical services are being provided

- Identifying and following any member who has missed or cancelled his/her appointments
- Establishing a system for tracking and identifying any clinical problems unique to the PCP's particular patient population. The system should focus on patients who require special attention, i.e., those for whom regular doctor visits are imperative and warrant special attention from the PCP's office to assure that the visits actually occur.

Specialty Care Physician Responsibilities

Specialists are required to coordinate the member's care with the member's PCP. Specialists are required to communicate their assessments, care provided, and management recommendations to the member's PCP within one week of treating the referred patient.

PCP Responsibilities

The PCP is the overall coordinator of care for the Santa Clara Family Health Plan members (SCFHP-NEMS). Responsibilities of the PCP include, but are not limited to the following:

- Assuring reasonable access and availability to primary care services.
- Providing preventive care and CHDP/EPSDT required services in conjunction with other providers, as necessary.
- Providing access to urgent care.
- Providing 24-hour coverage for advice and referral to care.
- Making appropriate referrals for specialty care.
- Providing coordination and continuity of care after emergency care, out-patient, in-patient, and tertiary care referrals, including:
  - Providing referral, coordination, and continuity of care for members needing mental/behavioral health services, drug and alcohol detoxification and treatment services, or referrals for seriously medically impaired and seriously emotionally disturbed members to Santa Clara Behavioral Health Services.
  - Providing referral, coordination, and continuity of care for members requiring Direct Observed Therapy for uncontrolled tuberculosis (TB).
  - Providing referral, coordination, and continuity of care for members requiring services from California Children Service (CCS), Early Start, Golden Gate Regional Center (GGRC), and the Local Education Agency (LEA).
  - Providing referral, coordination, and continuity of care for members requiring hospice care
- Case managing members or referring members for case management services, as necessary.

- Requesting authorizations for specialty care or services as necessary from the medical group or outside the medical group's network, as necessary.
- Communicating authorization decisions to the member.
- Assisting the member in making appointments or other arrangements for specialty care or procedures.
- Tracking and following up on member referrals.
- Utilizing and maintaining results of a comprehensive risk assessment tool for all pregnant women that is comparable to American College of Obstetricians and Gynecologists (ACOG) and Comprehensive Perinatal Services program (CPSP) standards. Primary care providers must have hospital admitting privileges with a network hospital.

Services for Members with Disabilities

The following criteria must be met for American with Disabilities Act (ADA) compliance and is assessed during the facility site review:

- Wheelchair access
- Water availability
- Elevator with floor selection within reach
- Pedestrian ramps with a level landing at the top and bottom of the ramp
- Designated parking
- Access in waiting rooms, exam rooms and bathroom; and
- Exam table access

When providers are located at sites that do not meet the Americans with Disabilities Act requirements, the medical group must assist the provider and the member with special arrangements to allow access to providers to meet their health care needs or provide referral to a provider who has access.

Access to Care and Appointment Standards

To ensure that members have timely access to medical care, SCFHP and NEMS MSO follows standards set by DHCS, a summary of which is shown in the charts below.

Appointment Availability

Licensed Health Care Provider	Service	Access Timeframe
PCP, Specialist	**Urgent Care Appointment** • Services not requiring Prior Authorization • Services requiring Prior Authorization	• Within 48 hours of request for appointment • Within 96 hours of request for appointment
PCP	**Non-Urgent Appointment—**for the diagnosis or treatment of injury, illness or other health condition	Within ten (10) business days of request for appointment
Specialist and Ancillary Services	**Non-Urgent Appointment—**for the diagnosis or treatment of injury, illness or other health condition	Within fifteen (15) business days of request for appointment
All	**Preventive Care Appointment** • Periodic follow-up • Standing referrals for chronic conditions • Pregnancy • Cardiac condition • Mental Health conditions • Lab and radiology monitoring	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/her practice
PCP, Specialist	**First Prenatal Visit**	Within two (2) weeks of request

Telephone Triage

Licensed Health Care Provider	Service	Access Timeframe
All Licensed NEMS MSO Providers	**Telephone Triage or Screening Services**	• 24 hours per day, 7 days per week. Waiting time within 30 minutes.

In Office Wait Time

Licensed Health Care Provider	Service	Requirement
PCP, Specialists	In office wait time for scheduled appointments	45 minutes or less

After Hours Accessibility

Licensed Health Care Provider	Service	Requirement
PCP	What instructions would you give a caller who is dealing with a life threatening situation?	• Go to the nearest emergency room • Hang up and dial 911
PCP	If the patient expresses an urgent need to speak with a clinician, is there a way to put them in touch with the physician or an on-call provider?	Yes
PCP	In what time frame can the patient expect to hear from the physician or on-call provider?	30 minutes or less

As indicated in the above chart, health care services must be available to members 7 days a week, 24 hours a day. To this end, you must arrange an on-call 24-hour service with a physician available to take the calls as appropriate. For further details on access standards, see relevant policies on the SCFHP website at www.scfhp.com.

UTILIZATION MANAGEMENT

NEMS MSO Utilization Management (UM) Department oversees authorization requests and monitors services provided to members. The Utilization Management Department processes authorization requests timely and in accordance with State and Federal requirements. Our staff does not compensate, provide financial incentives, or reward individuals performing utilization review for issuing denials of coverage. Additionally, there are no financial incentives for UM staff, or independent medical consultants to encourage utilization review decision resulting in underutilization or denials. All UM decisions are based on appropriateness of care and services, the member's benefit coverage, and by applying clinical criteria to make evidence-based medical necessity determinations.

Utilization Management Staff Availability

Utilization Management (UM) staff are available during regular business hours (Monday through Friday, 8:00am - 5:30pm) to discuss UM issues, including denial decisions and request a copy of the 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. Our fax number is 1(415) 398-2895. After normal business hours, members and providers can send secure voicemail, fax, and email to the UM department. Messages received are returned within one business day. Our staff identify themselves by name, title, and organization name when initiating or returning calls regarding UM issues.

Referrals

In most cases, PCPs must refer members to specialists within our NEMS medical group network. In some instances, a specific specialty may not be available within our network. When this occurs, contact us for options and assistance in finding an appropriate specialist. We will provide you with a list of contracted specialists and referral forms if requested.

Prior Authorizations (PA)

All requests for Prior Authorizations must be sent to NEMS MSO. Contact our Utilization Management Department or visit www.nemsmso.org/prior-authorizations for a current list of services requiring prior authorization. Requests for non-emergent services subject to prior authorization should be submitted at least 14 calendar days prior to the anticipated service date.

Prior Authorization Exceptions

The following services do not require prior authorization:

- Abortion Services – Outpatient procedure does not require prior authorization, unless hospitalization is needed.
- Sensitive Services - Medi-Cal members may self-refer to any providers for pregnancy testing, family planning services, HIV testing, abortion services, and treatment of sexually transmitted diseases
- EPSDT/CHDP Services provided by PCP, FQHC, Community Clinic, DPH per EPSDT/CHDP periodicity schedules and guidelines.
- OB/GYN Services – Members may self-direct to in-network providers for obstetrical and gynecological services (routine women's health preventive care services, including cervical cancer screening)
- Tuberculosis Care (includes screening, testing and treatment)
- Well Woman Care –Services provided according to ACOG guidelines with emphasis on preventive screening, including routine Pap smear, breast exam, and mammography.
- Preventive Care Screening – Colonoscopy/sigmoidoscopy, cervical cancer screening, breast cancer screening.
- Non-Medical Transportation – Contact member's health plan

Emergency Medical Services

Emergency Medical Services means those health care services covered under the Enrollee's Evidence of Coverage that are required for the immediate diagnosis and stabilization of an Emergency Medical Condition, until the condition is stabilized, including pre-hospital care and ancillary services routinely available in an emergency department. "Stabilization" means treatment to an Enrollee in an emergency as may be necessary to assure within reasonable medical or psychiatric probability that material deterioration of the Enrollee's condition is not likely to result from or during: the discharge of the Enrollee from an emergency department; the transfer of the Enrollee from the emergency department to another health care facility; or, the transfer of the Enrollee from the emergency department to an inpatient hospital setting.

Emergency Medical Services shall also include screenings, examinations, and evaluations for the purpose of determining whether a psychiatric emergency medical condition exists, and for which treatment is necessary to relive or eliminate the psychiatric emergency medical condition. Additionally, Emergency Medical Services include a reasonable supply of Medically Necessary discharge drugs to last the Enrollee until he or she can fill a prescription at a PLAN pharmacy.

Emergency Medical Condition

Emergency Medical Condition is defined as follows:

1.) For the Medi-Cal and Medicare lines of business, Emergency Medical Condition means a medical or psychiatric condition (including but not limited to active labor and delivery) manifesting itself by acute symptoms of sufficient severity, such as severe pain or unconsciousness, such that a reasonable layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:
   a) Placing the patient's health (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
   b) Serious impairment to bodily functions; or
   c) Serious dysfunction of any bodily organ or part.

Sensitive Services

Prior Authorization is not required for sensitive services (family planning, sexually transmitted disease services, and HIV testing) regardless of where services are rendered. NEMS MSO and its providers obtain member consent for sharing medical information regarding sensitive services. A minor's consent is required to disclose sensitive information to the minor's parents.

Out-of-Network Services

If covered services are not available in-network or are not available within a timeframe that is compliant with the timely access standards, NEMS MSO may choose to facilitate services to an out-of-network provider as appropriate. NEMS MSO authorizes referrals to non-contracted providers when there is a compelling medical reason that prevents service performance by a contracted NEMS MSO provider.

Prior Authorization

Prior authorization requests must be submitted to the NEMS MSO Utilization Management (UM) Department. The UM staff reviews prior authorization requests and decides based on eligibility criteria, benefit criteria, and medical necessity of the requested service. UM staff may request additional information from the requesting provider if the information submitted is not sufficient to decide. Most denials involve non-covered services, and unless specifically indicated, NEMS MSO does not authorize or pay for services that are not covered by Medi-Cal and/or Medicare, including cosmetic services, infertility treatment, and experimental and investigational procedures. All requests for Prior Authorizations (PA) can be submitted online using the provider portal or by submitting via fax with all supporting clinical documentation/ medical records to the Utilization Management fax line at 1(415) 398-2895.

You can also use the NEMS MSO EZ-NET Provider Portal to submit prior authorization requests online for faster determination. For additional information on how to create an account for the

NEMS MSO Provider Portal, visit our website below and follow the instructions for requesting access.

EZ-Net Provider Portal link: https://eznet.nems.org/EZ-NET60/Login.aspx

EZ-Net Portal is a web-based administrative tool for providers to communicate information with NEMS MSO and perform tasks via the internet without compromising security. Providers may use the Portal to submit Prior Authorization Requests, inquire about claims and authorization status, and download explanation of benefits (EOB).

Provider and staff can also view video tutorials available on the provider portal website on how to submit/inquire authorizations online, inquire claims status, access the latest NEMS Medical Group bulletins, and how to access the specialist roster.

Prior Authorization Turnaround Time

All prior authorization approvals require written notification of the decision to approve, deny, defer, or modify the authorization depending on the request type (urgent, routine, retrospective). The standard turnaround time for processing prior authorizations is as follows:

- Routine requests – five (5) business days.
- Urgent requests – within seventy-two (72) hours of receipt.
- Retroactive requests – thirty (30) calendar days from date of receipt.

The UM staff may issue a Retroactive authorization to a provider for services rendered if:

- The service is medically necessary and appropriate at time of treatment.
- It is outside of NEMS MSO's normal business hours and it is required on an urgent basis. Documentation must include an explanation as to why the procedure was urgent.
- The service is related to continuity of care.

Authorization Approval/ Denial

The Utilization Management (UM) Department reviews all prior authorizations requests to ensure all requests meet eligibility criteria, benefit criteria, and medical necessity of the requested service. The UM staff may request additional information from the requesting provider if a determination cannot be made from the information submitted.

Upon approval of the authorization, the UM department will generate an approval letter for each specific request, and send a copy of the approval letter to the following individuals:

- Requesting provider,
- Member's PCP,
- The member

For denials, the requesting provider receives notification of the decision via the provider portal or facsimile, and the authorization number for the case is provided. The member will also receive notification of the prior authorization denial, and a signed copy of the denial letter will be sent to the member within two (2) business days of the denial. The denial notification also includes an explanation of the denial, and it provides guidance to the member of the appeal process.

Approval and Denial Procedures

Our Utilization Management Department reviews Prior Authorization requests and approves or denies the requests based on eligibility criteria, benefit criteria, and medical necessity of the requested service. We may request additional information from the requesting provider if a determination cannot be made from the information received.

The majority of the denials involve non-covered services, and unless specifically indicated, we do not authorize or pay for services that are not covered by Medi-Cal and/or Medicare, including cosmetic services, infertility treatment, and experimental and investigational procedures.

Decision Notifications to Providers, Members, and SCFHP

- The requesting provider will be notified via fax with an authorization number given for approved cases.
- For approvals, members will be notified in writing via system generated approval letter.
- The member and requesting provider will be notified by mail if a TAR/ PA is denied. A signed copy of the denied letter will be sent to the member within two business days of the denial, with an explanation of reason(s) for the denial, and to inform the member of the appeal process.

Our Utilization Management Department will generate a denial letter for each specific request and send a signed copy of the denial letter to the requesting provider, the member's PCP, and the member. Members and/or providers can appeal denials of services by submitting an appeal to SCFHP.

Appeal of Utilization Management Decisions

Providers may appeal authorization denials for clinical services that do not meet administrative policy requirements, medical criteria, or other reason(s), and were denied by our NEMS MSO Medical Director or designated physician. **Provider appeals should be submitted in writing to SCFHP's Utilization Management Department by fax, online, or U.S. mail and be accompanied by a completed Provider Dispute Form.** The Provider Dispute Form is available to be downloaded or submitted online at www.scfhp.com/forms/submit-a-dispute. Contracted and

non-contracted providers have the right to appeal the authorization review determination, except in the following instances:

- The appeal is submitted more than 90 calendar days following the date of the Notice of Action (NOA)
- The denial was based on untimely notification for inpatient admission
- The service was not covered by Medi-Cal (under the evidence of coverage) at the time of the authorization request

Member Complaints, Grievances, and Appeals

Members are encouraged to bring their concerns to the attention of their PCP, NEMS MSO, or to SCFHP. If a member wants to file a complaint, grievance, or appeal, members or providers may submit the Grievance and Appeal Form to SCFHP:

- By downloading or submittinsg the form online via SCFHP's website www.scfhp.com/for-members/grievance-and-appeal-process
- By phone call to SCFHP's Customer Service at **1(800) 260-2055**, or TTY **1(800) 735-2929**.
- By mail via filling out the Grievance and Appeal Form or submit a letter:

  Attn: Grievance and Appeals Department
  Santa Clara Family Health Plan
  PO Box 18880
  San Jose, CA 95158
- By fax at **1(408) 874-1962**
- In person at Santa Clara Family Health Plan

If you are not satisfied with the coverage decision that NEMS MSO has made, you can appeal the decision through SCFHP. An appeal is a formal way of asking the health plan to review and change a coverage decision that we have made. Under certain circumstances, you can request an expedited fast coverage decision or fast appeal of a coverage decision.

If the member is dissatisfied with the appeal resolution, providers may assist members in seeking external review of the appeal by requesting a State Fair Hearing (for Medi-Cal members only) or applying for an Independent Medical Review (IMR) from the Department of Managed Health Care.

State Fair Hearing Forms are attached to Notice of Appeal Resolution letters for Medi-Cal members. Medi-Cal members can ask for a State Hearing by phone or in writing to:

California Department of Social Services State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430
Phone Number: **1(800) 952-5253** (Voice) or **1(800) 952-8349** (TDD/TTY)
Fax Number: **(833) 281-0905** (Attn: State Hearing Support)

Medi-Cal members can request an IMR by calling DMHC's toll-free telephone number, **1(888) HMO-2219**, or TDD line, **1(877) 688-9891**, for the hearing and speech impaired. DMHC's website, www.hmohelp.ca.gov, has complaint forms, IMR application forms, and instructions. Consumer Complaint and IMR forms are available in multiple languages.

Case Management and Care Coordination

NEMS MSO's Case Management Program is a collaborative approach with the members and/or caregivers, the providers, and state and community agencies for achieving client wellness and autonomy through advocacy, communication, education, identification of service resources, and service facilitation.

Our Case Management Department identifies any medical needs and coordinates referrals to primary care, specialty care, ancillary services, and carved-out services such as behavioral health and substance abuse treatment.

You may refer members with complex needs to our Case Management Department at **(415) 352-5179** or email casemanagement@nems.org.

Coordination of Care for Medi-Cal Members

Early and Periodic Screening, Diagnostic & Treatment (EPSDT)

EPSDT is a federally funded program for providing medically necessary services to correct or ameliorate a physical defect, mental illness or other medical condition in children under 21 years of age. These services are federally mandated to ensure that eligible members receive appropriate screening, preventive, diagnostic and treatment services. The EPSDT benefit includes the following screening services:

- Comprehensive health and developmental history (both physical and mental health development)
- Comprehensive unclothed physical exam
- Immunizations as appropriate
- Laboratory tests as appropriate
- Lead toxicity screening (All children must receive a screening blood lead test at 12 and 24 months of age; children between the ages of 36 months and 72 months of age should receive a screening blood lead test if they have not been previously screened for lead poisoning)
- Health education, as appropriate, to provide information about the benefits of healthy lifestyles and practices as well as prevention of diseases and accidents

- Vision services (at minimum, diagnosis and treatment for defects in vision, including eyeglasses)
- Dental services (at minimum, relief of pain and infections, restoration of teeth and maintenance of dental health)
- Hearing services (at minimum, diagnosis and treatment for defects in hearing, including hearing aids)
- Other necessary health care services as needed to correct or ameliorate defects, and physical/mental illnesses and conditions discovered through the screening services

For additional information on EPSDT services, go to www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/.

California Child Health & Disability Prevention Program (CHDP) Services

CHDP is funded by both state and federal governments to ensure the provision of a pre-specified maximum number of preventive care visits for children under 21 years of age who are enrolled in Medi-Cal.

Some of the services covered by CHDP include, but are not limited to:

- Dental screening
- Developmental assessment
- Health and development history
- Immunizations
- Laboratory tests and procedures including tests for serum levels of lead so that case managers from the Public Health Department Lead Program may follow up and investigate the child's home setting, as indicated
- Nutritional assessment
- Periodic health examination
- Psychosocial screening
- Speech screening
- Vision screening

Complete guidelines for CHDP preventive health services are included in the CHDP Periodicity Schedule for Health Assessment and Dental Referral and the Department of Health Services CHDP Health Assessment Guidelines, which are available through the Santa Clara County CHDP office or website at www.sccgov.org.

Developmental Disabilities: San Andreas Regional Centers (SARC)

We make every effort to assure that members with developmental disabilities receive all medically necessary screening, preventive, and therapeutic services as early as possible. If any of your child members fall 4-6 months below age-appropriate parameters or exhibit symptoms or conditions that indicate risk factors such as autism, cerebral palsy, mental retardation or seizures, you are required by law to refer them to a San Andreas Regional Center (SARC).

SARC is part of a statewide system of 21 locally based regional centers that offer supportive services and programs for California residents with developmental disabilities. Regional centers provide intake and assessment services to determine client eligibility and needs, and work with other agencies to provide the full range of early intervention services. Local regional centers can provide specific information on the services available in the member's service area. Services include respite day programs, supervised living, psychosocial and developmental services, and specialized training.

Contact information for the local SARC office is:

San Andreas Regional Center
300 Orchard City Drive, Suite 170
Campbell, CA 95008
Phone: **(408) 374-9960**
Intake Coordinator: **(408) 341-3475**
Fax: **(408) 376-0586**
Hours: 8:00 a.m. – 5:00 p.m.

Early Start Program for Developmentally Disabled Infants and Toddlers

The Early Start Program is a collaboration between the San Andreas Regional Centers and the Santa Clara County Office of Education to provide medically necessary diagnostic and therapeutic services for infants and children aged 0-2.9 years of age who have developmental disabilities.

During the IHA, PCPs identify those who have, or are at risk of acquiring, developmental delays or disabilities, including signs and symptoms of mental retardation, cerebral palsy, epilepsy or autism. California State legislation requires that PCPs refer children to Early Start Program for evaluation who are exhibiting a significant developmental delay, have multiple risk factors, or have an established risk factor; moreover, the law requires that this referral take place within 48 hours of your assessment.

A developmental disability is a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or other conditions similar to mental retardation that originates before the

age of 18, is likely to continue indefinitely, and constitutes a significant handicap for the individual. A developmental delay is an impairment in the performance of tasks or the meeting of milestones that a child should achieve by a specific chronological age.

Services are provided by SARC's Early Start Program and coordinated with assistance from SCFHP. SCFHP is a resource for providers and members (or their parents/guardians) who have questions about services for disabled children and the Early Start Program. Parents may contact the SCFHP Member Services Department at **1(800) 260-2055** for assistance with referrals.

Identifying Members with Suspected and/or Diagnosed Developmental Disabilities

Infants and children with the following conditions have a potential for being at risk for developmental disabilities, thus requiring Early Start services:

- Autism, or similar conditions
- Blindness or limited vision
- Spinal bifida
- Cancer
- Cerebral palsy
- Cleft palate
- Downs syndrome
- Epilepsy
- Hearing impairment
- Heart conditions
- HIV/AIDS
- Juvenile diabetes
- Lung disorders, including asthma and cystic fibrosis
- Mental retardation
- Neurologically impaired, spinal cord injuries
- Physical handicaps due to extensive orthopedic problems
- Seizures
- Sickle cell anemia

Referral Procedure for the Early Start Program & Regional Center Services

To make a referral to the Early Start Program, write, fax or call:

Santa Clara County Early Start Program
780 Thornton Way
San Jose, CA 95128
Fax: **(408) 295-6104**
Referral Hotline: **1(800) 404-5900**
Hours: 9:00 a.m. – 4:00 p.m.

Parents of children over 2.9 years of age with developmental disabilities should contact directly the school district of residence to locate the local San Andreas Regional Center for assistance.

Coordination of Care with Regional Centers and Early Start Program

SCFHP continues to provide for the medical needs of members receiving services from SARC/Early Start and coordinates with the Center to assist with the development of a care plan, or in meeting the care plan that has been developed.
The PCP is part of the interdisciplinary team supporting the member's medical as well as psychosocial and environmental needs. Screening, preventive and medically necessary and therapeutic services that are a normally covered benefit are continued to be covered by SCFHP.

California Children's Services (CCS) Program

California Children's Services (CCS) Program is a state-funded program that pays for the medical care of children (aged 0-21 years) who have physically handicapping conditions. Conditions that qualify for CCS are those that limit or interfere with physical function but can be cured, improved or stabilized, e.g., birth defects, handicaps present at birth or developed later, and injuries from accidents or violence. These conditions may require treatment with medicine, surgery or rehabilitation. CCS manages the eligible health condition which includes referrals to the appropriate specialists and facilities for care.

Providers should refer SCFHP-NEMS members with CCS medically-eligible conditions to CCS for case management and treatment of the particular condition. Notify NEMS MSO's Utilization Management Department at **(415) 352-5045** about any potential CCS-eligible condition.

Please note that members under the care of CCS continue to remain enrolled in SCFHP-NEMS for primary-care services and referrals unrelated to the CCS conditions. The PCP relationship remains intact for providing all primary care, medically necessary screening, diagnostic, preventative and treatment services unrelated to the member's CCS eligible condition, as well as forwarding any requested medical information the program(s) may request.

NEMS MSO UM staff help identify CCS eligible conditions through review of referrals, claims and encounters for diagnosis categories, as well as during hospital concurrent review. In addition, we work with providers, admitting physicians, hospital discharge planners, neonatologists, or hospital pediatricians, as appropriate, to ensure that potential candidates are referred to CCS.

NEMS MSO ensures that children in foster care and other out of home placement situations receive comprehensive, medically necessary services and preventative healthcare, especially

when a child is placed outside the SCFHP-NEMS service area. Additional questions can be directed to NEMS MSO Utilization Management at **(415) 352-5045**.

Additional Services for Members

In-Home Supportive Services (IHSS)

The IHSS program provides payment for non-medical in-home care for qualified individuals who are unable to remain safely in their homes without this assistance. Members must be evaluated by a social worker to be determined financially and functionally eligible. Eligible members must be:

- Citizen of the United States or a qualified alien, and a California resident.
- Over 65 years of age, or disabled, or blind (disabled children also eligible).
- One of the following:
    - Current recipient of Supplemental Security Income/State Supplementary Payment (SSI/SSP); or
    - Meet all the eligibility criteria for SSI/SSP except that your income is in excess of the SSI/SSP income levels; or
    - Meet all the eligibility criteria for SSI/SSP, including income, but do not receive SSI/SSP; or
    - Medi-Cal recipient who meets SSI/SSP disability criteria.
- Live in a residence, not an institution.
- Determined at risk for institutionalization based on initial IHSS screen.

The Public Authority Services by Sourcewise maintain responsibility for processing, approving/authorizing, and monitoring IHSS requests. Call **(408) 792-1600** for more information.

Home Health Care Services

SCFHP covers medically necessary health care services in the member's permanent or temporary place of residence, when requested by the primary care/attending physician. Covered services include hospice care, home health care, and home infusion therapy.

Hospice

Hospice is specialized interdisciplinary health care designed to provide palliative care, services, equipment and supplies to alleviate the physical, emotional, social and spiritual discomforts of a terminal illness. This care is provided to members who are diagnosed with a terminal illness and are only expected to live six months or less. The member may elect to receive hospice care

at home or in a Medi-Cal licensed facility. The facility and the hospice provider must have a contract with SCFHP and the care must be approved by SCFHP through their authorization process. The member may elect to revoke or discontinue hospice services at any time.

Home Health

Home health services include visits by registered nurses (RNs), licensed vocational nurses (LVNs), social workers, and home health aides and may include short-term intravenous infusion therapy, physical therapy, occupational therapy, speech therapy and respiratory therapy when prescribed by a licensed plan provider. The member must be confined to his/her home ("homebound") and need intermittent skilled nursing or related therapies. Prior authorization and concurrent review by SCFHP are required for home health services. Written treatment plans are requested and reviewed by SCFHP to assist with case management of members. Durable medical equipment (DME) is covered under a separate authorization when requested by a physician and provided in accordance with the treatment plan.

Home Infusion Therapy

Medically necessary home infusion therapy is a covered benefit through SCFHP. Treatment must be prescribed by a physician and be provided in accordance with a written treatment plan. Medical and prescription prior authorizations are required. The home health agency providing the care teaches the member and the supporting care providers how to administer products and maintain the infusion site. When the member's conditions makes outpatient infusion therapy possible, the member's care may be transferred to a contracted outpatient infusion therapy center.

Major Organ Transplants (Excluding Kidney and Corneas)

Under age 21

SCFHP provides coverage for medically necessary organ transplants for members under age 21, excluding experimental or investigational procedures. Such members are referred to the CCS Program for determination of admission to the CCS Program for services.
If the member is deemed eligible for CCS services, SCFHP assists with coordination of care with CCS for the covered condition, and with the PCP for other, non-CCS health care issues.

Medi-Cal: Ages 21+

Major organ transplant procedures are carved-out benefits for members of SCFHP-NEMS and are covered as a Medi-Cal fee-for service (FFS) benefit. Transplant procedures include:

- Bone marrow transplants

- Heart transplants
- Heart/lung transplants
- Liver transplants
- Lung transplant
- Combined liver and kidney transplants
- Combined liver and small bowel transplant

Case Management of Transplant Patients

Please inform SCFHP's Case Management Department as early as possible about any SCFHP-NEMS member who is a potential candidate for major organ transplant (except kidney-only or corneal transplants). Their nurse case manager facilitates the disenrollment process from Managed Care Medi-Cal to the FFS Medi-Cal, under the State's Transplant Waiver Program.

If the transplant group does not have the appropriate Medical Exemption form, SCFHP will fax or mail a copy of the document to them, with the instructions for completion attached. The completed document is to be mailed or faxed to the Health Care Options address located on the bottom of the Medical Exemption form, with a copy faxed to the SCFHP Case Manager at **(408) 874-1957**.

If the member is evaluated and determined not to be a candidate for a major organ transplant, the cost of the evaluation and responsibility for the continuing treatment of the member remains with SCFHP. The member and his/her PCP is informed of the Medi-Cal decision and assisted through the grievance and appeal process, if necessary.

Members Rights

NEMS MSO members have the right to:

- Be treated respectfully regardless of gender, culture, language, appearance, sexual orientation, race, disability, and transportation ability; given due consideration to a right to privacy and the need to maintain confidentiality of medical information.
- Receive quality, appropriate medical care, including preventive health services and health education.
- Take part actively in decisions about medical care. To the extent permitted by law, members also have the right to refuse or discontinue treatment.
- Know and understand his or her medical condition, treatment plan, expected outcome, and the effects these have on daily living.
- Formulate advance directives.

- Have access to family planning services, sexually transmitted disease services, and emergency services outside of the SCFHP network pursuant to the federal law.
- Minors of any age have the right to receive sexual assault treatment (including rape), drug or alcohol abuse, pregnancy testing, family planning, and sexually transmitted infections (STI) treatment without parental consent.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to a member's condition and ability to understand.
- Have the meaning and limits of confidentiality explained, and that if a member is under 18 that a provider or other staff may need to discuss treatment and associated issues with the member's parent or guardian. The member will also be notified if the parent or guardian is to be contacted.
- Confidential health records, except when disclosure is required by law or permitted in writing by the member. With adequate notice, a member has the right to review his or her own medical records with a primary care provider.
- Know about any transfer to another hospital, including information as to why the transfer is necessary and any alternatives available.
- Receive a referral from a primary care provider for a second opinion.
- Receive professional interpreter services at no charge. Members may choose if they prefer to use a family member or friend for interpretation, but only after being offered a professional interpreter at no charge first.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Freedom to exercise these rights without adversely affecting how a member is treated by NEMS medical group, SCFHP, providers, or the state.

Benefits

Pharmacy Benefits

SCFHP contracts with a Pharmacy Benefits Management (PBM) company to provide an extensive network of pharmacies throughout Santa Clara County. Our members may go to any contracted pharmacy to obtain their prescriptions. For a list of contracted pharmacies, please refer to the pharmacy directory available on SCFHP's website at www.scfhp.com**.**

Please feel free to call, fax, or email the SCFHP Pharmacy Services Department any time you have questions, comments, or suggestions about their pharmacy benefits:

Phone: **(408) 874-1796**
Fax: **(408) 874-1444**
Email: pharmacy@scfhp.com

Drug Formulary

The SCFHP drug formulary is a list of preferred generic and brand-name medications in various therapeutic classes that are covered under the SCFHP pharmacy benefit. The Drug Formulary exists to allow our providers and clinicians to determine the safest, most effective, and least costly drug therapy possible. The formulary is available on their website at www.scfhp.com.

The Drug Formulary is reviewed by the P&T Committee and updated based on comprehensive data on efficacy and safety that is available from evidence-based clinical studies, and for which evidence of performance in overall use in a variety of therapeutic settings has been established. The decisions are also based on the Department of Health Care Services (DHCS) contract requirement stating that the Formulary Drug List shall be comparable to the Medi-Cal Fee for Service list of contract drugs, except for drugs that are carved out through specific contract agreements.

Medications listed on the Drug Formulary may be subject to certain restrictions such as quantity limits, step therapy, age limit, or PA requirements. SCFHP also covers FDA-approved contraceptive drugs and devices, including emergency contraceptive drug therapy. Additionally, members may receive up to a 90-day maintenance supply of certain drugs specified in the Drug Formulary. (Note: injectable medications are not eligible for maintenance supply.)

Upon request, SCFHP covers up to a 60 day vacation supply of prescription medications. This is available once every 365 days for members who are traveling out of the SCFHP service area for a short period of time.

Certain over-the-counter (OTC) drugs are covered for Medi-Cal members unless otherwise specified; processing for OTC drugs should be handled in the same manner as that used for prescription drugs.

Formulary Exclusions

The following drugs are not covered under the Medi-Cal pharmacy benefits:

- Investigational drugs (these are not approved by the FDA)
- Infertility drugs
- Products for cosmetic indications
- Treatment of sexual dysfunction
- Agents “carved out” to the State’s regular FFS program (applies to Medi-Cal members only and includes medications that must be billed to the Medi-Cal Electronic Data System (EDS): i.e., HIV/AIDS-related antiretroviral drugs and antipsychotic drugs.)

- Most vitamin/dietary supplements other than prenatal vitamins for pregnant women and pediatric vitamins for children ages 0-6
- Any other stated as such in the EOC

Continuation of Drug Therapy

SCFHP allows new members to receive coverage for up to 30 days for drugs that are part of a provider-prescribed treatment regimen at the time of enrollment, regardless of whether the drug is on the formulary. Future coverage of the drug may require prior authorization.

Likewise, in the event of a change to our formulary, a current member may remain on a non-formulary drug or one that requires Step Therapy if the drug had been previously approved for an existing medical condition and the formulary alternatives would not be medically appropriate as determined through prior authorization.

Out-of-Pocket Payments

SCFHP-NEMS Medi-Cal members are not required to pay out of pocket for medically necessary prescription drugs.

Drugs Requiring a Coverage Determination or Formulary Exception (Drug Prior Authorization)

A drug prior authorization (PA) is necessary for the following:

- Non-formulary drugs
- Compound prescriptions over $50
- Formulary drugs for which the limitations and/or restrictions listed have not been met or are exceeded such as step therapy or quantity limit restrictions
- Any prescription over $500 (Pharmacies may contact MedImpact at **1(800) 788-2949** to request a high-dollar override)
- Rejected claims for which SCFHP plan limitations have been exceeded, including but not limited to those described below:
    - Excessive daily doses of acetaminophen
    - Excessive daily doses of narcotics

Procedures for Filing a Drug PA

Rather than waiting until contacted by a pharmacist, you may obtain prior authorization for a drug by:

- Downloading a Drug Prior Authorization Form directly from SCFHP's website at www.scfhp.com. Complete the form to the best of your ability and fax it to the SCFHP Pharmacy Department at **(408) 874-1444**.
- Calling SCFHP at **(408) 874-1796** and asking to initiate a prior authorization for an SCFHP-NEMS Medi-Cal member.

You may submit a prior authorization request directly to the SCFHP Pharmacy Department for review using the Drug Prior Authorization Form. Once a determination has been made, SCFHP faxes the pharmacy and physician with the decision as noted on the PA form. In the event of a negative decision, they also mail the appropriate Notice of Action to the member, with a copy to the prescribing provider.

For additional information on the Drug PA process, please see SCFHP's drug formulary, available on their website at www.scfhp.com.

3-Day Emergency Supply Override

When the contracted pharmacy cannot fill a prescription promptly and the patient's clinical situation demands immediate treatment as determined by the physician or pharmacist, the pharmacy may utilize the Emergency Supply Override, which guarantees reimbursement for up to a 3-day supply of a medication. To process an emergency supply, the pharmacy or physician may call the MedImpact Customer Service line at **1(800) 788-2949** for an override.

Submitting a Pharmacy Claim

Pharmacies should bill MedImpact for all covered drugs. Claims may be sent electronically or by mail.

- **Electronic Claim Submission**
  Electronic claims are sent to MedImpact for processing through a Point of Service environment in the National Council for Prescription Drug Programs (NCPDP) standardized format. The PBM issues payment to providers two times a month. Questions should be directed to the MedImpact Pharmacy Help Desk at **1(800) 788-2949**.
- **Paper Claim Submission**
  Pharmacies without electronic billing capabilities may submit paper claims by mail to:
  MedImpact
  ATTN: Pharmacy Claims
  10680 Treena Street, Stop 5
  San Diego, CA 92131

Behavioral Health Services

Mental Health

As part of the Initial Health Assessment of new SCFHP-NEMS members, the PCP should assess the member's mental health status. As part of the Early Start Program for Developmentally Disabled Infants and Toddlers, pediatricians and other PCPs are responsible for assessing the mental health needs of all children who are under 21 years of age.

During all patient encounters and throughout the course of a member's care, please watch for any signs of mental illness or a mental-health crisis such as severe depression, psychosis, mania, etc. Refer any mental health care needs identified through this process to an appropriate mental health provider to ensure that the patient receives timely access to appropriate levels of medical care for mental illness, substance abuse, and the management of psychiatric medications.

For assistance with referring members to mental health services, contact SCFHP's Member Services Department at **1(800) 260-2055**.

How to Access Mental Health Services – Medi-Cal

All inpatient and specialty outpatient mental health services for Medi-Cal beneficiaries have been "carved out" of SCFHP. They remain either in the county-operated Short-Doyle/Medical system or in the traditional Fee-for-Services (FFS) Medi-Cal. An exception is the outpatient service PCPs provide within the scope of their practice, and the psychotherapeutic drugs prescribed by him/her or the contracted psychiatrist.

Chiropractic and Acupuncture Services

SCFHP covers chiropractic services, limited to the treatment of the spine by manual manipulation. Chiropractic services are limited to two services per month in combination with acupuncture, audiology, occupational therapy and speech therapy services. SCFHP may pre-approve other services as medically necessary. Members do not generally need a referral for Chiropractic services but it may be required when provided by out-of-network FQHCs, RHCs and IHCs. Currently there are no RHCs in the service area. The following members are eligible for chiropractic services:

- Children under age 21
- Pregnant women through the end of the month that includes 60-days following the end of a pregnancy
- Residents in a skilled nursing facility, intermediate care facility, or subacute care facility

- All members when services are provided at hospital outpatient departments, FQHCs or RHCs that are in the SCFHP network

SCFHP covers acupuncture services to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. Outpatient acupuncture services (with or without electric stimulation of needles) are limited to two services per month, in combination with audiology, chiropractic, occupational therapy and speech therapy services when provided by a physician, dentist, podiatrist or acupuncturist. Members do not need a referral for the first two services per month, but SCFHP may pre-approve (prior authorize) additional services as medically necessary.

For more information about Chiropractic or Acupuncture services, contact SCFHP Customer Service at **1(800) 260-2055** or visit SCFHP's website at www.scfhp.com.

Vision Benefits

Vision Service Plan (VSP) administers vision benefits for SCFHP-NEMS Medi-Cal members. Optometry services are a vision benefit and are available every 24 months. Ophthalmology services are a medical benefit through SCFHP and there is no age restriction for these services for our line of business. Providers can refer a member to a participating VSP provider. For questions regarding vision benefits or to find a VSP provider, please contact VSP at **1 (800) 877-7195** or visit www.vsp.com.

Dental Services

SCFHP-NEMS Medi-Cal members are eligible for coverage for dental services through Medi-Cal Dental—the Medi-Cal fee-for-service dental program. Members that have Medi-Cal Dental may go to any dentist who accepts it. Contact Medi-Cal Dental for more information about covered dental services and Medi-Cal Dental providers in Santa Clara County:

Phone: **1(800) 322-6384**
Hours: 8 a.m. to 5 p.m., Monday–Friday
Website: denti-cal.ca.gov

SCFHP may also pay for dental care in certain cases. Those may include topical fluoride varnish for members younger than 7 years old (given by a primary care provider), drugs prescribed by a dentist based upon medical need, dental services for radiation treatment, and dental anesthesia. Please note that prior authorization may be required.

Sensitive Services

Sensitive Services are designated services by the State Medi-Cal program as available to members (minors and adults) without a referral or authorization in order to protect patient confidentiality and promote timely access. Sensitive Services include family planning services provided to individuals of childbearing age to temporarily delay pregnancy, pregnancy testing, abortion services, and confidential HIV testing and counseling. Minors and adolescents (12 – 17 years old) have the right to access sensitive services without parental consent. NEMS MSO and SCFHP encourage members to seek services from their PCP or to provide the information to their PCP to ensure continuity and quality of care. **Medi-Cal members may go out of network for sensitive services without prior authorization, except for prenatal care.** Non-Medi-Cal members may access sensitive services within our network without prior authorization. Information and records related to sensitive services are strictly confidential and shall not be released to any third party without the consent of the member involved, including adolescents.

Sterilization Services

California law requires that men or women who request sterilization (surgery that will end their ability to have children) complete a form (PM-330) attesting that they are giving informed consent for the procedure. These forms must be completed and signed prior to the surgery and filed in the medical record. Medi-Cal members may not waive the 30-day waiting period. A copy of the form must be attached to the claim when submitted for payment. Please consult with NEMS MSO or call SCFHP for any clarification.

Abortion Services

SCFHP-NEMS members may self-refer for outpatient abortion services since such services are not subject to prior authorization, medical justification, or any other utilization management procedure, except when performed using general anesthesia. Prior authorization is required for abortions services requiring the use of general anesthesia, regardless of whether the abortion is performed in an office, outpatient facility, or a hospital.

Sexually Transmitted Diseases or Sexually Transmitted Infections

Medi-Cal members can access services for sexually transmitted diseases from **any** willing provider, both in-network and out-of-network. NEMS MSO will cooperate with local health departments to promote the diagnosis and treatment of members with sexually transmitted diseases. Care provided for STDs include testing, diagnosis, immediate treatment, and medications. Local health departments and other out-of-plan providers are to refer the member back to the Primary Care Physician for any conditions requiring ongoing care beyond the initial diagnosis and treatment of the STD.

Minor Consent Services

Members of any age have the right to access some services without parental consent. Medical records and/or information regarding medical treatment specific to these services will not be released to parents and guardians, without the minor's consent.

These services include:

- Sexual assault, including rape
- Drug and alcohol abuse (**note:** methadone treatment requires guardian notification and consent)
- Pregnancy, including abortions
- Family planning services (**note**: sterilization requires guardian notification and consent)
- Sexually transmitted diseases

Initial Health Assessment (IHA)

As part of SCFHP's contractual agreements with the Department of Health Care Services (DHCS), the Managed Risk Medical Insurance Board (MRMIB), and various funding agencies, each new Medi-Cal member must receive an Initial Health Assessment from the PCP.

SCFHP requires that a good-faith effort be made by the PCP to conduct this initial assessment within 120 days of enrollment or, for pregnant members, as soon as possible after discovery of the pregnancy; for infants, the assessments should be scheduled in accordance with AAP periodicity recommendations. To help the PCP meet these timelines, SCFHP provides a list of new or re-enrolled members each month.

The initial history and physical examination helps establish relationships with patients in a non-crisis situation, and is an important aspect of a preventive medicine program. Generally, an IHA is comprised of:

- A comprehensive history, including medical, social, psychological and family background as well as lifestyle habits, such as tobacco, alcohol, nutrition/diet, exercise, and sexual activity.
- A complete physical examination to assess the member's present health status, including possible acute, chronic and/or preventive health needs.
- Age-specific assessments and services, including administering necessary immunizations (if this is not possible, appointments for appropriate services should be scheduled, with the date noted in the medical record).
- Screening for TB or other communicable diseases
- Recommendations for health education and mental-health services.

Please note that the following services *do not meet the criteria* for an IHA:

- A visit for evaluation and/or management of a specific problem.
- Perinatal visits, other than the initial complete assessment of a pregnant woman according to ACOG guidelines.
- Urgent-care and/or emergency visits or services

Initial Health Assessment – COVID-19

Initial Health Assessment Due to the COVID-19 PHE, DHCS temporarily suspended requirements for MCPs to complete Initial Health Assessments (IHA) within the required timeframes outlined in the MCP contract (120 days for most members) and allowed MCPs to defer completion of these IHAs until further notice. Starting October 1, 2021, MCPs must begin resumption of IHA activities that they temporarily suspended during the period of December 1, 2019 – September 30, 2021.

MCPs should utilize available data sources to identify all members who were: newly enrolled since December 1, 2019; have not received an IHA and do not meet exclusion criteria as detailed in contract and Policy Letter 08-003; have not engaged in primary care or perinatal services since enrollment; and, for whom an IHA or portions of an IHA are currently appropriate. MCPs should outreach to members identified and coordinate access to providers as needed to facilitate primary care or perinatal care engagement. For all members who are newly enrolled as of October 1, 2021, MCPs are required to complete this process and coordinate care engagement within the required contractual timeframes.

Health Education

NEMS members must be provided with health education services at no cost. Health education services include but are not limited to primary and obstetrical care, clinical preventive services, education and counseling, and patient education and clinical counseling.

These services can be provided through:

- Individual classes
- Group classes
- Workshops
- Support groups
- Peer education programs
- Disease management programs
- Educational materials

Health education services may include:

- Educational interventions designed to help members to access appropriate care
- Educational interventions that cover behaviors such as:
    - Tobacco use and cessation
    - Alcohol and drug use
    - Injury prevention
    - HIV/STI prevention
    - Family planning
    - Immunizations
    - Dental care
    - Nutrition
    - Weight control and physical activity
    - Parenting
- Educational interventions designed to assist members to follow self-care regimens and treatment therapies for existing medical conditions, chronic disease, or health conditions including:
    - Pregnancy
    - Asthma
    - Diabetes
    - Substance abuse
    - Tuberculosis
    - Hypertension

You may visit the resources page on our website www.nemsmso.org for available health education resources. If you would like more information about our health education resources, please contact NEMS MSO Provider Relations at 415-352-5186 option 3.

PROVIDER RELATIONS, PROVIDER POLICIES AND CREDENTIALING

The Provider Relations Department informs providers of various updates and changes pertaining to contracted health plans, policy changes, new services, resources available for providers, and an array of other responsibilities. In addition to functioning as key liaisons to providers, the Provider Relations Department staff is also responsible for the centralization of the following services to providers:

- Provider Credentialing and Re-credentialing
- Responding to Provider inquiries and complaints
- Provider education and New Provider Orientations
- Assist navigating the provider portal
- Assist with finding in-network providers
- Contract Management
- New Provider Orientation
- Creating and disseminating various NEMS MSO related Provider communication

Practitioner Credentialing/ Re-credentialing

We follow National Committee for Quality Assurance (NCQA) guidelines and standards for initial provider credentialing and re-credentialing. The credentialing cycle is generally every three (3) years for all Primary Care, Obstetrics and Gynecology, High Volume Providers, Ancillary Providers, and Organizational Providers. All providers must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified, or registered and must have a good standing in the Medi-Cal and Medicare programs. Providers terminated from either Medi-Cal or Medicare, or who have sanctions pending resolution, cannot participate in the NEMS MSO network.

All licensed independent practitioners providing care to NEMS members, including physician and non-physician medical practitioners (NMP) (i.e., physician assistant, nurse practitioner, certified nurse midwife), must meet NEMS MSO credentialing, screening, and enrollment requirements to participate in the NEMS MSO network. Our credentialing standards are based on federal and California state requirements and comply with our contracted Health Plan's contract with DHCS.

The practitioner credentialing process includes a comprehensive screening against federal and state sanctions databases, as well as verification of the practitioner's training and education, which may include assessment of quality indicators such as member complaints and facility site reviews. NEMS MSO has ongoing procedures to monitor and act to address issues of quality of care and service.

The credentialing committee does not make credentialing or re-credentialing determinations based on an applicant's age, gender, race, ethnic/national identity, sexual orientation, or the types of procedures performed by the applicant. Providers receive periodic notifications prior to expiration of licensure, certifications, and liability coverage, and are instructed to submit renewed copies of the documents. Failure to submit renewed documents prior to expiration may result in termination from the NEMS MSO network.

Specialists Responsibilities

Specialists must coordinate care with the member's PCP. Specialists are required to communicate their assessments, care provided, and management recommendations to the member's PCP within one week of treating the referred patient.

Provider Changes to Practice

Prior to implementing material changes to terms of payment, credentialing, and other rules of participation, NEMS MSO will issue written notice by fax, e-mail, or mail to providers within thirty (30) days of the change. Providers changing or adding a new office location, changing tax identification information, or adding/terminating a provider within the practice, must submit written notification to NEMS MSO at least ninety (90) days prior to the effective date of the change.

Providers are also required to notify us within thirty (30) days of any change in status such as licensure, malpractice claims settlement, and hospital privileges. Prior to initiating a contract termination without cause, providers must submit a written notice to NEMS MSO at least ninety (90) days in advance of the requested date of the contract termination.

Provider Network

We provide SCFHP with a provider roster on a quarterly basis, pursuant to a mutually agreed-upon schedule. All provider network and demographic changes are to be submitted to NEMS MSO Provider Relations Department, and the staff notifies SCFHP in an expedient and timely manner. All credentialing and provider training activities must be completed before a provider is sent to SCFHP for activation.

Provider Roster Requirements and Verification Process

Provider Rosters must be reviewed and updated on at least a quarterly basis, and any changes must be forwarded to NEMS MSO Provider Relations Department pursuant to the mutually agreed upon timeframe. The provider roster includes, but is not limited to the following information about Participating Providers or Individually Contracted Providers (ICPs):

- Name
- National Provider Identification (NPI) Number
- California License Number and Type
- Phone Number and address
- Hours of Operation
- Email Address (if available)
- Currently accepting new patients (yes/no)
- Specialty and/or practice area
- Board Certification
- Gender
- Languages spoken by the provider.
- Languages spoken by qualified medical interpreters on the provider's staff.
- Provider group or other affiliation
- Affiliated hospital and/or admitting privileges to a contracted hospital.

Additions to the Provider Network

To add a primary care provider, specialist, a non-physician medical practitioner (NMP) (i.e., physician assistant, nurse practitioner, certified nurse midwife), or an additional address for an existing SCFHP-NEMS provider, submit the information to NEMS MSO Provider Relations Department. The Provider Relations staff are responsible for obtaining provider training attestations forms and submitting required documents to SCFHP once completed. For questions regarding adding providers, contact:

Provider Relations Department
Phone: 1(415) 352 - 5186 **Option 3**
Fax: 1(415) 233 - 4892
Email: Provider.Relations@nems.org

Provider Information Changes or Terminations

To correct or change information on an existing contracted provider, submit a request along with the details of the changes via email or fax to NEMS MSO Provider Relations. We are required to notify SCFHP Provider Relations Department within five (5) business days when there are changes to a provider's panel (open or close) affecting member assignment. Contracted SCFHP-NEMS provider wishing to terminate their affiliation with SCFHP must first submit a termination notification to NEMS MSO, and the Provider Relations staff promptly notifies SCFHP of the provider termination. Terminations are effective no earlier than the first of the month following 30 days' notice.

Provider Orientation and Training

NEMS MSO is responsible for new provider training and education to be completed no later than ten days after the provider's effective date with SCFHP. An electronic version of the training and attestation is available on the SCFHP website or you may contact NEMS MSO Provider Relations to obtain a copy.

Training covers the following topics:

- SCFHP Programs
- Eligibility
- Access to Care
- Referrals, Prior Authorization, and Appeal to UM Decisions
- Members' Rights, including the right to full disclosure of healthcare information and the right to actively participates in healthcare decisions.
- Member Complaints and Grievances
- Benefits
- Initial Health Assessments (IHA)
- Coordination of Care for Medi-Cal Members
- DHCS Waiver Programs
- Health Education
- Cultural and Linguistic Services
- Seniors and Persons with Disabilities

Provider Access, Availability and Appointments

Santa Clara Family Health Plan (SCFHP), NEMS MSO and its providers shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the member's condition consistent with good professional practice. SCFHP and NEMS MSO establish and maintain provider networks, policies and procedures, and quality assurance monitoring systems sufficient to ensure compliance with clinical appropriateness standards. SCFHP ensures that all plan and provider processes necessary to obtain covered health care services, including but not limited to prior authorization processes, are completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the member's condition and in compliance with the requirements of the DMHC Timely Access Regulations.

Appointment Availability

Providers shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the member's condition consistent with good professional practice. NEMS MSO establishes and maintains provider networks, policies and procedures, and quality assurance monitoring systems sufficient to ensure compliance with clinical appropriateness standards.

After-Hours

All PCPs are required to have after-hours phone coverage 24 hours a day, 7 days a week. After-hours access must include triage for emergency care and direction to call 9-1-1 for an emergency medical condition. A physician or mid-level provider must be available for contact after-hours, either in person or via telephone. All after-hours member calls must be documented in the member's permanent medical records. If a provider who is not the member's PCP treats the member, the treating provider must forward documentation of services received to the member's PCP.

Emergency Services and Urgent Care

An emergency medical condition is defined as one that is manifested by acute symptoms of sufficient severity (e.g., severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in one of the following situations:

- Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions,
- Serious dysfunction of any bodily organ or part,
- Any psychiatric emergency and related medical condition(s).

Emergency services include medical screening, examination, medical and psychiatric evaluation by a physician, or – to the extent permitted by applicable law – by other appropriate personnel under the supervision of a physician, and within the scope of his/her licensure and clinical privileges, to determine if an emergency medical condition or active labor exists. If one exists, the physician will provide the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition within the capability of the facility.

In all instances when a member presents at an emergency room for diagnosis and treatment of illness or injury, pre-established guidelines for hospitals require appropriate triage of the severity of illness/injury. An authorization is not required for emergencies as defined by the examining physician. The examining physician determines required treatment to stabilize the patient.

Appointment Access Procedures

Our members make appointments for adult and child initial health assessments, preventive care appointments, children's preventive periodic health assessments, routine primary care, urgent care by calling their assigned Primary Care Practitioner (PCP). The PCP is responsible for referring members to specialty services. Members may self-refer to prenatal care and contact any in-network OB/GYN provider for an initial prenatal care appointment. Members are informed of their assigned PCP in the SCFHP ID Card mailing and receive a Member Handbook in the Welcome Packet that informs them how to access services, including directions to call 911 or to go to an Emergency Room in the case of an emergency.

Access Standards

We ensure that all plan and provider processes necessary to obtain covered health care services, including but not limited to prior authorization processes, are completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the member's condition and in compliance with the requirements of the DMHC Timely Access Regulations. Providers and Medical Groups are informed of these requirements through the SCFHP Provider Manual and reinforce standards through Joint Administrative Meetings (JAMs) with providers and Provider Monthly Updates. The California Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC) set forth access requirements for all health plans and their contracted providers, which include maintaining availability standards for appointments. The access standards are also reinforced in Joint Administrative Meetings (JAMs) with providers and our Monthly Provider Updates. Providers are required to comply with the following access standards.

Providers may demonstrate compliance with the primary care time-elapsed standards through implementation of standards, processes and systems providing advanced access to primary care appointments. "Advanced Access" is the provision, by an individual provider or by the medical group to which a member is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advanced scheduling of appointments at a later date if the member prefers not to accept the appointment offered within the same or next business day.

"Triage" or "Screening" as defined by DMHC means the assessment of an enrollee's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care, for the purpose of determining the urgency of the enrollee's need for care.

Claims Overview

Providers are encouraged to submit claims for payment as soon as practical to avoid denial for untimely submission. Professional providers are to bill for services rendered using a CMS-1500 claim form; Hospital and Institutional providers are to bill for services rendered using a UB-04 (CMC-04) claim form. All medical claim forms must be submitted with the rendering / attending physician's NPI number and full name listed. If service was performed by a mid-level provider, such as a Physician Assistant, a Nurse Practitioner, or a Registered Nurse, the supervising Physician's name and NPI number should be listed on the claim form for reimbursement.

NOTE: *We do **NOT** supply any claim forms, and faxed claims are **NOT** accepted. Providers and billers should purchase these forms from a supplier of their choice.*

All medical claims should be submitted to the following address:

NEMS MSO
Attn: Claims Department
2171 Junipero Serra Blvd, Suite 600
Daly City, CA 94014

The NEMS MSO Claims department is available to help with claims questions and can be reached at **(415) 352- 5186 option 2.**

Claim Requirements

NEMS MSO has established requirements for filing a claim. Failure to comply with these requirements may delay reimbursement. In order to be considered as a valid claim, each claim must be submitted within the timely filing period and meet the following criteria:

- All required fields must be completed
- Must be an original claim submitted on a standard current version (red drop-out ink) of a CMS-1500 or UB-04 to ensure clean acceptance and processing
- Claims must be for an eligible NEMS member (SCFHP, Health Net Medicare Advantage) at the time of service
- Contain correct national standard coding, including but not limited to CPT, HCPCS, Revenue codes, and ICD-10 codes
- The claim must not be altered or include any handwritten additions to procedure codes and/or charges
- Claim must be printed in black ink hat is dark enough to be electronically imaged, if paper
- NEMS MSO only accepts standard claim forms printed in Flint OCR Red, J6983 (or exact match) ink

Any claim(s) that does not meet the required criteria listed above will be rejected and a letter indicating the reason for the rejection will be sent to the provider along with the actual claim(s).

Electronic Claims

NEMS MSO offers providers the speed, convenience, and lower administrative costs of electronic claims filing, also known as Electronic Data Interchange (EDI). We prefer that all claims be submitted electronically and providers interested in submitting claims electronically should have their biller contact our Provider Relations Department to request information on how to enroll. Providers unable to send claims electronically must ensure that the paper claims meet all the claim requirements listed above on the claim's requirement section.

Timely Filing of Claims

NEMS MSO encourages all providers to submit claims for payment as soon as practical to avoid denial for untimely submission. The timely payment period is the same for electronic and paper claims.

NEMS MSO follows California Welfare and Institutional Code, Section 14115 (WIC §14115) and accepts provider claims as follow:

1) All claims shall be submitted no more than six months after the month in which the service is rendered, except in the following events:
    a) Patient does not identify as a Medi-Cal beneficiary within four months after the month in which the service was rendered.
    b) Provider has submitted the claim to a liable third party.

2) If claims are submitted to NEMS MSO beyond the six months filing time limit, and the delay is caused by circumstances beyond the control of the provider, NEMS MSO extends the period of submission of claims for a period not to exceed one (1) year after the month in which the service is rendered.

3) For original claim submitted to NEMS MSO between 6 and 12 months after the month of service that does not meet any exceptions allowing billing after six months, NEMS MSO applies the following reimbursement reduction to the late filing claim:
    a) The reimbursement amount will be reduced by 25 percent for claims submitted during the seventh through the ninth month after the month of service.

The reimbursement amount will be reduced by 50 percent for claims submitted during the 10th through the 12th month after the month of service.

General Claim Processing Guidelines

Acknowledgement of Claims

NEMS MSO acknowledges the receipt of electronic claims, whether the claims are complete, within two (2) business days. Paper claims are acknowledged within 15 business days following receipt. Claims received from a provider's clearinghouse are acknowledged directly to the clearinghouse in the same manner and time frames noted above.

Claim Processing Time

NEMS MSO will process and pay all clean claims within 45 business days of receipt.

Clean Claim

A clean claim is defined as a claim which, when it is originally submitted, contains all necessary information in the required claim fields, including attachments (if required for claim), and supplemental information or documentation needed to determine payer liability, and make timely payment.

Unclean Claim

An unclean claim lacks sufficient information to pay or deny and results in our Claims Department requesting additional information to process the claim. Claims submitted with information missing CPT codes, ICD-10, provider Tax Identification information, rendering physician's name, or any other information from the required fields on the claim form, will be returned to the provider by mail with a NEMS MSO cover letter indicating the information that is required for claims processing.

Interest Payment on Clean Claims Not Paid Timely

For Non-contracted / Out-of-Network Provider:

- Clean non-contracted provider claims must be paid within 30 calendar days of the first received date.
- If clean claims from non-contracted providers are paid beyond 45 business days, the claim will automatically include interest at the rate of fifteen (15) percent per annum for the period of time that the payment is late.
- The timely payment period is the same for both electronic and paper claims.

For Contracted / In-Network Provider:

- Contracted provider claims must be paid within 30 calendar days of the first received date.

- If clean claims from non-contracted providers are paid beyond 45 business days, the claim shall automatically include interest at the rate of fifteen (15) percent per annum for the period of time that the payment is late.
- The timely payment period is the same for both electronic and paper claims.

Interest Payment for Emergency Services:

- Late payment on a complete claim for emergency services and care, which is neither contested nor denied, interest payment is **the grater of** $15 for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15 percent per annum for the period of time that the payment is late.

Interest is due within five (5) working days of the payment of the claim without the need for any reminder or request by the service provider. In the event that the interest due on an individual late claim payment is less than $2.00 at the time that the claim is paid, the interest for that claim may be paid, along with interest on other such claims, within 10 calendar days of the close of the calendar month in which the claim was paid. A $10 penalty is due to provider if NEMS MSO fails to automatically include the interest due on a late claim to the same provider.
In an event when additional information is needed for making claims adjudication decision, MSO Claims team shall make best effort to:

- ✓ Contact outside source(s) for such needed additional information prior to making the decision to pay or deny the claim within the 60-days timeframe.
- ✓ Document the attempts for claim development efforts, including date, time, name of contact, subject, and content.

This time frame begins after receipt of the claim. NEMS MSO reserves the right to adjudicate claims using reasonable payment policies and non-standard coding methodologies. These policies and methodologies are consistent with available standards accepted by nationally recognized medical organizations, federal regulatory bodies.

Interest Payment Calculation:

Interest payment is calculated using the following formula:
[Payment Amount] x [Rate] x [Days divided by 365 (366 in a leap year)] = Interest Payment

Misdirected Claims

NEMS is financially responsible to adjudicate and pay for healthcare services outlined in the contracted Division of Financial Responsibility (DOFR).

(A) If a claim is sent to the Health Plan and is identified as the responsibility of NEMS for adjudicating the claim according to the contracted DOFR, the Health Plan will forward the claim to NEMS MSO within 10 working days of receipt of the claim that was incorrectly

sent to the Health Plan, via an agreed upon delivery method, either on paper or electronically via Secure File Transfer Protocol (SFTP) or secured web portal.

a. NEMS MSO processes misdirected claims forwarded by the Health Plan in the same manner as all other incoming claims sent by providers.
b. The “claim receipt date” entered in our database is the date when the misdirected claim is received by NEMS MSO.

(B) If a claim is incorrectly sent to NEMS MSO and is identified as the financial responsibility of the contracted health plan per DOFR specification, we must forward the claim to the contracted health plan within 10 working days of receipt. Misdirected papers claim must be forwarded to the appropriate entity prior to acknowledging receipt.

Billing Members

Under the California Health and Safety Code, Section 1379, it is illegal to bill a member who is enrolled in a State program for services provided. Providers are prohibited from billing NEMS members (both Medicare Advantage and Medi-Cal) for covered services since our members are never responsible to pay participating providers any amount for covered medical services, other than approved co-insurance, deductibles or copayment amounts as part of the member’s benefit package. Providers **may not** seek reimbursement from the member for a balance due for covered services, open bills, or balances in any circumstance, including when we have denied payment. Providers may only bill members for copayments, non-benefits, and non-covered services for which the member has willingly agreed to pay out-of-pocket.

Billing Medicare and Medi-Cal Members is strictly prohibited. Providers are prohibited from collecting Medicare Parts A and B deductibles, coinsurance or copayments from members enrolled in the Qualified Medicare Beneficiaries (QMB) program, which exempts members from Medicare cost-sharing liability. Providers can either accept our payment as payment in full or bill the state for applicable Medicare cost-sharing for members who are eligible for both Medicare and Medicaid.

This prohibition applies to all Medicare Advantage (MA) providers and not only those that accept Medicaid. In addition, balance billing restrictions apply regardless of whether the state Medicaid agency is liable to pay the full Medicare cost-sharing amounts.

Overpayments and Recoupments

Overpayments can happen for various reasons, including but not limited to:

- Claim processing error
- Service was paid by another third party (i.e. COB)

- Duplicate payment made by NEMS MSO when the service is payable, in part or full, to another provider
- Retroactive change to member eligibility

Providers who identify overpayments should send a refund with supporting documentation to:

NEMS MSO
Attn: Claims Refunds
2171 Junipero Serra Blvd., Suite 600
Daly City, CA 94014

If we identify an overpayment, a notice will be sent to the provider that includes the following:

- Member's name and ID number
- Provider's account number
- Claim number
- Date of service
- Overpayment amount
- Date of payment
- Detailed reasons for the refund request

Providers have 30 days from receipt of notice of overpayment to submit a written dispute if provider disagrees that overpayment has occurred. If the overpayment request is not contested by the provider within 30 days of receipt of overpayment notice and we do not receive a full refund or an agreed-upon satisfactory repayment amount within 45 days from the date of the overpayment notification, we will recoup the amount of the overpayment on future claim payments.

Procedure and Diagnosis Codes

Providers must use the appropriate ICD-10 codes and Healthcare Common Procedure Coding System (HCPCS) Level I and II codes, to indicate procedures on all claims, except for inpatient hospitals.

For all other uses, Level I Current Procedural Terminology (CPT-4) codes describe medical procedures and professional services. CPT is a numeric coding system maintained by the American Medical Association (AMA).

Coordination of Benefits (COB)

COB is used to determine the order of payment responsibility when a NEMS member is covered by more than one health plan or insurer. We are always the payer of last resort for Medi-Cal members; all other coverages are primary. State and federal laws require practitioners to bill other health insurers prior to billing us.

All claims must be submitted to us within 90 days from the date of payment on the primary payer's Explanation of Benefits (EOB) form. A copy of the EOB must accompany the claim. If the primary plan denies services asking for additional information, that information must be submitted to that carrier prior to submitting the claim to us. When we are the secondary payer under COB rules, we will generally pay the lesser of the following amounts for covered services:

- The actual charge made by the provider, less the amount paid by the other coverage
- The amount we would have paid if the individual did not have other coverage
- If the primary insurance payment exceeds the fully allowed contracted rate, neither NEMS MSO nor its member is financially responsible for any additional amount

Coordination of Benefits (COB), also referred to as non-duplication of benefits, is the practice of two or more plans coordinating their provision of health benefits to members who have multiple coverage.

- COB regulations were developed by the National Association of Insurance Commissioners (NAIC) and adopted by various state HMO regulators and Departments of Insurance. They are designed to accomplish member's benefit by having maximum benefits and minimal out-of-pocket expenses between coordinating plans.
- No member, plan, or provider will benefit from excess payments (over 100%) toward the costs associated with necessary health services.
- Claim expenses for services that have been provided by a plan may be shared by another plan.

Provider Dispute Resolution Mechanism

Providers have the right to a fast, fair, and cost-effective dispute resolution process for disputes regarding a claim payment, denial, billing determinations, and contract issues. NEMS MSO will ensure timely acknowledgement and resolution of provider disputes.

NEMS MSO will not request that providers resubmit claim or supporting documentation that was previously submitted to NEMS MSO as part of the claim's adjudication process unless NEMS MSO returned the information to the provider.

Provider Dispute Resolution (PDR) request is a written notice to North East Medical Services (NEMS) MSO appealing a claim that has been paid, adjusted, contested, or denied; or seeking resolution of a billing determination; or disputing a request for reimbursement of an overpayment of a claim.

NEMS MSO will not discriminate or retaliate against a provider due to a provider's use of the Provider Dispute process. A provider dispute is processed without charge to the provider; however, NEMS MSO has no obligation to reimburse the provider for any costs incurred during the provider dispute process.

NOTE: Claims denied due to provider's claim submission error or omission (e.g., missing modifier, incorrect CPT / ICD-10, or place of service code, missing EOB/EOMB or requested invoice, etc.) ***DO NOT*** *qualify for the Provider Dispute Resolution Mechanism and should be resubmitted within the claim's submission timeframe as a corrected claim. Please include a brief explanation of the error either noted on the claim or as an attachment.*

NEMS MSO PDR Process:

1. **Timeframe for PDR submission**. If the dispute is for a claim that was denied, contested, or underpaid, provider must submit a Provider Dispute Resolution request in writing along with any relevant and supporting documentation within 365 days of the last claim decision or action. If provider is disputing NEMS MSO request for reimbursement (i.e. refund) of a claim overpayment, provider must submit a written dispute within thirty (30) working days from receipt of the Notice of Overpayment.
2. **Elements**. The dispute must include:
    - Provider's Name
    - Provider's NPI and/or Tax ID Number
    - Provider Contact Information (Address and Phone Number)
    - Patient's Name and DOB
    - Claim Number from NEMS Explanation of Benefit
    - Copy of original claim being disputed
    - Identification of the disputed item(s)

- Explanation of the basis that provider believes the payment amount, adjustment, denial, or request for reimbursement is incorrect
- Other pertinent documentation to support the appeal

3. **Where to submit**. Providers may obtain a PDR form by visiting our website at https://www.nemsmso.org/claims-pdr/ . Providers will submit the written provider dispute to the following address:

   North East Medical Services
   Attn: MSO Provider Claim Dispute
   2171 Junipero Serra Blvd., Suite #600
   Daly City, CA 94014

4. **Acknowledgment**. NEMS MSO will send a written acknowledgment of a PDR request within fifteen (15) working days of receipt of a paper PDR, and within two (2) working days of receipt of an electronic PDR request.
5. **Request for additional information**. If NEMS MSO requires additional information in order to review and make a decision, NEMS MSO will send a written request to the provider within thirty (30) working days from receipt of the PDR, specifying the information requested. Provider has thirty (30) working days from receipt of request for additional information to submit an amended PDR with the required information. NEMS MSO will not request providers to resubmit additional information or supporting documents if these were previously submitted as part of the claim adjudication process.
6. **PDR Resolution**. After its review, NEMS MSO will issue a written determination, including a statement of the pertinent facts and reasons, to the provider within forty-five (45) working days from receipt of the provider dispute.
7. **Goodwill Pay**. If the determination finds that the original claim decision was correct, NEMS MSO may, upon its sole discretion, allow reconsideration based on certain extenuating circumstances and reprocess a claim for goodwill payment. Any payable amount for this claim will not warrant interest. Payment will be issued within five (5) working days from the date of the written dispute resolution.
8. **Overturned Claim**. If a dispute determination is in favor of the provider, claim will be reprocessed and payment plus applicable interest shall be issued within five (5) working days from the date of the written dispute resolution.
9. **Penalty for failure to automatically pay interest**. If NEMS MSO fails to pay interest due within 5 working days of the from written dispute resolution, additional penalty of $10 per claim shall be paid.
10. **Dispute Resolution Costs**. A provider dispute is processed without charge to the provider; however, NEMS MSO has no obligation to reimburse the provider for any costs incurred during the provider dispute process.

11. **No Discrimination**. NEMS MSO shall not discriminate or retaliate against a provider due to a provider's use of the provider dispute process.
12. **Retention of records**. Copies of provider disputes and determinations, including all notes, documents and other information upon which NEMS MSO relied to reach its decision, and all reports and related information shall be retained for no less than five (5) years.