



NORTH EAST
MEDICAL SERVICES

東北醫療中心

Management Services Organization (MSO)

North East Medical Services
Management Services Organization (MSO)

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Summary of Key Information

This document contains information for San Francisco Health Plan (SFHP) NEMS (Medi-Cal Beneficiaries), and **Health Net Medicare Advantage** program requirements. Additional information is available on the SFHP website (www.SFHP.org/providers) and the Health Net Medicare Advantage website (<https://ca.healthnetadvantage.com/>). **Please make sure to distinguish the contents and apply the information to the program with which you are affiliated.** Contact NEMS MSO Provider Relations at 1(415) 352 - 5186 option 3, for questions regarding the contents of the document.

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Welcome to the NEMS Provider Network

North East Medical Services (NEMS) as a Federally Qualified Health Center (FQHC), is eligible to contract with Managed Care Plans as a Risk Bearing Organization (RBO) to take full or partial risks for managed care members enrolled in the Plan. NEMS MSO is an internally developed Management Services Organization, which performs administrative services for the managed care members enrolled in the managed care plan and have selected NEMS as the primary care clinic/provider.

The NEMS RBO structure may vary by the type of contract it holds with the contracted health plan and/or its partnered hospital, and the participating PCP clinics/providers in the network.

In 2000, we partnered with California Pacific Medical Center (CPMC), together contracted with San Francisco Health Plan (SFHP), and formed the 1st full risk managed care network - NEMS network. Participating primary care providers/clinics include:

- NEMS San Francisco Clinics
- CPMC Family Health Center
- CPMC Pediatric Care Center
- 1100 Van Ness Avenue Clinic
- 2100 Webster Street Clinic
- 350 Rhode Island Street Clinic
- 3838 California Street Clinic
- 45 Castro Street Clinic
- 899 Valencia Street Clinic
- Mission Neighborhood Health Center
- Private community PCPs

In 2015, we partnered with Zuckerberg San Francisco General Hospital (ZSFG) to contract with SFHP and formed the 2nd full-risk managed care network, nicknamed NMS Network. The NEMS Clinics in San Francisco and San Mateo Counties are the participating primary care clinics in this network.

In 2019, we contracted with Health Net Medicare Advantage to offer our members the Health Net Seniority Plus Sapphire Premier II (HMO) plan. This plan gives our members access to our networks of highly skilled medical providers in our area. The Health Net Seniority Plus Sapphire Premier II (HMO) plan also includes Part D coverage, which provides members with the ease of having both their medical and prescription drug needs coordinated through a single convenient source. The NEMS Clinics in San Francisco and San Mateo Counties are the participating primary care clinics in this network.

Over the last 42 years, NEMS has grown from a small primary care clinic to a large, comprehensive health care organization, serving an estimated 250,000 people since its 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.

Contact Information

Provider Relations Department

Hours of operation: Monday through Friday, 8:00 a.m. to 5:30 p.m.

Telephone: 1(415) 352 - 5186 **option 3**

Email: Provider.Relations@nems.org

Please contact the Provider Relations Department for any questions or concerns pertaining to provider issues, network and contracting inquiries, and credentialing.

Utilization Management

Hours of operation: Monday through Friday, 8:00 a.m. to 5:30 p.m.

Telephone: 1(415) 352 - 5186 **option 1**

Please contact the Utilization Management Department for any questions regarding authorizations, covered medical services, and inpatient concurrent reviews.

Claims Department

Hours of operation: Monday through Friday, 8:00 a.m. to 5:00 p.m.

Telephone: 1(415) 352 - 5186 **option 2**

Please contact the Claims Department for any questions related to claims and reimbursement.

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, which 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). Medi-Cal providers who wish to provide services to managed care enrollees must participate in the managed care plan's provider network.

Health Net Seniority Plus Sapphire Premier II (HMO) MA Plan

The Health Net Medicare Advantage (MA) plan is an "all-in-one" alternative to original Medicare that covers all Medicare services [Medicare Part A (Hospital Insurance), Medicare Part B (Medical Insurance) and Medicare Part D (Prescription drug)]. NEMS Medi-Cal and

Medicare patients (Medi-Medi) patients who elect to enroll in the Health Net Seniority Plus Sapphire Premier II (HMO) MA Plan will receive additional benefits from Health Net.

The summary of benefits and additional information about Health Net can be found at <https://ca.healthnetadvantage.com/> and some services may require prior authorization. All prior authorizations and claims will go through NEMS MSO. For questions regarding care coordination, contact the NEMS MSO Care Coordination Team at CaseManagement@nems.org. For general questions, please contact NEMS MSO Provider Relations at provider.relations@nems.org

Dual Eligible

In San Francisco County, Medi-Cal beneficiaries who also have Medicare as primary coverage, may select to join a Medi-Cal Managed Care plan as the service delivery system for their Medical benefits. Medicare remains to be the primary coverage for these members and NEMS works with the MCP to coordinate these dual eligible members' health care needs.

Verifying Member Eligibility

A member's eligibility and PCP/Medical group assignment can change from month to month and beneficiaries will oftentimes not communicate or be aware of such changes. Why 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.

Medi-Cal BIC "Poppy" Design issued starting September 2016



Other options to check eligibility with SFHP are to:



- Call SFHP Provider Relations at 1(415) 547-7818 ext. 7084 (Use ID information for white SFHP card with logo. DO NOT USE YELLOW NEMS ID CARD)
- Call the SFHP Interactive Voice Response system (IVR) at (415) 547-7810, 24 hours a day 7 days a week.
- Call SFHP Member Services Department to speak with a friendly representative at (415) 547-7800, Monday-Friday, 8:30 a.m.-5:30 p.m.

NOTE: Possession of an SFHP ID card or Medi-Cal card (BIC) does not guarantee eligibility. The medical group and member’s PCP will be identified on the SFHP ID card once eligibility is confirmed.

For members under the NEMS/ Health Net Medicare Advantage line of business:

Request a copy of the member’s Health Net ID card and you can check eligibility using the Health Net provider portal at <https://www.healthnet.com/portal/provider/home.ndo>

Health Net Medicare Advantage card sample

 MEMBER INFORMATION Name: <First MI Last> Member ID#: <XXXXXXXXXX.XX> Issuer ID: <(80840)> <9151014609>	HMO <Plan Name> CMS#: <H3551.XXX.XXX> Effective: <MM-DD-YYYY>	FOR MEMBERS Member Services: (833) 502-8919 (TTY: 711) Mental Health Benefits: <1-800-646-5610 (TTY: 711)> 24-hr Nurse Advice: <1-800-853-5597 (TTY: 711)> < https://ca.healthnetadvantage.com >	FOR EMERGENCIES Dial 911 or go to the nearest Emergency Room (ER).
	PHARMACY INFORMATION  Rx Claims Processor: <CVS Caremark> RXBIN: <004336> RXPCN: <MEDDADV> RXGRP: <RX6270>	FOR PROVIDERS For eligibility, prior authorization or case management referrals: <1-800-431-9007> Pharmacy prior auth: <1-800-867-5564> For help: (PHARMACY USE ONLY) <1-888-865-5567>	Submit Part D Drug Claims to: <Health Net> <Attn: Pharmacy Claims> <P.O. Box 419069> <Rancho Cordova, CA> <95741-9069>
PROVIDER INFORMATION PPG Name: <> PPG Phone: <> PCP Name: <> PCP Phone: <> PCP Office Visit: <SXX>		MEDICAL CLAIMS EDI Payor <Health Net> ID: <68069> <Attn: Claims> <P.O. Box 9030, Farmington, MO 63640-9030>	

If you do not have an account to check eligibility on the Health Net Provider Portal, visit the Health Net website at https://www.healthnet.com/content/healthnet/en_us/providers.html and follow the steps to register to create an account.

You can also contact Health Net Medicare Advantage directly to check eligibility and speak with a friendly representative at **1 (800) 431-9007**.

From October 1 – March 31, you can call 7 days a week from 8 a.m. to 8 p.m. From April 1 – September 30, you can call Monday – Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

NOTE: Possession of the Health Net Medicare Advantage card, original Medicare ID card, or NEMS yellow ID card does not guarantee eligibility with Health Net. Once eligibility is confirmed, the medical group and member’s PCP will be identified on the Health Net Medicare Advantage ID card.

PCP Selection, Assignment, and Change

New members under the SFHP NEMS network are encouraged to select a Primary Care Physician (PCP) at the time of enrollment. When this does not happen, SFHP will automatically assign a PCP following an assignment algorithm that considers the members place of residence, primary spoken language, and other similar factors. SFHP 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 PCP to a PCP of their choosing and who is accepting new patients. SFHP will do its best to meet the member's request and if the PCP selected by the member is unavailable, SFHP 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 SFHP's Customer Service department.

To request a change of Primary Care Provider, a member may call **SFHP Member Services at (415) 547-7800 or (800) 288-5555 (toll free) at any time and request a 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 getting the new member ID card, the member may contact SFHP Member Services and a representative will assist in finding a PCP with an open panel.

Selecting a PCP for Health Net Medicare Advantage

Newly enrolled members in the Health Net Medicare Advantage plan are encouraged to select a Primary Care Physician (PCP) as soon possible. If members do not choose a PCP, or if the selected PCP is not available within the NEMS MSO Health Net Medicare Advantage Network, new members will be automatically assigned to a Medical Group or PCP near their home. The PCP selected must be within the NEMS MSO Health Net Medicare Advantage network and must be located within 30 miles or 30 minutes from where the beneficiary lives or works.

- Specialist and Ancillary vendor information can be found in the NEMS MSO online provider roster <http://www.nems.org/mso/forms.html> or
- Members may also visit the Health Net Medicare Advantage website at <https://ca.healthnetadvantage.com> to confirm the availability of a provider, or
- To ask about a specific PCP, the member must contact Member Services at the phone number printed on the back cover of their Health Net ID card.

Members may change their PCP for any reason, at any time. It is possible that the member's PCP might leave the plan's network of providers and the member will be required to find a new PCP. Member Services can assist in finding and selecting another provider and the member's request will be effective on the first day of the month following the date when Health Net

receives your request. Members can request a PCP change by calling Member Services or visit the Health Net Medicare Advantage website at <https://ca.healthnetadvantage.com> to make the request. Once the request has been finalized, the member will receive in the mail a new member ID card that shows the name and phone number of their new PCP.

Primary Care Physician and Service Provider Responsibilities

The PCP is the overall coordinator of care for the member and the responsibilities of the PCP include, but are not limited to:

- Assuring reasonable access and availability to primary care services.
- Providing all preventive care and CHDP/EPSTD required services.
- 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, outpatient, inpatient, 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 the San Francisco Community Behavioral Health Services
 - Providing referral, coordination and continuity of care for members requiring Direct Observed Therapy for uncontrolled tuberculosis
 - Providing referral, coordination and continuity of care for members requiring services from California Children Service (CCS), Early Start, Golden Gate Regional Center (GGRC), and 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 referrals that are made

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.

Access to Care

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 and SFHP establish and maintain 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, and 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 emergency situations as defined by the examining physician. The examining physician determines required treatment to stabilize the patient.

The following table contains NEMS Access Standards. 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.

Appointment Type	Access Standards
Routine care with PCP	Within 10 business days
Routine care with Specialist	Within 15 business days
Ancillary services	Within 15 business days
Mental Health	Within 10 business days
Urgent Care – All provider types	Within 48 hours of request
Urgent Care - services requiring prior authorization	Within 96 hours of request
Prenatal care (PCP)	Within 14 business days
Wait time in Provider office	Not to exceed 30 minutes
Time to answer phone at provider office	Not to exceed 10 minutes

Utilization Management (UM)

Prior Authorizations, Referrals, Decisions and Appeals to UM Decisions

NEMS Utilization Management Department processes authorization requests in timely manner and in accordance with State and Federal requirements. The Utilization Management staff is **available Monday – Friday 8:00 a.m. - 5:30 p.m. at 1(415) 352 - 5186 option 1**

Referrals

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

Prior Authorizations (PA)

All requests for Prior Authorization (PA) must be sent to NEMS MSO. Contact the Utilization Management department or visit <http://www.nems.org/mso/> 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:

- Sensitive services (see section Sensitive Services for more information)
- Obstetrical and gynecological services, including basic prenatal care and support services available through the member's medical group. The member will deliver in the hospital affiliated with her medical group. The member's obstetrical provider will request authorization for required testing.
- Emergency care (in or out of network)
- Preventive care (in network).

You can use the NEMS MSO Provider Portal to submit Treatment Authorization Requests (TARs) online for faster determination. For additional information on how to create an account for the NEMS MSO Provider Portal, visit the NEMS MSO website <http://www.nems.org/mso/providerportal.html>

Prior authorization requests can also be submitted directly to the Utilization Management Department via fax at 1(415) 398 - 2895 and they must include all supporting clinical documentation/ medical records to assist NEMS MSO's clinical reviewers with determining whether the request meet NEMS MSO criteria coverage.

Approval / Denial Procedure

The NEMS MSO Utilization Management (UM) Department reviews Prior Authorization requests and approves or denies the requests based on eligibility criteria, benefit criteria, and medical necessity of the requested service.

The Utilization Management department 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, 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.

Decision Notification to Provider/Member/Health Plan

- The requesting provider will be notified by provider portal/fax with authorization number given for approved case.
- The member 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.
- Medicare members will receive an approval letter within 2 business days of approval.

NEMS MSO UM 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 UM denials of services by submitting an appeal to the Health Plan.

Appeal of UM 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 the NEMS MSO Medical Director or designated physician. **Provider appeals should be submitted in writing to SFHP's UM department by fax, e-mail, or U.S mail and be accompanied by a completed Provider Request for an Appeal Form.** The request for appeal form is available on-line at www.sfhp.org/providers (click on "Provider Forms"). 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 and Grievances and appeals

NEMS SFHP are encouraged to bring their concerns to the attention of their PCP, NEMS Member Services Department or to the health plan. If a member wants to file a complaint or grievance, members or providers may complete the SFHP Grievance form found on the SFHP website <http://www.sfhp.org/providers/providers-forms/grievances/> or call SFHP's Customer Services at 1 (415) 547-7800 or 1 (800) 288-5555.

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

Request Type and Turnaround Time

Urgent Authorizations - Written or verbal notification of NEMS' decision to approve, deny, defer, or modify the authorization request is provided to the requesting provider within **72 hours of receipt**.

Routine Authorizations - Written or verbal notification of NEMS' decision to approve, deny, defer, or modify the authorization request is provided to the requesting provider within **five (5) business days of receipt**.

Retrospective authorization - Written notification of the decision to approve, deny, defer or modify the authorization request is provided within **30 calendar days of receipt of the request**. Requests must be submitted with "Retro Request" indicated on the form within **90 days of the service**. The TAR form should be faxed, submitted online, or mailed to the NEMS MSO Utilization Management Department along with the patient's consultation reports, treatment notes and/or surgical reports for clinical consideration. **NEMS 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

All prior authorization requests should be accompanied by medical records to assist NEMS' clinical reviewers with determining whether the request meets NEMS' criteria for coverage. Please contact the NEMS Utilization Management Department to find out if a particular service requires an authorization.

Case Management and Care Coordination

The 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.

The Case Management Team 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 the NEMS Case Management Team at 1(415) 352-5179 or email casemanagement@nems.org.

Coordination of Care for Medi-Cal Members

Golden Gate Regional Center (GGRC)

Golden Gate Regional Center is a nonprofit private corporation that contracts with the State Department of Developmental Services to provide or coordinate services and supports for individuals with developmental disabilities. According to Title 17, Section 54000 of the California Code of Regulations, a “Developmental Disability” is defined as a disability that is attributed to

- Mental Retardation
- Cerebral Palsy
- Epilepsy
- Disabling conditions found to be closely related to mental retardation or to require treatment like that required for individuals with mental retardation.

To be eligible for services, a person must have a disability that begins before the person’s 18th birthday, be expected to continue indefinitely, and present a substantial disability as defined in Section 4512 of the California Welfare and Institutions Code. Eligibility is established through diagnosis and assessment performed by regional centers.

Some of the services and supports provided by the regional centers include:

- Information and referral
- Assessment and diagnosis
- Counseling
- Lifelong individualized planning and service coordination
- Purchase of necessary services included in the individual program plan
- Resource development
- Outreach
- Assistance in finding and using community and other resources
- Advocacy for the protection of legal, civil, and service rights
- Early intervention services for at risk infants and their families
- Genetic counseling
- Family Support
- Planning, placement, and monitoring for 24-hours out-of-home care
- Training and educational opportunities for individuals and families
- Community education about developmental disabilities

San Francisco Health Plan and NEMS MSO are not financially responsible for the GGRC services provided to its members. An SFHP member who is eligible for GGRC services remains enrolled

with SFHP, and the medical group and PCP maintain responsibility for coordination of services and for continued medical care.

Medical group physicians can refer to GGRC by contacting:

Golden Gate Regional Center
875 Stevenson Street, 6th Floor
San Francisco, CA 94103
1(415) 546-9222

For additional information you can visit the GGRC at www.ggrc.org

Early Start Program (ES)

Infants and children under three years of age who have a developmental delay or disability or an established risk condition with a high probability of resulting in a delay may be eligible to receive early intervention, or “Early Start”, services including speech therapy. For a list of Early Start services, please visit Golden Gate Regional Center at www.ggrc.org

The medical group and primary care physicians are responsible for coordination of services with the Early Start Program and financially responsible for covering the initial evaluation and two speech sessions per month. Speech Therapy sessions in excess of two per month and other therapy services may be covered by the Early Start Program. An SFHP member who is eligible for Early Start services remains enrolled with SFHP, and the medical group and PCP maintain responsibility for coordination of services and for continued medical care.

Medical group physicians and case managers may refer to Early Start by contacting:

Golden Gate Regional Center
875 Stevenson Street, 6th Floor
San Francisco, CA 94103
1(415) 546-9222

Additional information about the Early Start Program can be found at www.dds.ca.gov/earlystart

Women, Infants, Child Program (WIC)

WIC is a nutrition/food program that helps pregnant, breastfeeding or postpartum women, and children less than 5 years of age to eat well and stay healthy. WIC eligibility is determined by federal income guidelines. Medi-Cal members are eligible. Services include free food vouchers, nutrition education, and breastfeeding support. To assist your patients in applying for the WIC program, you can fill out the WIC form (Referral for Children or referral for Pregnant Women) and advise your patient to make an appointment with WIC by calling 415-575-5788 or visit www.sfdph.org.

California Children's Services (CCS)

CCS provides special medical care for children age 21 years and younger who have physical disabilities and complex medical conditions. Services provided under the CCS program are reimbursed through the CCS program. SFHP and NEMS MSO are not financially responsible for the CCS services provided to its members. An SFHP member who is eligible for CCS services remains enrolled with SFHP, and the Primary Care Provider (PCP) coordinates and continues to provide care for all needs unrelated to the CCS condition.

Physicians and medical group staff are responsible for identification, referral, and case management of members with CCS eligible conditions. Until eligibility is established with the CCS program, the PCP and medical group continue to provide medically necessary covered services related to the CCS eligible condition. The member's PCP is responsible for all primary care and other services unrelated to the CCS-eligible condition and for coordinating care with CCS program staff and specialist.

Some eligible conditions include physical disabilities and complex medical conditions such as sickle cell anemia, cancer, diabetes, HIV, and major complications of prematurity.

Send the member's clinical information and the CCS referral form to:
California Children Services Telephone: 415-575-5700
30 Van Ness Avenue, Suite 200 Fax: 415-575-5790
San Francisco, CA 94102 www.dhcs.ca.gov

Comprehensive Perinatal Services Program (CPSP)

The comprehensive Perinatal Services Program (CPSP) is a Medi-Cal reimbursement program that funds a wide range of services for pregnant women, from conception through 60 days postpartum. Medi-Cal providers may apply to become approved CPSP providers. In addition to standard obstetrics services, women receive enhanced services in the areas of nutrition, psychosocial and health education from approved CPSP providers. This approach has shown to reduce both low birth weight rates and health care costs in women and infants. For more information, call the San Francisco Department of Public Health, Maternal, Clinic and Adolescent Health, Perinatal Services Coordinator 1(415) 575-5681.

Local Education Agency (LEA)

The San Francisco Unified School District's Local Education Agency (LEA) provides services in San Francisco school for low-income children (3-18 years of age) with one more of the following conditions:

- Vision or hearing impairment
- Orthopedically Challenged
- Developmentally Delayed

Children who have received the Early Start (ES) or Golden Gate Regional Center (GGRC) services are assessed between 2-3 years of age for referral to the San Francisco Unified School District Special Intake Unit for continued assistance.

Medical group physicians and the ES or GGRC must obtain written consent from the parents prior to referral and release any clinical information.

Services provided during the school year, under the LEA program are reimbursed by the San Francisco Unified School District. San Francisco Health Plan is not financially responsible for the LEA services provided to its members. A SFHP member who is eligible for LEA services remains enrolled with SFHP, and the medical group and PCP maintain responsibility for coordination of services and for continued medical care. As LEA provides services during the school year only, SFHP and its medical groups authorize and provide medically necessary services during the summer months. LEA services include:

- Nutritional assessment and non-classroom nutritional education
- Education and psychosocial assessments
- Developmental assessments
- Speech Services
- Audiology services
- Physician and occupational therapy
- Medical transportation
- School health aides

Local Education Agency, Special Education Therapy Unit – Telephone 1(415) 759-2895 or 1(415) 379-7693.

DHCS Waiver programs

HIV/ AIDS Waiver program provides Medi-Cal recipients with a written diagnosis of symptomatic HIV or AIDS with case management, in-home skilled nursing care, home-delivered meals, and non-emergency transportation. Qualified persons cannot be simultaneously enrolled in either the Medi-Cal Hospice or the AIDS Case Management Program. For more information, call West Side Community Services at 1(415) 355-0311, Option 8 or www.westside-health.org.

Home and Community-Based Services for the Developmentally Disabled (HCBS-DD) the purpose of this program is to provide in-home care and support to persons with disabilities. Services provided include homemakers for chores, home health aides and/or nurses, family training, vehicle 57 SFHP Network Operations Manual adaptation, respite care, day habitation, transportation and more. For referral and eligibility review contact Golden Gate Regional Center at (415) 456-9222. For more information visit <https://www.dhcs.ca.gov/services/ltc/Pages/default.aspx>

Multi-Purpose Senior Services Program (MPSSP) provides in-home care to members as an alternative to placing them in an institution. The County's Department of Aging administers the program. Services are available to physically disabled or aged members over 65 years of age who would otherwise require care at a skilled nursing facility (SNF) or intermediate care facility (ICF) level.

The PCP or specialist submits appropriate medical records and the MSSP referral to:
Institute on Aging for MSSP and Adult Day Health Care

3626 Geary Boulevard, Second Floor

San Francisco, CA 94118

1(415) 750-4150 or 1(415) 750-5330

www.ioaging.org

San Francisco Adult Day Services Network at 1(415) 808-7371

Nursing Facility Waiver services are provided to Medi-Cal recipients of any age who need in-home assistance with activities of daily living, protective supervision, private duty nursing, environmental adaptation, and case management. For more information, call 1(916) 552-9400

Genetically Handicapped Persons Program is a state-funded program that coordinates care and pays medical costs for eligible person age 21 years old or older with genetically-transmitted diseases such as hemophilia, cystic fibrosis, and sickle cell disease, as well as metabolic disorders such as phenylketonuria (PKU). For more information, call 1(916) 327 0470 or 1(800) 639-0597 or visit their website at <https://www.dhcs.ca.gov/services/ghpp>

Members Rights

NEMS 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 SFHP 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, San Francisco Health Plan, Health Net Medicare Advantage, providers or the state.

Benefits

Pharmacy Benefits

San Francisco Health Plan provides a pharmacy benefit for members in all SFHP programs. Pharmacy Benefits cover outpatient and self-administered medication that are listed in the program formularies. The formulary for SFHP Medi-Cal members, except for the Kaiser group, is managed by SFHP Pharmacy Services Department with oversight from the SFHP Pharmacy and Therapeutics Committee. The Formulary for SFHP Healthy Workers members is managed by the Pharmacy Services Department of the San Francisco Department of Public Health. For provider questions about the pharmacy network or for assistance with pharmacy claims processing, the below Pharmacy Benefits Manager should be contacted.

Program	Pharmacy Benefit Manager	Phone Number
SFHP Medi-Cal	Perform RX	1(888) 989-0091
SFHP Healthy Workers	MedImpact	1(800) 788-2949

For information about program-specific pharmacy benefits, exclusions, or the pharmacy network, visit www.SFHP.org or contact the SFHP Pharmacy Services Department at 1(415) 547-7818 ext. 7085.

Behavioral Health Services

San Francisco Health Plan covers outpatient mental health services for members with mild to moderate conditions. Beacon Health Strategies (Beacon) manages behavioral health services for all SFHP Medi-Cal members, including non-specialty (mild to moderate) mental health services, and behavioral health therapy (BHT) for members under age 21 diagnosed with Autism Spectrum Disorder. To refer a member for mental health services, call Beacon’s toll-free Access line at (855) 371-8117.

Mild to moderate mental health benefits include:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing, when clinically indicated to evaluate a mental health condition (prior authorization required)
- Outpatient services for the purpose of monitoring drug therapy
- Psychiatric consultation
- Outpatient laboratory, drugs, supplies, and supplements (continuation for current benefit)

Chiropractic and Acupuncture

For Medi-Cal members age 20 years and younger, chiropractic and acupuncture benefits are provided through fee-for-service Medi-Cal. These members must call to make their own appointments and utilize their blue and white Medi-Cal card for services

Vision Benefits

Vision Service Plan (VSP) administered vision benefits for SFHP Medi-Cal, and Healthy Workers. Optometry services are a vision benefit and are available every 24 months. Ophthalmology services are a medical benefit through SFHP and there is no restriction for these services for any 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

For Medi-Cal members age 20 years and younger, dental services, are provided by Denti-Cal. A pediatric Medi-Cal member can self-refer for dental services and should call 1-800-322-6384 for questions. A dental screening (by the PCP) is part of the Initial Health Assessment and CHDP check-ups.

Fluoride Varnish

Fluoride varnish is the safest newest form of topical fluoride that is now available to dentists, physicians, nurses, and medical assistants to prevent tooth decay.

- Fluoride varnish may be applied during a routine office visit for San Francisco Health Plan Medi-Cal member under six years of age.
- It does not need refrigeration and has a shelf life of about two years.
- The application requires no special equipment and is easier and more conveniently applied using a prepackaged single use (unit dose) tube, which comes with a disposable applicator brush. It is swabbed directly onto the teeth in less than three minutes and sets within one minute of contact with saliva.

Since many dentists are not willing to see children under six years of age, medical providers offer the best hope for preventing and controlling tooth decay through the application of fluoride varnish.

For provider and clinic staff training, please contact Margaret Fisher, RDHAP, BS, Oral Health Consultant from the San Francisco Child Health and Disabilities Prevention Program at 415-575-5719. If you are a CHDP provider, she can set up 1-hour training in your office. If you are not, inquire about becoming a certified CHDP provider or ask if they could make an exception.

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, SFHP, and Medicare Advantage 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 and Medicare Advantage members may go out of network for sensitive services without prior authorization, except for prenatal care.** Non-Medi-Cal members and Non-Medicare Advantage members may access sensitive services within NEMS MSO 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.

Abortion Services

NEMS SFHP and Medicare Advantage 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.

Sterilization Services

California law (Title 22, Sections 51305.1 and 51305.4) requires that Medi-Cal beneficiaries 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 30 days 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 primary surgeon's claim when submitted for payment. Please consult with NEMS MSO or call SFHP for any clarification.

Family Planning Services

Family Planning services can be obtained from any willing provider for the purpose of delaying or preventing pregnancy, including out-of-network providers on a self-referral basis and without prior authorization.

Non-reimbursable services include:

- Routine infertility studies or procedures.
- Reversal of voluntary sterilization.
- Hysterectomy for sterilization purposes only.
- Transportation, parking, and childcare.

Sexually Transmitted Diseases or Sexually Transmitted Infections

Medi-Cal and Medicare Advantage members can access services for sexually transmitted diseases from *any* willing provider, both in-network and out-of-network. NEMS MSO will cooperate with the 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. The local health department 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.

Health Assessments

Initial Health Assessment (IHA)

An IHA is an initial comprehensive preventive clinical visit with a primary care practitioner. DHCS requires that PCP's complete an IHA with new NEMS SFHP and NEMS Health Net Medicare Advantage members within 120 calendar days of enrollment for all ages. The IHA, at a minimum, includes a history of the member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases. It enables the member's PCP to assess and manage the acute, chronic, and preventative health needs of the member

Staying Healthy Assessment (SHA)

In addition to an IHA, the DHCS requires that PCPs and members also complete a Staying Healthy Assessment (SHA) tool/questionnaire. The SHA is an age-specific risk assessment tool that is repeated at specific age intervals. It is used to assess a member's health habits and status, such as nutrition, physical activity, home safety, exposure to violence, environmental safety, and sexual health and substance use as appropriate. The SHA forms can be found at www.sfhp.org/providers. For information on how to deem a provider's existing IHA forms, please contact Provider Relations at 1 (415) 547-7818 ext. 7084 or email provider.relations@sfhp.org.

Child Health and Disability Prevention (CHDP)

The Child Health and Disability Prevention (CHDP) is a preventive program that delivers periodic health assessments and services to low income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. Health assessments are provided by enrolled private physicians, local health departments, community clinics, managed care plans, and some local school districts. When billing for these Well Child exams, please refer to CHDP's crosswalk of HIPAA-compliant codes and submit claims according to the patient's assigned medical group.

The CHDP program oversees the screening and follow-up components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal children and youth. The CHDP Program is responsible for ensuring that high quality preventative services are delivered and available to eligible children and youth.

SHA Periodicity Table

Questionnaire	Administer	Administer/ Re-administer		Review
Age group	Within 120 days of enrollment	1 st scheduled Exam (after entering new age group)	Every 3-5 years	Annually (interval years)
0-6 months	√			
7-12 months	√	√		
1-2 years	√	√		√
3-4 years	√	√		√
5-8 years	√	√		√
9-11 years	√	√		√
12-17 years	√	√		√
Adult	√		√	√
Senior	√		√	√

Member Benefits

All NEMS members receive:

- Regular medical exams & visits,
- Immunizations,
- Specialist care,
- Inpatient hospital care,
- Emergency services,
- Interpreter services (at no cost to members)
- Health education materials and classes (at no cost to members)

For eligible SFHP NEMS members, we cover medical services that are medically necessary and covered by the Medi-Cal program at the time of service. Benefits include primary care, specialty care, durable medical equipment, home health, inpatient care, and skilled nursing care. Unless specifically indicated, North East Medical Services does not cover services that are not covered by Medi-Cal, including cosmetic services, infertility treatment, and experimental and investigational procedures.

PCP Initiated Member Reassignment or Member Dismissal from Practice

Based on reasonable cause, Medi-Cal beneficiaries under the SFHP/ NEMS Network may be removed from a Primary Care Provider's (PCP) membership list if requested by the PCP. Reasonable cause includes communication problems, inappropriate behavior, multiple missed appointments, member request, member fraud, irreconcilable breakdown of provider-patient

relationship and non-compliance. For members assigned to the SFHP/ NEMS Network, SFHP will review requests for reassignment on a case-by-case basis and may consider other issues in addition to those above listed.

All requests for reassignments must be coordinated through SFHP for Medi-Cal beneficiaries.

The PCP may initiate the process by calling SFHP, and must follow-up by faxing or mailing a letter, describing the reason for the proposed reassignment, but the requesting PCP should **not** send the member a written termination letter. Both the member and the provider are advised in writing of the Plan's decision regarding the reassignment and the member is helped selecting and establishing a relationship with a new PCP.

NOTE: *It is the responsibility of the PCP to provide services up to 30 days after the initiation of the switch or until the switch takes place, whichever happens first. Providers should have a written policy for their own practice to determine the need to dismiss a patient. Patient dismissal may not be a consequence of patient race, color, national origin, sex, sexual orientation, gender identity, or disability.*

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

For members eligible with SFHP, visit SFHP's website at www.sfhp.org to access SFHP's Health Education Library. Health education resources are available in SFHP's threshold languages (English, Chinese, Spanish, and Vietnamese). If you would like more information about health education, please contact the SFHP Population Health Program Manager at 1 (415) 615-5149 or email HealthEducation@sfhp.org.

For Health Net Medicare Advantage members - There is no coinsurance, copayment, or deductible for health and wellness education programs. The nurse advice line provides a toll-free telephonic coaching and nurse advice from trained clinicians. The nurse advice line is available 24 hours a day, 7 days a week for assistance with health-related questions. Members can access the nurse advice line by calling 1-800-893-5597, TTY (711).

Fitness Benefit

Health Net Medicare Advantage (MA) members are eligible for the Fitness Benefit, which provides a basic fitness membership at participating facilities, or you may request an in-home fitness program. You may contact Health Net Member services at 1800-431-9007 for additional information or for specific questions regarding health education materials.

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: NEMS MSO does **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:

**North East Medical Services MSO
Attn: Claims Department
2171 Junipero Serra Blvd, Suite 600
Daly City, CA. 94104**

The NEMS MSO Claims department is available to help with claims questions and can be reached at 1 (415) 382- 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 (SFHP, 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 that 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). NEMS MSO prefers that all claims be submitted electronically, and providers interested in submitting claims electronically should have their biller contact NEMS MSO Provider Relations 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 Timeframes – All claims must be submitted to NEMS timely for consideration of payment. Claims submitted after the appropriate filing deadline, and claims submitted prior to the actual date of service or delivery of supplies will be denied.

- Contracted or in-network providers must submit claims 90-days post-service. Post-service is defined as after the date of service for professional or outpatient institutional providers, or after the date of discharge for inpatient institutional providers
- Non-contracted or out-of-network providers must submit claims within 180 days post-service.

Claims submitted outside of the timely filing timeframes will be subject to timely filing denials. NEMS MSO policy requires that if the member has other health insurance coverage, with certain exceptions, providers are required to bill the member's other health insurance or primary insurance coverage prior to billing NEMS MSO.

NOTE: *The timely payment period is the same for both electronic and paper claims.*

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

Clean Claim

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

Unclean Claim

Lacks sufficient information to pay or deny, and results in the 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 on Claims

NEMS MSO will calculate and automatically pay interest, in accordance with the rate and formula determined by the Treasury Department on a 6-month basis, effective every January and July 1st, to all providers of service who have not been reimbursed for payment, within 45 business days after the receipt of their clean claim. Late payment on complete claims that are neither contested nor denied automatically include interest for the period that the payment is late. The interest period begins on the day after payment is due and ends on the day of payment. Interest is not paid on the following:

- Claims requiring investigation or development by NEMS MSO of the health plans.
- Claims for which no payment is due.
- Claims denied in full.
- Claims for which the provider is receiving PIP (Practice Improvement Programs).

Misdirected claims

When a claim is incorrectly sent to NEMS MSO and it is the responsibility of the member's health plan for payment, NEMS MSO will forward the claim(s) back to the provider within ten (10) business days from date of 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, Medi-Cal) for covered services, since NEMS 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 NEMS MSO

has 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, 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 the NEMS MSO 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, 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 part (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 Claims Refunds
2171 Junipero Serra Blvd, Suite 600
Daly City, CA. 94104**

If NEMS MSO identifies 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
- NEMS MSO date of payment
- Detailed reasons for the refund request

Provider has 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 NEMS MSO does not

receive a full refund or an agreed-upon satisfactory repayment amount within 45 days from the date of the overpayment notification, NEMS MSO 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. NEMS MSO is always the payer of last resort for Medical members; all other coverages are primary. State and federal laws require practitioners to bill other health insurers prior to billing NEMS MSO.

All claims must be submitted to NEMS MSO 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 NEMS MSO. When NEMS MSO is the secondary payer under COB rules, NEMS MSO 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 NEMS MSO 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, and are designed to accomplish the following: 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.

Currently, all the health benefits provided by San Francisco Health Plan and Health Net Medicare Advantage are subject to the COB provision.

Provider Claims Dispute Resolution Mechanism

A provider claim dispute is a written notice to North East Medical Services (NEMS) appealing or requesting reconsideration of a claim that has been reimbursed, adjudicated or denied; or seeking resolution of a billing determination; or disputing a request for reimbursement of an overpayment of a claim.

If a provider wants to dispute a claim payment or denial, the provider can submit a written dispute to the following address:

**North East Medical Services MSO
Attn: Provider Claims Dispute
2171 Junipero Serra Blvd, Suite 600
Daly City, CA. 94104**

Provider must submit a Provider Dispute Resolution Request (PDRR) form in writing along with any relevant and supporting documentation within 365 days of the last adjudication of the claim.

The PDRR must include:

- 1) Provider's Name and Contact Information (Address and Phone Number).
- 2) Provider's NPI Number.
- 3) Patient's Name and DOB.
- 4) Claim Number from NEMS Explanation of Benefit.
- 5) Copy of original claim being disputed.
- 6) Identification of the disputed item(s).
- 7) Explanation of the basis that provider believes the payment amount, adjustment, denial, or request for reimbursement is incorrect.
- 8) Other pertinent documentation to support the appeal.

NEMS will acknowledge the receipt of the PDRR within fifteen (15) working days of receipt of the dispute.

NEMS will issue a written determination, including a statement of the pertinent fact and reasons, to the provider within forty-five (45) working days after receipt of the provider claim dispute. If the initial submission of the PDR is incomplete, NEMS will return it to the provider

with identification of the missing information. Provider has fifteen (15) working days to resubmit an amended PDR with the requested information.

NEMS will issue a written determination to the provider within forty-five (45) working days after receipt of the amended PDRR.

NOTE: Claims that are denied due to provider's claim submission error or omission (e.g. missing modifier, incorrect CPT / ICD-10 or place of service code, etc.,) do not qualify for the Provider Claim Dispute Resolution Mechanism. These claims should be resubmitted within the time period for claim submission as "corrected claim" with a brief explanation of the error either noted on the claim or as an attachment.

CULTURAL AND LINGUISTIC SERVICES

NEMS MOS provides telephonic and in-person interpreter services, including American Sign Language, for all our members for NEMS covered services. All non-English speaking and limited English proficient members of NEMS and SFHP must have linguistic services available for all member service inquiries and medically related visits.

NEMS and SFHP members have a right to:

- Interpreter services at no charge, including signs and telecommunication devices for the hearing impaired.
- Request face-to-face or telephone interpretation services.
- Receive fully translated informing documents in threshold and concentration languages such as Member Service guides, grievance and Notice of Action letters, welcome packets, and marketing information.
- Receive referrals to culturally and linguistically appropriate community services.
- File grievances or complaints if linguistic needs are not met.

NEMS is required to inform providers that they must document primary language and need for language and/or interpretation services by a non-English proficient - or limited English proficient member in the member's medical record.

Providers are also required to:

- Document in the medical record if a member refuses professional interpreter assistance.
- Keep on file documentation of language proficiency for any office staff who communicates with members in non-English languages.
- Update NEMS and SFHP on any changes in your office's language capacity.
- Communicate updates on our membership's population noting changes in language, ethnicity, age, and gender.

NOTE: NEMS is committed to providing quality healthcare to its culturally diverse membership and we highly discourage the use of adult family, children, or friends as interpreters. Children cannot interpret unless there is a life-threatening emergency and no qualified interpreter is available.

If a NEMS member declines interpreter services, please document the interpreter refusal in the medical record. This is required by the California Department of Health Care Services (DHCS) and the California Managed Risk Medical Insurance Board.

To ensure access for members of all cultures, NEMS requires all providers and health care staff to complete cultural sensitivity training. The cultural sensitivity training must cover the use of language services, culture's impact on healthcare, working with members with disabilities, LGBT, aging, refugees and immigrants, and more.

CULTURAL AND LINGUISTIC TRAINING

Professional interpreter services for medical encounters must be offered to NEMS and SFHP's non-English speaking or limited English proficient Medi-Cal members, and Health Net Medicare Advantage members. Members have the right to receive oral interpreter services on a 24-hour basis at no cost to them. Interpreter services may be provided through an in-person interpreter or telephone language service.

NEMS is required to provide this service to SFHP Medi-Cal members. You must document a member's preferred language (if other than English) in the medical record, and if the service is offered and the member refuses, you must document the request and refusal of language/interpretation services in the member's medical record. In order to reduce health disparities, improve quality of care, and reduce medical errors and confusion, you should discourage members from using friends, family and minors as interpreters.

Linguistic Services Terms

- **Limited English Proficient (LEP):** When an individual cannot speak, read, write, or understand the English language at a level that permits him or her to interact effectively with clinical or non-clinical staff in a health care setting.
- **Language Access Services:** Language access services is the collective name for any service that helps an LEP patient obtain the same access to and understanding of health care as an English speaker would have. This can include the use of bilingual staff and interpreters. It also includes the provision of translated documents.
- **Interpretation:** The process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately and objectively in another language, taking the cultural and social context into account.

- **Translation:** The conversion of a written text into a corresponding written text in a different language

Why is Linguistic Access Important?

Accurate communication between patient and health care provider is essential for proper diagnosis, treatment, and patient compliance. It also:

- Helps reduce health disparities
- Helps improve quality of care and patient satisfaction
- Makes business sense
- Is important for compliance with federal and state requirements

Linguistic Access Reduces Health Disparities. Patients with language barriers:

- Experience more outpatient drug complications,
- Experience an increase in other medical problems and lower medication compliance,
- More likelihood of serious side effects
- More likelihood of unnecessary and invasive tests

Business Value Linguistic Access

- Reduce medical errors
- Increase patient satisfaction
- Increase compliance
- Decrease costs for diagnostic testing
- Reduce unnecessary admissions
- More efficient member interactions
- Better community relations

DHCS Medi-Cal Interpreter Services Requirements

- Interpreter services must be available 24/7 at no charge to the patient
- The following should be documented in the medical record:
 - o Patient's preferred language
 - o Patient's refusal of interpreter services
- Discourage the use of friends, family members, or minors as interpreters (unless specifically requested by the member after being offered professional interpreter services at no charge)
- Patients have the right to file grievances or complaints if linguistic needs are not met
- Interpreters and bilingual staff should be qualified (assessed for language capacity)
- Train providers and office staff about linguistic access and cultural awareness

Asking about language preference and working with LEP patient

It is important to make the patient feel comfortable and how you ask a patient his or her language will affect the response you receive. Providers are required to ask about language preference and document the patient's response. The following examples explain the best approach when asking patients about language preference:

“You won’t need an interpreter, will you?”

Phrasing the question this way is **not** the best approach as it sounds like an additional problematic task and discourages the patient, or the person who is making the appointment, from asking for the language assistance needed.

“What language do you speak at home?”

Phrasing the questions this way is **not** the best approach and it will get you information about the patient's home language but ignores the possibility that the patient may be bilingual in English as well.

“Will an interpreter be needed? In what language?”

Phrasing the question this way is **not** the best approach and the patient may say no because they believe they must either bring their own interpreter or have a family member interpret.

“In what language do you prefer to receive your health care?”

Asking the question this way **is the best** approach and will provide you information on the language the patient feels he or she needs to speak in a health-related conversation. If the answer is a language other than English, you can plan to have language assistance available for the patient, and you should add this information to the patient's record.

Avoid using family, friends or minors as interpreters

- They may withhold information from patient from embarrassment, protection, emotional involvement.
- May have their own agenda.
- Children: parent disempowerment, role reversal.
- Can cause guilt & trauma.
- May not be familiar with medical terminology.
- Serious mistakes can occur.

Working with Interpreters on-site

- Greet the patient first, not the interpreter.
- Face and talk to the patient directly.

- Speak at an even pace in relatively short segments.
- Speak in Standard English and avoid medical terminology and jargon.
- Ask one question at a time.
- Avoid interrupting the interpretation.
- Don't make assumptions about the patient's education level. An inability to speak English does not necessarily indicate a lack of education.

Working with Interpreters by Phone

When working with an interpreter over the phone, many of the principles of on-site interpreting apply. The only additional thing to remember is that the interpreter is “blind” to the visual cues in the room. When working with an interpreter over the phone, consider the following:

- When the interpreter comes onto the line, let the interpreter know who you are, who else is in the room, what sort of office practice this is, what sort of appointment this is.
- For example, “Hello interpreter, this is Dr. Chan. I have Mrs. Wong and her adult daughter here for Mrs. Wong’s annual exam.”
- Give the interpreter the opportunity to quickly introduce him/herself to the patient.
- If you point to a chart, a body part or a piece of equipment, verbalize what you are pointing to as you do it.

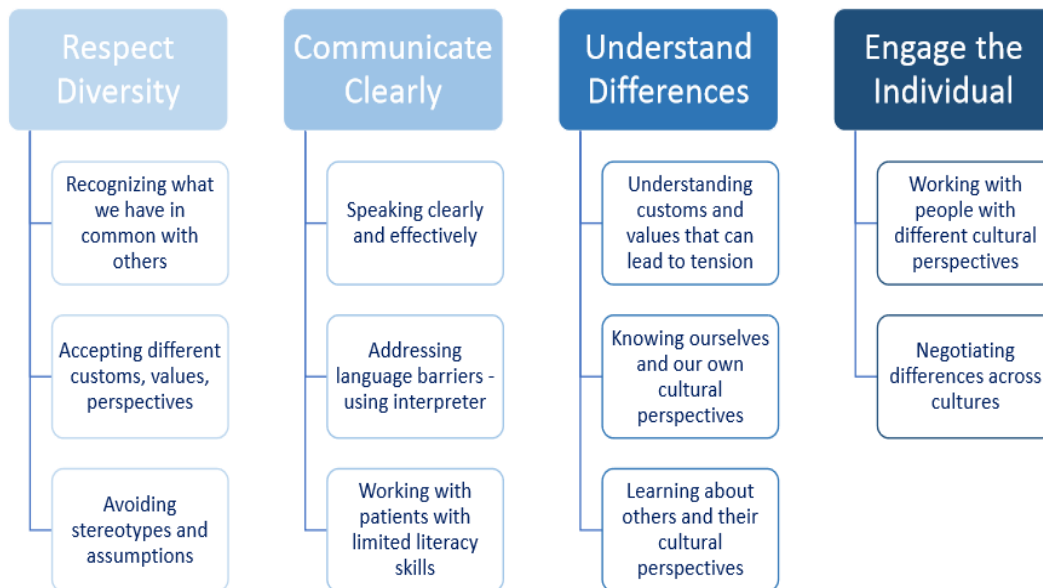
What is Culture?

Culture consists of a body of learned beliefs, traditions, and guides for behaving and interpreting behavior that is shared among members of a particular group, and that group members use to interpret their experiences of the world.

- Cultural awareness is being cognizant, observant, and conscious of similarities and differences among and between cultural groups.
- Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.
- Cultural humility is a commitment and active engagement in a lifelong process that individuals enter on an ongoing basis with patients, communities, colleagues, and with themselves.

Cross cultural communication focuses on how people from different cultures, backgrounds, beliefs and communities communicate across different cultures.

Tips to consider for effective cross-cultural communication



Other strategies for cross-cultural communication

- Avoid body language that may be offensive.
- Choose a speech rate and style that promotes understanding.
- Use open-ended questions.
- Speak directly to the patients and be an active listener.
- Check for understanding (ask if the patients understand).
- Be mindful of body language (written, spoken, and non-verbal).
- Create a welcoming environment.
- Be mindful that in the visit, healthcare providers tend to ask a lot of question.

Cultural awareness

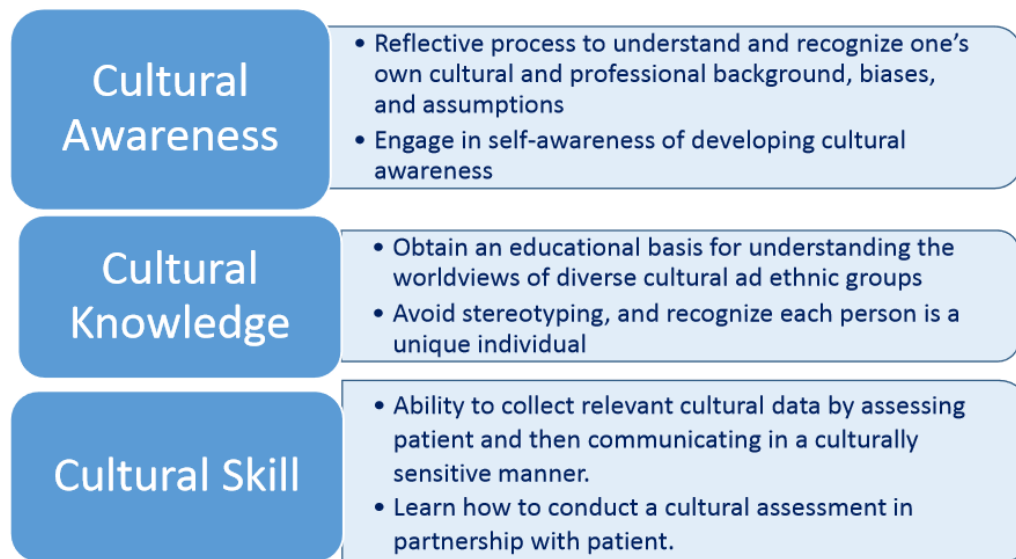
Cultural awareness is an individual's understanding of the differences between themselves and people from other backgrounds, especially differences in attitudes and values. Cultural awareness is extremely important for communication and it involves being able to stand back from ourselves and becoming aware of our cultural values, beliefs and perceptions and it can help people overcome cultural challenges in everyday life when interacting with others whose culture, values and beliefs we are not fully aware.

What is cultural Competence in Health Care?

- Recognition that people of different cultures have different ways of communicating, behaving, interpreting, and problem-solving.
- Recognition that cultural beliefs impact patient’s health beliefs, help-seeking activities, interactions with health care professionals, health care practices, and health care outcomes, including adherence to prescribed regimens.

Key Steps Towards Cultural Competence:

Building strong cross-cultural communication skills can help providers better understand the needs, values, and preferences of patients, and further establish a more collaborative relationship.



Caring for LGBTQ+ Communities

SFHP, NEMS, and Health Net Medicare Advantage members have diverse sexual orientations.

- Identify your own LGBTQ+ perceptions and biases as a first step in providing the best quality care.
- Many LGBTQ+ people do not disclose their sexual orientation or gender identity because they do not feel comfortable or they fear receiving substandard care.

SFHP, NEMS, and Health Net Medicare Advantage members have diverse gender identities

- Cisgender – people whose gender identity and gender expression align with their assigned sex at birth

- Transgender – people whose gender identity and/ or gender expression differs from their assigned sex at birth (people may or may not choose to alter their bodies hormonally and/ or surgically)

Tips for Working with Transgender Patients

- Treat transgender people as you would want to be treated.
- Always refer to transgender people by the name and pronoun that corresponds to their gender identity
- If you are unsure about the person’s gender identity, ask:
 - "How would you like to be addressed?"
 - "What name would you like to be called?"
- Focus on care rather than indulging in questions out of curiosity.
- The presence of a transgender person in your treatment room is not an appropriate “training opportunity” for other health care providers.
- It is inappropriate to ask transgender patient about their genital status if it is unrelated to their care.
- Never disclose a person’s transgender status to anyone who does not explicitly need information for care.

Source: Transgender law Center

Caring for Seniors and Persons with Disabilities (SPDs)

- Meeting the individual accommodation needs of SPDs to the extent possible ensures the following:
 - The practice provides appropriate and effective care
 - Compliance with the federal Americans with Disabilities Act (ADA) and Section 504 of the 1973 Rehabilitation Act.
 - The ADA and Section 504 require that healthcare services provide certain accommodations that ensure equitable and non-discriminatory access to care.
 - 70% of SFHP member with disabilities live with 2+ chronic conditions and 16% of these members have diabetes (compared with 7% in general population)
 - About 25% have 4+ chronic conditions
 - 30% of beneficiaries with disabilities receive treatment for mental health conditions annually

Accommodations: What Patients May Need

- Physical accessibility
- Effective communication
- Sign Language interpreters, assistive listening devices, print materials in accessible formats

- Policy modification (for example, to allow more time for an office visit)
- Accessible medical equipment

Interacting with Seniors

- Avoid ageist assumptions when providing information and recommendations about care
- Offer information in a clear, direct, and simple manner.
- Do not assume limitations exist just based on age
- Recognize the seniors as the expert in their own life

Quote from a senior activist: “As Seniors we know our capabilities and energy are diminishing, but want to retain the right to limit ourselves when the time comes, and not have young people put those limitations on us, to make them feel better.”

Interacting with People with Physical Disabilities

- Mobility and physical disabilities range from people who have mild to those with significant limitations.
- If shaking hands is appropriate, do so. People with limited hand use or who use prosthesis can usually shake hands. If people have no arms, lightly touch their shoulder.
- When speaking to a person using a wheelchair or scooter for more than a few minutes, try to find a seat or kneel so you are at the same eye level.
- Ask for permission before moving someone’s cane, crutches, walker, or wheelchair.

Interacting with people with Speech Disabilities

- Some (not all) people with limited speech have difficulty understanding what people say to them because of their disability, age, hearing loss, cognitive difficulties and/ or language differences.
- Do not raise your voice. People with speech disabilities can hear you.
- Always repeat what the person tells you to confirm that you understood.
- Ask questions one at a time. Give individuals extra time to respond.
- Pay attention to pointing, gestures, nods, sounds, eye gaze, and blinks.
- If you have trouble understanding a person’s speech, it is ok to ask them to repeat what they are saying, even three or four times. It is better for them to know what you do not understand than to make an error.

Interacting with People with Cognitive, Intellectual, or Psychiatric, Disabilities

- A cognitive, intellectual, or psychiatric disability can affect a person’s understanding, memory, language, judgment, learning and related information processing and communication functions. These disabilities include individuals with intellectual disabilities, head injury, strokes, autism, Alzheimer’s disease, and emotional disabilities.

- Offer information in a clear, concise, concrete, and simple manner.
- If you are not being understood, modify your method of communicating. Use common words and simple sentences.
- Allow time for people to process your words, respond slowly, or in their own way.
- Make sure the person understands your message.

Interacting with People with Disabilities

- People can have a range of visual disabilities, from having no vision to people who have low vision and may be able to read large print.
- When offering help, identify yourself and let people know you are speaking to them by gently touching their arm. If you leave people's immediate area, tell them so they will not be talking to an empty space.
- Speak directly facing the person. Your natural speaking tone is sufficient.
- When giving directions, be specific. Clock clues may be helpful, such as "the desk at 6 o'clock." When guiding a person through a doorway, let them know if the door opens in or out and to the right of to the left.
- People who are blind or have visual impairments may request (from SFHP) print materials in accessible formats such as digital, audio, large print, or Braille.

Thank you for being a part of the North East Medical Services (NEMS) MSO Provider Network.

Need more information? Contact the NEMS MSO Provider Relations Team

Provider Relations Department

Hours of operation: Monday through Friday, 8:00 a.m. to 5:30 p.m.

Telephone: 1(415) 352 - 5186 **option 3**

Email: Provider.Relations@nems.org