



**NORTH EAST**  
**MEDICAL SERVICES**

東北醫療中心

MANAGEMENT SERVICES ORGANIZATION (MSO)

## Provider Manual

This document contains information for San Francisco Health Plan (SFHP) NEMS (Medi-Cal Beneficiaries), and NEMS **Health Net Medicare Advantage** program requirements. Additional information is available on the SFHP website ([www.SFHP.org/providers](http://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.*** If you have any questions regarding the contents of the document, contact NEMS MSO Provider Relations at 1(415) 352 - 5186 Option 3

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**Our Mission:** To provide 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**.

## **HISTORY AND WHO WE ARE**

North East Medical Services (NEMS) was founded in 1968 and began serving patients in 1971 in response to the lack of adequate health care services for uninsured and underprivileged Asians in San Francisco, taking part in a nationwide movement to establish community-based health centers. For more than 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 since inception, we have received federal funding through the Community Health Centers (CHC) program.

In 1999, NEMS formed a managed care Management Services Organization (MSO) to

provide medical services for Medi-Cal patients from the San Francisco Health Plan.

To meet the growing demands for its services, we opened its first satellite clinic in San Francisco’s Visitacion Valley in 2000. Additional clinics throughout San Francisco, Daly City, and San Jose followed between 2004 and 2012. Today, we operate [12 clinics](#) throughout the San Francisco Bay Area.

NEMS MSO as a Federally Qualified Health Center (FQHC), is eligible to contract with Managed Care plan as a Risk Bearing Organization (RBO) to take full or partial risk to provide services in a managed care system for residents who qualify for Medi-Cal and have enrolled in the San Francisco Health Plan. NEMS MSO is an internally developed Management Services Organization, which performs administrative services for the managed care members enrolled in the San Francisco Health Plan and have selected NEMS as the primary care clinic/provider.

In 2000, we collaborated with California Pacific Medical Center (CPMC), and together contracted with San Francisco Health Plan (SFHP) and formed the first 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 collaborated with Zuckerberg San Francisco General Hospital (ZSFG) to contract with SFHP and formed the second full-risk managed care network known as NMS Network. The NEMS Clinics in the San Francisco and San Mateo Counties are the participating primary care clinics in this network.

In 2019, we expanded our services and added an additional program to the network and contracted with Health Net Medicare Advantage to offer 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.

## Contact Information

### Provider Relations

**Hours of operation:** Monday to Friday,

**8:00am – 5:30pm**

**Phone:** 1(415) 352-5186 **Option 3**

**Email:** [Provider.Relations@nems.org](mailto:Provider.Relations@nems.org)

Contact Provider Relations for questions or concerns pertaining to provider issues, network and contracting inquiries, and credentialing.

### Utilization Management

**Hours of operation:** Monday to Friday,

**8:00am – 5:30pm**

**Phone:** 1(415) 352-5186 **Option 1**

Contact the Utilization Management for questions regarding authorizations, case management, covered medical services, and inpatient concurrent reviews.

### Claims

**Hours of operation:** Monday to Friday,

**8:00am – 5:30pm**

**Phone:** 1(415) 352-5186 **Option 2**

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

## OUR PROGRAMS

### Medi-Cal Managed Care Program

Medi-Cal provides free and low-cost health care coverage services to low-income adults, families with children, pregnant women, seniors, people with disabilities, children in foster care, and adults formerly in foster care up to age 26. Certain populations that include adults, families with children, seniors, and people with disabilities, are required to enroll in Medi-Cal managed care. Other Medi-Cal enrollees, such as those with a Share of Cost, do not receive their Medi-Cal services through a managed care plan and remain in Fee-for-Service Medi-Cal. San Francisco Health Plan (SFHP) is one of two Medi-Cal managed care plans authorized by the California Department of Health Care Services (DHCS) to serve Medi-Cal members in San Francisco.

There are different types of Medi-Cal coverage, ranging from limited scope coverage (such as pregnancy related services only) to full scope coverage that is inclusive of primary, specialty, behavioral health, acute care services, vision, and dental. All SFHP Medi-Cal members have full scope Medi-Cal coverage. For most SFHP members, such as adults and seniors and people with disabilities, there is no cost sharing (premiums or copays). A small percentage of children over the age of 1 year in families with incomes above 160% of the federal poverty level pay low-cost premiums. Individuals can apply for Medi-Cal in person, online, via mail, or over the telephone. In addition, SFHP is a Certified Medi-Cal Managed Care Enrollment

Entity and the SFHP Service Center provides in person enrollment assistance for Medi-Cal and Covered California. Medi-Cal eligibility is determined by eligibility workers at the San Francisco Human Services Agency (HAS). Additionally, SFHP members may be enrolled in Medi-Cal due to their enrollment in other social services programs, such as CalWORKS, TANF, and SSI.

#### Application Resources:

- Apply online at [mybenefitscalwin.org/](http://mybenefitscalwin.org/) or [coveredca.com/apply/](http://coveredca.com/apply/)
- Apply over the phone by calling Toll-free. 1(855) 355-5757
- Apply in person:  
1440 Harrison Street  
San Francisco, CA 94103  
Monday through Friday, 8:00am to 5:00pm
- SFHP Service Center:  
7 Spring Street  
San Francisco, CA 94104  
Monday through Friday, 8:30am to 5:00pm  
1(800) 288-5555 to schedule an appointment.
- Submit application by mail or email to Human Services Agency:  
PO BOX 7988  
San Francisco, CA 94120  
[SFMedi-Cal@sfgov.org](mailto:SFMedi-Cal@sfgov.org)

### Medi-Cal and Health Care Options; Fee-for-Service vs. Medi-Cal Managed Care

The San Francisco Health Plan (SFHP) is one of two Medi-Cal managed care plans that maintains a contract with the California Department of Health Care Services (DHCS) to provide comprehensive Medi-Cal benefits to Medi-Cal enrollees in San Francisco. Individuals with dual Medicare and Medi-Cal coverage, sometimes referred to as “Medi-Medi” or

“duals”, are **not** required to enroll in Medi-Cal managed care but may choose to enroll in Medi-Cal managed care. In San Francisco, individuals required to enroll in Medi-Cal managed care are offered a choice of SFHP and Anthem Blue Cross. Health Care Options (HCO) is the statewide third-party administrator carrying out enrollment into a health plan. HCO provides information to Medi-Cal beneficiaries about their SFHP and Anthem Blue Cross health plan options through local HCO representatives and are located at the Medi-Cal or CalWORKs offices. Enrollment into a health plan usually takes from 15 to 45 days from the effective date of MC eligibility. Once enrolled in a health plan, Medi-Cal members may change their health plan monthly.

#### Health Care Options (HCO):

Health Care Options is the statewide third-party administrator for Medi-Cal Managed Care. HCO can provide information on enrollment, disenrollment, and Medi-Cal Managed Care Health Plans.

Phone: 1(800) 430-4263

### 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 (MCP) as the service delivery system for their Medical benefits. Medicare remains the primary coverage for these members, and NEMS works with the MCP to coordinate these dual eligible members' health care needs.

### VERIFYING MEMBER ELIGIBILITY

#### How to Check Eligibility

When a NEMS member seeks medical care, it is important that providers verify eligibility on the date of service. A member's eligibility and

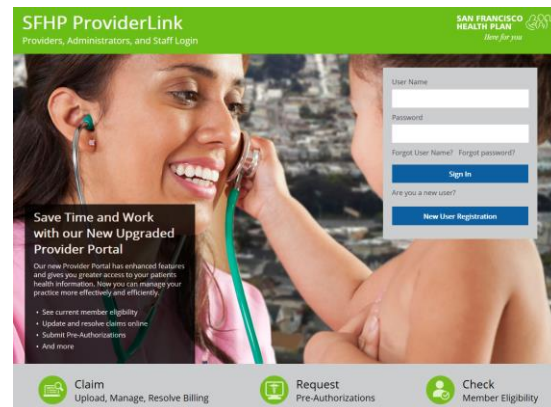
PCP/Medical group assignment can change from month to month, and beneficiaries will oftentimes not communicate or be aware of such changes. Failure to verify eligibility may result in non-payment of claims. Providers are encouraged to verify eligibility:

- To verify that the member is currently active.
- To verify medical group of PCPs 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 your services to an eligible member.

To Verify Eligibility for SFHP:



1. Request a copy of the member's Health Plan ID Card
2. Check eligibility using the Secure Provider Portal at [www.SFHP.org/providers/](http://www.SFHP.org/providers/) and click on provider login. Please visit the SFHP website and create an account to access the provider portal.



3. Call the SFHP Interactive Voice Response System (IVR) at 1(415) 547-7810. The system is available 24 hours a day, 7 days a week.

4. Call the SFHP Customer Service Department at 1(415) 547-7800, Monday through Friday, 8:30am to 5:30 pm.

**NOTE: For all lines of business, possession of a Health Plan ID Card (SFHP, Health Net MA) or Medi-Cal card (BIC) does not guarantee eligibility.**

### **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 a PCP is not selected, SFHP will automatically assign a PCP taking into consideration the member's place of residence, primary spoken language, and other similar factors. SFHP members who are auto assigned to a PCP may select another PCP. All members may change PCPs upon request if the PCP is accepting new patients. PCP Change requests made by the 15<sup>th</sup> day month will be effective on the first day of the following month. PCP changes should be directed to SFHP Customer Service Department.

To request a change of Primary Care Provider, a member may call **SFHP Member Services at 1(415) 547-7800 or 1(800) 288-5555 (toll free) to request a change.** A new member ID card

with the name and phone number of the new PCP will be mailed to the member.

## Members Rights and Responsibilities

San Francisco Health Plan Members have rights and responsibilities. Members are informed of their rights and responsibilities through member education materials.

SFHP members have the right:

- To be treated respectfully, with dignity, no matter what your gender, culture, language, appearance, sexual orientation, race, disability, and transportation ability is, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about the plan, our services, including Covered Services, our practitioners and providers and your rights and responsibilities.
- To be provided information about all health services available to them, including a clear explanation of how to get them.
- To be able to choose a primary care provider within the Contractor's network.
- To participate in decision making regarding their own health care, including the right to refuse treatment.
- To be able to have candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- To voice complaints or grievances, either verbally or in writing, about the organization or the care received.
- To receive care coordination.
- To request an appeal of decisions to deny, defer, or limit services or benefits.
- To receive oral interpretation services for their language
- To receive free legal help at their local legal aid office or other groups.
- To formulate advance directives.
- To have access to family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and Emergency Services outside the Contractor's network pursuant to the federal law.
- To request a State Hearing, including information on the circumstances under which an expedited hearing is possible.
- To have access to, and where legally appropriate, receive copies of, amend or correct their Medical Record.
- To disenroll upon request, beneficiaries that can request expedited disenrollment include, but are not limited to, beneficiaries receiving services under the Foster Care, or Adoption Assistance Programs, and members with special health care needs.
- To access Minor Consent Services.
- To receive written member informing materials in alternative formats (including braille, large-size print, and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with W & I Code Section 14182 (b)(12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand.
- To receive a copy of your medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how the Contractor, providers, or the State, treats you.
- To make recommendations regarding our member rights and responsibilities policy.

- Right to oral interpretation at no cost to the member.

### San Francisco Health Plan members have the responsibility to:

- Carefully read all SFHP materials immediately after you are enrolled so you understand how to use your SFHP benefits.
- Ask questions when needed.
- Follow the provisions of your SFHP membership as explained in this Manual.
- Be responsible for your health, understand your health problems, and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Follow the treatment plans your provider develops for you and consider and accept the possible consequences if you refuse to follow with the treatment plans or recommendations.
- Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.
- Make and keep medical appointments and let your provider know ahead of time when you must cancel.
- Communicate openly with your provider so you can develop a strong partnership based on trust and cooperation.
- Offer suggestions to improve SFHP.
- Help SFHP and your providers maintain accurate and current medical records by providing information promptly about changes in address, family status, other health plan coverage, and information needed to provide you with care.
- Notify SFHP as soon as possible if you are billed inappropriately or if you have any complaints.
- Treat all SFHP staff and health professionals respectfully and courteously.

- As required by Medi-Cal Program, pay any premiums, co-payments, and charges for non-covered services on time.
- You may refuse, for personal reasons, to accept procedures or treatment recommended by your medical group or primary care provider. If you refuse to follow a recommended treatment or procedure, your medical group or primary care provider will let you know if he or she believes that there is no acceptable alternative treatment. You may seek a second opinion as provided in this Manual. If you still refuse the recommended treatment or procedure, then SFHP has no further responsibility to provide any alternative treatment or procedure that you seek.
- Using your ID cards properly. Bring your SFHP ID card, a photo ID, and your Medi-Cal ID card with you when you come in for care.
- Telling us if you receive care at a non-SFHP contracted facility/provider.
- If you require an interpreter, you should request an interpreter in advance prior to your appointment.

Contact the San Francisco Health Plan Customer Service Department at 1(415) 547-7800 (local) or 1(800) 288-5555 (toll-free) for any questions or issues regarding member rights and responsibilities.

### PCP Assignments

At the time of enrollment with San Francisco Health Plan (SFHP), new members are encouraged to select a PCP from the SFHP provider network. If the member does not select a PCP, SFHP will automatically assign a PCP taking into consideration the member's place of residence, primary spoken language, and other similar factors. SFHP members who are auto-assigned a PCP may select another PCP of their liking, but members must choose a



physician who is taking new members from the list of internal medicine, general medicine, family practice, pediatrics, and OB-GYNs (women can choose an OB-GYN as their PCP).

A member's choice overrides automatic selection, and members automatically assigned PCPs are required to contact the SFHP Member Services Department to request a change. PCP change requests made by the 15th day of the month will be effective on the first day of the following month. The SFHP Customer Service department coordinates all PCP changes requests. Members enrolled in both Medi-Cal and Medicare (traditional Medicare) do not have to select a PCP.

Contact the San Francisco Health Plan Customer Service Department at 1(415) 547-7800 (local) or 1(800) 288-5555 (toll-free) for any questions or issues regarding selecting a PCP, and member rights and responsibilities.

### PCP Initiated Member Reassignment or Member Dismissal from Practice

Based on reasonable cause, a member 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. 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.** The requesting PCP should not send the member a written termination letter. The PCP may initiate the process by calling SFHP, but must follow-up by faxing or mailing a letter, describing the reason for the proposed reassignment. Both the

member and the provider will receive in writing the Plan's decision regarding the reassignment, and the member obtains assistance 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.***

### PCP Responsibilities

The PCP is the overall coordinator of care for the San Francisco Health Plan members (SFHP-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/EPSTD 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

the San Francisco 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.

## 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. NEMS MSO staff do 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

NEMS Utilization Management (UM) staff are available to members and providers 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.

## General UM Information

It is the responsibility of the provider to establish coverage eligibility and medical group assignment prior to delivering services. This avoids the possibility of providers obtaining reimbursement denials for services already rendered. Authorizations are contingent upon the member's eligibility, benefit program, and are not a guarantee of payment.

Routine services provided by Primary Care Physicians do not require prior authorization. Regardless of where services are received, a prior authorization is not required for emergency services and sensitive services (family planning, sexually transmitted disease services, HIV testing). Basic prenatal care, OB/GYN and family medicine providers for routine and preventive care, preventive care services, and several other services do not require prior authorization but must be

obtained from providers affiliated with NEMS MSO.

**Please note that any contracted or non-contracted provider may render emergency treatment without authorization.**

Please verify eligibility using one of the following methods for each date of service:

- Use the San Francisco Health Plan (SFHP) Secure Provider Portal  
[Sfhpprovider.healthtrioconnect.com](https://sfhpprovider.healthtrioconnect.com)
- Call the SFHP Interactive Voice Response System (IVR) at 1(415) 547-7810. The system is available 24 hours a day, 7 days a week.
- Call the SFHP Customer Service Department at 1(415) 547-7800, Monday through Friday, 8:30am to 5:30 pm.

**The following services do not require prior authorization:**

- Emergency care including emergency medical transportation.
- Urgent Care provided at an Urgent Care Center
- DEXA Scans
- GYN Services (routine women's health preventive care services, including cervical cancer screening)
- Mammograms
- Tuberculosis Care (includes screening, testing and treatment)
- Preventive Services (within medical group)
- Referrals to Specialists (within medical group)
- Sensitive Services: Includes family planning services, HIV and Sexually Transmitted Infection (STI) testing and counseling, and outpatient abortion services. Medi-Cal members can access these services with any



provider who is contracted or with a non-contracted Medi-Cal provider.

- Standing referrals to Specialty Care
- HIV testing and treatment of sexually transmitted infections (STI)

### 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

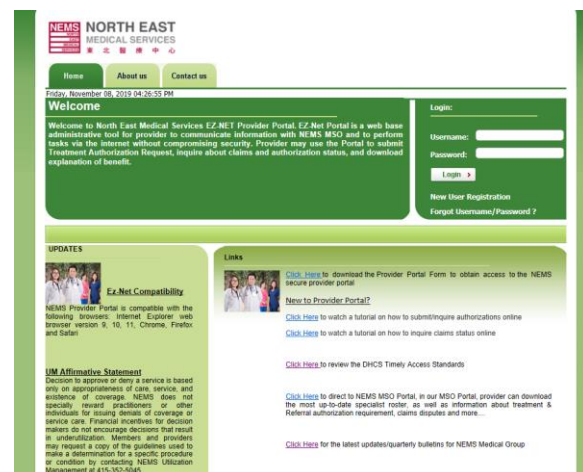
cosmetic services, infertility treatment, and experimental and investigational procedures. All requests for Prior Authorizations (PA) can be submitted online using the provider portal or by submitting via fax with all supporting clinical documentation/ medical records to the Utilization Management fax 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.

### **General Provisions**

There are certain procedures, services, and medications that require prior authorization from the NEMS MSO Utilization Management Department. Providers are required to request approval in advance for services and procedures requiring prior authorization. Please visit the link below to access the authorization grid for the listing of procedures requiring prior authorization.

<https://www.nems.org/mso/forms.html>

San Francisco Health Plan (SFHP) regulates drugs and medications prescribed for NEMS MSO members, and certain drugs are not included in the NEMS MSO Utilization Management review process. Prescribed medication must be included on the SFHP drug formulary, and certain medications on the drug formulary list require prior authorization. Such requests must be submitted directly to SFHP for determination. Prescribed medications are regulated separately by SFHP and are not included in the pharmacy benefit.

### **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, NEMS MSO 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.

## 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](http://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 is not covered by Medi-Cal (under the evidence of coverage) at the time of the authorization request.

## Case Management and Care Coordination

Case Management strives to assist patients and families navigate through the managed healthcare system. The MSO Nurse Case Managers provide advocacy for patients and interact with healthcare team members to find solutions in providing effective, quality, and efficient care. The objectives are to facilitate timely discharges, coordinate care across the continuum, prompt and efficient use of resources, and quality improvement activities that lead to optimal patient outcomes. Our Case Management Program includes, but is not limited, to the following activities:

- Assessment/reassessment and Care Plan development.

- Care coordination and Medical interpretation at critical appointments.
- Patient education of disease process; Coaching of self-management.
- Medication Reconciliation.
- Home Visit after hospital discharges.
- Assistance in accessing community resources, e.g., SF Paratransit, CCS, LEA, IHSS, GGRC, etc.

The member's primary care provider in collaboration with NEMS MSO Case Management team provides basic Case Management services. Case Management is the coordination of care and services provided to members who have experienced a critical event or diagnosis requiring extensive use of resources, and who require assistance navigating the Health Care system to facilitate appropriate delivery of care and services. The Complex Case Management Program is considered an opt-out program, therefore, all eligible SFHP-NEMS members have the right to accept or decline participation in Case Management.

The primary goal of complex case management is to help members regain optimum health or improved functional capability in the right setting. Complex Case Management involves comprehensive assessment of the member's medical condition; determination of available resources and benefits; and development and implementation of a case management plan with assessments, performance goals, monitoring and follow-up.

Members with more complex medical and/or social needs may require a specific Case Manager, separate from the member's Primary Care Provider. This may occur under the following conditions:

- Medically complex or costly care (e.g., AIDS, high risk pregnancy, terminal illness)

- Coordinating out-of-network services (e.g., drug treatment services, CCS eligible services)
- Members with potential access difficulties (e.g., member having unique linguistic needs)
- Transition with changing Medi-Cal coverage and benefits (e.g., during major organ transplant, during hospital discharge, Skilled Nursing Facility Discharge)

Once care coordination need is identified, the Case Manager works collaboratively with the member, the member's family, PCP, specialists, ancillary providers, hospitals, social services, etc. to ensure the member receives appropriate treatment for acute and chronic conditions.

The Case Management staff identify members in need of coordination of care from the following sources:

- Existing prior authorizations
- PCP or Specialist's referrals
- Referrals from the Utilization Management team
- Authorization requests/ inquiries from out-of-network providers and/ or programs

NEMS MSO maintains a summary report of case management activities, and list of members Utilization Management staff at NEMS MSO. Providers may refer patients with complex medical needs to the NEMS MSO Case Management team by email to [CaseManagement@nems.org](mailto:CaseManagement@nems.org) or by phone at 1(415) 352-5179.

## Quality Improvement

The purpose of NEMS Quality Improvement (QI) Program is to systematically monitor, evaluate, and improve the quality of care and services provided to members. The QI Program is designed to ensure that members have access to quality medical services that are safe,

being case managed, with documentation of their status (i.e., active, inactive, discharged with disposition). Documentation of Health Action Plan(s) includes PCP approval and ongoing communication between case managers and PCPs. The NEMS Utilization Management Committee and the Quality Improvement Committee review quarterly the Case Management reports and summaries and make recommendations on program effectiveness and/or changes.

The primary goals of the program are to:

- Enhance the quality of life of the client.
- Provide support and advocacy to member and Provider.
- Decrease fragmentation of care.
- Promote cost-effectiveness.
- Improve client and provider satisfaction.
- Meet regulatory and accreditation requirements.

Case Managers coordinate individual services for members whose needs include ongoing assistance with coordinating health care services. The Case Managers work collaboratively with all members of the healthcare team, including the Primary Care Provider, Specialist Providers, and Discharge Planners at the affiliated hospitals, and effective, accessible, equitable, and meet their unique needs.

The QI Program identifies annual goals for selected measures. The scope and goals of the QI Program are comprehensive and encompass major aspects of care and services within the NEMS health care delivery system, including clinical and non-clinical issues that affect its membership. NEMS evaluates the overall effectiveness of the QI Program through an evaluation process. The QI Program evaluation, which may include reviewing and monitoring the results of QI measures, goals, interventions, and barriers.

Provider cooperation in the QI Program is required to improve the quality of care and services for members including member experience. Providers must cooperate with all independent quality review and improvement activities required by NEMS pertaining to the provision of services to members. Providers must allow NEMS access to their facilities for the purposes of site review, case management, and other quality management activities. NEMS may utilize provider performance data for quality improvement activities such as HEDIS and pay-for-performance.

### **SBIRT**

Primary care providers (PCPs) provide Screening, Brief Intervention and Referral to Treatment (SBIRT) to members with substance abuse disorders, as well as those who are at risk of developing these disorders. PCPs screen members as part of routine care for alcohol and substance misuse. PCPs refer members identified with possible alcohol/substance misuse to the alcohol and drug program for evaluation and treatment. PCPs' early intervention with a patient may induce a positive change in health-related behavior.

### **Long-Term Care**

A NEMS Medi-Cal member receiving long-term care (LTC) at a Skilled Nursing Facility (SNF) may be disenrolled from managed care Medi-Cal and transferred to Fee-for-Service Medi-Cal, if the SNF admission exceeds the month of admission and the following month. Disenrollment will become effective on the first day of the second month following the member's month of admission to a SNF. Providers must notify NEMS of all members admitted for LTC by submitting notification of admission to the NEMS UM department via fax at 1(415) 398-2895.

### **Care Transition**

When a member is admitted to a hospital or SNF, a NEMS Case Manager works closely with the discharge planner at the facility to ensure that member is safely transitioned to home or an alternate level of care. The NEMS Case Manager assist with connecting members with medically necessary services, follow-ups with providers, and community support services as needed upon discharge. A NEMS Case Manager contacts the member after hospital discharge to perform medication reconciliation and assess member's resource and referral needs.

### **Health Homes Program**

The Health Homes Program (HHP) is a federally funded program designed to improve the health outcomes of qualified Medi-Cal members with certain chronic conditions and complex medical needs. NEMS is a Community-Based Care Management Entity (CB-CME) that provides extensive care coordination services at no cost to the member. The six main HHP services include:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports

Each HHP member is assigned a nurse case manager who will work with the care team to ensure all services and health care needs are met. The care team may consist of member's primary care provider, specialist(s), pharmacist, housing navigator, and social worker. Providers may refer patients with complex medical needs to the NEMS MSO Case Management team by email to [CaseManagement@nems.org](mailto:CaseManagement@nems.org) or call 1(415) 352-5179.



## **Provider Appointment Availability Survey**

On an annual basis, SFHP administers the Provider Appointment Availability Survey (PAAS) to measure patient access to care against Department of Managed Health Care's (DMHC) Access to Care Standards. The survey is conducted annually over the phone or via fax, during the third or fourth quarter of the year. SFHP selects a random sample of primary care physicians, specialists, and ancillary providers to survey. Providers should complete the survey or transfer the call/fax to an alternate staff member who will complete the survey. Any non-response is considered non-compliant and will require a corrective action plan.

## **PROVIDER RELATIONS, PROVIDER POLICIES AND CREDENTIALING**

The Provider Relations Department is responsible for informing providers of various updates and changes pertaining to contracted health plans, policy changes, new and current 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
- Assisting with navigating the provider portal
- Assisting with finding in-network providers
- Contract Management
- New Provider Orientations
- Creating and disseminating various NEMS MSO related Provider communication

## **Practitioner Credentialing/ Re-credentialing**

NEMS MSO follows 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. NEMS MSO's credentialing standards are based on federal and California state requirements and comply with our contracted Health Plan's (SFHP) 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.

For additional questions regarding credentialing contact:

**Provider Relations Department**

**Phone: 1(415) 352 - 5186 Option 3**

**Email: [Provider.Relations@nems.org](mailto:Provider.Relations@nems.org)**

## Specialists Responsibilities

Specialists are required to 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 NEMS MSO 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

NEMS MSO provides SFHP with a provider roster on at least 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 SFHP in an expedient and timely manner. All credentialing and provider training activities must be completed before a provider is sent to SFHP for activation.

## Provider Roster Requirements and Verification Process

On at least a quarterly basis, 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
- 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

On at least a quarterly basis, NEMS MSO must notify SFHP of new Participating Providers through the submission of provider network files. SFHP delegates credentialing to NEMS MSO and SFHP has criteria that will prevent activation of a new Participating Provider's record until all credentialing and provider information are received from NEMS MSO. 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 SFHP-NEMS provider, submit the information to NEMS MSO Provider Relations Department. The Provider Relations staff is responsible for obtaining provider training attestations forms and submitting all the required documents to SFHP once completed. For additional 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](mailto:Provider.Relations@nems.org)

## Provider Information Changes or Terminations

To correct or change information on an existing contracted provider, providers must submit a request along with the details of the changes via email or fax to NEMS MSO Provider Relations. NEMS MSO is required to notify SFHP Provider Relations Department within five (5) business days when there are changes to a provider's panel (open or close) affecting member assignment. Contracted SFHP-NEMS provider wishing to terminate their affiliation with SFHP must first submit a termination notification to NEMS MSO, and the Provider

Relations staff notifies SFHP of the provider termination in a timely fashion. Terminations are effective no earlier than the first of the month following 30 days' notice and must be submitted on the SFHP Provider Status Change Form.

NEMS MSO is responsible for choosing another provider to assume the terminating providers' members and are required to inform SFHP Provider Relations Department of the reassignment decision. SFHP will notify members of this information by sending a notification of the contract termination to the member, with instructions on selecting a new PCP or with a new PCP already assigned, followed by a new SFHP ID card. Members have the option of selecting another PCP should they choose not to accept the new provider assigned by SFHP. If a PCP is affiliated with more than one contracted medical group and terminates their affiliation with a medical group or groups but remains in the SFHP network, the affected members will remain assigned to that PCP through one of the PCP's remaining affiliated group or groups. SFHP will notify members of their medical group reassignment accordingly.

## 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 SFHP. An electronic version of the training and attestation is available on the SFHP website or you may contact NEMS MSO Provider Relations to obtain a copy.

Training covers the following topics:

- SFHP 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 participate in healthcare decisions.
- Member Complaints and Grievances
- Benefits
- Staying Health Assessments (SHA)
- 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

SFHP regularly communicates with and updates NEMS MSO of policy changes, new Medi-Cal program requirements, provider/member survey results and other quality improvement outcome information through mechanisms such as special mailings, Provider Newsletters, and/or Joint Administrative Meetings (JAMs) attended by representatives of each medical group.

## Provider Access, Availability and Appointments

Provider offices and clinics shall meet the following access and availability standards for scheduling appointments and tracking telephone services. Members must always have 24-hour access to PCP services. NEMS MSO and SFHP encourage members to call their PCP with all questions or concerns. However, if the provider is not available, members are instructed to call Teladoc to speak with a licensed physician at 1(800) 835-2362 or by visiting [www.sfhp.org/teladoc](http://www.sfhp.org/teladoc). Members can get a phone or video consultation with a Teladoc physician 24 hours a day and 7 days a week in 30 minutes or less.

Members can also call **SFHP's 24/7 Nurse Advice line at 1(877) 977-3397**. Registered

nurses who can assist with advice, next steps, and potential triage staff the nurse advice line.

## Access to Care and Access Standards

### Access Standards

San Francisco Health Plan (SFHP) 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. SFHP establishes and maintains provider networks, policies and procedures, and quality assurance monitoring systems sufficient to ensure compliance with clinical appropriateness standards. SFHP 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. SFHP requires its providers to comply with the following access standards. Providers and Medical Groups are informed of these requirements through the SFHP Provider Manual and reinforce standards through Joint Administrative Meetings (JAMs) with providers and Provider Monthly Updates.

### 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, 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

SFHP 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 SFHP 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

San Francisco Health Plan (SFHP) 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. SFHP establishes and maintains provider networks, policies and procedures, and quality assurance monitoring systems sufficient to ensure compliance with clinical appropriateness standards. SFHP

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. Providers and Medical Groups are informed of these requirements through the SFHP 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.

<b>Criteria</b>	<b>Standard</b>
<b>Initial Prenatal Care appointment</b>	Within 14 calendar days
<b>Emergency Care</b>	Immediately
<b>Urgent Care – for services not requiring prior authorization</b>	Within 48 hours*
<b>Urgent Care – for services requiring prior authorization</b>	Within 96 hours of request*
<b>Non-urgent Primary Care</b>	Within 10 business day of request**
<b>Non-urgent appointment with Specialists</b>	Within 15 days of the request **
<b>Non-Urgent appointments with non-physician mental health care provider</b>	Within 10 business day of the request**
<b>Non-Urgent Ancillary Services (for diagnosis or treatment)</b>	Within 15 business days of request**
<b>Telephone Triage or Screening Waiting time</b>	Not to exceed 30 minutes*
<b>Wait time to speak to an SFHP Customer Service Representative during normal business hours</b>	Not to exceed 10 minutes

**\*Exception 1:** Appointment may be extended if the referring/treating and/or triage licensed health care provider determines and notes in the relevant record that a longer waiting time

will not have a detrimental impact on the health of the enrollee.

**\*\*Exception 2:** Exception 1 plus Preventive care services, and periodic follow up care, including but not limited to, standing referrals to specialist for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, 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 practice.

### **Procedures for Ensuring Access**

Providers and Medical Groups are informed of access requirements through the SFHP Provider Manual and in Joint Administrative Meetings (JAMs) with providers and Provider Monthly Updates.

### **Telephone Triage Procedures**

SFHP providers must maintain standard protocols and guidelines for processing calls from patients that include:

- When the call should be immediately transferred to a physician on duty
- When the patient should be instructed to go to the emergency room
- Notification of emergency medical services (911) for emergency situations
- After-hours availability instructions
- Members who cannot reach their PCP's office during or after business hours may contact Teladoc by calling 1(800) 835-2362 or by visiting [www.sfhp.org/teladoc](http://www.sfhp.org/teladoc) Members can get a phone or video consultation with a telehealth physician 24 hours a day and 7 days a week in 30 minutes or less. This service is free of charge and is language interpreter services

are available. Teladoc's California-licensed physicians can:

- Treat simple medical conditions.
- Prescribe some types of medications, but not controlled substances.
- Instruct members to see their regular PCP or specialist for follow-up care.
- Assess whether the member needs to go to the emergency room or needs urgent care.
- SFHP also provides members with a contracted Nurse Advise Line (NAL). The NAL will be available 24/7 for 365 days/year and maintain standard protocols and guidelines for processing calls from members that include the following:
  - Clinical assessment and education
  - Determination of when the call warrants immediate consultation with the on-call supervisor" and "Determination of when the call warrants immediate consultation with the NAL physician.
  - Determination of when the patient should be instructed to go to the emergency room.
  - Notification of emergency medical services (911) for emergency situations.
  - Faxed information to the member's provider describing who called, the nature of the call and actions taken by the NAL.
  - NAL waiting time not to exceed 30 minutes.

### **Provider Satisfaction Survey**

SFHP conducts an annual Provider Satisfaction Survey to measure providers' satisfaction with the Plan. The survey is conducted among contracted providers. Results of the survey and recommendations for improvements are shared

with the SFHP Quality Improvement Committee, Governing Board, and Executive Team through the annual summary report. All SFHP contracted providers and their affiliated groups can view or obtain a copy of the survey by calling SFHP Provider Relations at 1(415) 547-7818 ext. 7084 or emailing [provider.relations@sfhp.org](mailto:provider.relations@sfhp.org).

## **CLAIMS AND ENCOUNTER DATA**

### **Claims Overview**

NEMS MSO encourages providers 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 claim form. NEMS MSO has established requirements for filing a claim. Failure to comply with these requirements may delay reimbursement.

The NEMS MSO Claims department is available to assist with claims questions and can be reached at 1(415) 352- 5186 **Option 2**.

All medical paper claims for **NEMS MSO** must be submitted to the following address:

**NEMS MSO  
Claims Department  
2171 Junipero Serra, Suite 600  
Daly City, CA 94104**

**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.

### **Claim Requirements**

To be considered a valid claim, each claim must be submitted within the timely filing period and meet the following criteria:

- All required claim fields must be completed.
- Submitted on a standard current version (red drop-out ink) of a CMS-1500 or UB-04
- Claim is for an eligible NEMS-SFHP member at the time of service.
- Claims contains national standard coding, including but not limited to CPT, HCPCS, revenue codes, and ICD-10 codes.
- Claim must not be altered or contain handwritten additions or changes to procedure codes.
- Claim must be printed in black ink that is dark enough to be electronically imaged.
- Standard claim forms must be printed in Flint OCR Red, J6983 (or exact match) ink.

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

### **Electronic Data Interchange (EDI)**

Electronic Data Interchange (EDI) is a powerful tool used for communicating claim information that was traditionally submitted on paper. NEMS MSO offers providers the speed, convenience, and lower administrative costs of electronic claims filing. It is preferred that all claims be submitted electronically, and providers interested in submitting claims electronically should contact NEMS MSO Provider Relations at 1 (415) 352-5186 **Option 3**, to request information on how to enroll.

### **Timely Filing Timeframes**

All claims must be submitted timely for consideration of payment. Claims submitted after the appropriate filing deadline, prior to the actual date of service, and/or prior to delivery of supplies will be denied.

- Contracted or in-network providers must submit all claims (inpatient and outpatient)

90 days post service. Post service is defined as after the date of service.

- Non-contracted providers 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 providers check eligibility to ensure that the member does not have primary insurance coverage with another health insurance provider. If it is determined that the member has a different primary coverage, providers are required to bill the member's primary health insurance prior to billing NEMS MSO.

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

## General Claims Processing Guidelines

### Acknowledgement of Claims

NEMS MSO acknowledges receipt of electronic claims, whether the claims are complete, within two (2) business days; paper claims acknowledgement occurs within fifteen (15) business days. The same manner and timeframe noted above applies for claims received from a provider's clearinghouse, and the claims acknowledgment is sent directly to the clearinghouse.

### Claim Processing Time

All clean claims will be processed and paid within forty-five (45) business days of receipt.

### Clean Claim

A claim submitted for payment that contains all necessary information in the required fields, including attachments if required for the claim, and any documentation required to determine payer liability.

### Unclean Claim

Any claim lacking sufficient information to pay or deny, resulting in the Claims Staff requesting additional information to adjudicate the claim will be rejected and returned to the provider.

### Interest on Claims

NEMS MSO will calculate and automatically pay interest, in accordance with the rate and formulae determined by the Treasury Department on a 6-month basis, effective January and July 1<sup>st</sup>, to all providers within forty-five (45) business days after the receipt of their clean claim. The interest period begins on the day after payment is due and ends on the day of payment.

NEMS MSO does not pay interest on the following:

- Claims for which no payment is due.
- Claims denied in full.
- Claims for which the provider is receiving Practice Improvement Program (PIP) funds

### Misdirected Claims

Claims incorrectly sent to NEMS MSO but are the responsibility of the health plan for payment, will be forwarded back to the provider within ten (10) business days from date of receipt.

### Billing Members

If NEMS MSO fails to pay for health care services rendered to eligible SFHP-NEMS, California Health and Safety Code, Section 1379, prohibits the provider from billing the member for any sums owed by NEMS MSO or San Francisco Health Plan. Providers may not seek reimbursement from the member for a balance due for covered services, open bills, balances in any circumstance, including when a claim is denied.



## Overpayment and Recoupments

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

- Processing error
- Services paid by another third party (i.e., COB)
- Retroactive change to member eligibility
- Duplicate payment

A provider who has identified an overpayment should send a refund with supporting documentation to the following address:

**NEMS MSO  
Claims Refunds  
2171 Junipero Serra, Suite 600  
Daly City, CA 94104**

If NEMS MSO identifies an overpayment, a notice will be sent to the provider with the following information:

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

The provider has 30 days from receipt of payment to submit a written explanation contesting the overpayment notification. If the overpayment request is not contested within thirty (30) days of receipt of the overpayment notice, and a full refund is not received within forty-five (45) days from the overpayment notification, NEMS MSO will recoup the amount of the overpayment on future claims.

## Coordination of Benefits (COB)

Coordination of benefits is the practice of two or more plans coordinating their provision of health benefits to members who have multiple coverage. Coordination of benefits is used to determine the order of payment responsibility when more than one health plan or insurer covers a NEMS MSO member. Federal laws require practitioners to bill other health insurers prior to billing NEMS MSO. Since all other coverages are primary for eligible Medi-Cal members, NEMS MSO is always the payer of last resort for Medi-Cal members.

All claims must be submitted to NEMS MSO within ninety (90) days from the date of payment on the primary payer's Explanation of Benefits (EOB) form, and a copy of the EOB must accompany the claim. Under the secondary payer COB rules, NEMS MSO will pay the lesser of the following amount for covered services:

- The amount that would pay if another coverage did not exist.
- The actual charge from the provider, less the amount paid by the other coverage.
- If primary insurance payment exceeds the allowed contracted rate, neither NEMS MSO nor its member are financially responsible for additional payment.

Currently, all the health benefits provided for SFHP-NEMS are subject to COB provision.

## Provider Dispute Resolution Mechanism

A provider claim dispute is a written notice appealing or requesting reconsideration of an unfavorable determination made by NEMS MSO for a prospective, concurrent, or retroactive request for service of an enrollee. The appealing provider must submit a written appeal request, using the Provider Dispute Resolution (PDR) form within 365 days from the receipt of a service or claim denial, along with any relevant and supporting documentation. NEMS MSO ensures that punitive action is not taken against providers who either submit appeals or support a member's appeal.

Providers wanting to dispute a claim payment or denial can submit a written dispute to the following address.

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

NEMS MSO will acknowledge receipt of the PDR within fifteen (15) working days of receipt of the dispute, and will issue a written determination, including a statement of the pertinent fact and reasons, to the provider within forty-five (45) business days after receipt of the claim dispute. Claims denied due to the provider's submission error or omission (e.g., missing modifier, incorrect CPT/ICD-10/revenue codes, place of service, etc.) do not qualify for the provider claim dispute resolution mechanism. Such claims must be resubmitted within the specified timeframe for claim submission as a "corrected claim", with a brief explanation of the error noted either on the claim or as an attachment. Failure to submit a claims dispute within the specified timeframe will result in denial of the dispute.

All supporting documentation submitted with the dispute must be legible and include the following information:

- Claim number from EOB and/or authorization number.
- Provider's NPI, Name, contact information and NPI.
- Copy of other coverage EOB's/ RAs or denials.
- Copy of original claim being disputed.
- Reason for dispute.
- Copy of medical records if disputing for medical necessity.
- Other pertinent documentation supporting the appeal or copies of all correspondence to and from NEMS MSO documenting timely follow-up.



## NEMS MSO WEBSITE AND PROVIDER PORTAL

North East Medical Services (NEMS) maintains a comprehensive, user-friendly website with information and tools for members, providers, and the community. The NEMS website and NEMS EZ-NET Provider Portal provides additional educational resources for members and provides details of the services that encompass NEMS MSO and the group of multilingual, multicultural health care professionals providing primary care, medical specialties, dental, optometry, ancillary, preventive, and health promotion services. All NEMS Clinic providers are bilingual in English and either Chinese (Cantonese and Mandarin), Vietnamese, or other languages and dialects.



### Member Education

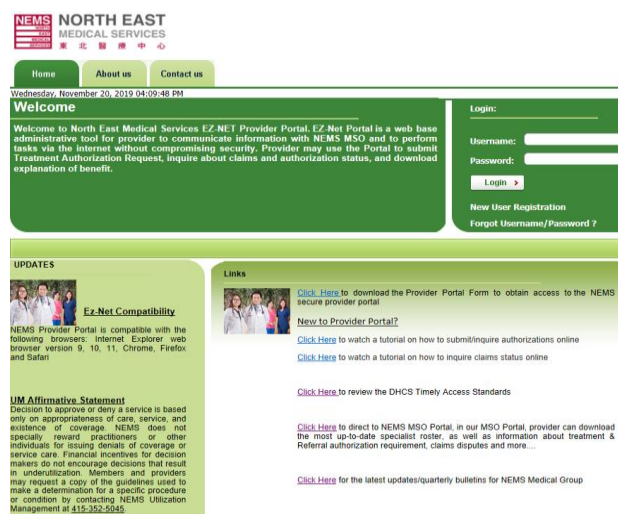
In addition to Primary Care Services and Specialty Care Services, NEMS members have access to our multilingual Health Education Resources that include information on the following:

- [Asthma](#)
- [Cardiovascular Health](#)
- [Children's Health](#)
- [Dental Health](#)
- [Diabetes](#)
- [Digestive and Intestinal Health](#)

- [Eye Health](#)
- [Food and Nutrition](#)
- [General Health](#)
- [HIV/STI Prevention](#)
- [Infectious Diseases](#)
- [Injury Prevention](#)
- [Medications](#)
- [Men's Health and Women's Health](#)
- [Mental Health](#)
- [Perinatal and Child Health](#)
- [Substance Use and Abuse](#)

Please visit [www.nems.org](http://www.nems.org) to learn more about the resources available on the NEMS website.

### Provider Portal and Registration



The NEMS EZ-NET provider portal is an efficient and secure way for providers and their staff to perform multiple functions that include the following:

- Submit prior authorizations online.
- Check status of authorizations.
- Check claims status.
- Download and print authorization letters.
- Download and print remittance advice (RA)

It is recommended that providers and staff confirm patient eligibility directly through the patient's respective health plan (SFHP), as the health plan will have the most current eligibility

information. The use of the provider portal is highly encouraged to streamline your practice's workflow.

### User ID and Password

NEMS MSO requires that providers and their staff complete the Provider Portal Form to obtain access to the NEMS secure provider portal. To download the provider portal form, visit the links section in our NEMS EZ-NET home screen listed below, and select "download the Provider Portal Form."

<https://eznet.nems.org/EZ-NET60/Login.aspx>

The Provider Relations Department will validate your account and information submitted on the form, and if granted access, will provide you with the username and password selected via email. Every person accessing the provider portal is required to have their own username, and we discourage sharing passwords and username information.

### Forms and Resources



The NEMS MSO Portal offers various resources and information related to our Management Services Organization, and is designed for providers, hospitals, and medical groups who have contracts with NEMS to provide managed care services to patients enrolled in San Francisco Health Plan's Medi-Cal program.

In the forms and resources section of the NEMS MSO Portal, you can find the following information:

- Specialist Roster
- Ancillary Roster
- NEMS-SFHP Benefits and Authorization Grid
- Prior Authorization form
- Provider Portal Access Request Form
- Instructions on submitting a Provider Dispute Resolution
- Provider Dispute Resolution (PDR) Request form

For additional questions, and to request additional information, contact the NEMS MSO **Provider Relations Department**.

Hours of operation: Monday through Friday, 8:00am – 5:30pm

Phone: 1(415) 352-5186 **Option 3**

Email: [Provider.Relations@nems.org](mailto:Provider.Relations@nems.org)

## **CULTURAL AND LINGUISTIC SERVICES AND TRAINING**

NEMS MSO provides telephonic and in-person interpreter services, including American Sign Language, for all our members for covered services. All non-English speaking, monolingual, hearing impaired and Limited English Proficient (LEP) members of NEMS MSO must have linguistic services available for all member service inquiries and at all medically related visits. Bilingual staff assessed for proficient language capacity may provide linguistic services.

NEMS MSO 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.***

The California Department of Health Care Services (DHCS), and the California Managed Risk Medical Insurance Board require that if a NEMS member declines interpreter service, please document the interpreter refusal in the medical record.

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. 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, considering the cultural and social context.
- **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:
  - Patient's preferred language
  - 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 about their language preference 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 question 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?”**

This is the best approach. Phrasing the question this way will provide you with information on the language the patient needs to speak

comfortable 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.
- Do not 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, and 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 for a quick introduction 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.

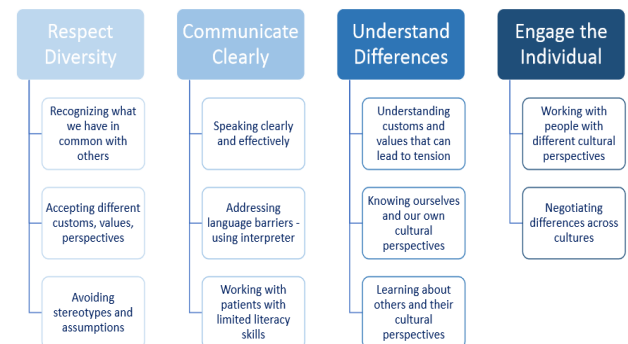
## What is Culture?

Culture consists of a body of learned beliefs, traditions, and guides for behaving and interpreting behaviors shared among members of a 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 patient understands)
- 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 become aware of our cultural values, beliefs, and perceptions. Cultural awareness can help **people overcome cultural challenges in everyday life** when interacting with others



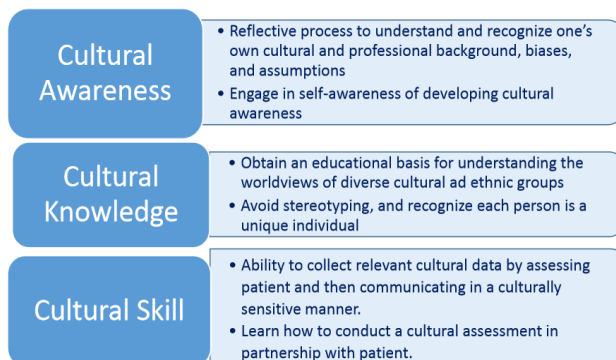
whose culture, values, and beliefs we are not fully aware.

## 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 influence 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 and NEMS MSO 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 and NEMS MSO 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 having difficulty communicating your message, 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 Visual 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 print materials in accessible formats such as digital, audio, large print, or Braille.

## HEALTH NET MEDICARE ADVANTAGE

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.

Please contact Health Net’s Medicare Advantage Member Services at 1 (800) 431-9007 for additional information. From October 1 to March 31, you may contact Health Net seven days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you may contact Health Net Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays. **TTY** users should call **711**. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. **Calls to this number are free. 8:00 a.m. to 8:00 p.m., seven days a week**



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 are the responsibility of North East Medical Services (NEMS) MSO. For general questions pertaining to network providers and covered services, please contact NEMS MSO Provider Relations via email at [provider.relations@nems.org](mailto:provider.relations@nems.org) or at 1(415) 352-5186 **Option 3**.

## ELIGIBILITY

To Verify Eligibility for Health Net Medicare Advantage:

1. Request a copy of the member’s Health Net ID card and check eligibility using the Health Net Provider Portal at [www.healthnet.com/portal/provider/home.ndo](http://www.healthnet.com/portal/provider/home.ndo)

## Health Net Medicare Advantage ID card

 HMO <Plan Name> CMS# <H561-XXXX-XXXX> Effective <MM-DD-YYYY>	<b>FOR MEMBERS</b> Member Services: (833) 502-8919 (TTY: 711) Mental Health Benefits: 1 (800) 646-5610 (TTY: 711) 24-hr Nurse Advice: 1 (800) 855-6567 (TTY: 711) < <a href="https://ca.healthnetadvantage.com">https://ca.healthnetadvantage.com</a> >	<b>FOR EMERGENCIES</b> Dial 911 or go to the nearest Emergency Room (ER).
<b>MEMBER INFORMATION</b> Name: <First MI Last> Member ID: <XXXXXXXXXX> Issuer ID: <83949> <9151014909>	<b>PHARMACY INFORMATION</b>  Rx Claims Processor: <CVS Caremark> RXBIN: <000335> RXPCN: <MEDCARE> RXGRP: <R06270>	<b>FOR PROVIDERS</b> For eligibility, prior authorization or case management referrals: 1-800-431-9007 Pharmacy prior auth: 1-800-867-6566 For help (PHARMACY USE ONLY): 1-888-865-6567
<b>PROVIDER INFORMATION</b> PPG Name: <> PPG Phone: <> PCP Name: <> PCP Phone: <> PCP Office Visit: <500>	<b>Submit Part D Drug Claims to:</b> <Health Net> <Attn: Pharmacy Claims> <P.O. Box 419069> <Rancho Cordova, CA> <95741-9069>	<b>MEDICAL CLAIMS</b> EDI Payer ID: <68069> <Health Net> <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 provider portal link provided above, and follow the steps to register to create an account.

2. You can also contact Health Net Medicare Advantage directly to check eligibility and speak with a friendly representative at **1 (800) 431-9007**. Hours of operations differ during open enrollment.

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 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 as 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 Medicare Advantage ID card.

Members may change their PCP for any reason, at any time. Member Services can assist in finding and selecting another provider, and the member's request will be effective on the first day of the following month when Health Net receives the request. A PCP change request can be made by calling Member Services or visit the Health Net Medicare Advantage website at <https://ca.healthnetadvantage.com> to make the request. Once the request is finalized, the member will receive in the mail a new member ID card that shows the name and phone number of their new PCP.

## Provider Portal and Registration

The NEMS EZ-NET Provider Portal is an efficient and secure way for providers and their staff to perform multiple functions that include the following:

- Submit prior authorizations online.
- Check status of authorizations.
- Check claims status.

- Download and print authorization letters.
- Download and print remittance advice (RA).

It is recommended that providers and staff confirm patient eligibility directly through the patient's respective health plan (**Health Net Medicare Advantage**), as the health plan will have the most current eligibility information. The use of the provider portal is highly encouraged to streamline your practice's workflow for authorization submission.

***See NEMS MSO Website and Provider Portal section of this manual for information on creating an account and the resources available in the provider portal.***

## UTILIZATION MANAGEMENT

### General UM Information

It is the responsibility of the provider to establish coverage eligibility and medical group assignment prior to delivering services. This avoids the possibility of providers obtaining reimbursement denials for services already rendered. Authorizations are contingent upon the member's eligibility, benefit program, and are not a guarantee of payment.

**Please note that any contracted or non-contracted provider may render emergency treatment without authorization.**

### 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 NEM MSO provider.

## Prior Authorizations

Prior authorization requests must be submitted to the NEMS MSO Utilization Management (UM) Department. The UM staff reviews prior authorization requests and makes determinations 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.

### General Provisions

There are certain procedures, services, and medications that require prior authorization from the NEMS MSO Utilization Management Department. Providers are required to request approval in advance for services and procedures requiring prior authorization. Please visit the link below to access the authorization grid for the listing of procedures requiring prior authorization.

<https://www.nems.org/mso/forms.html>

### 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 – Not applicable**

**NOTE: TO ENSURE REIMBURSEMENT, ALL SERVICES REQUIRING AN AUTHORIZATION MUST BE PRE-APPROVED PRIOR TO SERVICING ELIGIBLE MEMBERS.**

*CONTACT THE UTILIZATION MANAGEMENT DEPARTMENT TO DISCUSS CONTINUITY OF CARE AND SAME DAY APPROVALS FOR OUT-OF-NETWORK OFFICE VISITS, FOLLOW-UP VISITS, AND CONSULTATIONS.*

### UM APPEALS

An appeal is a formal way of asking NEMS MSO to review and reconsider coverage for denied services. Health Net Medicare Advantage Members can appeal unfavorable coverage determinations made by the NEMS MSO Utilization Management Staff directly with Health Net member services. Eligible members must contact Health Net member services at 1(800) 431-9007 for instructions and options on initiating an appeal.

### Access Standards

Health Net MA, 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. NEMS MSO establishes and maintains provider networks, policies and procedures, and quality assurance monitoring systems sufficient to ensure compliance with clinical appropriateness standards. Health Net 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.

**Providers are required to comply with the following access standards.**

<b>Urgent Appointments</b>	<b>Wait Time</b>
For services that do not need prior approval	48 Hours
For services that do need prior approval	96 Hours
<b>Non-Urgent Appointments</b>	<b>Wait Time</b>
Primary care appointment	Within 10 business days
Specialist appointment	Within 15 business days
Appointment with a mental health care provider (who is not a physician)	Within 10 business days
Appointment for other services to diagnose or treat a health condition	Within 15 business days

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.

**Provider Appointment Availability Survey**

On an annual basis, Health Net Medicare Advantage administers the Provider Appointment Availability Survey (PAAS) to measure patient access to care against Department of Managed Health Care's (DMHC) Access to Care Standards. The survey is conducted annually over the phone or via fax, during the third or fourth quarter of the year. Health Net Medicare Advantage selects a random sample of primary care physicians, specialists, and ancillary providers to survey. Providers should complete the survey or transfer the call/fax to an alternate staff member who will complete the survey. Any non-response is considered non-compliant and will require a corrective action plan.

*The following section "CLAIMS AND ENCOUNTER DATA" pertains **ONLY** to the Health Net Medicare Advantage line of business. Please contact NEMS MSO Claims Department at **1(415) 352-5186 Option 2**, for any billing or claims related questions.*

## **CLAIMS AND ENCOUNTER DATA – HEALTH NET MEDICARE ADVANTAGE**

### **Claims Submission**

NEMS MSO prefers and encourages providers to submit claims electronically. Providers unable to send claims electronically can submit paper claims on the proper type of form. Requirements for paper claim forms are described below. NEMS MSO only accepts standard claim forms printed in Flint OCR Red, J6983 (or exact match) ink. Paper claim forms must be typed in black ink in either 10 or 12-point Times New Roman font, and on the required original red and white claim form to ensure clean acceptance and processing. Claims submitted on black and white, handwritten, or nonstandard forms will be rejected, and a letter will be sent to the provider indicating the reason for rejection, but the original claims will not be returned. To reduce document-handling time, providers must not use highlights, italics, bold text, or staples for multiple page submissions. Copies of the CMS-1500 (02/12) form cannot be used for submission of claims since a copy may not accurately replicate the scale and OCR color of the form.

**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.

Medicare CMS-1500 and CMS-1450 completion and coding instructions, are available on the Centers for Medicare & Medicaid Services (CMS) website at [www.cms.gov](http://www.cms.gov).

**All paper claims and supporting information must be submitted to the following addresses:**

<b>Professional service claim on CMS-1500</b>	<b>Hospital/Facility claim on UB-04</b>
NEMS MSO Medicare Advantage Claims Department 2171 Junipero Serra, Suite 600 Daly City, CA 94104	Health Net Medicare Claims PO Box 9030 Farmington, MO 63640-9030

### **Mandatory Items for Claims Submission**

All professional and institutional claims require the following mandatory items:

- 1) Appropriate type of insurance coverage (box 1 of the CMS-1500).
- 2) Billing provider tax identification number (TIN), address and phone number.
- 3) Billing provider National Provider Identifier (NPI).
- 4) Bill type (institutional) and/or place of service (professional).
  - a. Original submission is indicated with a 1 in claim frequency box or resubmission code (box 22).
  - b. Codes 7 and 8 should be used to indicate a corrected, void, or replacement claim and must include the original claim ID.
- 5) Patient name, health plan subscriber identification (ID) number, address, sex, and date of birth must be included.
- 6) Other health insurance information and other payer payment, if applicable.

- 7) Patient or subscriber medical release signature/authorization.
- 8) Accept assignment (box 13 of the CMS-1500).
- 9) Referring/Ordering provider name and NPI.
- 10) Check if lab work was performed outside the physician's office and indicate charges by the lab (box 20 on CMS-1500).
- 11) Rendering/attending provider NPI (only if it differs from the billing provider) and authorized signature.
- 12) Primary diagnosis code and all additional diagnosis codes (up to 12 for professional; up to 24 for institutional) with the proper ICD indicator, (only ICD 10 codes are applicable for claims with dates of service on and after October 1, 2015).
- 13) Diagnosis pointers are required on professional claims and up to four are be accepted per service line.
- 14) Diagnosis codes, revenue codes and CPT, HCPCS, modifiers, or HIPPS codes that are current and active for the date of service. Claims with incomplete coding or having expired codes will be contested as invalid or incomplete claims.
- 15) Authorization, if applicable, should be sent in the 2300 Loop, REF segment with a G1 qualifier for electronic claims (box 23 for CMS-1500 or box 63 for UB-04).
- 16) Referral information, if applicable.
- 17) Inpatient institutional claims must include admit date and hour and discharge hour (where appropriate), as well as any Present on Admission (POA) indicators, if applicable.
- 18) Inpatient professional claims must include admit and discharge dates of hospitalization.
- 19) Admission type code for inpatient claims.
- 20) Admitting diagnosis required for inpatient claims.
- 21) Outpatient claims must include a reason for visit.
- 22) Statement from and through dates for inpatient.
- 23) Service line date required for professional and outpatient procedures.
- 24) National Drug Code (NDC) for drug claims as required.
- 25) Universal product number (UPN) codes as required.
- 26) Accommodation code is submitted in Value Code field with qualifier 24, if applicable.
- 27) Charges for listed services and total charges for the claim.
- 28) Days or units.
- 29) Early Periodic Screening, Diagnosis, and Treatment (EPSDT)/family planning indicators (box 24 in CMS-1500).
- 30) Name and address of service location.

The list above is not a fully inclusive list of claim form required elements. Additional fields may be required, depending on the type of claim, line of business and/or state regulatory submission guidelines. To avoid possible denial or delay in processing, the above information must be correct and complete.

## Electronic Data Interchange (EDI)

Electronic Data Interchange (EDI) is a powerful tool used for communicating claim information traditionally submitted on paper. NEMS MSO offers providers the speed, convenience, and lower administrative costs of electronic claims filing. It is preferred that all claims be submitted electronically, and providers interested in submitting claims electronically should contact NEMS MSO Provider Relations at 1 (415) 352-5186 **Option 3**, to request information on how to enroll.



## Acknowledgement of Claims

NEMS MSO acknowledges electronically submitted claims, whether the claims are complete, within two business days via a 277CA acknowledgement report to the clearinghouse following receipt. NEMS MSO acknowledges paper claims within fifteen (15) business days following receipt. If a paper claim is paid or denied within fifteen (15) days, the Remittance Advice (RA) is the acknowledgment of claims receipt. A provider may obtain an acknowledgment of claim receipt in the following manner:

Claims received from a provider's clearinghouse are acknowledged directly to the clearinghouse in the same manner and timeframes noted above.

## Definition of Clean Claim and Unclean Claim

A complete claim is a claim, or portion of a claim, that is submitted on a complete form adopted by the National Uniform Billing Committee and which includes attachments and supplemental information or documentation that provide reasonably relevant information or information necessary to determine payer liability.

**IMPORTANT NOTE:** All facility claims must be billed on the UB-04 form.

A clean claim is a claim that has no defect or impropriety, including lack of required substantiating documentation for non-participating providers and suppliers. The member's name, identification number, physician name(s), date of service (DOS), diagnosis code(s), and billed amount among, but not all, the required elements to process the claim. Emergency services, out-of-area urgently needed services, and out-of-area renal dialysis do not require prior authorization to be considered as a clean claim. Unclean claims lack sufficient information to pay or deny and result in an examiner requesting additional information to process. The following are examples of what is considered an unclean claim (this list is not all-inclusive):

- A claim does not have the necessary fields completed to process the claim, for example, the provider identification (ID) number.
- The claim does not have a diagnosis that is immediately identifiable as an emergency; out-of-area urgently needed service, or out-of-area renal dialysis.
- The claim lacks the necessary medical records for medical review to determine the medical necessity or liability for urgent or emergency care.
- A claim that appears to be fraudulent or is in a foreign language or currency.

In accordance with standards established by the Centers for Medicare & Medicaid Services (CMS), and AB1455 (Claims Settlement Practices and Provider Dispute Resolution Mechanism) guideline, all clean claims must be paid or denied within thirty (30) calendar days from the received date; unclean claims must be either paid, contested, or denied within sixty (60) calendar days from date of received.

## Timely Filing of Claims

NEMS MSO encourages all providers to submit claims for payment as soon as practical to avoid denial for untimely submission. Timely filing for accepted claims received is as follows:

- From contracted or in-network provider, within 90 calendar days after the date of service.
- From non-contracted or out-of-network provider, within 365 days after the date of service.

If a received claim is under the responsibility of the member's Health Plan for adjudication, NEMS-MSO will forward the claim to the member's HMO within ten (10) business days from date of receipt.

## Date of Receipt

The date of receipt is the business day when the claim is delivered electronically or physically to the designated address for submission. (See **Claims Submission** section).

## Timely Reimbursement of Claims

NEMS MSO pays clean Medicare Advantage claims, or portion thereof, from a contracted or non-contracted provider within thirty (30) calendar days from the claim receipt date. NEMS MSO will pay or deny all claims within sixty (60) calendar days of receipt. In an event when additional information is necessary for claim adjudication, the Claims team shall make attempt to contact outside source(s) for such needed additional information prior to making the decision to pay or deny the claim within the sixty (60) day timeframe. The timely payment period is the same for both electronic and paper claims. The claims turnaround timeframe begins after receipt of the claim unless the claim is contested or denied. 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 and federal regulatory bodies.

### **Hospitals submitting inpatient acute care claims for Health Net Medicare Advantage members:**

- Hospital claims for inpatient or outpatient claims must be submitted directly to Health Net (see **Claims Submission** section).
- Health Net uses an All-Patient Refined Diagnosis Related Groups (APR DRG) pricing methodology that is consistent with Department of Health Care Services (DHCS) implemented Version of APR DRG pricing.

NEMS MSO reimburses Medicare claims, including non-contracted provider claims, at no less than 100% of the Medicare fee schedule and/or rate, using one of the following:

- CMS Fee schedule
- Medicare allowable amount
- Resource-based relative value scale (RBRVS)
- Diagnosis-related groups (DRG's)

Non-contracted providers furnishing services to Medicare members and submitting identical information they would submit for payment under Original Medicare will be paid the 100% of Medicare Allowed amount. NEMS MSO does not apply sequestration reduction to non-contracted provider claims. In an event when a non-contracted provider's claim is denied for payment:

- The Claims department must send a claims denial to the provider, providing the specific reason for the denial, and a description of the appeals process.
- The provider has the right to request a reconsideration of the denial of payment.
- The provider must file the reconsideration within sixty (60) days from the date of the claim's denial.
- The provider must include a signed [Waiver of Liability form](#) holding the member harmless, regardless of the outcome of the appeal. See form at the end of this section for additional details.

## Interest Payment on Clean Claims Not Paid Timely

Interest payment on clean claims not paid timely within 30 calendar days of receipt applies only to claims by non-contracted provider. Contracted provider claims have no interest due. Late payment on complete Medicare Advantage claims neither contested nor denied automatically include interest for the period the payment is late. The interest period begins on the day after payment is due and ends on the day of payment. Interest payment does not apply to the following:

- Claims requiring investigation or development by NEMS MSO or Health Plan.
- Claims for which no payment is due.
- Claims denied in full.
- Claims for which provider is receiving PIP.

The interest rate is determined by the applicable rate on the day of payment, and the rate is determined by the Treasury Department on a 6-month basis, effective every January and July 1. For the correct rate, providers may access the Treasury Department web page <https://www.fiscal.treasury.gov/fsservices/gov/pmt/promptPayment/rates.htm> for the correct rate.

Interest is calculated using the following formula:

Payment amount x rate x days divided by 365 (366 in a leap year) = interest payment

## Balance Billing

The state and federal law, along with the Health Plan, and NEMS policy prohibit balance billing to eligible members. Balance billing occurs when a participating provider bills a member for fees and surcharges beyond a member's copayment and coinsurance responsibilities for services covered under a member's benefit program, or for claims denied by NEMS MSO. Participating providers are prohibited from initiating or threatening to initiate a collection action against a member for non-payment of a claim for covered services. Participating providers agree to accept reimbursement from NEMS MSO for services as payment in full and final satisfactory, except for applicable copayments, coinsurance, or deductibles. Participating providers may bill a member for non-covered services when the member is notified in advance that the services to be provided are not covered and the member, nonetheless, requests in writing that the services be rendered. Participating providers who exhibit a pattern and practice of billing members will be contacted by NEMS and subject to disciplinary action.

## Billing Medicare-Medi-Cal Members 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

## Denial of Claims

NEMS MSO notifies the rendering providers in writing of a denied claim no later than thirty (30) calendar days after receipt of the claim. The denial date is the day when the denial is transmitted electronically or by U.S. mail.

A denial notice contains the following elements:

- Date of denial notice.
- Member name.
- Provider name.
- Specific service denied.
- Date of service.
- Denied amount.
- Member responsibility amount.
- Information regarding the providers' appeal rights with Health Net. Include plan name, address, and telephone number for appeals.

The Centers for Medicare & Medicaid Services (CMS)-approved Integrated Denial Notice - Notice of Denial of Payment (IDN-NDP) letters must be sent to members when the claim denial results in any member financial liability. The IDN-NDP letter includes the denial notice page, accompanying member appeals language and Notice of Non-Discrimination and multi-language insert.

For both the denial notice and appeals page, NEMS MSO is not permissible to omit any standardized language, nor alter the template, including font size, without contracted health plan and CMS approval. Minor changes to the denial notice page that do not affect the intent of the document may be allowed upon approval from the Medicare Compliance Department. NEMS MSO shall not send denial notices to capitated members if they are not financially liable for the services.

Information required in the space reserved for the explanation of a denial must specify the reasons for the denial, as required under 42 CFR 422.568 (e)(2). For Medicare Advantage providers, the CMS-approved Industry Collaboration Effort (ICE) standardized Single Service Claim Denial Letter and Multiple Services Claim Denial Letter are located under Approved ICE Documents on the ICE website at [www.iceforhealth.org/library.asp](http://www.iceforhealth.org/library.asp) . Additional information is available on the CMS website at [www.cms.gov](http://www.cms.gov) or from the ICE website at [www.iceforhealth.org](http://www.iceforhealth.org) .

## Contested Claims

A contested claim is one that NEMS MSO cannot adjudicate or accurately determine liability because additional information is required from either the provider, the claimant, or the third party. NEMS MSO notifies the provider of service in writing of a contested claim no later than thirty (30) calendar days after receipt of the claim. The contested date is the date when the contest was transmitted electronically or by U.S. mail.

You may contest incomplete claims or claims requiring additional information in writing by NEMS MSO in the form of an Explanation of Payment/Remittance Advice (EOP/RA). NEMS MSO may send, in some circumstances, additional written communication within the timeframes noted above. Each EOP/RA includes instructions on how to submit the required information to complete the claim if NEMS MSO has contested it. Each EOP/RA reflecting a denied, adjusted, or contested claim includes instructions on how to file a provider dispute, including the web link to procedures for obtaining provider dispute forms and the mailing address for submission of the dispute.

## General COB Information

No member, plan, or provider will benefit from excess payments (over 100%) toward the costs associated with necessary health care. 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.

- The National Association of Insurance Commissioners (NAIC) developed COB regulations, and are adopted by various state HMO regulators and Departments of Insurance, and the regulations 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 provided by a plan may be shared by another plan.

## Payment Processing for Medicare/Medi-Cal Crossover Claims

Welfare and Institutions Code, Section 14109.5 limits Medi-Cal's payment of the deductible and coinsurance to an amount which, when combined with the Medicare payment, should not exceed the amount paid by Medi-Cal for similar services. Therefore, the combined Medicare/Medi-Cal payment for all services of a claim may not exceed the amount allowed by Medi-Cal for all services of the claim.

## Overpayment Reimbursement/Member Cooperation

NEMS MSO and the contracted health plan have reserved the right to request overpayment reimbursements made because of COB. Any uncooperative member issues should be forwarded to the NEMS MSO Claims Department at:

**NEMS MSO Claims Department  
2171 Junipero Serra, Suite 600  
Daly City, CA 94104**

## Provider Dispute

Whenever possible, provider and NEMS MSO should attempt to resolve informally the issues at the time of the initial contact. If an issue cannot be informally resolved, NEMS MSO offers nonparticipating providers a dispute and appeal process.

## Medicare Non-Contracted Provider Appeals (Waiver of Liability)

In accordance with CMS regulations, non-contracted providers with a Medicare Advantage organization may file a standard appeal for a claim denied completely or in part, but only if they submit a completed [Waiver of Liability Statement](#). If provider completes a Waiver of Liability Statement, provider waives the right to collect payment from the member, except for any applicable cost sharing, regardless of the determination made on the appeal.

If provider of service submits an appeal and NEMS MSO upholds the denial completely or in part, the provider will have additional appeal rights available including, but not limited to, reconsideration by a CMS contracted independent review entity. To submit an appeal, mail the request and completed [Waiver of Liability Statement](#) within sixty (60) calendar days after the date of the Notice of Denial of Payment to the following address:

**NEMS MSO Claims Appeal  
2171 Junipero Serra, Suite 600  
Daly City, CA 94104**

## Medicare Advantage Non-Participating Provider Disputes

Non-contracted (out-of-network) service providers submitting claims for NEMS MSO members are reimbursed at 100% of the current Medicare Physician Fee Schedule. If a non-contracted provider believes that the payment amount received for a service is less than the amount paid by Original Medicare, or disagrees with a non-payment decision, the provider has the right to submit request for reconsideration of claim payment known as the provider dispute. Non-contracted provider claims dispute also include reasons such as:

- Bundling issues
- Down coding

Payment dispute request must be submitted within 120 days from the date of the initial payment decision and must include complete documentation (such as a remittance advice from a Medicare carrier) to support the payment dispute. Submit the payment dispute in writing to the following address:

**NEMS MSO Claims Dispute  
2171 Junipero Serra, Suite 600  
Daly City, CA 94104**

## **Determination of the Dispute**

NEMS MSO will review the dispute and provide a determination in writing within thirty (30) calendar days from the time we receive the dispute.

- If we agree with provider's position, we will pay the correct amount including any due interest.
- If necessary, documentation is missing for review of the provider dispute, NEMS MSO may request for such information via phone or in writing to the provider.
- If the requested information is not received within fourteen (14)-calendar days from date of the request, review of the dispute will be conducted based on available information in the file.
- If the requested information is received after the fourteen (14)-calendar day deadline, we will consider the evidence before making and issuing the final determination.
- We will send the determination in writing if we deny the payment dispute, stating the reasons for the determination.

NEMS MSO may dismiss the dispute as untimely filed if the dispute request is not received within the 120-days timeframe. The dismissal must be issued in writing to the provider, explaining the reason for dismissal, and the non-participating provider has up to 180 calendar days from the date of dismissal notice to provide additional documentation for good cause for late filing. If the decision is to uphold the dismissal after reviewing the additional documentation, NEMS MSO will issue a letter or EOB to the provider explaining that good cause has not been established.

## **Second Level Dispute**

Providers that have exhausted the NEMS MSO internal dispute process and insist services were not reimbursed fairly will be informed about their right to file a Second Level dispute with the Managed Care Plan directly. If a provider decides to submit a Second Level dispute to the Managed Care plan, NEMS MSO will forward all related materials including but not limited to the original claim's denial, and the written determination of the original dispute, to the Health Plan within 180 calendar days of receiving a written notice from the Plan.

## **Retention of Provider Disputes Record**

NEMS MSO is required to retain copies of the provider disputes and the determinations, including all notes, documents, and other information that were used to reach the decision, for a period of not less than ten (10) years.



## MEDICARE MANAGED CARE PROVIDER APPEALS

### WAIVER OF LIABILITY STATEMENT

(For non-contracted provider Medicare Advantage claim appeals only)

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\_\_\_\_\_  
Enrollee's Name

\_\_\_\_\_  
Medicare Beneficiary Identifier (MBI)

\_\_\_\_\_  
Provider

\_\_\_\_\_  
Dates of Service

\_\_\_\_\_  
Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## **BENEFITS AND CARE COORDINATION**

### **Pharmacy Benefits**

San Francisco Health Plan (SFHP) provides pharmacy benefits for members in all SFHP programs. Pharmacy benefits cover outpatient and self-administered medications listed in the program formularies. The formulary for NEMS-SFHP members is managed by the SFHP Pharmacy Services Department with oversight from the SFHP Pharmacy and Therapeutics Committee.

For provider questions about the pharmacy network or for assistance with pharmacy claims processing, you may contact the Pharmacy Benefits Manager below.

<b>PROGRAM</b>	<b>PHARMACY BENEFIT MANAGER (PBM)</b>	<b>PHONE NUMBER</b>
SFHP MEDI-CAL	Perform Rx	1(888) 989 - 0091

For information about program-specific pharmacy benefits, exclusions, or the pharmacy network visit [www.sfhp.org](http://www.sfhp.org) or contact the SFHP Pharmacy Services Department at 1(415) 547-7818 x 7085.

### **Behavioral Health Services**

San Francisco Health Plan covers outpatient mental health services for Medi-Cal members with mild to moderate conditions. Beacon Health Options (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 1(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 of current benefit).

### **Chiropractic and Acupuncture**

For Medi-Cal members age 20 years and younger, chiropractic benefits are provided through fee-for-service Medi-Cal. These members must call to make their own appointments and utilize their blue-and-white or "California poppies" Medi-Cal card for services. For Medi-Cal members, acupuncture benefits are available for treatment of chronic pain. Benefit limits apply for members 21 and over. There are no benefit limits for services obtained through EPSDT.

## **Vision Benefit**

Vision Service Plan (VSP) administers vision benefits for SFHP Medi-Cal members. Optometry services are a vision benefit and are available every 24 months. Ophthalmology services are a medical benefit through SFHP and there is no age restriction for these services for any line of business. Providers can refer a member to a participating VSP provider. To find a VSP provider and for questions regarding vision benefits, please contact VSP at 1(800) 877-7195 or visit [www.vsp.com](http://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. Dental via IHSS/Public Authority. Refer IHSS Independent Providers to the IHSS/Public Authority if they have questions regarding their dental coverage or need to enroll in the dental plan. Healthy Workers HMO members currently enrolled with Liberty Dental can call 1 (888) 703-6999 to find a participating dental provider.

## **Fluoride Varnish**

Fluoride varnish is the safest and 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 members 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. The fluoride varnish 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 (6) years of age, medical providers offer the best hope for preventing and controlling tooth decay through the application of fluoride varnish. If you are a CHDP provider seeking provider/staff training, please contact the San Francisco CHDP office at 1(415) 575-5719. If you are not, inquire about becoming a certified CHDP provider or ask if they could make an exception.

## Sensitive Services

Services listed below should be provided to Medi-Cal members without a referral or authorization to protect patient confidentiality and promote easy access. Sensitive Services include family planning, screening, and treatment for sexually transmitted infections (STI), HIV testing, and abortion. Medi-Cal members may go outside of their medical group network for these services, except for prenatal care.

### 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 this 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 thirty (30) day waiting period. A copy of the PM-330 form must be attached to the claim when submitted for payment. Please consult your medical group or call SFHP for any clarification.

### Abortion

Abortion services are available to all SFHP members without referral or authorization. Outpatient abortion services are not subject to prior authorization, medical justification, or any other utilization management procedures. Inpatient hospitalization for the performance of an abortion requires prior authorization. An authorization is not required by SFHP for general anesthesia associated with abortion services; however, a medical group may require a prior authorization.

### 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.

### Family Planning – Adult Sterilization and Consent

NEMS MSO ensures that sterilization services provided to its members meet the federal requirements imposed by the Federal Government. The Sterilization Consent Form Requirements can be found in the California Code of Regulations Section 51305.1-51305.4, 51305.6-51305.7.

**Sterilization shall be covered ONLY if the following conditions are met:**

- The member is at least 21 years of age at the time of the written consent for sterilization is obtained.
- The member is **not** mentally incompetent.

- The member can understand the content and nature of the informed consent process as specified in the California Code of Regulations
- The member is not institutionalized.
- The member has voluntarily given informed consent in accordance with all the requirements in California Code of Regulations Section 51305.1-51305.4, 51305.6-51305.7.
- At least thirty (30) days, but not more than 180 days have passed between the date of the written informed consent and the date of the sterilization.

Visit the California Code of Regulations Section 51305.1-51305.4, 51305.6-51305.7, for full criteria, details, or to read in its entirety the sterilization regulations sections. In addition, consent must be voluntary, and the individual must not be coerced to employ sterilization or any method of sterilization. Under Medi-Cal, vasectomies and tubal ligations are family planning services. Medi-Cal members of childbearing age may access these services from any provider, including out-of-network providers without prior authorization.

NEMS MSO requires completion of the State of California Health and Welfare Consent Form (PM 330) before providing a sterilization procedure to SFHP-NEMS. The physician performing the sterilization service must ensure that the Consent Form (PM 330) is signed and completed. The physician must document the informed consent process in the medical record and include the signed Consent Form (PM 330) in the medical record. A copy of the Consent Form must be submitted with the claim to be eligible for reimbursement. Noncompliance with Sections 51305.1 through 51305.6 shall result in nonpayment for sterilization services.

## 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 SFHP 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, DHCS requires that PCPs and members also complete a SHA tool/questionnaire. The SHA is an age-specific risk assessment tool repeated at specific age intervals. The SHA is used to assess a member's health habits and status, such as nutrition, physical activity, environmental safety, and sexual health and substance use as appropriate. You can find the SHA forms at <https://www.sfhp.org/providers/provider-forms/staying-healthy/>. 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](mailto:provider.relations@sfhp.org).

## **Child Health and Disability Program (CHDP)**

The Child Health and Disability Prevention (CHDP) is a preventive program that delivers periodic health assessments and services to low income and uninsured children and youth under 21 years of age in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. To provide these assessments, providers must enroll in the CHDP program. Enrolled private physicians, local health department clinics, community clinics, and some local school districts provide health assessments. When billing for these Well Child exams, please refer to CHDP's crosswalk of HIPAA-compliant codes available on the DHCS website and submit claims according to the patient's medical group listed in the Claims Matrix above.

## **Coordination of Care for Medi-Cal Members**

### **Golden Gate Regional Center (GGRC)**

Golden Gate Regional Center (GGRC) 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 attributable to:

- Intellectual disability
- Cerebral palsy
- Epilepsy
- Autism, or
- Disabling conditions found to be closely related to intellectual disability or to require treatment like that required for individuals with intellectual disability.
- Additionally, individuals at risk of having a child with a developmental disability may be eligible for referral for genetic diagnosis, counseling, and other prevention services.

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 Title 17, Section 54001 of the California Code of Regulations. Eligibility is established through diagnosis and assessment performed by regional centers. GGRC provides services for developmentally disabled/delayed persons and their families, including:

- Living Skills Training
- Family Support and Training
- Respite Care
- Day care
- Supportive living services and housing placement (residential care, or assisted living)
- Advocacy for the protection of legal, civil, and service rights o Lifelong individualized planning and service coordination
- Supportive employment/vocational programs

San Francisco Health Plan is not financially responsible for the GGRC services provided to its members. A 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 and case managers may refer members by contacting Golden Gate Regional Center's Intake Unit via phone, fax, or email: Phone: 1(888) 339-3305 Fax: 1(888) 339-3306 Email: [intake@ggrc.org](mailto:intake@ggrc.org)

Medical group physicians and case managers may contact the San Francisco County's Golden Gate Regional Center office at 1355 Market Street, Suite 220, San Francisco, CA 94103, Phone: 1(415) 546-9222. For additional information and referral forms, you can visit the GGRC website at [www.ggrc.org](http://www.ggrc.org).

### **Early Start Program (ES)**

Infants and children, up to 36 months 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 through GGRC. For a list of Early Start services, please visit Golden Gate Regional Center at [www.ggrc.org](http://www.ggrc.org). The medical group and primary care physicians are responsible for coordination of services with 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's Intake Unit via phone, fax, or email:

**Phone: 1(888) 339-3305**

**Fax: 1(888) 339-3306**

**Email: [intake@ggrc.org](mailto:intake@ggrc.org)**

Providers can download the Early Start Referral Form at <http://www.ggrc.org/services/applying-for-services>

Golden Gate Regional Center office can be contacted at 1355 Market Street, Suite 220 San Francisco, CA 94103 Phone: 1(415) 546-9222 and additional information about the Early Start Program can be found at [www.dds.ca.gov/earlystart](http://www.dds.ca.gov/earlystart).

### **Women, Infants, Children Program (WIC)**

WIC is a nutrition/food program that helps pregnant, breastfeeding, or postpartum women, and children less than 5 years of age stay healthy and eat well. Federal income guidelines determine WIC eligibility, and many Medi-Cal members are eligible for WIC services that include free food vouchers, nutrition education, and breast-feeding support.

Medical group physicians can refer to WIC in several ways:

- By calling 1(888) WIC-WORKS or 1(888) 942-9675 for an appointment, or in San Francisco 1(415) 575-5788
- By visiting their website at <https://www.sfdph.org/dph/comupg/oprograms/NutritionSvcs/WIC/default.asp>
- By referring members to any WIC Center, current locations can be found here: <https://www.sfdph.org/dph/comupg/oprograms/NutritionSvcs/WIC/WIClocations.asp>



All WIC referral forms can be found on the website below.

<https://www.sfdph.org/dph/comupg/oprograms/NutritionSvcs/WIC/WICRefForms.asp>

## California Children's Services (CCS)

CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services for children age 21 years and younger who have CCS-eligible physical disabilities and complex medical conditions. The CCS program reimburses for services provided that fall under the CCS program, and SFHP is 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 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. The PCP and medical group continue to provide medically necessary covered services related to the CCS eligible condition until eligibility is established with the CCS program. 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 specialists. 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 the following address:

**California Children's Services**  
**30 Van Ness Avenue, Suite 210**  
**San Francisco, CA 94102**

**Telephone: 415-575-5700**

**Fax: 415-575-5790**

<https://www.dhcs.ca.gov/services/ccs>

Once a referral to CCS is obtained, you can check eligibility status by contacting CCS at 1(415) 575-5700.

## 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 an approved CPSP provider. In addition to standard obstetric 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, Child and Adolescent Health, Perinatal Services Coordinator at 1(415) 558-4040. You can also go to the website for more information <https://www.cdph.ca.gov/CPSP>.

## Local Education Agency (LEA)

The San Francisco Unified School District's Local Education Agency (LEA) provides services in San Francisco schools for low-income children starting at age three, school-age children in grades K-12, and transition services for eligible students up to age 22 with one or 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. Prior to referral and to release any clinical information, Medical group physicians and the ES or GGRC must obtain written consent from the parents. 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. An 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
- Physical and occupational therapy
- Medical transportation
- School health aides

Local Education Agency, Special Education Services can be reached at 1(415) 759-2222.

## 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 simultaneously enroll 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, ext. 1242 or [www.westside-health.org](http://www.westside-health.org).

**Home and Community-Based Services for the Developmentally Disabled (HCBS-DD)** provides in-home care and support to persons with disabilities. Services provided include homemakers for chores, home health aides and/or nurses, family training, vehicle adaptation, respite care, day habitation, transportation, and more. For referral and eligibility review, contact Golden Gate Regional Center at (415) 546-9222. For more information visit [www.dhcs.ca.gov/services/ltc/Pages/DD.aspx](http://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx).

**Multi-Purpose Senior Services Program (MSSP)** 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 skilled nursing facility (SNF) or intermediate care facility (ICF) level.

The PCP or specialist submits appropriate medical records and the MSSP referral to the following:

Institute on Aging for MSSP and Adult Day Health Care  
3575 Geary Boulevard  
San Francisco, CA 94118  
Telephone: 1(415) 750-4150 or 1(415) 750-5330  
Fax: 1(415) 750-5338  
[www.ioaging.org](http://www.ioaging.org)

San Francisco Adult Day Services Network  
Telephone: 1(415) 808-7371  
[www.sfadultday.org](http://www.sfadultday.org)

**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(833) 388-4551 or visit their website at [https://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-\(HCB\)-Alternatives-Waiver.aspx](https://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx)

**Genetically Handicapped Persons Program** is a state-funded program that may provide additional care coordination and services for eligible persons, 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). More information on how to apply for GHPP services and eligibility can be found at <https://www.dhcs.ca.gov/services/ghpp/Pages/default.aspx>

## Health Education

SFHP 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

Visit SFHP's website at [www.sfhp.org](http://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 SFHP Population Health Program Manager at 1(415) 615-5620 or email [HealthEducation@sfhp.org](mailto:HealthEducation@sfhp.org).

## Major Organ Transplant

SFHP-NEMS members who are eligible and pre-authorized for major organ transplants are transferred/disenrolled from Medi-Cal Managed Care into Fee-for-Service Medi-Cal. Medi-Cal Managed Care members who are disenrolled due to a major organ transplant may be reenrolled 12-months after the transplant.

The transplant procedures covered under the Medi-Cal fee-for-service program include:

- Bone Marrow
- Liver
- Heart
- Lung
- Lung/Heart (combined transplant)
- Liver/Small Bowel (combined transplant)
- Small Bowel

Kidney and corneal transplants are not considered "major" organ transplants; coverage of these surgeries is the responsibility of NEMS MSO, and these Medi-Cal members should not be disenrolled. Providers should send prior authorization requests for members who are under age 21 and in need of any organ transplant, including kidney and corneal, to California Children's Services Program (CCS). SFHP and NEMS MSO are responsible for the costs of covered medical care until the effective date of disenrollment, including the costs of transplant evaluation, organ acquisition and bone marrow search.

SFHP and NEMS MSO are responsible for the cost of transplant-associated medical and hospital care for a donor or prospective donor, even if the donor is not a member of SFHP or NEMS MSO, until the effective date of the member's disenrollment.

## Second Opinions

NEMS MSO ensures its members have access to second opinions from qualified health care professionals. Primary Care Physicians, Specialists, and members (if practitioners refuse) have the right to request a second opinion, at no cost to the member, from a qualified participating healthcare professional, acting within their scope of practice. The participating healthcare professional should possess clinical background, including training and expertise, related to the illness, or disease condition(s) associated with the request for a second opinion.

Requests for second opinions are not granted if the Chief Medical Officer (CMO) or physician designee (MD) determine two different qualified providers have reached the same opinion. Under such circumstances, no additional opinions may be requested. NEMS MSO will approve a member's or practitioner's request for a second opinion from a qualified health care professional for reasons that include, but are not limited to, the following:

- The member questions the reasonableness or necessity of recommended surgical procedures.
- The member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.
- The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, the treating health professional is unable to diagnose the condition and requests consultation, or the member requests an additional diagnosis.
- The treatment plan in progress is not improving the medical condition of the member within an appropriate period given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment; or
- The member has attempted to follow the practitioner's advice or consulted with the initial practitioner concerning serious concerns about the diagnosis or plan of care.

NEMS MSO follow SFHP's second opinion policy, and members may request a second opinion from any qualified primary care practitioner or qualified specialist within the same medical group. If a qualified specialist is not available within NEMS MSO, the Utilization Management Department may authorize an out-of-network visit. The Utilization Management Department reviews all requests for out of-network second opinions and may approve requests, and all decisions are made within our standard timeframes, but only the Chief Medical Officer (CMO) or physician designee (MD) may defer or deny such requests.

With respect to the second opinions, members have the right to the following:

- To obtain the names of two physicians who are qualified to give a second opinion.
- To obtain a second opinion within thirty (30) calendar days or, if the medical need is emergent or urgent, to obtain an opinion within a timeframe that is appropriate to the member's condition and does not exceed seventy-two (72) hours.
- To see the second opinion report.

## Standing Referral to Specialty Care

A member with a life threatening, degenerative, or disabling condition is eligible for a standing referral that allows the specialist to act as the care coordinator in lieu of the PCP. The member continues to see the PCP for problems unrelated to the qualifying condition(s). NEMS MSO issues standing referrals for specialty care when medically necessary. A standing referral reduces or eliminates the need for repeated authorization requests when regular use of a specialist is medically appropriate. Members with HIV/AIDS are eligible for a standing referral to an identified HIV/AIDS specialist who acts as their primary care provider and coordinator of care. NEMS MSO case management staff will assist with identification of and referral to a HIV/AIDS specialist, upon request.

## Non-Covered Services

Members can be financially responsible for non-covered services **only** if the provider obtains a **written acknowledgment from the member or member's parent or guardian prior to providing a non-covered service**. The member must agree in writing that they will be financially responsible for the non-covered service. If the provider does not obtain a written acknowledgement before delivery of the non-covered service, then the provider will be responsible for the charges associated with the non-covered service. Each written acknowledgement must be specific for the non-covered service provided.

## Member Liability

Other than cost sharing, such as applicable copayments and deductibles, members cannot be financially responsible for the costs of any covered and authorized medical services.