Community Health Plan of Imperial Valley New and Existing Provider Training

Welcome

Welcome to Community Health Plan of Imperial Valley:

- We thank you for being part of our network of participating physicians, hospitals, and other healthcare professionals
- We hope this presentation guide is informative and useful
- **For assistance, please call us at 1-833-236-4141**

Objectives

Upon completion of the training, New/Existing Providers will:

- Have the tools and resources to support our CHPIV members
  - Provider Library
  - Policies and Procedures
- Meet the Medi-Cal requirements to be onboarded as a new provider and continue to meet DHCS requirements for ongoing provider training. Attestation is required to maintain eligibility.

Agenda

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Provider Trainings

- Required Training for All Providers
- Value-Add Provider Trainings

About Community Health Plan of Imperial Valley

About Community Health Plan of Imperial Valley

Community Health Plan of Imperial Valley (CHPIV) is the local Medi-Cal managed care plan serving Imperial county, organized by the Imperial County Local Health Initiative.

Imperial County Medi-Cal Footprint

~90,000 Members

Initial Managed Care Contract Awarded in 2013

25+ Years Medi-Cal Experience

800+ Providers

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CHPIV Medi-Cal Members

Member Eligibility

Standard practice is to have eligibility reviewed for all members being seen at your practice at each visit.
There are multiple ways to check member's eligibility status

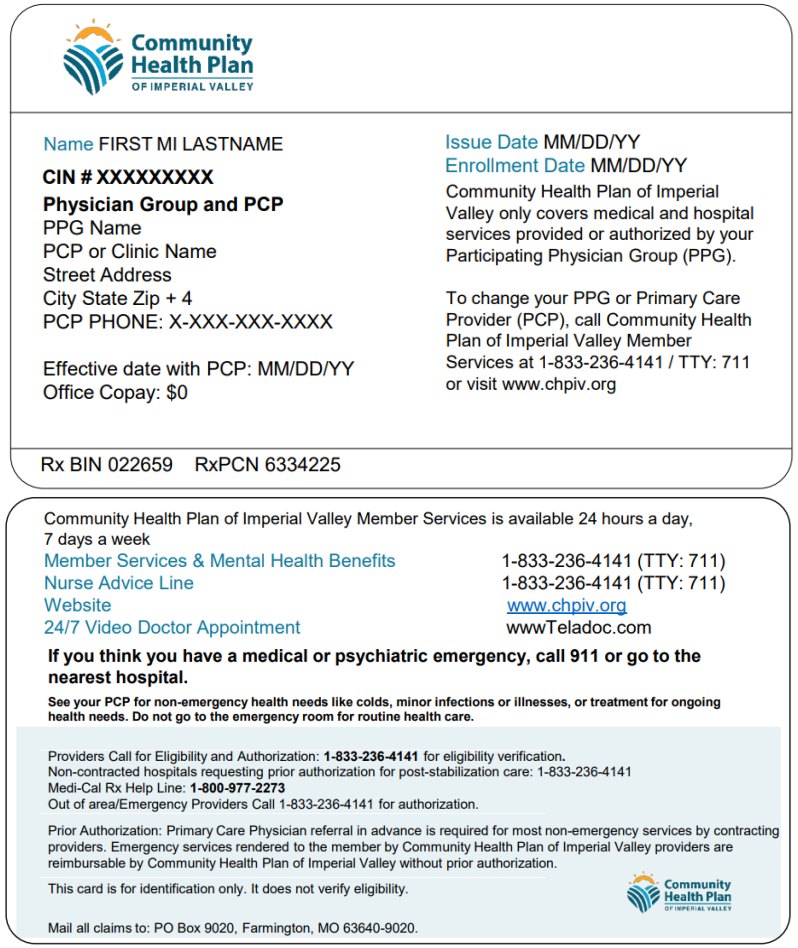
Medi-Cal AEVS
1-800-456-2387
www.Medi-cal.ca.gov

Provider Portal
provider.healthnetcalifornia.com

CHPIV Provider Services
1-833-236-4141

Member Identification Cards

CHPIV Member ID Card



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Name FIRST MI LASTNAME

CIN # XXXXXXXXX

Physician Group and PCP
PPG Name
PCP or Clinic Name
Street Address
City State Zip + 4
PCP PHONE: X-XXX-XXX-XXXX

Effective date with PCP: MM/DD/YY
Office Copay: $0

Issue Date MM/DD/YY
Enrollment Date MM/DD/YY
Community Health Plan of Imperial Valley only covers medical and hospital services provided or authorized by your Participating Physician Group (PPG).

To change your PPG or Primary Care Provider (PCP), call Community Health Plan of Imperial Valley Member Services at 1-833-236-4141 / TTY: 711 or visit www.chpiv.org

Rx BIN 022659 RxPCN 6334225

Community Health Plan of Imperial Valley Member Services is available 24 hours a day, 7 days a week

Member Services & Mental Health Benefits	1-833-236-4141 (TTY: 711)
Nurse Advice Line	1-833-236-4141 (TTY: 711)
Website	www.chpiv.org
24/7 Video Doctor Appointment	wwwTeladoc.com

If you think you have a medical or psychiatric emergency, call 911 or go to the nearest hospital.

See your PCP for non-emergency health needs like colds, minor infections or illnesses, or treatment for ongoing health needs. Do not go to the emergency room for routine health care.

Providers Call for Eligibility and Authorization: **1-833-236-4141** for eligibility verification.
Non-contracted hospitals requesting prior authorization for post-stabilization care: 1-833-236-4141
Medi-Cal Rx Help Line: **1-800-977-2273**
Out of area/Emergency Providers Call 1-833-236-4141 for authorization.

Prior Authorization: Primary Care Physician referral in advance is required for most non-emergency services by contracting providers. Emergency services rendered to the member by Community Health Plan of Imperial Valley providers are reimbursable by Community Health Plan of Imperial Valley without prior authorization.

This card is for identification only. It does not verify eligibility.

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Mail all claims to: PO Box 9020, Farmington, MO 63640-9020.

Medi-CAL Identification Card

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An Overview of Common Benefit Offerings

Medical Services Offered by the Health Plan	Behavioral Health Services
Care Management Services	The health plan is responsible for Mild to Moderate Services Call Healthnet at 1-833-236-4141 (TTY:711) for more details
Durable Medical Equipment (DME)	Individual/Group Evaluations and Treatments
Emergency Care; Hospitalization	Psychotherapy / Psychiatric Consultations
Family Planning Services; Maternity and Newborn Care	Psychological Testing
Routine Adult and Pediatric Examinations	Prior Authorization is not required for initial assessment for Outpatient Behavioral Health Services
Gender Alignment	**Services Provided By County Agencies**
Health Education Materials/Programs	California Children's Services (CCS) - Eligible Conditions
Home Health/Hospice Services	Services Provided at Regional Health Centers
Skilled Nursing Facility Care	**Non-Covered Services**
Vision Services	Experimental or Not Medically Necessary Specialty Services
Interpreter Services	Cosmetic Surgery
Podiatry Services	Services to Reverse Surgically-Induced Infertility
Non-emergency medical transportation (NEMT) and Non-medical transportation (NMT). For NEMT -A provider must complete a Physician Certification Statement (PCS) form	Services Provided Outside of the U.S.A except for Emergency Services in Canada and Mexico

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Refer to the Provider Library for more information and the chart to the left for further information.

Carved Out Services

Some catastrophic conditions have been carved out of the health plan and are not covered by CHPIV under its Medi-Cal managed care contract with the California Department of Health Care Services (DHCS).

- Transplant cases for members under age 21 are managed by the state of California.
- County care management programs include California Children's Services (CCS), waiver and regional service programs.
- Refer to the Public Health topic for additional information on these programs.

Refer to the Provider Library for more information and the chart to the left for further information.

CARVE OUTS and WAIVERS Note: The PCP maintains responsibility for all primary care services regardless of members' enrollment in any public health programs.								
	Excluded under CHPIV Contract	Waiver*	Carve Out**	Disenrolled	Enrolled	Referral Source	Authorizing Source	Payer Source
AIDS Waiver	X	X		X (patient choice)		PCP, Specialist	Local AIDS Waiver program	Local AIDS Waiver Program
Alcohol and Drug Treatment	X		X		X	PCP	County Alcohol and other Drug Treatment (AOD) Programs	AOD
CCS***	X		X		X	PCP, Specialist	CCS	CCS
Dental	X		X		X	PCP, Self	TAR Local	MCFFS
Direct Observation Therapy (DOT)	X		X		X	PCP	TAR Local	MCFFS
Home & Comm. Based waiver - Department of Developmental Services	X	X			X	PCP	Regional Center	Regional Center
Home & Comm. Based waiver - IHO (HMC, SNF, Model)	X		X	X (patient choice)		OCO	IHO Sacramento	IHO Sacramento
Home & Comm. Based waiver - DOA (MSSP)	X		X		X	PCP, Specialist, Self	Dept. of Aging Local Contractor	Dept. of Aging Local Contractor
LEA	X		X		X	Self, PCP	LEA	LEA
Specialty Mental Health Only	X		X		X	PCP, Self	County Mental Health Plan	County Mental Health Plan
Organ transplant - child (CCS)	X		X		X	PCP, Specialist	CCS	CCS
Regional center coord. (Early Start)	X		X		X	PCP, Specialist	DDS	DDS
Refugee Health	X		X	N/A	N/A	PCP, Other	LHD	LHD

* Programs in which payer source is other than CHPIV and the member is usually disenrolled (exceptions: HCBS waivers under DDS and MSSP)
**Programs in which the payer is other than CHPIV and the member is not disenrolled (exception: LTC)
***For coordinated Care Initiative (CCI) counties, Managed Long-Term Supports and Services (MLTSS) are part of the benefits.

Medi-Cal Pharmacy Benefit

As of January 1, 2022, pharmacy benefits and services transitioned from managed care to State's responsibility under the Rx benefit program known as Medi-Cal Rx.

As a prescribing Medi-Cal Provider, registration for the Medi-Cal Rx web portal will be required to access pharmacy services tools, pharmacy claim submissions and status updates.

Visit the Medi-Cal Rx website for more information or call 1-800-977-2273

To request prior authorization, complete a Prior Authorization Form and fax it to 800-869-4325.

Member Grievances

In the event a member has a complaint and wishes to take action, members can:

- Ask to complete a Grievance Form while in the provider's office. Providers must have these forms readily available in their offices. Forms are available at the following link Forms
- Call Member Services and file a verbal grievance at 1-833-236-4141 (TTY:711)
- Submit a grievance online at www.healthnet.com
- Call the California Department of Social Services - Fair Hearing Department: 1-800-952-5253 or 1-800-952-8349 (TDD)
- Contact the Ombudsman Program: 1-888-452-8609

The plan has 30 calendar days from the receipt of the grievance to investigate and respond to the member

Member Rights and Responsibilities

CHIPV MEMBERS HAVE THESE ***RIGHTS***

- To be treated with respect and dignity, 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 and its services, including covered services, practitioners, and member rights and responsibilities.
- To make recommendations about member rights and responsibilities policy.
- To be able to choose a primary care provider within the plan's network.
- To have timely access to network providers.
- To participate in decision making regarding your own health care, including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care you got.
- To get care coordination.
- To ask for an appeal of decisions to deny, defer or limit services or benefits.
- To get no-cost interpreting services for your language.
- To get free legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To ask for a State Hearing if a service or benefit is denied and you have already filed an appeal with the plan and are still not happy with the decision, or if you did not get a decision on your appeal after 30 days, including information on the circumstances under which as expedited hearing is possible.
- To access minor consent services.
- To get no-cost written member information in other formats (including braille, large-size print, audio format and accessible electronic formats) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions 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 truthfully discuss information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand, regardless of cost or coverage.
- To have access to and get a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by the health plan, your providers or the State.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Clinics, midwifery services, Rural Health Centers, sexually transmitted infection services and emergency services outside the plan's network pursuant to the federal law.

Member Rights and Responsibilities

CHPIV MEMBERS HAVE THESE ***RESPONSIBILITIES***

- Act courteously and respectfully. You are responsible for treating your doctor and all providers and staff with courtesy and respect. You are responsible for being on time for your visits or calling your doctor's office at least 24 hours before the visit to cancel or reschedule.
- Give up-to-date, accurate and complete information. You are responsible for giving correct information and as much information as you can to all of your providers, and to CHPIV. You are responsible for getting regular check-ups and telling your doctor about health problems before they become serious.
- Follow your doctor's advice and take part in your care. You are responsible for talking over your health care needs with your doctor, developing and agreeing on goals, doing your best to understand your health problems, and following the treatment plans and instructions you both agree on.
- Use the emergency room only in an emergency. You are responsible for using the emergency room in cases of an emergency or as directed by your doctor. Emergency care is a service that you reasonably believe is necessary to stop or relieve sudden serious illnesses or symptoms, and injury or conditions requiring immediate diagnosis and treatment.
- Report wrong-doing. You are responsible for reporting health care fraud or wrong-doing to CHPIV. All calls are strictly confidential.

California Children's Services

The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at public schools.

For more information on CCS, call Provider Services at 1-833-236-4141 or visit California Children's Services

- CHPIV members will be eligible to enroll in, or continue enrollment in, California Children's Services (CCS).
- This will include children from birth up to 21 years of age with CCS-eligible medical conditions.
  - CCS will pay for services associated with the eligible diagnosis.
  - California Health & Wellness is not responsible for services/conditions that are approved by CCS.
  - CCS will only reimburse services provided by CCS-paneled providers and CCS-approved hospitals
- Providers are expected to refer a child to CCS if there is sufficient clinical detail to establish, or raise a reasonable suspicion, that a member has a CCS-eligible medical condition.

Provider Responsibilities

Key Physician Responsibilities

- Manage the medical and health care needs of members
- Educate members on maintaining healthy lifestyles and preventing illness
- Provide referrals for specialty and subspecialty care and other medically necessary services which the PCP does not provide.
- Actively participate in quality initiatives and programs (e.g. HEDIS)
- Perform an Initial Health Appointment (IHA) within 120 days.
- For any members with mild to moderate substance use disorders, the provider should also complete an SABIRT (Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment) to members ages 11 years and older, including pregnant women to address specific conditions and future treatment recommendations.
- Additional PCP responsibilities are listed in the Provider Manual

Key Specialist Responsibilities

- Maintain contact with the PCP
- Obtain authorization from the health plan if needed, before providing services.
- Coordinate the member's care with the PCP
- Provide the PCP with consult reports and other appropriate records within five business days.
- Be available for or provide on-call coverage through another source 24 hours a day for management of member care.
- Maintain the confidentiality of medical information
- Actively participate in and cooperate with all the health plan's quality initiatives and programs.

CHPIV providers should refer to their contract for complete information regarding provider obligations and mode of reimbursement.

2023 Childhood Blood Lead Levels Screening

2023 Childhood Blood Levels Screening Webinar

- Understand the hazards of lead exposure on children.
- Define the Department of Health Care Services (DHCS) CBLLs screening requirements
- Understand what lead testing code to use.
- Know what documentation and reporting must be completed.
- Know where to find additional information.

Testing

- Screening for elevated blood levels can be conducted by finger stick test or via venous blood draw.
- Confirming or retesting of blood lead levels should be conducted through the venous blood test.
- Use the California Department of Public Health Guidelines for interpreting blood lead levels and follow-up activities for elevated blood lead levels. The California Management Guidelines on Childhood Lead Poisoning for Health Care Providers is available at https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/CDPH%20Document%20Library/Lead_HAGs_Table.pdf.

Codes

- Submit codes as evidence of lead testing. Use the following codes to submit claims/encounters as evidence of lead testing:

Description	Codes[1]
Venous blood collection	CPT 36415
Capillary blood collection	CPT 36416
Lead test	CPT 83655
Preventive medicine counseling (15-minute intervals)	99401, 99402, 99403, 99404
Abnormal lead level in blood	ICD-10 R78.71
Toxic effect of lead and its compounds, accidental (unintentional), initial encounter	ICD-10 T56.0X1A
Toxic effect of lead and its compounds, accidental (unintentional), subsequent encounter	ICD-10 T56.0X1D
Toxic effect of lead and its compounds, accidental (unintentional), sequela	ICD-10 T56.0X1S
Encounter for routine child health examination without abnormal findings	ICD-10 Z00.129
Encounter for screening for disorder due to exposure to contaminants	ICD-10 Z13.88
Contact with and (suspected) exposure to lead	ICD-10 Z77.011

- Report all lead test results! Health care providers and labs performing blood lead analysis on blood specimens must report all lead test results along with patient demographic, ordering physician, and analysis data on each test performed to the Childhood Lead Poisoning Prevention Branch (CLPPB) via email at EBLRSupport@cdph.ca.gov.

Exceptions

You are not required to perform a lead screening if:

- The legal parent/guardian refuses the lead screening and signs a voluntary refusal statement.
- In your professional judgment, lead testing poses a greater risk for the child than lead poisoning.

You must document reasons for not providing the lead screening or not obtaining the voluntary refusal statement in the child's medical record.

Tools available

We offer the following tools to help you identify children who need a lead test.

- Electronic care gap reports by email.
- Cozeva® web-based care gap reports.

Contact your Health Net representative for information on how to sign up for the care gap report or how to review the reports.

Health Net participates in the following lead screening activities to ensure compliance with state requirements:
- Lead screen monitoring.
- Medical record audits.
- Member and provider education.

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Medi-Cal for Kids and Teens

EARLY PERIODIC SCREENING DIAGNOSIS AND TESTING (EPSDT)

Federal law enacted in 1967 established **Early and Periodic Screening, Diagnostic and Treatment (EPSDT),** which guarantees all medically necessary services to children and youth under age 21 enrolled in Medi-Cal. As of 2023, California refers to EPSDT as **Medi-Cal for Kids & Teens**

What is Medi-Cal for Kids & Teens?

- Requires comprehensive age-appropriate health care services be provided to all Medi-Cal enrolled children and youth under age 21
- Requires preventive screening, diagnostic services, and treatment services
- Screenings, coverage requirements, and definition of medical necessity for children enrolled in Medi-Cal are more robust than that for adults' care

Complete and attest the webinar here

Goal for Medi-Cal for Kids and Teens

Ensure that children get the

Right Care

at the

Right Time

in the

Right Place

Initial Health Appointment (IHA)

- DHCS requires that **each new patient** has an **Initial Health Appointment** (IHA) completed within **120 days** of their enrollment into the Health plan.
  - IHA can be completed by a primary care physician (PCP), nurse practitioner, certified nurse midwife, or physician assistant.
- The IHA is required by DHCS for all newly enrolled patients, including those with disabilities. Providers must follow DHCS requirements for completing the IHA, in accordance with DHCS Plan Letters.
- All forms must be placed in the member's medical record file
- For any members with mild to moderate substance use disorders, the provider should also complete an SABIRT (Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment) for members ages 11 years and older, including pregnant people to address specific conditions and future treatment recommendations.

Take the IHA Webinar – now available at this link IHA Webinar

Note: *The Individual Health Education Behavior Assessment (IHEBA) and the Staying Healthy Assessment (SHA) forms are no longer required.*

IHA Requirements	
Physical, social and mental health history	Assessment of need for preventive screening or services and health education
Identification of high-risk behaviors	Diagnosis and plan for treatment of any disease
Physical examination	

PCP Transfers

Members have the right to change their primary care physician (PCP) every 30 days. If a PCP is affiliated with a participating provider group (PPG), then the PCP should follow the PPG policies as well.

Members can request PCP change prior to their visit by calling ***Member Services*** at 1-833-236-4141

Or the provider can have the member complete a ***PCP Change Request For*****Request for PCP/PPG Change Form** to have the member re-assigned to a practice.

If faxed on Date of Service:

- Requires member signature
- Requires Member ID#
- Member must answer NO to all questions regarding prior services rendered
- Takes up to six days to update in the system
- If member has received services by another provider within the same month, then the PCP change may not become effective until the following month
- Fax number is listed at the bottom of the form

Access to Care and Availability Standards

The plan's appointment accessibility and provider availability policies, procedures and guidelines for providers and health care facilities providing primary care, specialty care (including seldom used or unusual specialty services), behavioral health care, urgent care, ancillary services, and emergency care, are in accordance with applicable federal and state regulations, contractual requirements and accreditation standards.

CHPIV and its participating providers are required to demonstrate that, throughout the geographic regions of the plan's service area, a comprehensive range of primary, specialty, institutional, and ancillary care services are readily available and accessible within reasonable timeframes. Additionally, CHPIV and its participating providers are required to demonstrate that members have access to non-discriminatory and appropriate covered health care services within reasonable period of time appropriate for the nature of the member's condition and consistent with good professional practice. This includes, but is not limited to, provider availability, waiting time and appointment access with established time-elapsed standards.

Timely Access to Care standards

- Access To Care
- Appointment Availability Standards

Click for more information about Access to Care and Appointment Availability Standards

Type of Appointment	Scheduling Time Frame
Non-Urgent Primary Care	Within 10 business days of request
Urgent Care/No Prior Authorization Required	Within 48 hours of request
Urgent Care/Prior Authorization Required	Within 96 hours of request
Emergent	On demand service/24 hours a day, 7 days a week
Specialist	Within 15 business days of request
Non-Urgent/Ancillary Services for diagnosis or treatment of injury, illness or other health condition	Within 15 business days of request
First Prenatal Visit	Within two weeks of request
Clinical: Appointments for member for covered health care services shall be within the time period appropriate for their individual condition.	

Access to Care and Availability Standards – Behavioral Health and Other Access Standards

Appointment Type	Appointment Access Standards
BEHAVORIAL HEALTH APPOINTMENTS	
Urgent care appointment with non-physician behavioral health care provider or behavioral health physician (Psychiatrist) that does not require prior authorization	Within **48 hours** of request
Urgent care appointment with non-physician behavioral health care provider or behavioral health care physician (Psychiatrist) that requires prior authorization.	Within **96 hours** of request
Non-urgent care appointment with behavioral health care physician (Psychiatrist)	Within **15 business days** of request
Non-urgent care appointment with non-physician behavioral health care provider	Within **10 business days** of request
Non-urgent follow-up appointment with non-physician mental health care provider (NPMH)	Within **15 business days** of request

AFTER-HOURS ACCESS	
After-hours physician availability	Call back within **30 minutes**
After-hours ER instructions	Appropriate **emergency instructions**
TELEPHONE ACCESS	
Telephone answer time during normal business hours	Answers call within **60 seconds**
Telephone call-back for non-urgent issues	Calls patients back withing 1 business day
IN-OFFICE WAIT TIME	
In-office wait time scheduled appointments with PCP	Not to exceed **30 minutes**

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Appointment Rescheduling

- Promptly re-schedule in a manner that is appropriate for the member's health care needs.
- Apply applicable timely access standards to the rescheduled appointment.
- Ensure continuity of care consistent with applicable professional practice

Facility Site and Medical Record Review Training

California Collaborative Site Review Training workgroup is comprised of 22 Medi-Cal plans in California that have come together to create one comprehensive training to educate Our Primary Care Network providers.

- This training has been mandated by the Department of Health Care Services (DHCS) as directed through All Plan Letter (APL) 20-006. the updated standards to take affect as soon as the Public Health Emergency defined by Governor Newsom has been lifted for California.
- These revised Tools and Standards are in response to the growing number of Preventative measures set forth from a multitude of organizations such as the CDC, USPSTF, OSHA, AAP to name a few.

These trainings comprise of a Facility portion and a Medical Records portion.

- Our goal is to update these training videos as our industry changes.
- DHCS has made it their mission to revise these tools about every 2 years to aid in the health of California's Medi-Cal recipients and provide the highest quality of service.

Facility Site Review Training
Medical Record Review Training

Secure Methods of Sharing Information

Members are entitled to confidential treatment of member communications and records. Case discussion, consultation, examination, claims and treatment are confidential and must be conducted discreetly. A provider shall permit a patient to request, and shall accommodate requests for, confidential communication in the form and format requested by the patient, if it is readily producible in the requested form and format, or at alternative locations. More information on secure methods of sharing information and medical record confidentiality can be found HERE.

Additional Information and Topics Included in this link:

- Confidentiality of Medical Information
- Agencies Must be Authorized to Receive Medical Records
- Basic Principles
- Procedure

Mandatory Data Sharing Agreement

The state of California established the California Health and Human Services (CalHHS) Data Exchange Framework (DxF) to oversee the electronic exchange of health and social services information in California.

Entities listed below must sign a data sharing agreement (DSA). To sign the DSA, go to https://signdxf.powerappsportals.com.

Participating entities that must sign a DSA include:

- General acute care hospitals.
- Physician organizations and medical groups.
- Skilled nursing facilities.
- Clinical laboratories.
- Acute psychiatric hospitals.

The Plan may apply a corrective action plan if the agreement is not signed.

Provider Incentive Programs

HEDIS Incentive Programs Overview

The plan offers incentive payments to qualifying primary care physicians (PCPs) in recognition of their efforts to improve quality of care for its Medi-Cal members

- PCPs are awarded for care gaps closed in various HEDIS measures.
- FQHC/RHC/IHS and FQHC look-alike providers are awarded for meeting the minimum performance level (MPL) and having a certain % of improvement (1% for providers meeting MPL and 2% for providers below MPL) in various HEDIS measures.
- All 12 counties statewide with active W-9 on file.
- Other eligibility requirements exist.

A useful tool to maximize your HEDIS incentive is the Cozeva® Portal

Providers have support in the following areas when they sign up on Cozeva® Portal.

- Track measure rates using the Registries scorecard.
- View patient-level detail on gaps in care.
- Track estimated/potential incentive payments.
- Print face sheets to facilitate pre-visit planning.
- Close data gaps instantly by uploading records.
- More frequent incentives (quarterly vs. semiannual).

More timely and secure e-payments through PayPalHyperwallet®.

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CHIP and HIP

The **Clinic HEDIS Improvement Program** is a financial incentive program that recognizes Medi-Cal primary care clinics for their efforts to:

- Maintain open primary care physician panels (does not apply to clinics at maximum capacity)
- Submit accurate and timely encounters
- Demonstrate improvement of selected HEDIS measures

What are the eligibility criteria?

- Be a clinic in Imperial County
- Be directly contracted with CHPIV as a participating Medi-Cal provider
- Be in good standing with Community Health Plan of Imperial Valley
- Be a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Indian Health Service (IHS) provider
- Open to accepting new CHPIV Medi-Cal enrollees (does not apply to clinics at max. capacity)

The **HEDIS Improvement Program** is a financial program that recognizes participating primary care physicians (PCPs) for their efforts to:

- Maintain open PCP panels (does not apply to clinics at maximum capacity)
- Submit accurate and timely encounters
- Show improvement of their HEDIS measures

What are the eligibility criteria?

- Be a PCP in Imperial County
- Be directly contracted with CHPIV as a participating Medi-Cal PCP
- Be in good standing with Community Health Plan of Imperial Valley
- Open to accepting new Medi-Cal enrollees (does not apply to physicians at max. capacity)

For additional information, please contact your plan representative or email HN_provider_relations@healthnet.com

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Claims

Claim Submission Requirements

Timely Filing of Claims

- ✓ First time Claims
  - In accordance with Medi-Cal law and the Medi-Cal Provider Participation Agreement (PPA), providers have 180 days from the last day of the month of service to submit initial Medi-Cal claim.
- ✓ Contested Claims
  - Submission of requested information should be within 365 calendar days
- ✓ Provider Appeals/Disputes
  - Submission of a provider appeal/dispute should be within 365 calendar days from the date of the denial

Claim Definitions

- **Clean Claim** - 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 Claim** - An unclean claim lacks sufficient information to pay or deny, and results in an examiner requesting information from a source outside the Medicare Advantage Organizations (MAOs), such as a participating physician group (PPG) or hospital. The following are examples of claims considered to be unclean (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.*
- **Contested Claim** – A contested claim is one for which CHPIV needs more information in order to process the claim
- **Denied Claim** – A claim that has been processed, not paid and given a denied status because it has been determined to not meet payment approval requirements (*Member not eligible at time of service, service not authorized, etc.*)

Claim Submission Processes

Electronic Claim

- CHPIV encourages participating providers to submit claims electronically. An authorized vendor may be used for electronic claim submission. CHPIV has contracts with TransUnion Healthcare to provide claims clearinghouse services for claims submission. Contact the CHPIV's EDI Claims Department to establish electronic claims submission or for more information:
  - Electronic Data Interchange (EDI) 1-800-225-2573 ext. 6075525
  - Claims must be submitted within 180 days from date of service
  - Claims are processed within 45 working days
  - **Payor ID: 95567**
- For more information about claims and billing please visit the Medi-Cal Provider Library
- Or contact Provider Services at **1-833-236-4141**
- **Provider Portal**
  - **Claims can also be submitted via the CHPIV Provider Portal** provider.healthnetcalifornia.com

Paper Claims

CHPIV only accepts the Centers for Medicare & Medicaid Services (CMS) most current:

- CMS-1500 form - complete in accordance with the guidelines in the National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual**, updated each July.**
- CMS-1450 (UB-04) form - complete in accordance to UB-04 Data Specifications Manual, updated each July.

Other claim form types will be upfront rejected and returned to the provider.

Send written correspondence, claims, tracers, adjustment requests, or denial reconsiderations to:

Health Net Medi-Cal Claims
PO Box 9020
Farmington, MO 63640-9020.

***Additional Paper Claim Requirements**:*

Paper claim forms must be typed in black ink with either 10- or 12-point Times New Roman font, and on the required original red and white version 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. To reduce document handling time, providers must not use highlights, italics, bold text, or staples for multiple page submissions. Copies of the form cannot be used for submission of claims, since a copy may not accurately replicate the scale and optical character recognition (OCR) color of the form. CHPIV only accepts claim forms printed in Flint OCR Red, J6983 (or exact match) ink and does not supply claim forms to providers. Providers should purchase these forms from a supplier of their choice.

Provider Appeal/Dispute Resolution Process

CHPIV's provider dispute resolution process ensures correct routing and timely consideration of provider disputes (or appeals). Participating providers use this process to:

- Appeal, challenge or request reconsideration of a claim that has been denied or adjusted
- Respond to a contested claim that the participating provider does not agree requires additional information for adjudication.
- Challenge a request by CHPIV for reimbursement for an overpayment of a claim
- Seek resolution of a billing determination or other contractual dispute with CHPIV
- Appeal a participating physician group's (PPG's) written determination following its dispute resolution process when the dispute involves an issue of medical necessity or utilization review, to CHPIV for a de novo review, provided the appeal is made within 60 business days of the PPG's written determination
- Challenge capitated PPG or hospital liability for medical services and payments that are the result of CHPIV decisions arising from member grievances, appeals and other member services actions
- Challenge capitation deductions that are the result of CHPIV's decisions arising from member billings, claims or member eligibility determinations

Appeals submission address:
Health Net Medi-Cal Appeals
PO Box 989881,
West Sacramento, CA 95798-9881

- Providers have one year from the date of payment/denial to appeal, contest or resubmit a corrected claim
- **More information can be found HERE**
- **Provider Appeal/Dispute form can be found HERE**

Provider Grievances

A provider grievance is an oral or written expression of dissatisfaction or concern that does not involve a prior determination. Provider grievances include quality of care concerns, access to care concerns, complaints regarding delays of referrals or authorizations, patient dumping issues, and provider refusals to submit medical records. There are two types of provider grievances:

- administrative - concerns of a non-clinical nature
- clinical - concerns of a clinical nature

Provider grievances may be submitted orally or in writing within **180 days** of the date of occurrence. The first step in registering a grievance is to call the Provider Services Center at **1-833-236-4141**

The second step is to submit it in writing with the following information:

- a description of the problem, including all relevant facts
- names of involved people
- date of occurrence
- supporting documentation

Participating providers are notified in writing of receipt of a grievance within five business days. A grievance received without all required information is returned to the submitting provider with instructions for resubmitting the grievance with the missing information. The provider must resubmit the completed grievance within 30 business days of receipt of the request for additional information.

Providers are informed in writing of resolution of the grievance within 30 business days. If resolution of the case exceeds 30 business days, the plan will send the provider a letter of explanation by the 30th business day, documenting the reason for the delay and an estimated completion date for the resolution.

More information can be found HERE

Balance Billing and Other Billing Prohibitions

Balance billing is **strictly prohibited** by state and federal law and CHPIV's PPA.

Balance billing occurs when a participating provider bills a member for fees and surcharges above and beyond a member's copayment and coinsurance responsibilities for services covered under a member's benefit program, or for claims for such services denied by CHPIV or the affiliated PPG.

Participating providers are also prohibited from initiating or threatening to initiate a collection action against a member for nonpayment of a claim for covered services. Participating providers agree to accept CHPIV's fee for these services as payment in full, except for applicable copayments, coinsurance or deductibles.

Providers are prohibited from charging Medi-Cal members for the completion of any form that is required by, or is necessary for the administration of, the Medi-Cal benefit. This includes, but is not limited to, CMS-1500 and UB-04 claim forms, health histories, patient consent forms, and medical record transfer forms.

CHPIV providers are prohibited from charging a CHPIV Medi-Cal member for a missed appointment. Medi-Cal managed care members are not share-of-cost beneficiaries and are not subject to copayments or deductibles for office visits, so they cannot be held accountable for these charges in the event of a missed appointment. Additional information on billing prohibitions is available in the CHPIV Medi-Cal provider operations manuals in the Provider Library

Additional Claims/Billing tools and Resources

CMS1500 Billing Instructions

- HERE

UB04 Billing Instructions

- HERE

Provider Library "Billing and Submission"

- HERE

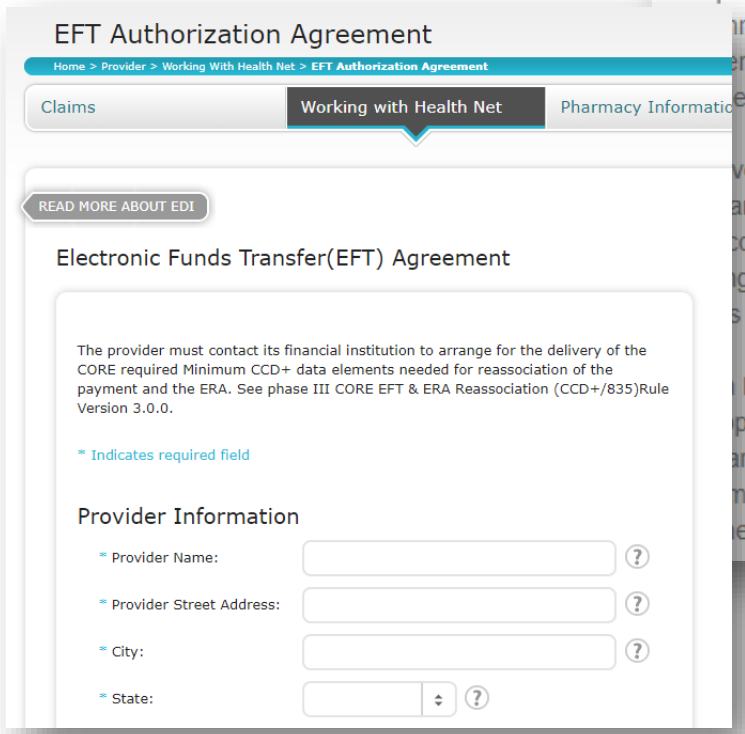
Medi-Cal.gov Provider Billing Tips

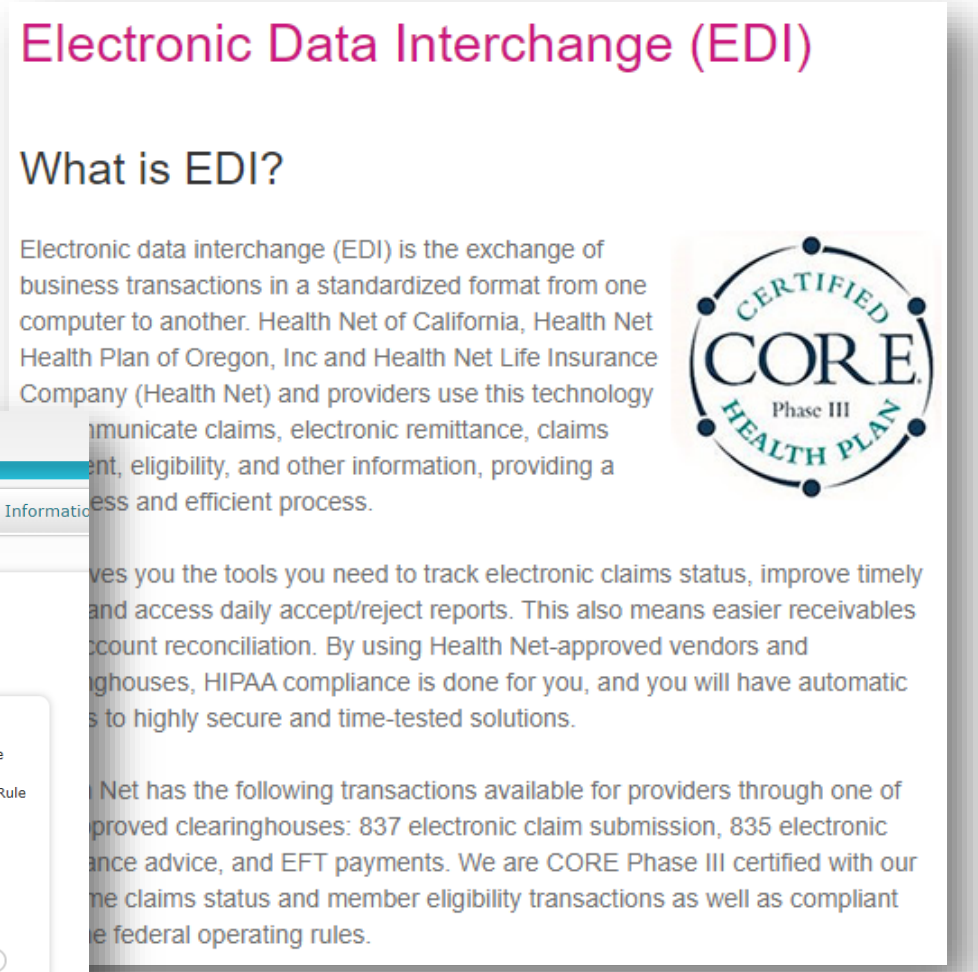
- HERE

Sign up for Electronic Funds Transfer (EFT)

To sign up for Electronic Funds Transfer (EFT), please follow this LINK and complete the EFT Agreement form.

Click HERE to learn more about Electronic Data Interchange (EDI)





Fraud, Waste and Abuse

Fraud is intentional misrepresentation or deception for the purpose of obtaining payment or other benefits not otherwise due. **Waste** is the overutilization or inappropriate utilization of services and misuse of resources. **Abuse** includes those practices that are inconsistent with accepted sound fiscal, business or medical practices. The following are examples of fraud and abuse:

- Intentional misrepresentation of services rendered
- Deliberate application for duplicate reimbursement
- Intentional improper billing practices
- Failure to maintain adequate records to substantiate services
- Failure to provide services that meet professionally recognized standards of health care
- Conducting excessive office visits or writing excessive prescriptions
- Provision of unnecessary services

CHPIV is responsible for reporting to the state its findings of suspected fraud and abuse by participating providers or vendors under its Medi-Cal and Cal MediConnect plans. Suspected fraud and abuse is identified through various sources that include aggregate data analysis, review of high-cost providers, review of CPT-4 codes with potential for over-use, members, the state, law enforcement agencies, other providers, and associates.

Providers and their office staff are legally required to report suspected cases of fraud and abuse to Health Net. Reports of suspected fraud may be made anonymously to the Fraud Hotline.

Utilization Management

Utilization Management

Health Net's utilization management (UM) program is designed to ensure that members receive timely, medically necessary and cost-effective health care services at the correct level of care. The scope of the program includes all members and network providers.

Elements of UM process are as follows

- Prior authorization
- Concurrent review
- Discharge planning
- Care management
- Retrospective review

Prior Authorization Process

To request prior authorization or coordinate a primary care physician (PCP) referral for services *other than advanced imaging services and cardiac imaging*:

- A Primary Care Physician must complete the Inpatient or Outpatient California Medi-Cal Prior Authorization form:
  - Inpatient – HERE
  - Outpatient – HERE
- *The PCP and specialist should retain a copy of the Ip or OP prior authorization form in the member's chart*
- Fax a copy of the prior authorization form to the Medical Management Department at:
- Fax: 800-743-1655
  Phone: 800-421-8578
- Transplant fax:
  833-769-1141
- This ensures the plan identifies case management needs and assists the member with coordination of care, when appropriate
- This also enables the plan to assist in the detection of and referral to appropriate agencies for carve-out services, such as California Children's Services (CCS)

**Specialists submitting paper claims must include the prior authorization form with the claim. This supports the PCP-to-specialist referral and helps prevent delays in payment*

**Specialists submitting electronic claims must indicate the name of the referring provider in box 23 of the CMS-1500 claim form*

The PCP or specialist must give the Medical Management Department as much advance notice as possible when requesting prior authorization. For elective inpatient or outpatient services, fax requests for prior authorization at least **five days** before the anticipated date of service. It is recommended not to schedule services prior to receiving the review decision. The Medical Management Department needs time to notify the provider of the review decision prior to the services being rendered.

Required Information

When requesting prior authorization, please click on the link for details on required information. **Required Information**

The Medical Management Department reviews the information and calls back with the review decision. If the service is authorized, an authorization number is given.

Submission of Prior Authorization Requests

Fax the prior authorization form to the Medical Management Department. Use the fax number on the form to submit requests 24 hours a day, seven days a week.

Routine Authorization (Pre-Service) Deferral Needed

An initial decision may be deferred for 14 calendar days from the date of receipt of the original request if the referring provider, treating provider, or triaging health professional has determined and noted in the relevant record that a longer waiting time will not have detrimental 1367.03(a)(5)(H). Click **HERE** for more information.

National Imaging Associates

Health Net has contracted with National Imaging Associates Inc. (NIA) for radiology benefit management.

The program includes management of non-emergent, high-tech, outpatient radiology services through prior authorization. This program is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

Health Net oversees the NIA program and is responsible for claims adjudication.

For Commercial HMO/PPO/EPO/POS/HSP and Ambetter HMO/PPO, prior authorization is required for the following outpatient radiology procedures:

- CT/CTA/CCTA
- MPI
- MRI/MRA
- MUGA scan
- PET scan

Key provision: Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in non-payment of your claim. A separate prior authorization number is required for each procedure ordered.

Prior authorization is not required through NIA for services performed in the emergency department, on an inpatient basis or in conjunction with a surgery. Prior authorization and/or notification of admission in those instances is required through the health plan. To obtain authorization through NIA or for more information, visit NIA website.

National Imaging Associates

National Imaging Associates, Inc. (NIA) is responsible for prior authorization for advanced imaging services and cardiac imaging.

Prior authorization requests must be submitted to NIA online or by phone as follows. NIA does not accept fax submissions.

www.RadMD.com (24 hours a day, seven days a week, except when maintenance is performed once every other week after business hours)

National Imaging Associates Contact Information

PRODUCT	HOURS OF OPERATION	PHONE NUMBER
Commercial	Monday through Friday, from 8 a.m. to 8 p.m.	800-424-4802
Medi-Cal	Monday through Friday, from 8 a.m. to 8 p.m.	800-424-4809

TurningPoint Healthcare Solutions, LLC

TurningPoint Healthcare Solutions, LLC is responsible for prior authorization for musculoskeletal procedures.

TurningPoint conducts its review activities 8am – 5pm on normal business days in each time zone (PST in California). If a provider needs to contact TurningPoint for prior authorization *on a holiday, after normal business hours, or weekends,* TurningPoint has medical professionals on-call 24 hours a day, 7 days a week.

Prior Authorization will be required for all inpatient cases as well as any code within the scope that currently requires it. Providers should be encouraged to also obtain Prior Authorization for these procedures in the outpatient settings (including Ambulatory Surgical Centers), even if there is not a current Prior Authorization requirement.

HOW TO OBTAIN PA?

- WEB INTAKE *Preferred method*

To access to TurningPoint's Provider Portal, you must be a registered user. Contact their Provider Relations Team at:

PHONE: 866.422.0800
EMAIL: providersupport@turningpoint-healthcare.com
WEBSITE: www.myturningpoint-healthcare.com

- PHONE INTAKE: Call TurningPoint at 855.332.5898 or 949.966.0297
- FAX INTAKE: 949.774.2254 Send request and/or medical records
- US MAIL INTAKE: Providers may physically mail in a request and/or medical records to:

Attn: Utilization Review Dept
TurningPoint Healthcare Solutions, LLC
1000 Primera Blvd, Suite 3160
Lake Mary, FL 32746

TurningPoint Healthcare Solutions, LLC (Cont'd)

Musculoskeletal (MSK) Procedures	
ACL Repair	Partial Knee Replacement
Acromioplasty and Rotator Cuff Repair	Revision of Total Hip Replacement
Allograft for Spinal Fusion [BMP]	Revision of Total Knee Replacement
Ankle Fusion	Sacral Decompression
Cervical Disc Replacement	Sacroiliac Joint Fusion
Cervical Laminectomy and Discectomy	Shoulder Fusion
Cervical Spinal Fusion	Shoulder Replacement (Total, Reverse, Revision, Hemi)
Elbow Replacement	Spinal Cord Neurostimulator
Femoroacetabular Arthroscopy	Spinal Devices (Facet Implant)
Hip Arthroscopy	Spinal Fusion for Scoliosis
Hip Resurfacing	Spinal Fusion- Unspecified
Implantable Infusion Pumps	Spine Non-Specific
Knee Arthroscopy	Thoracic Laminectomy and Discectomy
Kyphoplasty and Vertebroplasty	Thoracic Spinal Fusion
Laminectomy- Unspecified	Total Ankle Replacement and Revision
Lumbar Disc Replacement	Total Hip Replacement
Lumbar Laminectomy, Discectomy, and Laminotomy	Total Knee Replacement
Lumbar Spinal Fusion	Wrist Fusion
Meniscal Repair and Allograft Transplantation	Wrist Replacement
Osteochondral Defect Repair	

UM DETERMINATIONS & NOTIFICATIONS

TurningPoint will notify the provider, facility and member with a written notification letter regarding the status of the request including supporting information for the initial UM determination.

TurningPoint will make an outbound courtesy call to the physician office regarding the determination status of the case (approved or denied).

If a Peer to peer is requested, it will be conducted by TurningPoint.

Appeals will be handled by HealthNet/Centene.

Case/Care Management

The Case Management program identifies members as being at high risk for hospitalizations or poor outcomes and who have barriers to their health care.

Trained nurse care managers, in collaboration with a multidisciplinary team, provide coordination, education and support to the member in achieving optimal health, enhancing quality of life and accessing appropriate services.
Once a member is selected to participate in the program, a case manager contacts the member's provider to coordinate care.

- Providers may refer members for case management and complete the Care Management Referral Form
- Members may self-refer to the program by calling the member services telephone number on the back of their identification (ID) card.

Continuity of Care

Under our continuity of care (COC) policy, the health plan will honor CHPIV member's continuity of care with a provider whom they have a pre-existing relationship (even if the provider is out of network). The member may continue an active course of treatment and does not have to request for continuity of care.

Hospitals

Notification of Hospital Admissions

Provider Type

- Physicians (does not apply to D-SNP)
- Participating Physician Groups (PPG)
  (does not apply to Health Savings Plan - HSP)
- Hospitals
- Ancillary

Timely notification of Health Net member inpatient admissions assists with timely payment of claims, reduces retroactive admission reviews and enables Health Net to concurrently monitor member progress. Health Net requires hospitals to notify the Hospital Notification Unit and the PPG (if applicable) or provider of a member's inpatient admission within 24 hours (or one business day when an admission occurs on a weekend or holiday) to the Hospital Notification Unit.

For the following services:

- All inpatient hospitalizations.
- Skilled nursing facility (SNF) admissions.
- Inpatient rehabilitation admissions.
- Inpatient hospice services.
- Emergency room admissions.

Failure to notify according to the requirements in the Provider Participation Agreement (PPA) may result in a denial of payment.

Notification of after-hours admissions may be made by phone (the information is recorded by voicemail), fax, or web. On the next business day, a Health Net representative verifies eligibility, obtains information regarding the admission and, if applicable, provides a tracking number for the case.

**For details on what patient information needs to be submitted click HERE

Community Health Plan of Imperial Valley health net

Hospital and Inpatient Facility Discharge Planning

Provider Type

- Participating Physician Groups (PPG)
  (does not apply to Health Savings Plan - HSP)
- Hospitals

Ancillary

Participating providers are required to work with hospitals and inpatient facilities (general acute care hospitals, long-term acute care hospitals and skilled nursing facilities) to create an appropriate discharge plan and care transition protocol for Health Net members, including post-hospital care and member notification of patient rights.

Each hospital or inpatient facility must have a written discharge planning policy and process that includes:

- Counseling for the member or family members to prepare them for post-hospital or post-inpatient facility care, if needed.
- A transfer summary that accompanies the member upon transfer to a skilled nursing facility (SNF), intermediate-care facility, or a part-skilled nursing or intermediate care service unit of the hospital.
- Information regarding each medication dispensed must be given to the member upon discharge.

https://providerlibrary.healthnetcalifornia.com/medi-cal/provider-manual/utilization-management/hospital-discharge-planning-epo-hmo-hsp-ppo-medi-cal.html

Community Health Plan OF IMPERIAL VALLEY health net

Hospital and Inpatient Facility Discharge Planning

Members have the right to:

- Be informed of continuing health care requirements following discharge from the hospital or inpatient facility.
- Be informed that, if the member authorizes, a friend or family member may be provided information about the member's continuing health care requirements following discharge from the hospital or inpatient facility.
- Actively participate in decisions regarding medical care. To the extent permitted by law, participation includes the right to refuse treatment.
- Appropriate pain assessment and treatment.

Requests for Authorization for Post-Stabilization Care at Non-Participating and Participating Hospitals

Health Net is responsible for the coverage and payment of emergency services and post-stabilization care services to the provider that furnishes the services. This can be a participating provider, subcontractor, downstream subcontractor, or nonparticipating provider.

Requests for post-stabilization authorization:

When a member is stabilized after emergency services but needs continued care before safely being discharged or transferred, the health care provider must request an authorization for post-stabilization care. The request must clearly state that the patient has been stabilized and the hospital is requesting authorization for post-stabilization care. Notification to Health Net of emergency room treatment or admission does not satisfy the requirement. Notification of admission for inpatient care does not satisfy the requirement. Post-stabilization requirements do not apply if the member has not been stabilized after emergency services and requires medically necessary continued stabilizing care.

Response time to requests:

Health Net must approve or disapprove a request for post-stabilization care within 30 minutes. The post-stabilization care must be medically necessary for covered medical care. If the response to approve or disapprove the request is not given within 30 minutes, the post-stabilization care request is authorized. This applies to a participating provider, subcontractor, downstream subcontractor, or nonparticipating provider.

Required documentation

All requests for authorization, and responses to requests, must be documented. The documentation must include, but is not limited to:

- Date and time of the request.
- Name of the provider making the request.
- Name of the Health Net representative responding to the request.

Requests for Authorization for Post-Stabilization Care at Non-Participating and Participating Hospitals

Conditions of financial responsibility:

Health Net is financially responsible for post-stabilization care services that are not pre-authorized, but are administered to maintain, improve, or resolve the member's stabilized condition if the Plan:

- Does not approve or disapprove a request for post-stabilization care within 30 minutes.
- Cannot be contacted.
- Is unable to reach an agreement with the treating provider concerning the member's care and a Plan physician is not available for consultation.

If this situation applies, the Plan must give the treating provider the opportunity to consult with a Plan physician. The treating provider may continue with care of the member until a Plan physician is reached or one of the following criteria is met:

- A Plan physician with privileges at the treating provider's hospital assumes responsibility for the member's care;
- A Plan physician assumes responsibility for the member's care through transfer;
- The Plan and the treating provider reach an agreement concerning the member's care; or
- The member is discharged.

A request for authorization for post-stabilization care can be made to the Hospital Notification Unit. Hospitals are required to provide Health Net with the treating physician and surgeon's diagnosis and any other relevant information reasonably necessary for Health Net to make a decision to authorize post-stabilization care or to assume management of the patient's care by prompt transfer.
A hospital's contact with the patient's participating physician group (PPG) to request authorization to provide post-stabilization care does not satisfy the requirements of the above laws. Hospitals and other providers may not contact the patient's PPG for authorization for post-stabilization care.

Electronic Medical Records or Administrative System

In accordance with the Provider Participating Agreement (PPA) and State regulation 42 CFR 482.24 section (d) , hospitals and facilities must ensure compliance and prompt electronic notification of patient admissions, discharges and transfers. The following organizations have been designated as qualified health information organizations (QHIOs) and are available to assist with Data Exchange Framework (DxF) requirements:

Link to https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.24

QHIOs	Website
Los Angeles Network for Enhanced Services (LANES)	lanesla.org/
Manifest MedEx	manifestmedex.org/
SacValley MedShare	sacvalleyms.org/
San Diego Health Connect	sdhealthconnect.org/
Applied Research Works, Inc.	drupal.org/applied-research-works-inc
Health Gorilla, Inc.	healthgorilla.com/
Long Health, Inc.	longhealth.io/
Orange County Partners in Health-Health Information Exchange (OCPH-HIE)	ochealthinfo.com/ems/oc-meds/hie
Serving Communities Health Information Organization (SCHIO)	schio.org/

Behavioral Health Services

Behavioral Health Services Overview

**subject to change due to benefit coming in-house*

Purpose: Delivers clinically based workplace solutions to improve productivity for its clients and enhance the lives of its members
Mission: To help people be healthy, secure and comfortable

- Providers may call 1- 844-966-0298 option 3 for Behavioral Health (BH) service inquiries or visit the
- provider.healthnetcalifornia.com
- For more inquiries or education & training providers may contact
- providerlibrary.healthnetcalifornia.com

- **Members can self refer to Health Net for behavioral health services**

  Starting January 1, 2024, using the member portal to locate a physician in their area or by calling behavioral health services at 1-844-966-0298.

To bill your CVHIP Behavioral Health Claims please follow by line of business below:

Medi-Cal:

Health Net Medi-Cal Claims
P.O. Box 14621
Lexington, KY 40512-4621

Payer ID: 22771

Commercial:

Health Net Commercial Claims
P.O. Box 10456
Van Nuys, CA 91410

Payer ID: 95567

Medicare:

Health Net Medicare Claims
P.O. Box 9030
Farmington, MO 63640-9030

Payer ID: 68069

IFP:

Health Net Commercial Claims – IFP
P.O. Box 9040
Farmington, MO 63640-9040

Payer ID: 68069

Behavioral Health Covered Services

Network Covered Services

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing to evaluate a mental health condition
- Outpatient services that include laboratory work, medications and supplies
- Outpatient services for the purposes of monitoring medication therapy
- Psychiatric consultations

For additional behavioral health county support, please call or visit your local County Mental Health Office:
bhs.imperialcounty.org

PCPs Responsibility for Behavioral Health Coordination

PCPs are responsible for coordinating referrals for members requiring specialty or inpatient mental health services (SMHS) to county mental health plans (CMHPs). PCPs retain responsibility for coordination of ongoing care for co-existing medical and mental health needs and provision of medically necessary medications.

No Wrong Door Policy and Screening & Transition of Care Tools

INFORMATIONAL ONLY, NOT A PROVIDER REQUIREMENT

NO WRONG DOOR POLICY

As of July 1, 2022, DHCS implemented a “no wrong door" policy to ensure beneficiaries receive mental health services regardless of the delivery system where they seek care (via county behavioral health, Medi-Cal managed care plan (MCP), or the fee-for-service delivery system). This policy allows beneficiaries who directly access a treatment provider to receive an assessment and mental health services, and to have that provider reimbursed for those services by their contracted plan, even if the beneficiary is ultimately transferred to the other delivery system due to their level of impairment and mental health needs. In certain situations, beneficiaries may receive coordinated, non-duplicative services in multiple delivery systems, such as when a beneficiary has an ongoing therapeutic relationship with a therapist or psychiatrist in one delivery system while requiring medically necessary services in the other. DHCS also clarified that patients with co-occurring mental health and Substance Use Disorder (SUD) conditions may be treated by providers in each of the behavioral health delivery systems, if the covered services are not duplicative and meet specified requirements for contracting and claiming.

Additional Tools, Guidance, Resources, Training and FAQs available HERE

Imperial County Contact Information: Complete the appropriate Medi-Cal Screening Tool assessment or Transition of Care Tool assessment, if appropriate, and **fax a PDF of the tool to 442-265-1703 FAX** Follow-up with phone call to **442-265-1525** to confirm receipt and assessment appointment provided to member.

SCREENING & TRANSITION OF CARE TOOLS

Adult Screening Tool for Medi-Cal Mental Health Services: The Adult Screening Tool for Medi-Cal Mental Health Services is required for use when an individual age 21 or older, who is not currently receiving mental health services, contacts the Medi-Cal Managed Care Plan (MCP) or county Mental Health Plan (MHP) to seek mental health services. This tool determines whether an individual should be referred to the MCP delivery system or to the MHP delivery system for a clinical assessment and ensures that individuals have timely access to the appropriate mental health delivery system. *Adult Screening Tool for Medi-Cal Mental Health Services*

Youth Screening Tool for Medi-Cal Mental Health Services: The Youth Screening Tool for Medi-Cal Mental Health Services is required for use when an individual under age 21, or a person on behalf of an individual under age 21, who is not currently receiving mental health services, contacts their Medi-Cal Managed Care Plan (MCP) or county Mental Health Plan (MHP) to seek mental health services. This tool determines whether an individual should be referred to the MCP delivery system or to the MHP delivery system for a clinical assessment and ensures that individuals have timely access to the appropriate mental health delivery system. *Youth Screening Tool for Medi-Cal Mental Health Services*

Transition of Care Tool for Medi-Cal Mental Health Services: The Transition of Care Tool for Medi-Cal Mental Health Services (hereafter referred to as the Transition of Care Tool) leverages existing clinical information to document an individual’s mental health needs and facilitate a referral to the individual’s Medi-Cal Managed Care Plan (MCP) or county Mental Health Plan (MHP) as needed. The Transition of Care Tool is to be used when an individual who is receiving mental health services from one delivery system experiences a change in their service needs and 1) their existing services need to be transitioned to the other delivery system or 2) services need to be added to their existing mental health treatment from the other delivery system. *Transition of Care Tool for Medi-Cal Mental Health Services*

CalAIM

CalAIM Overview

DHCS has developed a multi-year framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program to:

- **Address many of the complex challenges facing California's most vulnerable residents**
- Provide for **non-clinical interventions focused on a whole-person care (WPC) approach** that targets social determinants of health (SDoH) and reduces health disparities and inequities.

Two significant programs within CalAIM:

1. **Enhanced Care Management** (ECM) provides a whole-person approach to care coordination that addresses clinical and non-clinical circumstances of high-need Medi-Cal members; building on the current Health Homes Program and Whole Person Care pilots.
2. **Community Supports** (formally ILOS) are designed to be used to provide health-related services as an alternative to covered Medi-Cal benefits. Community Supports will be integrated with care management for members at high levels of risk and are intended to address SDoH in a way that is cost-effective.

Populations of Focus

1. **Homeless individuals** or those at risk of becoming homeless
2. **High utilizers** with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits
3. **Serious Mental Illness (SMI) / Substance Use Disorder (SUD)**
4. **Individuals at risk for institutionalization**
   - who are eligible for long-term care services, or
   - with serious mental illness (SMI), children with serious emotional disturbance (SED) or substance use disorder (SUD) with co-occurring chronic health conditions.
5. **Nursing facility residents** who want to transition to the community
6. **Individuals transitioning from incarceration** with complex physical or behavioral health needs
7. **Children or youth** with complex physical, behavioral, developmental, and oral health needs

Enhanced Care Management (ECM)

The Enhanced Care Management (ECM) benefit is a new, statewide benefit established by the Department of Health Care Services (DHCS) to provide a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries enrolled in Medi-Cal managed care. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to populations of focus.

Effective January 1, 2022, the Medi-Cal ECM benefit designed by DHCS and authorized by the Centers for Medicare and Medicaid Services (CMS). The following seven core services are provided at the point of care:

- Outreach and engagement
- Comprehensive assessment and care management plan
- Enhanced care coordination
- Health promotion
- Comprehensive transitional care
- Member and family supports
- Coordination of and referral to community and social support services

Community Supports (CS)

Community Supports (CS) are key services offered by California Advancing and Innovating Medi-Cal (CalAIM), a Department of Health Care Services (DHCS) initiative to address the social determinants of health and improve health equity statewide. CS services are medically appropriate and cost-effective alternatives to state plan services. DHCS has pre-approved 14 CS services to address the needs of members – including those with the most complex challenges affecting health, such as homelessness, unstable and unsafe housing, food insecurity and/or other social needs.

- Asthma Remediation
- Community Transition Services/Nursing Facility Transition Services to a Home
- Day Habilitation Programs
- Environmental Accessibility Adaptation (Home Modification)
- Housing Deposit
- Housing Tenancy and Sustaining Services
- Housing Transition Navigation
- Medically Tailored Meals
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Personal Care Services and Homemaker Services
- Recuperative Care
- Respite Services
- Short-Term Post-Hospitalization Housing
- Sobering Centers

How to Become a CalAIM Provider

Are you eligible? To be eligible for EPI, an ECM provider must:

1. Be in good standing with the health plan.

2. Be contracted with CHPIV as an ECM participating provider.

3. Be open to accept and have the capacity to serve new Medi-Cal enrollees eligible for ECM services. Incentive administration

CalAIM Resources for Providers

NOTE: Enhanced Care Management (ECM) services do not need prior authorization starting January 1, 2023.

CalAIM (California Advancing and Innovating Medi-Cal) is a multi-year initiative by the California Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal members through broad delivery system, program and payment reform across the Medi-Cal program. (Note, Community Supports (CS) program services are available for Cal MediConnect enrollees.)

The **CalAIM Resources** page has been developed to provide tools and resources to help providers easily navigate the CalAIM program so they can better serve our members. On this page you will find the most current information:

- Guides
- Forms
- Provider Trainings
- Latest CalAIM updates
- and more!

Provider Portals and Resource Links

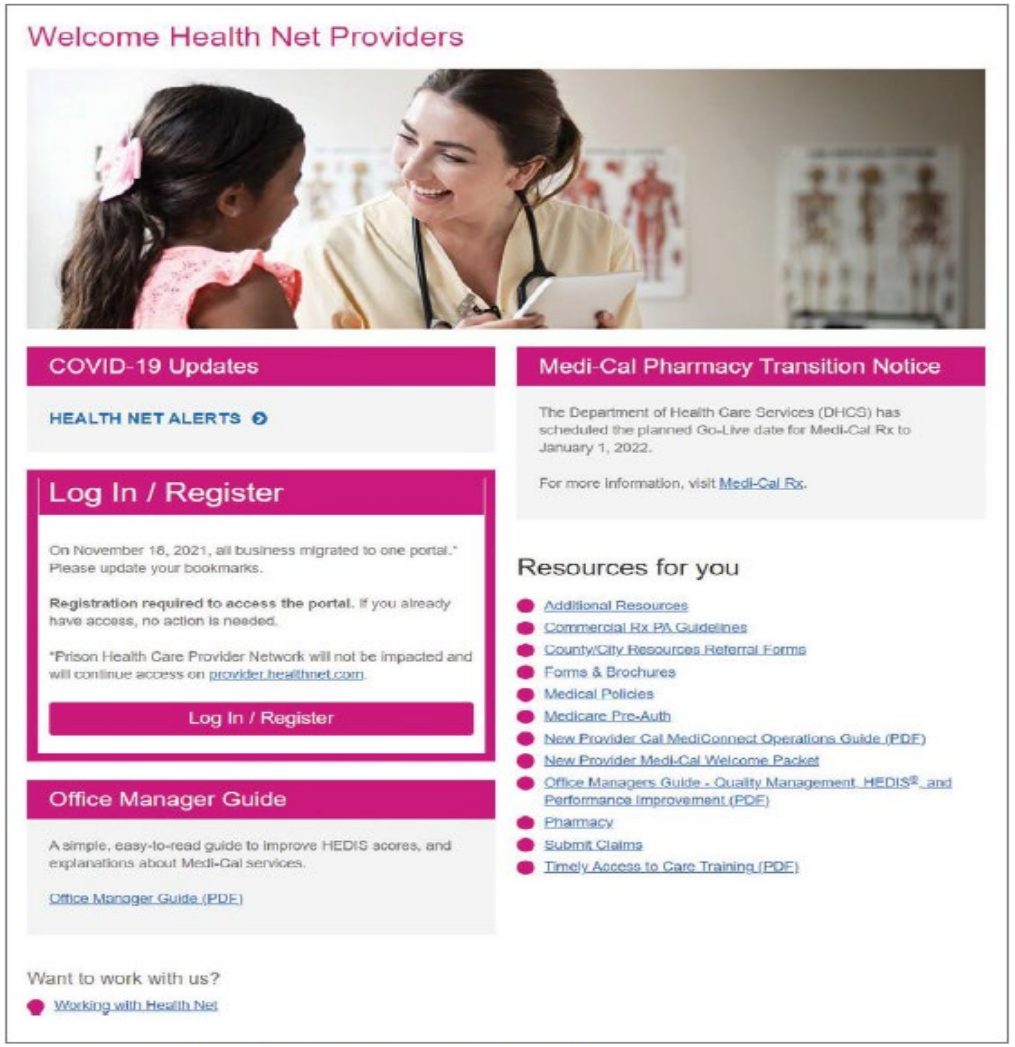
CHPIV Public/Member Site

To access the CHPIV public/member site, please go to www.chpiv.org

Provider Website

For quick access to tools and resources, visit the Provider website

- Register for the secure portal
- Learn how to submit claims online
- Get pharmacy information
- View webinar calendars
- Get medical policies at your fingertips
- Find frequently asked questions (FAQs) and answers



Actual provider portal image may look different.

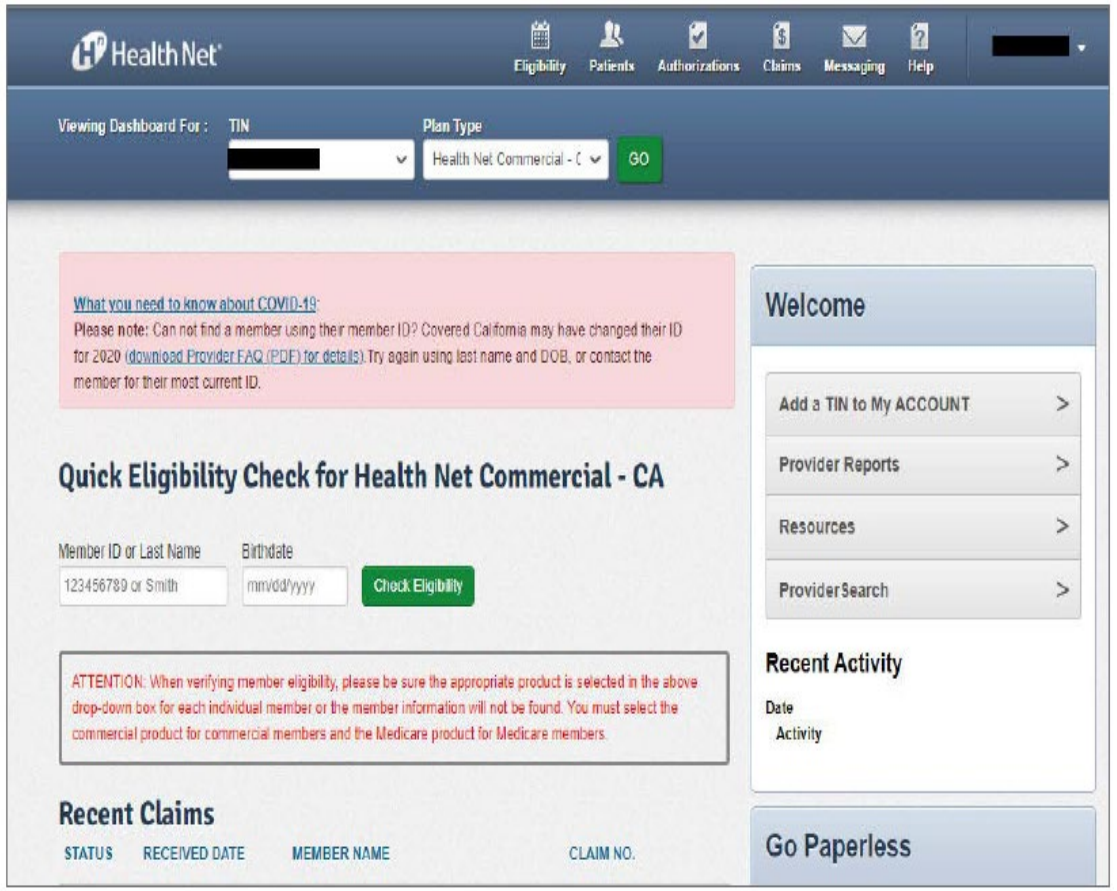
Web Portal – Post Login Site

Register for the secure portal here Register

The provider portal can help make your job easier:

- Manage your account
- Look up a member's eligibility
- Find a member's Schedule of Benefits
- Get easy access to medical management (prior authorization requests, health risk assessments (HRAs), care plans, health records)
- Check claim status

Portal Technical Support Team: 1-866-458-1047



Screen shots may not match the current look of the provider portal.

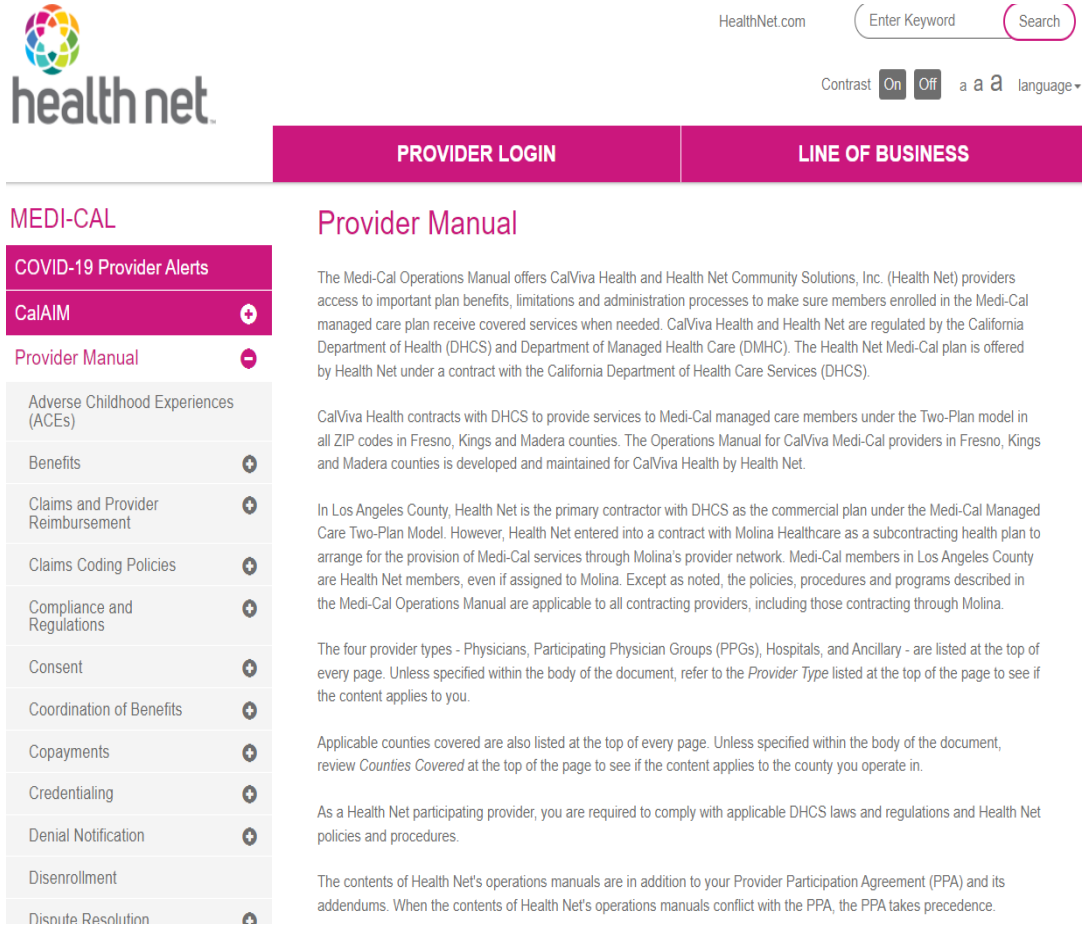
[1]Some features or functions may only be available based on provider type.

Provider Library and Operations Manual

Go to the on healthnet.com for more information on the **Provider Manual.** The Provider library content available to providers in real-time via the provider portal.

Includes, but not limited to:

- Appeals, Grievances and Disputes
- Benefits
- Claims and Provider Reimbursement
- Claims Coding Policies
- Contacts
- Credentialing
- Denial Notification
- Education, Training and Other Materials
- Encounters
- Members Rights & Responsibilities
- Forms and References
- Participating Physician Group (PPG) Performance Scorecard
- Provider Oversight
- Quality Management Program and Resources
- Updates and Letters
- Utilization Management



Provider Resources

Provider Engagement

ENSURE YOUR PROVIDER REP HAS ACCURATE EMAIL CONTACT INFO FOR YOUR PRACTICE

The Provider Engagement team's goal is to deliver personalized and effective training, tools and other support to assist providers in providing care to our members in the most efficient manner.

A vital part of our Provider Engagement service philosophy centers on direct personal communication with Providers.

Products we support:
Medi-Cal, Medicare, Commercial

Services we offer:
- In person Support
- Operational Support to resolve issues of highly escalated nature
- Provider Training and Education – In person or webinar
- Resources and Tools

You can reach our team @ HN_Provider_Relations@healthnet.com

Provider Engagement Contact List

Georganna McBride
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Georganna.M.McBride@cahealthwellness.com

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Provider Engagement Manager
Sandra.vega@HEALTHNET.COM

Erica Valdivia
Provider Engagement Director
Erica.Y.Valdivia@healthnet.com

Contact Resources

- **Member and Provider Services:** 1-833-236-4141 to request the following:

  Interpreter Services, Transportation, Eligibility, claims issues, Case Management, etc.
- **Enrollment Service Line:**

  1-833-236-4141
- **Health Equity Department:**

  1-800-977-6750
- **Health Education Information Line:**

  1-800-804-6074
- **Web and Secure Portal:**
  - provider.healthnet.com and provider.healthnetcalifornia.com
  - 1-866-458-1047
- **Provider Engagement email:**

  HN_Provider_Relations@healthnet.com

Emergency Preparedness

HAVE A PLAN READY WHEN DISASTER STRIKES

During state of emergencies, CHPIV provides assistance to affected members, ensuring that those impacted have continued access to health care services and prescriptions. Providers will receive updates from the health plan with information and resources when a state of emergency is declared. Information includes topics such as:

- Health plan contact information
- Prior authorization, precertification and referrals
- Filing claims
- Prescription information
- Member insurance cards and health care information
- Coping assistance
- Additional information, policies changes, etc.

RESOURCES FOR MEMBERS

In active crisis:

- CalHOPE Crisis Services – Delivers crisis support for communities impacted by a national disaster. Call (833) 317-HOPE (4673)
- SAMHSA'S Disaster Distress Helpline – Provides 24/7, 365 days of crisis counseling and support for emotional distress related to natural or human-caused disasters. Call 1-800-985-5990 or text TalkWithUS to 66746 to speak with someone.

Impacted by disaster or excessive stress:

- MHN – Refer members who are ready for a mental health evaluation and treatment. Call 1-800-327-4103
- Case Management – For help or to learn more, refer members to Behavioral Health Case Management. Call 1-866-801-6294
- Community Connect – Use this tool to search online for free or reduced cost local resources like medical care, food, job training, and more based on a ZIP code. Visit the Aunt Bertha website, enter a ZIP code and click on Search, for more information.
- Telehealth – Cost-effective and user-friendly when in-person contact is not required.
- myStrength – Offers online self-care resources that cover a range of topics (i.e., stress, anxiety, chronic pain, and more). Note: If a member needs emergent or routine treatment services, call MHN at 1-800-327-4103. Members can download the myStrength app at Google Play or the Apple Store. Visit the myStrength website to join online. Click Sign Up. Complete the myStrength sign-up process with a brief wellness assessment and personal profile.

Quality Improvement Program

CLICK HERE TO ACCESS QUALITY IMPROVEMENT INFORMATION AND RESOURCES

Here you will find information on various topics, including:

- Quality Performance Improvement Projects
- Quality Measures
- MHN Outreach Programs
- Health Education Programs
- Initial Health Appointments
- Notice of Access Standards
- Medical Records Review and Facility Site Review
- Pharmacy Management
- And more

Member Value-Added Services

Value-Added Services

Transportation Services

Physician Certification Statement Form -

To request patient transportation, use the **Physician Certification Statement Form** to document the specific transportation restrictions of a member due to a medical condition and request non-emergency medical transportation (NEMT) for Medi-Cal members. A PCS form is **not** required for non-medical transportation (NMT).

Providers who may complete and sign the PCS form include:

- Participating physician group (PPG) or independent practice association (IPA)
- Doctor of medicine (MD)
- Registered nurse (RN)
- Nurse practitioner (NP)
- Primary care physician (PCP)
- Licensed vocational nurse (LVN)
- Physician assistant (PA)
- Certified midwife
- Discharge planner employed or supervised by the hospital, facility or physician's office where the patient is being treated and has knowledge of the patient's condition when completing the form.

Nurse Advice Line

The Nurse Advice Line was developed to assist members in obtaining primary care. Information is available 24 hours a day. The program is a service offered in conjunction with the primary care physician and does not replace the PCP.

According to the health plan's access-to-care standards, all PCPs must provide 24-hour telephone service for instructions, medical condition assessment and advice.

The plan's Medi-Cal Member Services Department coordinates member access to the Nurse Advice Line:

TFN: 1-833-236-4141

TTY: 711

Health Equity Department and Cultural and Linguistic Services

HEALTH EDUCATION

The Health Equity department has free programs, services and resources for members and providers

- Free health education classes to provider groups, schools, hospitals and community-based organizations
- Free health screenings at health fairs
- Member newsletter
- Pregnancy Matters
- Preventative screening guidelines
- Health Education Information Line; 1-800-804-6074
- To order and request health education informational material on various topics please fill out the Health Education Material Request Form HERE
- And more for more information please visit the provider library HERE

CULTURAL AND LINGUISTIC SERVICES

The Health Equity Department ensures that materials and interpreter services are available in member's language

Interpreter Services

- Free health education material in threshold languages
- Request interpreter services: 1-833-236-4141 (TTY – 711)
- 24-hour access at no cost
- 72-hour notice for in person interpreter service request
- Qualified interpreters are trained on health care terminology
- Workshops and trainings are provided to contracted providers. Email the Training Request form to **HealthEducationDept@healthnet.com** or call our Health Equity Department at 1-800-977-6750.

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Telehealth

What is Telehealth?

Telehealth is a two-way interaction between you and your patients through telecommunication devices. It is an alternative approach to in-person visits for qualified providers to deliver care and services to patients.

Who can provide Telehealth?

- Physicians
- Clinical social workers
- Physician assistants
- Certified registered nurse anesthetists
- Nurse midwives
- Clinical psychologists
- Clinical social workers
- Physical and occupational therapists
- Speech-language pathologists
- Registered dieticians or nutrition professionals

Use the correct codes for claims and encounters

When submitting claims, be sure to use correct procedural codes for the covered service or benefit given to patients.

TELEHEALTH TYPES	CODING GUIDANCE
SYNCHRONOUS TELEHEALTH: These visits are "real-time" face-to-face, audio-visual contact between you and patients to communicate through teleconferences, webcams, smartphones or tablets. **Example:** A doctor having a videoconference on Zoom with a patient to talk to them about their diabetes and discuss their blood sugar levels. **SYNCHRONOUS TELEPHONE:** These "real-time" audio-only visits are considered synchronous visits but do not include video interaction. These visits are used for patients who do not have access to or choose not to use video or web access.	Use the appropriate office visit E/M code (99201-99205, 99211-99215) or preventative services code (99381-99385, 99391-99395) **Place of service (POS):** 02 **Telehealth modifier:** 95, G0, GT **Originating site:** Q3014 **Transmission fee:** T1014 **Audio only codes:** 98966-98968 (non-physician), 99411-99443 (as of May 13, 2020) Apply the applicable ICD-10 codes for billing diagnosis

Teledoc

WHEN A PCP ISN'T AVAILABLE, MEMBERS CAN USE TELEDOC FOR VIRTUAL CARE

Improved Access to Care for all Commercial and Medi-Cal Members

Patients rely on getting an appointment with their primary care physician (PCP) for proactive wellness, condition management and care. However, if a member cannot get an appointment with their PCP for immediate care, Teladoc can provide an option to get same-day health care services via a virtual visit. By serving as an alternative on weekends and after hours, Teladoc can also potentially help members avoid unnecessary emergency room and urgent care visits.

Help Members Sign Up

Let members know they can get started with Teladoc by:

- Downloading the Teladoc App from Google Play or the Apple Store
- Visiting the Teladoc website at www.teladoc.com/hn.
- Calling Teladoc at 800-TELADOC (800-835-2362).

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by email at provider_services@healthnet.com, by telephone (800-675-6110) or through the Health Net provider portal

Provider Training

Required Training for ALL Providers

ANNUAL TRAINING WILL BE *REQUIRED* FOR ALL PROVIDERS AND INCLUDES:

- Adverse Childhood Experiences (ACES) Module 2
- Blood Lead Screening
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey
- CalAIM (includes Community Health Workers, Doula Services, Street Medicine, Find Help, Partnership with Skilled Nursing Facilities)
- California Children's Services Program
- Continuity of Care (COC) and Long-Term Services & Supports (LTSS)
- Communication Skills
- Connecting the Dots: How to Co-Manage an Individual with Complex Health Needs
- Cultural Competency
- Dementia Training
- Diabetes Prevention Program
- Dual Special Needs Plan (D-SNP)
- Dyadic Services
- EPSDT Services (Medi-Cal for Kids & Teens)
- Flu Vaccine Update
- Facility Site Review
- Gender Affirming Care
- Healthcare Barriers for Gender Diverse Populations
- HEDIS Training
- Implicit Bias
- Initial Health Appointment
- Justice Involved Population
- Language Assistance Program (LAP)
- Medicare STARs
- Model of Care (MOC)
- Motivational Interviewing
- National Health Literacy
- New Provider and On-Going Network Training
- Population Health Management
- Provider Dispute Resolution
- Reproductive Justice
- Risk Adjustment
- Seniors and Persons with Disabilities
- Social Drivers of Health and Disparity
- Special Needs and Cultural Competency
- Telehealth (eConsults)
- Topical Fluoride Application for Non-Dental PCPs

To access ALL required provider trainings, click **HERE**

Please note this list my be subject to change

Attestation Requirement

In order to get credit for contractual obligations as it relates to provider training, providers are ***required*** to complete pre-registration and post-attestation for all trainings.

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Value-Added Provider Trainings

The **Provider Training Calendar** has webinar information and Training materials on many topics:

- Advancing Antibiotic Stewardship
- HEDIS Incentive Program Trainings (C-HIP, HIP, H-QIP)
- One Provider Portal for All Your Needs!
- COZEVA 101 Webinars
- AND many more

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THANK YOU for reviewing this new provider training deck.