Scripps | Health Plan Services

Provider Operations Manual

For Contracted Professionals, Facilities & Ancillary Providers

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Key Contacts

Hours of Operation: Monday- Friday from 8:00am – 5:00pm

Mailing Addresses:

Scripps Health Plan Services	Claims Address:	Provider Dispute Resolution
Mail Drop: 4S-300 10790 Rancho Bernardo Road San Diego, California 92127	P.O. Box 2079 La Jolla, California 92038	P.O. Box 2079 La Jolla, California 92038

Claims	
Claims Status Inquiry	**888-680-2273**
Claims Fax	**858-260-5844**
Provider Disputes Inquiry	**888-680-2273**
Provider Disputes Fax	**858-260-5845**
Contracts and Provider Relations	**ProviderRelations@ScrippsHealth.org**
Irene Evans, Contract Manager	**858-927-5400**
Loretta Moody, Provider Relations	**858-927-5425**
Rosalia Munaco-Gonzalez, Provider Relations	**858-927-5391**
Annette Carter, Provider Data Updates	**858-927-5427**
Elvia Cabrera, Scripps Care Link Access	**858-927-5452**
Melanie Molina, Provider Data Updates	**858-927-5426**
Ruby Paragas, Payer Relations	**858-927-5361**
Credentialing	
Application Inquiries	**619-260-7105**
Application Fax	**619-686-3450**
Non-Application Inquiries	**858-927-5358**
Phone Number	**858-678-7939**
Credentialing Fax	**858-260-5843**
Customer Service	**CustomerService@ScrippsHealth.org**
Phone Number	**888-680-2273**
TTY line (for the hearing impaired)	**888-515-4065**
Customer Service Fax	**858-260-5844**
Enrollment Inquiry	**888-680-2273**
Enrollment Fax Number	**858-260-5844**
Appeals & Grievances	**SHPSAppealsandGrievancesDG@ScrippsHealth.org**
Phone Number	**858-927-5907**
Fax	**858-260-5826**
Delegation Oversight	**SHPDelegationOversight@ScrippsHealth.org**
Phone Number	**858-927-5362**
Fax	**858-964-3139**
Utilization Management	
Referral Inquiry	**888-680-2273**
Referral Fax (Routine)	**858-260-5861**
Referral Fax (Emergent)	**858-260-5870**
Referral Fax (Out of Area) Fax	**858-260-5859**
Compliance & Privacy	**SHPSCompliance@ScrippsHealth.org**
Compliance Officer	**858-927-5360**
Website	**www.Scripps.org**

Mission

Scripps strives to provide superior health services in a caring environment and to make a positive, measurable difference in the health of individuals in the communities we serve.
We devote our resources to delivering quality, safe, cost effective, socially responsible health care services.
We advance clinical research, community health education, education of physicians and health care professionals and sponsor graduate medical education. We collaborate with others to deliver the continuum of care that improves the health of our community.

Vision

Scripps Health will continue to be the leading health care delivery system in the greater San Diego community, as evidenced by the highest clinical quality, patient safety, and patient, physician and employee satisfaction. This will be achieved through unending focus on patient-centered and compassionate care, cost-effective operations, research, advanced technology and innovation.

Values

We provide the highest quality of service

Scripps is committed to putting the patient first and quality is our passion. In the new world of health care, we want to anticipate the causes of illness and encourage healthy behavior for all who rely on us for service. We teach and encourage patients to participate in their care and to make well-informed decisions. We will be their advocate when they are most vulnerable. We measure our success by our patients' satisfaction, their return to health and well-being, and our compassionate care for dying patients, their families and friends.

We demonstrate complete respect for the rights of every individual

Scripps honors the dignity of all persons, and we show this by our actions toward one another and those we serve. We embrace the diversity that allows us to draw on the talents of one another. We respect and honor the cultural, ethnic and religious beliefs and practices of our patients in a manner consistent with the highest standards of care. All this is done in a compassionate setting. Our goal is to create a healing environment in partnership with all caregivers who are committed to serving our patients.

We care for our patients every day in a responsible and efficient manner

Scripps serves as a major community health care resource for San Diego County and, as such, we are accountable for the human, financial and ecological resources entrusted to our care as we promote healing and wholeness. We begin from a base of excellence and collaborate with co-workers, physicians, patients, and other providers to find new and creative ways to improve the delivery of health care services. All members of our community will have access to timely, affordable and appropriate care.

I. SHPS Roles and Responsibilities

Scripps Health Plan Services (SHPS) is a health plan that is licensed by the California Department of Managed Health Care (DMHC). Our Knox-Keene HMO license allows us to function as a health maintenance organization. We partner with fully licensed HMOs that operate within our service area. Our role is to provide comprehensive health care services to our enrolled membership. Health care services are provided by SHPS' integrated network of participating contracted providers (hospitals, physicians, and ancillary providers). SHPS provides managed care services to the following medical groups:

- Scripps Clinic Medical Group (SCMG)
- Scripps Coastal Medical Center (SCMC)
- Scripps Cardiovascular and Thoracic Surgery Center (SCTSC)
- Scripps Hospitalist Medical Services (SHMS)
- SHPS also adjudicates some institutional claims for Mercy Physicians Medical Group (MPMG), Primary Care Associates Medical Group (PCAMG), and Scripps Physicians Medical Group (SPMG).

The following are our responsibilities:

- Claims Payment
- Contracting
- Credentialing
- Eligibility Administration
- Financial Management
- Customer Service
- Provider Relations
- Quality Improvement
- Regulatory Compliance
- Reporting
- Sub capitation Administration
- Utilization Management
- Third Party Recovery

SHPS is committed to meeting the requirements within our contracts, both with our Health Care Service Plan (HCSP) partners and our health care provider partners. Specific departments within SHPS ensure compliance with the contractual obligations.

Customer Service

The Customer Service Department is the initial contact for both members and providers. Their responsibilities vary and are an integral part of the health plan. They coordinate with each and every department within SHPS, act as a liaison to the HCSPs, and coordinate provider inquiries.

Customer Service Representatives are prepared to answer inquiries from members and providers for an array of issues, ranging from:

- Provider claim and authorization statuses for those claims and authorizations that are SHPS' responsibility
- Authorization or Claim Denials
-
- Inquiries regarding the Contracted Provider Dispute Resolution Process
- General questions regarding UM criteria

Provider Relations

Contracting/Provider Relations performs the following services for SHPS:

- Capitation Payment Inquiries
- Complex Claim and Utilization Management Issue Resolution
- Contract Analysis
- Contract Negotiation, Implementation and Interpretation
- Enrollment Issue Resolution
  Liaison Between Contracted Providers and SHPS Departments
- Maintenance of Network Management
- Provider Education

Scripps EHR – Epic Scripps Care Link

Scripps Clinic Medical Group (SCMG) and Scripps Coastal Medical Center (SCMC) providers have direct access to review and submit claims and referrals or verify eligibility through their Epic system access. Epic also supports an external Provider Portal, Scripps Care Link, allowing access to Network Providers to view and submit referrals, view claims and verify eligibility. For additional information on accessing Scripps Care Link, contact Provider Relations at (858) 927-5452 or via email, ProviderRelations@ScrippsHealth.org. If you have any questions about an authorization, contact Customer Service at (844) 337-3700.

Eligibility Administration

SHPS is responsible for implementing and maintaining an accurate database of HMO, POS, managed care members enrolled with SHPS contracted medical groups (i.e. Scripps Clinic Medical Group or Scripps Coastal Medical Center) where SHPS has financial risk or has Utilization Management responsibilities. SHPS works very closely with the contracted HCSPs to obtain timely and accurate membership data. There is a time delay, as the HCSPs must also rely upon receipt of accurate data from their clients. Policies and Procedures are in place to ensure that a member's eligibility is verified by the HCSP prior to enrolling a new HMO member in the SHPS database. The majority of

HCSPs have contract language, which enables them to retroactively add or terminate an HMO or POS member.

Providing Culturally & Linguistically Competent Care

Everything we do is to promote the health and well-being of our Members, and without regard to one's social or economic background. Cultural and Linguistic Competence is the ability of health care providers and organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the health care encounter.

Provider Access to Language Services

State and federal law* requires that health plans establish a Language Assistance Program (LAP) for Limited English Proficient (LEP) Members. Under the law, contracted providers are required to assist Members in accessing language services made available by each health plan.
Providers can access a qualified medical language interpreter for office appointments or any other Member encounter by contacting the Member's health plan. Scripps Clinic & Scripps Coastal Medical Center providers have access to interpreter services through in-office **Blue Phones**. Health plans also provide translation of vital documents, denial notices, appeal letters and any other plan documents.
**CA H&SC Sect. 1367.04 and 28 CCR 1300.67.04; ACA Sect. 1157*

Interpreter Services

Providers can request interpreters for Members whose primary language is not English (including Members requiring an American Sign Language interpreter) by calling the Member's health plan. Face-to-face interpreter service requests must be submitted at least **five (5) days** prior to the appointment date. Please note that even with prior notice, interpreters for face-to-face services may not be available for all languages. Should an interpreter not be available for face-to-face services, health plans can also make arrangements for telephone interpreting services. Be prepared to provide the following information to connect you with the most appropriate resource:

- Member information including: Name, Member ID, and Date of Birth
- Age, Gender, Country of Origin and Regional Dialect information *to help interpreters provide culturally appropriate interpretation*
- Provider information including: Appointment Date & Time, Office location, Provider Name, and type of appointment (e.g., OB/GYN, post-acute stay, follow-up, preventive care, etc.)
- For Phone Interpretation: Phone Number – this is the number the interpreter will call your office for a scheduled appointment

Translation Services

SHPS issues certain Utilization Management and Claims documents that fall within the scope of language access regulations and include a DMHC approved notice of translation services in 15 languages. This notice accompanies the following SHPS produced non-standardized vital documents:

1. UM Denial notifications, *including denial, modification or delay in service*
2. UM Delay notifications *for additional information or expert review*
3. Claims denial notifications *for Member liability*
4. Letters that require a response from the Member
5. Provider termination letters

Language Access Program Contacts

To request Interpreter or Translation services for a patient, you may directly contact the Language Access Program representative for the Member's health plan. Below is a list of LAP contact information for each health plan contracted with SHPS:

Plan	Interpreter Access	Translation Requests *Protect PHI by encrypting e-mails.*
Aetna	(800) 525-3148	(877) 287-0117
Anthem Blue Cross	(888) 254-2721	(800) 677-6669
Blue Shield of CA	(800) 541-6652 *to request onsite interpretation, dial "0" to speak with a provider services agent.*	(209) 371-5838
Blue Shield of CA Promise Health Plan	(800) 544-0088	(800) 605-2556, or (800) 544-0088 ext. 6397
Cigna	(800) 806-2059	*Send Word document for translation to* Culturalandlinguisticsunit@cigna.com
Health Net	(800) 641-7761 *Mon-Fri, 8am to 5pm* (800) 546-4570 *afterhours*	626-683-6307
SCAN	(866) 745-5010 *phone interpreter* (800) 559-3500 *face-to-face interpreter*	(800) 559-3500
UnitedHealthcare	(800) 730-7270 *Spanish* (800) 938-2300 *Chinese* (800) 624-8822 *All Other Languages*	(800) 730-7270 *Spanish* (800) 938-2300 *Chinese* (800) 624-8822 *All Other Languages*

You can also contact SHPS Customer Service at **(888) 680-2273** for assistance in accessing language services for a Member through their health plan.

Promoting appropriate Language Assistance in Provider Offices

The first step in assessing a patient's language needs is to ask.

Office staff should ask patients, "what is your preferred language?" during registration or when scheduling an appointment. Providers should consider the use of an "I Speak . . ." poster or card and maintain language preferences in patient medical records. Providers may also consider leaving after-hours messages in the predominant non-English language of their patients.

When using a Phone or Live Interpreter

Remember to speak to the patient directly, at an even pace and in short sentences. Avoid run-on or complicated sentences, sentence fragments, idiomatic expressions, or asking multiple questions at one time.

Unless insisted upon by the patient, it is never okay to rely on friends or family members (especially minor children) for interpretation.

Free Provider Cultural & Linguistic Resources are available on the ICE website, including a Provider Toolkit for Caring for Diverse Populations:
https://www.iceforhealth.org/library/documents/ICE_Provider_Tool_Kit_March_2017.pdf

Member Rights and Responsibilities

Scripps Health Plan Services is committed to treating members in a manner that respects their rights. We also have certain expectations of Members' responsibilities. Upon enrollment Members are given a Welcome Letter which contains this list of member rights and responsibilities.

As a member, you have the Right to:

1. Receive considerate and courteous care, with respect for your right to personal privacy and dignity;
2. Receive information about all health services available to you, including a clear explanation of how to obtain them;
3. Receive information about your rights and responsibilities;
4. Receive information about Scripps Health Plan Services, the services we offer you, the physicians and other practitioners available to care for you;
5. Select a PCP and expect his/ her team of health workers to provide or arrange for all the care that you need;
6. Have reasonable access to appropriate medical services;
7. Participate actively with your physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment;
8. A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage;
9. Receive from your physician an understanding of your medical condition and any proposed appropriate or medically necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment;
10. Receive preventive health services;
11. Know and understand your medical condition, treatment plan, expected outcome and the effects these have on your daily living;
12. Have confidential health records, except when disclosure is required by law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your PCP;
13. Communicate with and receive information from Customer Service in a language you can understand;
14. Know about any transfer to another hospital, including information as to why the transfer is necessary and any alternatives available;
15. Obtain a referral from your PCP for a second opinion;
16. Be fully informed about the Scripps Health Plan Services grievances procedure and understand how to use it without fear of interruption of health care;
17. Voice complaints about Scripps Health Plan Services or the care provided to you;
18. Make recommendations regarding Scripps Health Plan Services Member rights and responsibilities policy.

SHPS Roles and Responsibilities

You, as a Scripps Health Plan Services Member, have the Responsibility to:

1. Carefully read all of your Health Plan materials immediately after you are enrolled so you understand how to use your benefits and how to minimize your out of pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Scripps Health Plan membership as explained in the Evidence of Coverage and Disclosure Form or Health Service Agreement;
2. Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed;
3. Provide, to the extent possible, information that your physician, and/or the Plan need to provide appropriate care for you;
4. Understand your health problems and take an active role in making health care decisions with your medical care provider, whenever possible.
5. Follow the treatment plans and instructions you and your physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations;
6. Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given;
7. Make and keep medical appointments and inform the Plan physician ahead of time when you must cancel;
8. Communicate openly with the PCP you choose so you can develop a strong partnership based on trust and cooperation;
9. Offer suggestions to improve the Scripps Health Plan;
10. Help Scripps Health Plan Services to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health plan coverage;
11. Notify Scripps Health Plan as soon as possible if you are billed inappropriately or if you have any complaints;
12. Treat all Plan personnel respectfully and courteously as partners in good health care;
13. Pay your copayments and charges for non-covered services on time; and
14. For all mental health and substance abuse services, follow the treatment plans and instructions agreed to by you and the MHSA and obtain prior authorization for all nonemergency mental health and substance abuse services.

II. Medical Management Program

Utilization Management

The purpose of the Utilization Management (UM) Program is to maintain a comprehensive, coordinated process, which promotes and monitors the effective utilization of health care resources within the SHPS' health care delivery system. Activities of the UM Program include prospective (before), concurrent (during), and retrospective (after) review of healthcare services including coordination of appropriate discharge planning. SHPS may delegate UM activities to qualified entities that meet specific regulatory requirements.

The Medical Management Committee ("MMC") is responsible for the ongoing monitoring, evaluation, and improvement of the UM Program. This committee is also responsible for monitoring clinical practices, evaluation of provider utilization, and monitoring and trending of provider appeals and grievance determinations. SHPS's Chief Medical Officer, or designee, chairs this committee.

Authorization review is performed by each Plan Medical Group ("PMG") Medical Director or assigned physician advisor. Each specialty department head is responsible to provide expert review consultation upon request. Other responsibilities of the department heads includes business unit specific review and analysis of business unit specific UM performance indicator monitoring in conjunction with the MMC and the Chief Medical Officer, or designee.

SHPS and its delegated entities require all authorization requests to be screened by qualified health professionals using decision making criteria that are objective and based on accepted medical evidence. Medical necessity criteria must be reviewed annually and updated as appropriate. Medical necessity criteria must be available to Providers and members upon request. Services not meeting standard medical necessity criteria are forwarded to the Chief Medical Officer or designee for review. Activities within the scope of the UM Program include the following:

- Referral Management
- Prior Authorization
- Concurrent Review
- Retrospective Review
- Discharge Planning
- Emergent Care
- Out of Area coordination of care and repatriation
- Continuity of Care and transition of care when medically appropriate
- UM Key Service and Administrative Performance Indicators
- New Medical Technology review and determination
- Complex Case Management

Please note, you may contact the Customer Service Department in order to obtain a copy of the medical criteria used to make a determination or if you have any general questions regarding UM criteria. For questions on a specific case, contact the physician listed on the denial letter or the Medical Director for the member's medical group:

Scripps Clinic Medical Group
Dan Dworsky, M.D. (858) 554-8374
Scripps Coastal Medical Center – North Division
Anthony F. Chong, FAAFP (858) 678-6652
Scripps Coastal Medical Center – South Division
Anthony F. Chong, FAAFP (858) 678-6652
Scripps Coastal Medical Center – Escondido Division
Anthony F. Chong, FAAFP (858) 678-6652

Prior Authorization

Prior Authorization is the process of evaluating medical services prior to scheduling to determine medical necessity, appropriateness, eligibility, and benefit coverage. Services requiring prior authorization should not be scheduled until a Provider receives approval from SHPS or its delegated entity. SHPS reserves the right to deny payment for authorized services if it is determined that inaccurate information was provided to support the authorization request. Requests should be submitted by the requesting provider via the applicable referral management system. Requests must be accompanied by all pertinent medical records and supporting documents to avoid unnecessary delays. The following medical information should accompany all requests, as appropriate, to ensure that reviewing physicians have sufficient clinical information prior to authorizing a particular service:

- Medical history related to the diagnosis
- Results of any diagnostic tests previously performed (including lab and radiology reports)
- Consultation reports related to the diagnosis from other Providers
- Information on referrals pending for other Providers.

Prior Authorization is NOT required for:

- Emergency services
- Family planning services
- Preventive care, like immunizations and annual physicals
- Basic prenatal care
- Sexually transmitted disease (STD) services
- Human immunodeficiency virus (HIV) testing

SHPS is not delegated for the review of new medical technologies or experimental/investigational services. Providers may submit a completed prior authorization request to SHPS to determine whether a requested service is considered experimental or investigational.

Prior Authorization for Inpatient & Outpatient Services

Hospitals are required to notify SHPS within one working day following any inpatient admission (including delivery of a newborn), in order for hospital services to be covered. Prior authorization is also required for inpatient or outpatient surgery. Retroactive authorization requests for non-emergent services rendered will not be approved. Please check with SHPS' Utilization Management department if you have questions regarding prior authorization guidelines.

Emergent care does not require prior authorization for services, however NOTIFICATION IS REQUIRED

The following Inpatient and Outpatient services and procedures require Prior Authorization (PA):

Elective Inpatient Admissions

Includes admissions to:

- Acute Care Hospital
- Inpatient Psychiatric Facility
- Long Term Acute Care Hospital
- Acute Rehabilitation Facility
- Skilled Nursing Facility
- Hospice

SHPS may not be delegated for mental health services for some health plans. Contact the member's health plan for referral and PA guidelines when SHPS is not the delegated entity.

Out of Area Services

SHPS is not responsible for treatment or services (including emergency services) provided outside of San Diego County. Contact the member's health plan for coverage and PA requirements for services requested outside of San Diego County. Claims for emergency services should be forwarded to the member's health plan.

Outpatient Services

- Ambulance: non-emergency air or ground transportation
- Advanced Diagnostic Imaging
- Bariatric surgery and care
- Cardiac Rehabilitation
- Chemotherapy
- Cosmetic procedures and surgery
- Cyberknife Surgery (see above, ***Inpatient***)
- Dermatologic Procedures
  - Dermabrasion and chemical peel
  - Chemical exfoliation and electrolysis
  - Laser skin treatment
  - Skin injections and implants
- Durable Medical Equipment (DME)
- Genetic Testing (except for advanced maternal age mothers who require MaterniT21 testing, Scripps labs must be used)
- Hearing Aids
- Home Health Services & Home Infusion
- Infertility Services (GIFT, ZIFT, and in vitro fertilization is NOT covered)
- Infusion Therapy
- Injectables
- Integrated Medicine Clinic referrals
- Intensity Modulated Radiation Therapy (IMRT)
- Maxillofacial Procedures (as covered)
- Neuro & Spinal cord stimulators
- Occupational Therapy
- Orthotics, inserts and braces
- Out of network referrals to specialists
- Outpatient Surgery (including procedures performed at an ambulatory surgery center or outpatient department of a hospital)
- Pain management
- Physical Therapy
- Prosthetics
- Proton Therapy
- Pulmonary Rehabilitation
- Radiation Therapy
- Reconstructive Surgery (to correct or repair abnormal structures of the body caused by congenital development defects, trauma, infection, tumors or disease, in order to improve function, or create a normal appearance, to the extent possible)
- Second Opinions, out of network
- Speech Therapy
- Standing referrals
- Stereotactic Radiosurgery and Stereotactic Body Radiotherapy (SBRT)
- Transgender surgery and services

- Transplant surgery & services

Outpatient Mental Health & Substance Use Disorder Services
SHPS is not delegated for mental health services for some of the health plans, contact the member's health plan for referral to a mental health or substance use disorder provider and to request prior authorization guidelines. Contact SHPS for any questions regarding coverage by health plan.

Out of Area Services

SHPS is not responsible for emergency treatment or services provided outside of San Diego County. Contact the member's health plan for coverage and Prior Authorization requirements for services requested outside of San Diego County. Claims for emergency services should be forwarded to the member's health plan. SHPS is only responsible for services outside the county when the specific treatment cannot be provided within the SHPS network. These services must be prior authorized and an agreement in place for the reimbursement of services. Failure to obtain prior authorization will result in the denial of payment for these services.

Emergent Inpatient Admissions

SHPS requires notification of all emergent inpatient admissions by the close of the next business day (when emergent admissions occur on weekends or holidays). For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the Emergency Department. Notification of admission is required to verify eligibility and to authorize continued care – including level of care, and initiate concurrent review and discharge planning. SHPS requires that notification includes member demographic information, facility information, date of admission and clinical information sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting notification and medical necessity requirements or failure to include all of the needed documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient admission. Emergent admission notification can be electronically provided via fax at 858-260-5876.

Referrals and Prior Authorization Process

Prior Authorization requests for medical services, referrals and notifications to SHPS should be submitted online via Scripps Care Link. If you are not yet signed-up for this easy-to-use and secure online resource, you may contact SHPS's Provider Relations team at ProviderRelations@scrippshealth.org, or via phone (888) 680-2273.

Routine & Urgent/Emergent prior authorization requests may be faxed to (858) 260-5861.

Contacting UM Staff

SHPS staff is available 8 a.m. to 5 p.m. Monday through Friday to answer questions from Providers and Members regarding Utilization Management. After office hours, Providers may call Customer Service at (888) 680-2273 to be transferred to the Scripps Central Transfer Center for Urgent medical requests.

SHPS Authorization and Referral Responsibilities

SHPS and its delegated entities are required to provide prompt and timely decisions on prior authorization requests appropriate for the nature of the Member's condition.

Below is a table of turnaround times based on regulations.

Standard Requests: SHPS must make a decision as expeditiously as the member's health condition requires and the decision cannot exceed the state and federal timelines.
Urgent Requests: When a provider indicates or determines that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, SHPS must make a decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after the receipt of the request for service.
Extension: Extensions may be needed by SHPS when there is not sufficient information to make a determination and it is in the member's best interest to take more time to make the determination.

CATEGORY	COMMERCIAL TIMEFRAMES	MEDICARE TIMEFRAMES
Standard requests	Within five (5) working days of receipt	Within fourteen (14) working days of receipt
Urgent (Expedited)	Within seventy-two (72) hours of receipt	Within seventy-two (72) hours of receipt
Extension for Urgent Requests	As expeditiously as possible, not to exceed an additional thirty (30) calendar days	As expeditiously as possible, not to exceed an additional fourteen (14) calendar days
Extension for Standard	Up to forty-five (45) calendar days when it is in the member's best interest to obtain additional information that would support the request.	Up to fourteen (14) calendar days when it is in the member's best interest to obtain additional information that would support the request. Not to exceed twenty-eight (28) days from the date of receipt.

Retrospective	Within thirty (30) calendar days of receipt of all necessary information	Within thirty (30) calendar days of receipt of all necessary information
Standard Pharmacy	Within two (2) working days of receipt of request	Within fourteen (14) working days of receipt
Expedited Pharmacy	Within twenty-four (24) hours from the receipt of request	Within seventy-two (72) hours of the receipt of request
Concurrent Review	Within five (5) working days of notification	Within two (2) working days of notification
Medicare Only		
Detailed Notice of Discharge (DND)	Not more than two (2)calendar days prior to inpatient discharge	
Detailed Explanation of Non-Coverage (DENC)	No later than two (2) calendar days before coverage ends	

Clinical Guidelines (Review Criteria)

SHPS utilizes the following nationally developed clinical guidelines and criteria based on professionally recognized standards of practice, reviewed by actively practicing physicians, and adopted and approved by the Medical Management Committee (MMC) in making referral and authorization decisions. Guidelines are listed in order of priority:

1. Inpatient Services (Commercial Members)
    a. MCG™ (formerly Milliman Clinical Guidelines)
2. Outpatient Services (Commercial Members)
    a. Clinical guidelines of each health plan
    b. MCG™
    c. Local Coverage Articles (LCAs)
    d. UptoDate®
    e. Hayes Technologies
3. Inpatient (Medicare Members)
    a. CMS National Coverage Determinations (NCDs)
    b. CMS Local Coverage Determinations (LCDs)
    c. MCG™
4. Outpatient (Medicare Members)
    a. CMS National Coverage Determinations (NCDs)
    b. CMS Local Coverage Determinations (LCDs)
    c. Health Plan Published Evidence-based Guidelines
    d. MCG™
    e. UptoDate®
    f. Hayes Technologies

Contracted providers may request copies of UM guidelines or other review criteria used by SHPS in the course of UM activities by calling the Customer Service Department at (888) 680-2273.

Medical Necessity Determination Process

UM staff obtains and reviews any necessary clinical information and uses clinical guidelines and criteria approved by the MMC and based on professionally recognized standards of practice in addition to his/her clinical expertise to determine the medical necessity of proposed care. The UM staff will consider the following factors when applying criteria to a given individual:

- Age
- Co-morbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment (when applicable)

Characteristics of the local delivery system available to members such as skilled nursing or sub-acute care facilities and home care to support the patient following hospital discharge and the ability of local hospitals to provide all recommended services within the estimated length of stay must be considered.

If the UM staff is not able to approve the proposed care based on the available information, the case is referred to the appropriate Chief Medical Officer/Physician Advisor for review and determination of medical necessity. When expert review is indicated, the Chief Medical Officer/Physician Reviewer will consult with an appropriate specialist not involved in providing the member's care.

SHPS strictly adheres to the following policy when reviewing service authorization requests and/or request for payment for services:

- UM decision making is based only on appropriateness of care and service and existence of coverage.
- The organization does not reward practitioners or other individuals for issuing denials of coverage or service.
- Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization.

Experimental/Investigational Services, Clinical Trials, and New Medical Technology

SHPS will monitor requests for the use of new medical technologies including, but not limited to, medical and surgical treatments and procedures, pharmaceuticals, and medical equipment, and refer those request to the Member's health plan. Each health plan is responsible for determining coverage and medical necessity for new medical technologies.

Denial Determination

A SHPS Physician Reviewer must review the request and any available clinical information, prior to issuance of a denial based on lack of medical necessity. As a part of the review, the Chief Medical Officer/Physician Reviewer may discuss the case with the attending or requesting physician. Denials of service based on medical necessity will always be issued by a physician reviewer. Denial notifications to providers include the name and phone number of the physician responsible for the decision should you wish to discuss the specific SHPS UM criteria used to render a determination.

A written denial notice is mailed within twenty four (24) hours of the decision to the requesting physician, the enrollee or enrollee's legal guardian, if applicable. Denial determinations for emergent services will be given to the requesting physician, and member when applicable, verbally or via fax, immediately upon completion of the review. Written notification of the determination will follow within twenty four (24) hours. It is the policy of SHPS to notify all members and providers of the routine and expedited appeal process for denied authorization requests. If you believe a denial determination is incorrect, you have the right to appeal on behalf of the member. Appeals should be submitted within sixty (60) days of the denial notice.

SHPS is required to process an appeal within thirty (30) days of receipt. In some cases, an expedited seventy two (72) hours appeal is appropriate when the time necessary in routine decision making may pose an imminent and serious threat to the member's health or well-being, including but not limited to potential loss of life, limb, or major bodily function. Physicians may request an expedited appeal orally or in writing, as provided for in the initial denial notice – appeal rights. Information for appeals is also available through SHPS's Appeals & Grievance team, through the Customer Service Department, or from the Member's health plan. SHPS is not delegated by other health plans to review appeals and grievances on their behalf. Appeals & grievances received by SHPS are immediately forwarded to the Member's health plan for resolution.

After Services are Authorized

Providers will receive a written authorization that will specify the extent of the services authorized - providers may not exceed those authorization limits without an additional authorization form, except in the case of a medical emergency. Providers should inform the patient's primary care physician of the need for further referral, treatment, or consultation. Please use the required authorization form or enter via the Scripps Care Link via In-Basket to request additional services. Scripps Care Link access requires a user name and password. For additional information on the Scripps Care Link, contact Provider Relations at (858) 927-5399 or via email, ProviderRelations@ScrippsHealth.org. If you have any questions about an authorization, contact Customer Service at (888) 680-2273 and request the Utilization Review Coordinator.

Concurrent Hospitalization Review

All inpatient stays are reviewed to determine the appropriate level of care in accordance with written guidelines. Telephonic and/or on-site chart reviews are conducted at all contracted Hospitals and Skilled Nursing Facilities by licensed UM staff. An initial review of all hospitalizations will occur within one business day of the notification to SHPS. Subsequent reviews are conducted

as deemed necessary by the UM nurse to ensure that the length of stay and level of care meet clinical criteria. If the criteria have not been met or medical record documentation is inadequate to authorize continued stay, the nurse reviewer will consult with the patient's attending physician, physician advisors, or other appropriate hospital staff to obtain additional information.

In the event that a Member is admitted to a facility outside the SHPS's Service Area, the UM department will work with the Out-of-Area (OOA) facility and the member's health plan to assess whether repatriating the member (transferring the Member to a SHPS-contracted facility) is indicated, determine when it is medically appropriate for the member to be safely transferred back into the service area, and assist in coordination of the transfer. The UM staff reviews admissions to Out-of-Network (OON) facilities telephonically. The UM staff facilitates transfer of the patient to a SHPS contracted hospital as soon as medically appropriate.

Discharge Planning

Discharge planning is a process that begins prior to an inpatient admission with an assessment of each patient's potential discharge needs. Discharge planning activities are carried out by SHPS or a delegated entity's UM staff in coordination with hospital staff, which may include discharge planners, social workers, or nurse case managers in conjunction with the treatment team.

Retrospective Authorization Review

Medical record review to determine appropriate utilization of services may be conducted in cases where there is a question regarding medical management, or for cases in which SHPS was not notified before or during the provided service. Cases for retrospective review are often identified upon receipt of an unauthorized claim. Cases may also be identified through requests for retrospective authorization from OON or OOA Providers. Retrospective reviews will be processed within thirty (30) days of receipt.

Emergency Services

"Emergency services" means a medical and/or psychiatric screening, examination, and evaluation by a physician, or by other appropriate licensed persons, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

"Emergency Services & Care" means services provided for an emergency medical condition, including a psychiatric emergency medical condition or active labor, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the Member's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part; or
4. A psychiatric disorder placing the member in immediate danger to himself/herself or to others, or is unable to provide or use food, shelter or clothing

"Active labor" means a labor at a time at which either there is inadequate time to effect safe transfer to another hospital prior to delivery or a transfer may pose a threat to the health and safety of the patient or the unborn child.

A patient is **"stabilized"** or **"stabilization"** has occurred when, in the opinion of the treating physician, or other appropriate licensed persons, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient.

Emergency Services Providers may screen and stabilize a member without prior authorization in order to stabilize an emergency medical condition.

Second Medical Opinions (Medicare Advantage Plans only)

A second medical opinion by an appropriately qualified healthcare professional is available in accordance with CA Health and Safety Code 1383.15. A second medical opinion will be covered by SHPS, if requested by the member or a participating health professional, for any of the following reasons:

- If member questions the reasonableness or necessity of the recommended surgical procedures.
- If the member questions their diagnosis or plan of care for a condition that threatens loss of life, limb, loss of bodily functions, or substantial impairment, including a serious chronic condition.
- If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating provider is unable to diagnose the condition.
- If the treatment plan in progress is not improving the medical condition within an appropriate period of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
- If the member has attempted to follow the plan of care or consulted with the initial provider regarding serious concerns about the diagnosis or plan of care.

Members or Providers may request a second opinion through SHPS's UM Department or the member's PMG. Requests will be reviewed and facilitated through the authorization process. A request for a second opinion about care provided by the member's PCP must be obtained by another qualified participating provider within the member's PMG and the PMG shall provide the second opinion. For a second opinion consult about care from a specialist, the member or provider may request authorization to receive the second opinion from a specialist of the same or equivalent specialty within any PMG in the SHPS network.

When there are no qualified providers within the network, the member may request authorization for a second opinion consultation from an out-of-network provider. If authorization is received for an out-of-network provider, the authorization will be for a consult only and that provider should not perform, or provide care beyond the consult, as SHPS does not provide reimbursement for such care. For questions about second opinions or a copy of the SHPS's policy, please visit www.scrippshealthplan.com.

SHPS is not delegated to provide authorizations for second medical opinions for commercial members. ***Contact the member's health plan for referral and PA guidelines when SHPS is not the delegated entity.***

Standing Referrals

Members who require specialized care over a prolonged period for a life-threatening, degenerative or disabling condition, including Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), may be granted a standing referral to a specialist who has expertise in treating the condition or disease, or for the purpose of having the specialist coordinate the member's healthcare. Specialists and specialty care centers are validated to assure the provider holds appropriate accreditation or designation as having special expertise in treating the condition or disease *(see also SHPS-400, "Credentialing & Re-Credentialing)*; A list of specialists, including HIV/AIDS specialists, are reviewed and updated annually, emailed to the UM/Case Management & Provider Relations staff and kept in shared files *(see also SHPS-408, "Identification of HIV/AIDS specialists")*.A listing of specialists and specialty care centers, including HIV/AIDS specialists are available to providers via the plan website to assist in the referral process; The PCP can request authorization for an out-of-network specialist, if one is not available within SHPS' Network, who can provide appropriate specialty care to the member as determined by the PCP in consultation with SHPS' Chief Medical Officer and as documented in the treatment plan.

Requesting a Standing Referral

Members and their treating/referring physicians may contact Customer Service to request a Standing Referral:

1. The PCP and specialist determine the need for continuing care from the specialist and request authorization based on an agreed upon treatment plan, if any. Treatment plans may limit the number of specialist visits or the length of time the visits are authorized, and may require the specialist to make regular reports to the PCP.
2. The determination shall be made within three (3) business days of the date the request from the member or the member's PCP and all appropriate medical records and other items of information necessary to make the determination are provided.
3. If authorized, the referral will be made within 24 hours of the decision, specifying the services that are approved. Services shall be authorized as medically necessary for proposed treatment, of a duration not to exceed one year at a time, utilizing established criteria and consistent with benefit coverage.
4. Once a determination has been made, the referral shall be made within four (4) business days of the date of the proposed treatment plan, if any, is submitted to the UM team.
5. The PCP retains the responsibility for basic case management and coordination of the member's care, unless a specific arrangement is made to transfer care to the specialist for a specified period of time, in accordance with the PCP contract with SHPS.
6. After receiving the standing referral approval, the specialist is authorized to provide healthcare services that are within the specialist's area of expertise and training to the member in the same manner as the PCP.
7. When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, SHPS will refer the member to an HIV/AIDS specialist who meets California Health and Safety Code criteria.
8. Member Denial Letters for Standing Referrals will include:

   a. Clear and concise explanation of the reasons for the denial or modification of the originally requested service;
   b. Clinical reasons for the Plan's decision to deny, delay, or modify health care services.
9. Written communications to a member of a denial, delay or modification of a request include information as to how the member may:
   a. File a grievance to the Plan;
   b. Request an Independent Medical Review in cases where the member believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers
10. Written communications to a Physician or other health care provider of a denial, delay, or modification of a request shall include the following information:
   a. The name of the health care professional responsible for the denial, delay, or modification;
   b. The direct telephone number or an extension of the healthcare professional responsible for the denial, delay, or modification to allow the requesting Physician or health care provider to easily contact them.

Re-openings

A "**reopening**" is a remedial action taken to change a final determination or decision of a Medicare Advantage referral even though the determination or decision was correct based on the evidence of record. A request must be made in writing clearly stating the request is for a reopening, meet the definition of terms for reopening, and include a good cause for reopening. At no time will a request for an appeal be considered a reopening and a determination may not be reopened if it is currently being appealed. The referral is reviewed to determine if a clerical error was made. If a clerical error is identified, the case is updated with the new findings and status is changed

Complex Case Management Program

SHPS' Complex Case Management Program uses a client/caregiver approach to promote availability of appropriate care and resources while maximizing the member's quality of life and health care benefits. Case Management is a collaborative process with the patient, family, physician, and other treating entities, designed to meet the individual's needs while promoting quality outcomes. Our Case Management nurses work closely with Plan Providers to develop and implement the most appropriate treatment plan for the member's needs. Providers interested in referring a member to the Complex Case Management Program, can call SHPS Customer Service department at (888) 680-2273. Any individual involved in the care of a member may make a referral to the Complex Case Management Program, including the Primary Care Provider (PCP), Specialist, Discharge planner, and Plan staff.

Each case is considered on an individual basis. Cases not accepted into the Complex Case Management Program are kept on file for future reference. Referrals to the Complex Case Management Program are screened for medical, psychosocial, financial, and related needs no later than thirty (30) calendar days from the date the member is eligible for Complex Case Management. The Case Manager assesses each referral through medical records and discussion with the PCP and other involved parties, as needed. Referrals for Case Management services include, but are not

limited to, the following situations in which care coordination is needed to meet members' needs while promoting appropriate utilization of services and cost-effective outcomes:

- Transplants
- Chronic pain management
- Behavioral health issues
- Medication management
- Out-of-area/out-of-network services
- Care facilitation
- Second opinion coordination
- Social support issues

As appropriate, the Case Manager will facilitate care coordination for Members who have the following indicators:

- Three (3) or more acute hospital admissions per year
- Two (2) or more emergency department visits in a three (3)-month period
- Non-compliance with medical recommendations and care
- Complex medical needs that require close monitoring
- Home-health needs
- Life expectancy of six (6) months or less
- Inpatient hospital stay of greater than ten (10) days
- Complex psychosocial or functional requirements
- Quality issues related to clinical care

When a member is accepted into the Complex Case Management Program, the Case Manager performs the following functions:

- Serves as a liaison and resource for providers and members and their families
- Communicates information to caregivers to obtain consensus on a plan of care
- Develops and coordinates a plan of care with realistic and appropriate goals/outcomes
- Assists with the transfer of members from one facility to another
- Facilitates physician-to-physician communication and other communication when needed
- Manages all Authorizations for services for the assigned member
- Makes appropriate referrals to state and county waiver programs or other community resources

The Case Manager closes a case when one or more of the following endpoints have been established:

- Services are no longer needed due to resolution of the patient's illness or the patient's death
- Reasonable goals and objectives in the Plan of Care have been met and the member's condition is stabilized
- Family and other support systems are able to adequately provide needed services
- Care coordination is ongoing without the need for oversight by the Case Manager
- The member has moved out of the Service Area
- The member refuses Case Management services

Communication to Providers

SHPS communicates updates to policies, procedures, and regulatory requirements to providers via:

- This Provider Manual, which is provided upon initial contracting with SHPS, and when updated
- Directly via mail, email or fax
- Via communication with the PMG to distribute information to their affiliated physicians.

SHPS provides required notification to providers about:

- The policy requiring an appropriate physician advisor to be available to discuss all UM denial decisions.
- The contact information of the medical reviewer, as indicated in the provider denial letter.
- The opportunity to discuss a behavioral or non-behavioral health care UM denial decision with a physician or other appropriate reviewer.
- The method of obtaining UM Criteria, and updates or changes to UM criteria

Continuity of Care

SHPS is in compliance with CA Health and Safety Code Sections 1300, 1367, 1373 and provides continuity of care for members currently receiving a course of treatment from a terminated provider and for new enrollees who are undergoing an Active Course of Treatment from a nonparticipating provider. Transitions of Care (TOC) include member notifications when an individual in a course of treatment enrolls in SHPS and when a medical group or provider is terminated from the network. SHPS also facilitates transitions of care when changes occur within the provider network as well as for new members and members with special needs and circumstances. The member should request a transition of care form from their Health Plan Customer Service to expedite the approval of the transition of care.

When a member is actively receiving care and that care may be disrupted by the departure of a physician from the network, the member will be notified at least 60 days prior to the provider termination date. When the provider fails to notify SHPS timely of their termination with the plan, SHPS will notify the member as soon as possible.

III. Claims & Provider Reimbursement

As required by California Assembly Bill 1455, the Department of Managed Health Care (DMHC) has set forth regulations establishing "fair and reasonable" claims settlement practices, and the process for resolving claims disputes for commercial managed care products regulated by the DMHC.

The purpose of this notice is to inform you of your rights, responsibilities, and related procedures as they relate to claim settlement practices and claim disputes for **Commercial HMO** products where Scripps Health Plan Services (SHPS) is the primary payor, or has been delegated to perform claims payment and provider dispute resolution processes. AB 1455 does not apply to Medicare or Med-Cal managed care products. Specific obligations of AB 1455 – including a provider's right to fair claims reimbursement practices – have been included. Unless otherwise provided herein, *italicized* terms have the same meaning as set forth in Sections 1300.71 and 1300.71.38 of Title 28 of the California Code of Regulations.

SHPS is delegated by specific HCSPs to pay claims. Please refer to the most recent Health Plan Matrix – Professional or Institutional to determine where to submit claims. The Health Plan Matrices provide general guidelines. You may obtain the most current Health Plan Matrices by calling SHPS Customer Service at 1-888-680-2273.

The Claims Department is responsible for accurately and promptly processing claims for which SHPS is financially responsible. SHPS utilizes a claim scrubbing software program that automatically applies Medicare Correct Coding Initiative (CCI) edits along with other coding guidelines for appropriate billing practices. This software provides auditing logic for all modifiers allowing payment modifications, if appropriate. SHPS will process claims based on the industry standards, CPT guidelines, CCI edits, Medicare guidelines and in compliance with State and Federal regulations.

Submitting Claims to SHPS

Claims for services provided to members assigned to SHPS must be sent to the following:

Electronically: We currently accept claims submission via Change Healthcare (please contact your vendor to add payor ID 330099) and Office Ally (SHPS1).

Via Mail:

Scripps Health Plan Services
Attention: Claims
P.O. Box 2079
La Jolla, CA 92038

Claims that are not the responsibility of SHPS (i.e. carve-outs, non-delegated services, incorrect responsible payor, COB, etc.) are forwarded to the responsible payor within ten (10) calendar days. ***Plans are required to forward misdirected claims to the appropriate medical group/IPA and medical groups must forward misdirected claims to the appropriate health plan.***

ICD-10

SHPS conforms to ICD-10 clinical coding conversion and does not accept claims with ICD-9 codes. Professional and Institutional claims received electronically or on paper with ICD-9 codes will not be accepted with dates of service on or after October 1, 2015. These claims will be returned to the provider. The provider will be required to resubmit the claims with the appropriate ICD-10 codes. A claim cannot contain both ICD-9 and ICD-10 codes if the services span after October 1, 2015. These claims must be split on separate claims to reflect the dates of service September 30, 2015 and prior, with ICD-9 codes and dates of service October 1, 2015 and after, with ICD-10 codes.

Claims Submission Requirements:

SHPS accepts claims from contracted providers within 90 calendar days of the date of service and non contracted providers within 180 days of the date of service. SHPS reserves the right to deny reimbursement of claims submitted beyond this timeframe and shall take into account extenuating circumstances or "good cause" for a delay in submission. The forms CMS 1500, UB-04 or equivalent form shall include, but not be limited to the following data elements:

- Enrollee's name, address, member ID, date of birth, sex, date(s) of service, place of service, diagnostic code(s) and description(s) and the authorization number.
- Procedures, services or supplies furnished. CPT codes for the current year shall be used for all professional services and HCPCs codes shall be used for supplies, equipment, injections, etc. Items not listed shall be billed utilizing CPT and HCPCs claims submission guidelines
- Skilled Nursing Facility Claims require Level of Care
- Inpatient forms UB04 require at least (1) DRG code
- For ESRD claims, the Box 39 and 41 must be completed to determine reimbursement
- Box 32 – Service Facility/Location information
- Taxonomy Codes on Institutional claims
- Physician Group, Physician's name and Facility Name
- National Drug Code (NDC) qualifier, number quantity and unit/basis of measure. If any of these elements are missing, the line or claim will be denied
- National Provider Identifier ("NPI") Number
- Provider's address and telephone number
- Billed Charges
- Units (when applicable)
- Resubmission code is required for all corrected claims. If resubmission code is 6, 7, or 8, Field 22 on the CMS 1500 and filed 4 on the UB-04 the original claim number is required.

Plans may not impose a deadline for claims submission that is less than 90 days for contracted providers and less than 180 days for non-contracted providers. Plans must accept a late claim if the provider files a formal provider dispute with the payor and demonstrates "good cause" for the claim filing delay.

Special or Unique Billing Codes:

A Provider whose contract has the approval to use special billing or unique billing codes please follow there instructions:

- Special billing code(s) be sent at the line level (2400 loop) or the 837 claim file.
- Specifically the 2400 NTE segment with qualifier of ADD.
  For example: NTE*ADD*EP
- In cases where a description needs to be sent along with the code, the caret character (^) needs to be added to separate the code from the description.
- All other 5010 Requirements are to be followed.

Claim Receipt Verification:

Providers will receive an automatic claim receipt notification in the same format the original claim was submitted. For verification of claim receipt by SHPS, contact Customer Service at **(888) 680-2273**. Providers who have access to Epic's web portal may view claims status online.

Plans must acknowledge receipt of all provider claims, whether or not complete, electronically, by post, phone or website. Plans must provide providers with a Notice to Provider of Dispute Mechanisms whenever a plan contests, adjusts or denies a claim.

Timeliness Claims Submission

Commercial Enrollees: Claims that are the financial responsibility of SHPS must be submitted **within one hundred eighty (180) calendar days from the date of service**.

- If SHPS is not the primary payer based on the Coordination of Benefits (COB), the provider may submit a supplemental or COB claim within one hundred eighty (180) calendar days from the Date of Payment or Date of Contest or Denial, or notice from the primary payer. The Provider Remittance Advice (PRA) from the primary payer must be included with the claim.
- If SHPS receives a claim that is not our financial responsibility, but the responsibility of the member's HCSP, SHPS will forward the claim to the member's HCSP within ten (10) working days of the receipt of the claim that was incorrectly sent to SHPS. Please review your Health Plan Matrix – Professional and Institutional before billing to ensure you are submitting your claims to the correct entity.

Medicare Advantage Enrollees: Claims that are the financial responsibility of SHPS must be submitted **within three hundred sixty-five (365) calendar days from the date of service**.

- If SHPS is not the primary payer based on the Coordination of Benefits (COB), the provider may submit a supplemental or COB claim within three hundred sixty-five (365) calendar days from the Date of Payment or Date of Contest or Denial, or notice from the primary payer. The PRA from the primary payer must be included with the claim.
- If SHPS receives a claim that is not our financial responsibility, but the responsibility of the member's HCSP, SHPS will forward the claim to the member's HCSP within ten (10) working days of the receipt of the claim that was incorrectly sent to SHPS. Please review

your Health Plan Matrix – Professional and Institutional before billing to ensure you are submitting your claims to the correct entity.

Claims Reimbursement

SHPS will adjudicate complete claims within sixty (60) calendar days, forty-five (45) working days, of Date of Receipt. For Medicare Advantage claims, SHPS will adjudicate within 30 calendar days. A complete claim is defined as a claim that may be processed without obtaining additional information from the provider of service or from the patient.

SHPS may contest or deny a claim, or portion thereof, by notifying the Provider in writing on the PRA that the claim is contested or denied, within sixty (60) calendar days, forty-five (45) working days, after the Date of Receipt (30 calendar days for MA Members) of the claim by SHPS. If an uncontested Provider claim is not processed within sixty (60) calendar days, forty-five (45) working days (30 calendar days for MA Members), then the Provider is entitled to applicable late payment interest rate.

Plans must reimburse claims with the correct payment including the automatic payment of all interest and penalties due. Plans must contest or deny claims within 45 days (HMO) of receipt.

Modifications

SHPS employs several techniques to detect inaccurate claims reimbursements to providers. SHPS pro-actively makes appropriate claims adjustments and applies interest to reimbursements. Payment errors that are identified prior to the check runs are adjusted by reprocessing and re-adjudicating it at the correct rate. All claims adjustments or modifications which affect reimbursement are reflected on the PRA.

Plans must provide an accurate and clear written explanation of the specific reasons that each claim has been denied, adjusted or contested.

Claim Overpayments

If SHPS determines a claim or claims have been overpaid, SHPS will notify the Provider in writing through a separate notice. The notice will clearly identify the claim(s), the name of the member/patient, the Date of Service(s) and a clear explanation of the basis upon which SHPS believes the amount paid on the claim(s) was in excess of the amount due, including applicable State or Federal interest and penalties on the claim(s). SHPS must submit a written request for a refund of an overpayment to the Provider within three hundred and sixty-five (365) calendar days from the Date of Payment, or last action on the claim. CMS requires that SHPS seek overpayment recoveries for payments made in the last five years on behalf of MA members.

Plans must appropriately request refunds for claims that have been overpaid.

To Contest the Notice: If the Provider contests SHPS's notice of overpayment of a claim, the Provider, within thirty (30) working days of the receipt of the notice of overpayment of a claim, must send written notice to SHPS. The notice must state the basis upon which the Provider believes that the claim was not overpaid. SHPS will process the contested notice in accordance with SHPS's Provider Dispute Resolution Process described in this Provider Operations Manual.

No Contest: If the Provider does not contest SHPS's notice of overpayment of a claim, the Provider must reimburse SHPS within thirty (30) working days of the Provider's receipt of the notice of overpayment of a claim. If a provider reimbursement is not received and posted at SHPS within 45 working days of the initial letter, the claim will be offset from future monies owed to the provider.
Offsets to Payments: SHPS may only offset an uncontested notice of overpayment of a claim against a Provider's current claim submission when the Provider fails to reimburse SHPS within the time frame set forth above. In the event that an overpayment of a claim or claims is offset against the Provider's current claim or claims pursuant to this section, SHPS will provide the Provider with a detailed written description. The specific overpayment or payments that have been offset against the specific current claim or claims will be identified in the initial overpayment notification letter.

Provider Dispute Resolution Program

A Provider Dispute is a provider's written notice to SHPS challenging, appealing or requesting reconsideration of a claim or a bundled group of substantially similar multiple claims that are individually numbered. The disputed claim(s) must meet at least one of the following conditions:

- Denied, Adjusted or Contested, or
- An adjudication error or other contract interpretation dispute, or
- Disputing a request for reimbursement of an overpayment of a claim, or
- Disputing a request of a refund letter from Scripps Health Plan Services.

Each Contracted Provider Dispute must be in writing and contain at a minimum the following information:

- Written notation on the cover sheet that it is a Provider Dispute Request
- Provider's Name
- Provider's Identification Number (Tax ID)
- Provider's Contact Information, and

If the Provider Dispute concerns a claim the following must be provided:

- Member/Patient Name and Date of Birth
- Corrected claim (if appropriate)
- Reports or other supporting attachments, i.e. progress notes, operative reports, etc.
- A clear written identification of the disputed item(s)
- SHPS claim number(s)
- Copy of the SHPS PRA
- The Date of Service
- A clear explanation in writing of the basis upon which the Provider believes the payment amount, request for additional information, contest, denial, adjustment or other action is incorrect

Bundled Claims: If the Provider Dispute involves a bundled group of substantially similar claims each claim must be individually numbered. If the Provider Dispute is not about a claim, a clear written explanation of the issue and the provider's position on such issue. If the Provider Dispute represents a member or group of members the following written information must be provided:

- The names and identification number(s) of the member or members
- The Date of Service
- A clear written explanation of the disputed item and the Provider's position on the dispute
- A member's written authorization for Provider to represent said member.
- Claim number(s)

SHPS Provider Dispute Resolution Team shall process all provider disputes. If the Provider Dispute involves an issue of medical necessity or utilization review, the provider shall have an unconditional right of appeal. Providers shall appeal the claim dispute for a de novo review and resolution for a period of sixty (60) working days from SHPS's Date of Determination.

Included in this Provider Manual is the Provider Dispute Resolution Form (Exhibit 3) which must be used to submit a Provider Dispute Resolution Request. This form is also available at www.scrippshealthplan.com.

All Provider Disputes must be sent to the attention of SHPS Provider Disputes Department:

By Mail:
Scripps Health Plan Services
Attention: Provider Dispute Resolution
P.O. Box 2079
La Jolla, CA 92038

By Physical Delivery
10790 Rancho Bernardo Road
4S-300
San Diego, CA 92127

By Fax:
(858) 260-5845

Commercial Enrollees: Contracted Provider Disputes for Commercial Enrollees **must be received by SHPS within three hundred and sixty-five (365) calendar days** from SHPS' date of last action that led to the dispute, or in the case of inaction, Contracted Provider Disputes must be received by SHPS **within three hundred and sixty-five (365) calendar days** after the time for contesting or denying a claim has expired. Contracted Provider Disputes that do not include all required information set forth in Section "1" may be returned to the submitter for completion. An amended Contracted Provider Dispute, which includes the missing information, must be submitted to SHPS **within thirty (30) working days of the receipt of a returned Contracted Provider Dispute.**

Medicare Advantage Enrollees: SHPS complies with the Centers for Medicare & Medicaid Services (CMS) Provider Dispute Resolution for Non-Contracted Providers timelines to Contracted providers. Submission of a Medicare Advantage Provider Dispute **must be received by SHPS within one hundred twenty (120) calendar days** from SHPS' date of last action that led to the

dispute (i.e. EOB's, PRA's, or Letters). Additionally, Medicare Advantage Enrollee Provider Disputes must include all of the data elements noted in DISPUTE RESOLUTION PROCESS FOR CONTRACTED PROVIDERS, Section "1" Definition of Contracted Provider Dispute. Provider Disputes that do not include all required information set forth in Section "1" may be returned to the submitter for completion. An amended Contracted Provider Dispute, which includes the missing information, must be submitted to SHPS **within fourteen (14) calendar days** of the receipt of a returned Provider Dispute.

Providers Disputes would include:

- Decisions where a provider contends that the amount paid for a covered service is less than the contracted rate including those claims denied for no authorization.
- Provider payment disputes where there is a disagreement between provider and SHPS about SHPS' payment policies related to coding.
- Providers must submit documentation and good cause for late filing.

Providers Disputes would ***not*** include:

- Medical necessity determinations
- Disputes for which no initial determination has been made

SHPS will acknowledge receipt of all Contracted Provider Disputes by sending an acknowledgment letter within fifteen (15) working days from the Date of Receipt by SHPS.

Providers may inquire about a provider dispute and speak with the PDR team by calling SHPS Customer Service at **(888) 680-2273** for inquiries regarding the status of a Provider Dispute, or about filing a Provider Dispute.

SHPS will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) working days after the Date of Receipt of the Provider Dispute. If the Provider Dispute is regarding an underpaid claim and it is determined in whole or in part in favor of the provider, SHPS will pay any outstanding monies determined to be due, and applicable State interest and penalties required by law or regulation.

Plans must resolve provider disputes within 45 days of receipt of the provider dispute.

Time Period for Resolution and Written Determination of Medicare Advantage Enrollee Contracted Provider Dispute: Notification will be made **within sixty (60) calendar days** after the Date of Receipt of the Medicare Advantage Enrollee Contracted Provider Dispute or the amended Medicare Advantage Enrollee Contracted Provider Dispute. Notification will be made **within thirty (30) calendar days** after the Date of Receipt of the Medicare Advantage Enrollee Non-Contracted Provider Dispute or the amended Medicare Advantage Enrollee Non-Contracted Provider Dispute.

Past Due Payments: If the Contracted Provider Dispute involves a Commercial enrollee's claim and it is determined in whole or in part in favor of the Provider, SHPS will pay any outstanding monies determined to be due, and applicable State interest and penalties required by law or regulation.

If the Contracted Provider Dispute involves a Medicare Advantage enrollee's claim and it is determined in whole or in part in favor of the Provider, SHPS will pay any outstanding monies determined to be due, and applicable Federal interest and penalties required by law or regulation.

Additional Protections for Contract Providers

AB 1455 requires health plans and their delegates responsible for reimbursement to abide by certain other requirements promulgated by the DMHC, which are considered to generally prevent unfair and/or unreasonable claims settlement practices.

Contracting:
In compliance with AB1455, SHPS adheres to the following standards:

A. Plans must contractually require its claims processing organizations and/or its capitated provider(s) to comply with the requirements of these regulations.
B. Plans must provide Information for Contracting Providers, the Fee Schedule and Other Required Information disclosures to all contracted providers on or before January 1, 2004, initially upon contracting and upon the contracted provider's request.
C. Plans must provide contracted providers with 45 days' notice of any modifications to the Information for Contracting Providers, to the Fee Schedule or Other Required Information.
D. Plans may not require providers to waive protections or assume any plan obligations pursuant to the Knox-Keene Act.

Requests for Additional Documentation (Medical Records): Plans must justify to DMHC that requests for medical records more frequently than in three-percent (3%) of the claims submitted over any 12-month period for non-emergency services and twenty percent (20%) of the claims submitted for emergency services were reasonably necessary.

Authorizations: Plans cannot rescind or modify an authorization for services after the provider renders the services pursuant to a prior authorization.

Industry standard rules have been developed by the National Association of Insurance Commissioners (NAIC) in order to assist with this evaluation. Additionally, some states have also developed their own standards (which typically follow the general guidelines of the NAIC rules). These rules have been adopted by SHPS's and are called "the Order of Benefit Determination" (OBD). These guidelines are detailed below and shall be utilized by SHPS's staff when determining primary and secondary payer responsibility.

Coordination of Benefits (COB) & Order of Benefit Determination

At the time the Provider obtains patient billing information from the Member, the Provider should also determine if additional insurance resources exist. When they do exist, these resources must be identified on the claim form in order for SHPS to adjudicate the claim properly.

In General, when a Member is the primary beneficiary (as an employee, individual subscriber, policyholder or retiree), that plan is billed first (the primary plan) and the plan that covers the Member as a dependent is the secondary plan. If the person is a Medicare beneficiary (including

Medicare Advantage Members), in accordance with Title 18 of the Social Security Act, Medicare shall be secondary to the plan covering the person as a dependent.

Dependent Child Covered Under More Than One Plan

- For a dependent child whose parents are married or are living together, whether or not they have ever been married the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.
- For a dependent child whose parents are divorced or separated or are not living together, if a court decree states that one of the parents is responsible for the dependent child's health care expenses or coverage, that plan is primary.

Contact SHPS Customer Service if you have questions about benefit coordination or to request SHPS's Coordination of Benefits & Order of Benefit Determination Policy.

Subrogation: (Third Party Liability)

SHPS can subrogate in the event a claim results from an injury or loss attributed to the negligence or other action of another party. SHPS may seek a legal remedy on behalf of the member. Members are required to provide accurate information with regard to their health coverage and failure to do so is considered fraud.

SHPS Providers have direct contact with SHPS Members, making them the best source of timely third-party liability (TPL) notification to SHPS. Providers have an obligation to report the existence of other insurance or liability due to an accident or injury caused by a third party. Cooperation is essential to ensure prompt and accurate reimbursement.

IV. Quality of Care

Quality Management

The purpose of the SHPS Quality Management (QM) Program is to maintain a comprehensive, coordinated process that continually evaluates, monitors, and improves the quality of clinical care and service provided to enrollees within the SHPS health care delivery system.

The QM Department should be notified immediately if you identify a potential quality or risk management issue. Also, the QM Department must be involved in all patient behavioral issues, such as patient disenrollment or discharge from a practice.

SHPS' QM Program incorporates review and evaluation of all aspects of the health care delivery system. Following is an outline of several components of the QM Program.

Medical Record Review/Documentation Audits

SHPS will use approved standards that are communicated to providers. Medical record audit activities are often directed to the PCP, however audits of other practitioners and ancillary providers will be conducted as directed by the Compliance, as a result of claims trends, suspected fraud waste or abuse and/or as directed by any of our Scripps Health Plan Services Committees. .

Grievances and Complaints:

SHPS is not delegated for grievances and complaints by any of the Health Plans. SHPS will maintain a process for resolving enrollee complaints in conjunction with the HCSPs. The QM Department will have overall responsibility for:

- Maintaining and updating grievance policies and procedures
- Review and evaluation of the operations and results of the grievance process
- Review and assessment of trended data for identification and implementation of care service, and/or process improvements
- Utilization of any emergent patterns of grievances in the formulation of policy and procedure changes
- Utilization of any emergent patterns of grievances in the formulation of policy and procedure changes

Recommendations for grievance policy changes will be referred to the Policy and Procedure Committee (PPC) for review and approval as applicable.

Organizational Provider Quality Assessments

Prior to contracting with a hospital, skilled nursing facility, free standing surgical center, or home health agency, SHPS will confirm that the facility has obtained accreditation from a recognized accreditation body and has met all state and federal licensing requirements. Re-verification of this information is performed at least every three (3) years.

Corrective Action Process

When the Credentialing and Peer Review Committee (CPRC), Medical Management Committee (MM), HCSP or one of the related Review Panels determines that inappropriate care or sub-standard services have been provided or services which should have been furnished have not been provided, the Associate Medical Director of QM is responsible for communicating concerns identified by the CPRC Committee and working with the provider to develop a corrective action plan. The SHPS CPRC Committee reserves the right to terminate a Provider contract. SHPS also recognizes that HCSPs retain the right to make final decisions on all recommendations pertaining to a provider's participation in the HCSPs delivery system.

Sanction activities currently used by SHPS are described in the Disciplinary Policy/Appeals Process and Reduction, Suspension or Termination of Provider Status Policy.

Preventive Care Guidelines

SHPS has adopted the US Preventive Services Task Force (USPSTF) Preventive Care Guidelines as the standard that will be used from a utilization and quality perspective. Your review and usage of these guidelines will ensure best practices for your patients. The link to review these standards is: http://www.ahrq.gov/clinic/prevenix.htm.

Provider Credentialing

SHPS is fully delegated to perform all credentialing activities for contracted HCSPs. Practitioners should email the SHPS Provider Relations team at ProviderRelations@ScrippsHealth.org if they are interested in joining the network or interested in hospital privileges. A single application may be used for both Scripps Health Plan Services and Scripps Health facilities.

Each contracted practitioner and allied health care professional (e.g. Physician Assistant and Nurse Practitioner), is re-credentialed no less than every thirty-six (36) months. The credentialing staff will send out a practitioner profile and re-credentialing questionnaire to be completed. In order to maintain an active status as a SHPS provider, you must complete and return all applications and other requested credentialing documents immediately.

As part of the credentialing and re-credentialing process, the Quality Management (QM) staff performs Site Visits and Medical Record Review, as needed.

VI. Compliance & Privacy

Regulatory Compliance

Scripps Health Plan Services (SHPS) has a responsibility to our Members and the community, to provide health care ethically and with integrity. In building upon the Mission and Values of Scripps Health, every Provider, employee, and business affiliate of SHPS is expected to strive for the highest standards of individual and organizational conduct. This includes performing our respective roles in an honest and ethical manner, in both personal and business activities, and being compliant with all laws and regulations that govern the delivery and coverage of health care. SHPS Compliance Department is responsible for providing guidance and interpretation of legislation and regulations which impact the daily operations of SHPS Managed Service Operations (MSO), its Members, and Providers in the delivery of care.

The ***Anti-Kickback Statutes*** prohibit knowingly and willfully soliciting, receiving, offering, or paying any inducement (e.g. a kickback, bribe, or rebate) for referrals for services that are paid for, in whole or in part, under a Federal health care program. This includes any referral from any type of Provider and for any item or service. Criminal penalties include fines (up to $25,000 per violation) and up to 5-years in prison per violation. Providers may also be civilly liable under the ***False Claims Act***.

The ***Stark Law*** (or Physician Self-Referral) prohibits a provider from referring a Medicare patient for certain designated health services to an entity with which the provider (or a member of his or her family) has an ownership/investment interest or a compensation arrangement. Exceptions to this rule are called "Safe Harbors" and are highly prescriptive. Providers who have questions about the Stark Law should contact appropriate legal counsel. This law does not require the federal government to prove intent to defraud or misrepresent.

Fraud, Waste and Abuse

SHPS is committed to fostering an atmosphere of integrity, honesty and ethical behavior. SHPS' Compliance Program supports health plan employees and contracted Providers in the effective implementation of policies and procedures, oversight and monitoring processes, and establishing best practices. SHPS Anti-Fraud Plan is integrated into SHPS routine compliance monitoring activities and is used to organize and implement an effective strategy to identify and reduce costs to health plans, Providers, Members and others impacted by fraudulent activities; and to protect consumers in the delivery of healthcare services through timely detection, investigation and reporting (or prosecution) of suspected fraud.

Health care **Fraud** is knowingly or willfully executing, or attempting to execute, a scheme to defraud any health care benefit program, or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program through false representation. Fraud occurs when an individual knows, or should have known, that something is false or does not faithfully represent the truth, and takes deceptive actions, or actions inconsistent with the billing & coding standards of federally administered health programs that results or could result in improper reimbursement to themselves or another person.

The **False Claims Act** (FCA) protects the Government from being overcharged or sold substandard goods or services. The civil provisions of the FCA make a person liable for treble (x 3) damages if he or she knowingly carries out any act to obtain property from the Government by misrepresentation; knowingly conceals or avoids an obligation to pay the Government; makes or uses a false record or statement supporting a false claim; or presents a false claim for payment or approval. The terms "knowing" and "knowingly" mean that a person, with respect to information–has actual knowledge of the information; acts in deliberate ignorance of the truth or falsity of the information, or; acts in reckless disregard of the truth or falsity of the information, and; require no proof of specific intent to defraud. There also are criminal penalties for submitting false claims, which may include fines, imprisonment, or both.

Abuse in health care includes actions that may directly or indirectly result in unnecessary costs to SHPS, the Medicare program, or any health care benefit program. Abuse includes improper payment; payment for services that fail to meet professionally recognized standards of care; or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the Provider has **not** knowingly or intentionally misrepresented the facts to obtain payment.

Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the health care system. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

In 2012, Donald Berwick, M.D. (then head of the CMS) estimated that **Fraud** and **Abuse** cost the US health system $272 billion annually. The immediate effects of this glut includes higher premiums, higher costs of services, more regulatory burdens on Providers, and leaves the most vulnerable in our communities uninsured and with fewer dollars available for their immediate health care needs.

Health care **Fraud** and **Abuse** comes in many forms, including:

- Falsification of a claim or any part of a claim which may impact the rate of reimbursement, capitation or other remuneration
- Unbundling of claims for which payment guidelines establish those services should be billed as a "bundle" (one payment for multiple services).
- Up-coding or Down-coding of claims or otherwise making a false representation of the clinical severity, complication or other factor impacting the rate of reimbursement.
- Use of benefits by non-covered persons (with or without the knowledge or abetment of the beneficiary).
- Excessive charges for services or supplies above the Fair Market Value charges for those items or services or contrary to an agreed upon contracted rate.
- Charges for services which are included in the capitation rate.
- Soliciting, offering or receiving a kickback, bribe or other self-inducement, in violation of the Stark Law and/or Anti-Kickback regulations (e.g., paying for the referral of patients or the assignment of Members).
- ***Fraud*** or ***Abuse*** perpetrated by plan staff or contracted network staff for purposes of self-inducement or to improperly compensate or receive compensation from a Network Provider.

- ***Fraud*** and ***Abuse*** perpetrated by plan staff or contracted network staff in collusion with Providers, Members, and/or applicants.
- Provider collusion to unfairly raise the market price of a specific medical service.
- Use of health plan ID cards by persons who are not entitled to benefits
- Falsification of drug prescriptions

Reporting Compliance Issues and Concerns:

SHPS' policies and the *Standards of Conduct* require all contracted Providers and their employees to promptly report instances of non-compliance related to a managed care patient or impacting SHPS operations or activities. Providers and employees are advised to report concerns to the Plan Compliance Officer. All communications are maintained in a confidential manner, to the extent permitted by applicable law, and will be used only for the purpose of investigating and correcting instances of non-compliance, as necessary.

Linda Pantovic, Plan Compliance Officer
858-927-5360 *Confidential Phone & VM*
Pantovic.Linda@scrippshealth.org

Reporters may also make an anonymous report to the Scripps Health Compliance Alertline by calling (888) 424-2387. This service is managed by an unbiased third-party, and is available day & night.

Notice of Non-Retaliation – You Are Protected

It is SHPS' policy that neither retribution nor retaliation for reporting a suspected or actual compliance violation or concern will be tolerated. Efforts will be made to protect the identity of the employee to the extent allowable by law. Anonymity cannot be protected if individuals identify themselves or provide information that may reveal their identity. No matter how you choose to report an issue or concern, so long as it is made in good faith, you are protected from retaliation by Scripps Health and SHPS policy, as well as Federal and State law.

Fraud and Abuse Prevention and Detection:

Potential fraud or abuse cases will be submitted to the Plan Compliance Officer for tracking, review, investigation, and reporting to the Regulatory Oversight Committee, the Management Advisory Committee (MAC) and any government agencies as required by law or as appropriate. Referrals are also made to the Credentialing & Peer Review Panel for issues concerning misconduct, the quality of care, documentation or other concerning practices of a credentialed Provider. Reports of potential fraud or abuse cases may come from a variety of sources including but not limited to Members, UM staff, claims staff, Providers, government agencies, Customer Service staff, or Case Management staff.

SHPS monitors internal data to identify potential **Fraud** or **Abuse** issues including but are not limited to claims data, PCP panel size assessment, medical record reviews, grievances and

complaints, Member surveys, risk management reports, Provider surveys, UM statistics, staff surveys, sentinel event reports, financial data and laboratory reports.

Complete details of SHPS Anti-Fraud Plan and training materials may be obtained by contacting the Plan Compliance Officer at (858) 927-5360 or SHPSCompliance@scrippshealth.org.

Medicare Managed Care Compliance

The Centers for Medicare & Medicaid Services (CMS) is the regulator for Medicare managed care products, including Medicare Advantage ("MA" or Part C) plans and Prescription Drug (Part D) plans. CMS requires that SHPS' first tier, downstream and related entities (FDRs) fulfill Medicare Compliance Program requirements. If you are contracted with us to provide health care services to our MA Members, you are considered a "first tier entity." If you subcontract health care or administrative services, those subcontractors are considered "downstream entities."

The CMS publishes the Medicare Managed Care Manual (MMCM) which is the primary reference for rules regarding MA Members. Specific compliance responsibilities of Providers and affiliates can be found in your Provider agreement or Chapter 21 of the MMCM. These requirements are further explained in our First Tier, Downstream, and Related Entities (FDR) Provider Guide (the FDR Guide). Some of the requirements are described below but you should review the FDR Guide and ensure you have a process in place to support your compliance with all of the requirements. If you do not already have a copy of the FDR Guide, one may be requested by calling Customer Service at **(888) 680-2273**. Additionally, you are responsible for communicating the Medicare Compliance Program requirements to your downstream entities.

1. **Standards of Conduct & Compliance Policies**. FDRs must distribute a Standards of Conduct and/or Medicare compliance policies to employees and contractors within 90 days of hire or contracting, when updates are made, and annually thereafter. You may provide either SHPS' *Standards of Conduct for Network Providers*, or your own comparable Code of Conduct and/or compliance policies, to your employees and downstream entities that provide services for SHPS' MA Members.
2. **Fraud, Waste and Abuse Training**. FDRs must provide the CMS Fraud, Waste and Abuse training to employees and contractors within 90 days of hiring or contracting, and annually thereafter. This training is available on the Medicare Learning Network, and is titled "Combating Medicare Parts C and D Fraud, Waste, and Abuse Training." You may be exempted from completing training, but only if you are "deemed." You are considered deemed if you participate in traditional fee-for-service Medicare or if you are accredited as a durable medical equipment, prosthetics, orthotics and supplies supplier.
3. **General Compliance Training**. FDRs must provide CMS' General Compliance training to employees and contractors within 90 days of hiring or contracting, and annually thereafter. CMS' training is available on the Medicare Learning Network, and is titled "Medicare Parts C and D General Compliance Training." There is **no exemption** to General Compliance Parts C and D Training.
4. **Exclusion List Screening**. FDRs and their employees and contractors may not be excluded from participation in federally funded health care programs. Prior to hire or contracting, and monthly thereafter, FDRs must screen their employees and downstream entities against the following lists:

5. Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE)
6. General Services Administration (GSA) System for Award Management (SAM)
7. **Failure to Comply**. If SHPS' FDRs fail to meet these CMS Medicare compliance program requirements, it may lead to implementation of a corrective action plan (CAP), retraining, or termination of your contract and relationship with SHPS. Our actions in response to noncompliance will depend on the severity of the compliance issue. Note: Contract termination may not be limited to services for MA Members
8. **Maintaining Documentation**. You are required to maintain evidence of your compliance with the Medicare program requirements (including preservation of medical records) for no less than **10 years**.

Member Privacy & Confidential Information

It is the expectation of our members, a tenet of quality healthcare, and a requirement of State and Federal law that we protect the privacy of health information. SHPS Providers and their employees must ensure the privacy of confidential medical records and related information for all patients. Each contracted Provider is a Business Associate and must comply with certain provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and regulations from the Department of Health and Human Services – Office of Civil Rights ("OCR") that relate to the privacy of protected health information ("PHI"). Protected information includes, but is not limited to:

- Patient Appointment and other non-clinical Records
- Patient Medical Records (Including Electronic Health Information)
- Files containing PHI or other protected information
- Faxes sent and received containing PHI
- Medical Claims documents and supporting materials
- Organizational, utilization, quality or medical staff committee minutes and documentation
- Information received from non-SHP providers and external agencies containing PHI or privileged information

SHPS has carefully developed policies that both establish best practices for the management of personal and confidential information as well as support and encourage patients to exercise their rights regarding their protected information. Protecting your patient's privacy must be a conscious effort as you conduct patient care. As a SHPS Provider, you are expected to:

1. Ask the patient to identify who is involved in their care so that you can share relevant health information.
2. Provide patients with the opportunity to agree to have individuals stay or be excused before you discuss their care.
3. Share sensitive information with others and conduct phone calls in a private location, especially when discussing potentially stigmatizing conditions.

Each provider must maintain a Confidentiality Policy and Procedure, which ensures patient information, remains confidential. SHPS reserves the right to request a copy of a provider's Confidentiality Policy and Procedure.

Notice of Privacy Practices

Health plans informs Members and their representatives of the privacy oversight program annually and upon enrollment by sending a ***Notice of Privacy Practices***, which includes requisite disclosures as stipulated in the Privacy Rule. You can download a copy of Scripps Health Plan Services ***Notice of Privacy Practices*** by visiting www.scrippshealthplanservices.com.

Providers are responsible for complying with SHPS' policies regarding proper handling of Protected Health Information (PHI), including maintaining their own Notice of Privacy Practices and making it available publicly.

Reporting Privacy Incidents

Providers must immediately notify SHPS when they become aware of a suspected or confirmed breach of a patient's protected health information (PHI). Reporting privacy breaches immediately upon discovery is critical to minimizing your risk of penalties and fines. Report all suspected privacy breaches to SHPS Compliance Department via email at SHPSCompliance@scrippshealth.org or telephonically **(858) 927-5360**.

Report lost or stolen laptops, computer equipment, tablets, mobiles phones and other handhelds or data storage devices immediately to Scripps IS Help Desk at **(858) 678-7500**. Help Desk Analysts are available day and night to assist with remediation of a lost or stolen device.

Safeguarding Member Information

All contracted Providers are required to sign a *Business Associates Agreement* which describe Providers' specific obligations to protect and safeguard the privacy of patient information. This agreement requires Providers understand their responsibilities as they relate to:

1. **Minimum Necessary.** Be aware when accessing or disclosing patient information outside of Scripps verbally or electronically. Do not store electronic protected health information on hard drives or removable devices (e.g., memory sticks, PDAs, laptops) or on non-Scripps owned or controlled devices unless they have been equipped with encryption software.
2. **Password Protection.** Do not share your password(s) as your logon represents your electronic signature. The integrity of your orders or documentation is at risk if passwords are shared and you may be legally responsible for actions in such circumstances.
3. **E-Mail.** Providers should not include any confidential patient information in the body of any email without such information being safeguarded in password protected documents, email encryption or other approved mechanism.
4. **Authorized Access.** Access only accounts of the patients who are under your care. Information systems activity and network access is monitored and reviewed on a regular basis as part of SHPS Privacy Program.

Nondiscrimination in Health Care

SHPS does not discriminate exclude, or treat individuals differently on the basis of sex, sexual orientation, gender identity, national origin, ethnicity, religion, race, color, creed, nationality, primary-language, education, disability, age, or any other individually definable factor. To assist Members in accessing services, SHPS provides:

1. Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.
2. Free aids and services to people with disabilities such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, and other formats.

SHPS complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act, which includes notification of nondiscrimination and information for accessing language services in all significant Member materials.

SHPS Providers must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). SHPS requires Providers to deliver services to SHPS Members without regard to sex, sexual orientation, gender identity, national origin, ethnicity, religion, race, color, creed, nationality, primary-language, education, disability, age, or any other individually definable factor. This also includes expressions of gender identity, pregnancy and sex stereotyping.

Participating Providers and medical groups may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost-care. Providers must not discriminate against enrollees based on their payment status and cannot refuse to serve Members because they receive assistance with Medicare cost sharing from a State Medicaid Program.

Section 1557 Investigations

SHPS' Compliance Officer is responsible for overseeing civil rights complaints. If a Member believes that SHPS has failed to provide access or language services or that SHPS has discriminated against the Member in another way (such as on the basis of race, color, national origin, age, disability, or sex), the Member should be directed to contact the Plan Compliance Officer. Additionally, SHPS Providers are expected to disclose all complaints subject to Section 1557 of the Affordable Care Act to SHPS' Compliance Officer.

Facilities, Equipment and Personnel

Provider offices, facilities, equipment, personnel and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements including the accessibility requirements of the Americans with Disabilities Act (ADA).

VII. Providers' Role & Responsibilities

Access to Care Standards

Access Standards: As a contracted provider of SHPS, you are required to comply with HCSP and regulatory standards regarding access to care and services for SHPS members. The following standards are monitored on an ongoing basis:

Non-Emergent Appointment Access Standards – Medical

Appointment Type	Time-Elapsed Standard
Non-urgent appointments for Primary Care Physician (PCP)	Must offer the appointment within ten (10) business days of the request
Non-urgent appointments with Specialist physicians (SPC)	Must offer the appointment within fifteen (15) business days of the request
Urgent Care appointments that do not require prior authorization (PCP)	Must offer the appointment within forty-eight (48) hours of request
Urgent Care appointments that require prior authorization	Must offer the appointment within ninety-six (96) hours of request
Non-urgent appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within fifteen (15) business days of the request

Exceptions: Preventive Care Services and Periodic Follow-Up Care:

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

Preventive Care Guidelines

SHPS has adopted the US Preventive Services Task Force (USPSTF) Preventive Care Guidelines as the standard that will be used from a utilization and quality perspective. Your review and usage of these guidelines will ensure best practices for your patients. The link to review these standards is: http://www.ahrq.gov/clinic/prevenix.htm.

Advanced Directives

The Omnibus Budget Reconciliation Act of 1990 is intended to provide individuals with information about their state's laws regarding advanced directives and encourage compliance by health care providers with any advance directives. An advanced directive is any written document, made in advance of an incapacitating illness or injury, in which an individual specifically makes choices about health care treatments or names someone to make these treatment decisions if he or she is incapable.

Under this law, you are required to inform patients about their rights to institute an Advance Directive. Since SHPS does not have direct contact with its members as patients:

- The physician must communicate information to each patient regarding the right to institute an advance directive and,
- The physician is required to document the results of this discussion in the patient's medical record file. If the patient completes an advance directive, a copy of it should be included in this file.

What We Expect From You

It is our priority at SHPS to assist your practice adhere to federal, state, and health plan requirements, such as regulations, reporting, policies and procedures, and industry best practice procedures.

As a Provider of SHPS, you are required to:

- Understand and abide by the Knox Keene Health Care Service Plan Act of 1975 that protects members from receiving bills or statements of any kind. The only exclusions and exceptions are: non-authorized services (if member is made aware of financial responsibility in advance and in writing), non-covered services, and/or co-payments
- Provide all covered Hospital or Professional or Ancillary services to members enrolled through SHPS as authorized
- Freely communicate with patients regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations
- Provide all services in a professional manner in adherence with non-discriminatory practices to all members disregarding a member's disability, sex, culture, religion, language, or ethnic background as set forth in Section 1557 of the Affordable Care Act Verify member eligibility with their responding health plan in a timely manner prior to services being provided. SHPS is not delegated for eligibility verifications and is therefore not able to provide eligibility on behalf of the member's health plan

Compliance & Reporting

- Obtain prior Authorization from SHPS when required. Failure to obtain prior authorization may result in non-payment of claims. It is your responsibility to request authorization prior to services being rendered
- Adhere to the HCSP Formularies and Mandatory Generic Prescription policies.
- Participate in the Quality Improvement and Utilization Management procedures defined by SHPS
- Comply with credentialing and re-credentialing requirements as stipulated
- Ensure SHPS has current Medical and DEA Licenses on file

- Use SHPS contracted providers for your Hospital, Professional and Ancillary service needs
- If an out-of-plan second opinion is authorized, co-payments should be consistent with in-plan co-payments to the same type of provider
- Adhere to SHPS Fraud, Waste, and Abuse & Compliance training as stipulated above in accordance to *Chapter 21, Section 50.3, 42 CFR §§ 422.503(b)(4)(vi)(C), 423.504(b)(4)(vi)(C)*
- Contractor retains records to support all Compliance Activities for at least ten (10) years or longer if required by applicable law
- Participate and provide all required information for appeals, audits, and reviews as requested by SHPS within the requested timeframes
- Adhere to all Senate Bill 137 (Hernandez, 2015) requirements as outlined by SHPS and the DMH C in accordance with Chapter 649, Section 1367.27
- Respond accurately and timely to all contract, amendment, addendum, credentialing or validation requests as requested by any employee of the department

Provider Directory

SHPS maintains and validates information as delegated by health plans and the Department of Managed Healthcare (DMHC). One of the requirements for health plans, and its delegated entities like SHPS, is to follow all Uniform Provider Directory Standards as outlined by the DMHC in Senate Bill 137 (Hernandez, 2015). As a SHPS contracted provider, you are expected to respond to requests of information validation by any employee of the Provider Relations, Contracting, or Compliance department. This information is then provided to multiple health plans that SHPS has contracted with for managed care services.

Provider Relations is also here to assist you in communicating changes to network health plans should you need any assistance in making updates. You may contact SHPS Customer Service Monday through Friday from 8am-5pm by calling 1-888-680-2273 or via e-mail at ProviderRelations@scrippshealth.org.

Verifying Eligibility

SHPS members should present for services with their insurance identification card issued by their HCSP. HCSP ID cards contain pertinent information about the member's Primary Medical Group (PMG) and co-payments. SHPS members will have SCMG or SCMC listed as their PMG. You are responsible for verifying eligibility with the HCSP prior to rendering authorized services.

Member Billing

As a provider, you agree contractually to look solely to SHPS as the source of final payments for managed care patients referred by SHPS contracted medical groups. It is a violation of law to bill HMO and managed care members directly except for copayments, coinsurance or for benefits not covered by primary and/or secondary insurance. For benefits not covered by the member's insurance, it is the Provider's obligation to obtain a written waiver from the member prior to rendering any non-covered service.

SHPS has various contracts with HCSPs. In some cases, members may have Medi-Cal as a secondary payor. It is the Provider's responsibility to verify copayment and coinsurance requirement for both primary and secondary coverage. **Under no circumstances,** should a provider demand or otherwise attempt to collect reimbursement from a member or from other persons on behalf of the member, for any service included in the member's scope of benefits except any applicable copays, deductibles or coinsurance as required under the primary and secondary coverage.

ICD-10 Coding Accuracy

As a health care provider you are expected to report all diagnosis codes that impact the patient's care and ensure these diagnoses are accurately documented in a medical record. This includes the main reason for the episode of care; and all co-existing, acute or chronic conditions; and pertinent past conditions that impact clinical evaluation and therapeutic treatment. Symptoms that are common to the main reportable diagnosis should not be coded. Report ICD-10-CM codes to the highest level of specificity on all billing forms and/or encounter data forms. The Risk Adjustment Payment model implemented by The Centers for Medicare and Medicaid Services (CMS) relies upon the diagnosis code to ensure that physicians and providers are paid appropriately for the services they render to Medicare Advantage Beneficiaries.