Scripps | Health Plan Services

Newsletter

December 2025 – 4th Quarter Edition

PROVIDER RELATIONS EMAIL UPDATE

Please be sure to use the appropriate email for a prompt response.

Topic	Email Address
Letter of interest inquiries	SHPS Provider Relations <providerrelations@scrippshealth.org>
Contracted network inquiries/updates	SHPS Provider Relations <providerrelations@scrippshealth.org>
EFT/ERA requests	SHPS Provider Relations <providerrelations@scrippshealth.org>
Scripps Carelink inquiries	Scripps Carelink <scrippscarelink@scrippshealth.org>

SCRIPPS CARE LINK – NEW ACCESS REQUEST FORM

Scripps Care Link is our online web portal where you can check Scripps Health Plan member eligibility, enter referral requests, check the status of your referral requests, and view claims. Contracted providers can send in-basket messages to SHPS departments and retrieve remittance advice.

New electronic request form for Care Link access: Scripps Care Link Access Request
Supervisors/Managers/Site Administrators please notify us when a staff person who has access to the portal is no longer employed by your group/facility. For security purposes, we need to terminate their access. As a reminder, we grant individual access; therefore, your login credentials should not be shared with anyone. Everyone must submit an individual access request. Please be sure to provide a valid work email (no personal emails) when requesting access. This will allow us to provide you with important Carelink updates,

For access issues and status inquiries please use the new email Scrippscarelink@scrippshealth.org
For password resets and unlocking your account please call the Help Desk at 858-678-7500.

SHPS MATRICES

Scripps Health Plan Services Professional Matrix
Scripps Health Plan Services Institutional Matrix

PROVIDER OPERATIONS MANUALS

SHP Manual SHPS Manual

PROGRAM DESCRIPTIONS

SHP Quality Management Program Description
SHP Utilization Management Program Description
SHPS Quality Management Program Description
SHPS Utilization Management Program Description

ELECTRONIC FUNDS TRANSFER (EFT)

Complete the new EFT Enrollment form electronic-funds-transfer.pdf and return your signed form to SHPS by fax (858)260-5851 or email to ProviderRelations@scrippshealth.org

A prerequisite is being able to retrieve your ERAs (835 files) via one of our Clearinghouses, Office Ally, or Change Healthcare. Once your Vendor EFT is activated, paper Remittance Advices (RAs) will no longer be provided by SHPS.

RAs should be available electronically via your clearinghouse or through Scripps Care Link. Confirm your EFT is active and contact Providers Relations to report any issues.

CANCELED CHECKS: A $15 service fee will apply for copies of Canceled Checks or Remittance Advice. Once payment is received a copy will be issued. Sign up for Carelink and **EFT** to avoid fee.

SENATE BILL 137

Senate Bill 137 defines strict requirements for the accuracy of both online search tools and the provider directory for payors and practitioners in California. The law requires that medical groups and/or plans validate the provider's information once or twice a year based on your contracted Status. Update your information by completing the Provider Demographic Update form:
Provider Directory Changes - Scripps Health Plan

PROVIDERS/GROUPS TERMINATING THEIR CONTRACTS

Scripps Health Plan Services (SHPS) requests a minimum of ninety (90) days written notice when providers are seeking to terminate their contracts with SHPS. This allows time to coordinate and ensure members (patients) receive the sixty (60) day notice. In addition, to ensure continuity of care for our members (patients), we request the terminating provider indicate the desired provider for whom all open referrals should be reissued to.

REMINDER: Please email ProviderRelations@scrippshealth.org when someone has joined or left your practice

CLAIMS SUBMISSION REQUIREMENTS AND MODIFIER GUIDANCE

According to the **Scripps Health Plan Provider Operations Manual**, all claims submitted on CMS-1500, or UB-04 forms must include complete facility and claim location details to ensure proper adjudication:

- **CMS-1500 Form**: Box 32 must list the **service facility location**—the site where services were rendered. This information is essential for accurate claim processing.
- **UB-04 Form**: Box 2 must include the **billing provider's address**, which also serves as the claim location.
- Claims missing this required information will be **rejected** due to incompleteness.
- **Multiple Procedures modifiers (51 and 59)** and the **Bilateral Procedures modifier (50)**. Please keep the following in mind when billing:
  - When the modifiers are billed appropriately, our system logic is designed to automatically apply payment reductions for multiple and/or bilateral procedures.
  - Ensure that when assigning modifiers, use the procedural hierarchy when assigning modifiers.
    - Failure to use appropriate modifiers will result in rejection/denial for incorrect billing.
- **Accurate member information:** We continually update our system to ensure member information accuracy, therefore, it is imperative that when submitting claims, you submit them with accurate member information in order to not have the claim rejected. Specifics that should be accurate include:
    - Correct name (spelling and first/last order)
    - Correct DOB
    - Correct sex/gender
    - Correct Healthplan ID#
- **Proof of Timely Filing –** contracted and non-contracted providers have a certain amount of time to submit their claims. When claims are submitted late, they are denied for timely filing.
  - If there is justification for why the claim was submitted late, please provide it with the claim submission, to avoid the denial.

PROVIDER DISPUTE RESOLUTION

Please be advised that the Provider Dispute Resolution Program is there to assist all providers whenever there is a dispute or issue with how a claim was processed. Customer Service will no longer be responsible for forwarding claims to the Claims Department for review.

To reduce PDRs, some common trends have been identified that will help us reduce denials on the front end.

- ***NCCI Coding Edits – there are national coding edits/guidelines that providers need to abide by when billing. There are exceptions to these guidelines based on justification through medical records.***
  - ***Medically Unlikely Edits (MUE) – these are related to number of units being billed per procedure codes.***
  - ***Mutually Exclusive (ME) or Procedure to Procedure Edits – these are related to codes that should not be billed together.***
    - ***In both cases, for claims not to be denied, please bill the claim with medical records justifying the use of units or codes, for review and possible payment.***

Any provider who wishes to dispute a payment or identifies an error in claim processing must submit a Provider Dispute Resolution (PDR).

Provider Dispute Resolution (PDR) Request

The reiteration of this procedure is intended to streamline the review process and ensure all disputes are formally documented and handled through the appropriate channels. Thank you for your attention to this update and for helping ensure a smooth transition.

CONTINUING EDUCATION OFFERED by DEPT of HEALTH & HUMAN SERVICES

We are committed to fostering multicultural diversity and promoting health equity. This allows everyone the opportunity to be as healthy as possible regardless of race, ethnicity, age, gender, location, socioeconomic status or other demographic factors. Below are resources to assist you in providing cultural and linguistic appropriate services.

Education - Think Cultural Health

CLAIMS ADJUDICATION

New Claims Reimbursement Timeliness Requirements Effective January 1, 2026

⏱️ **New State Requirement: 30-Day Claims Payment Deadline**

The California Department of Managed Health Care (DMHC) has adopted new claims processing standards for **commercial large group health plans**, effective **January 1, 2026**, under **Assembly Bill 3275** and related guidance (APL 25-007). These changes aim to streamline reimbursement timelines and improve provider cash flow.

📌 **What You Need to Know**

Beginning **January 1, 2026**, SHPS is required to:

✅ **Pay or contest** all clean claims submitted by contracted providers **within 30 calendar days** of receipt.

☑️ **Notify the provider** within the 30-day timeframe if a claim is contested, with a clear explanation of the denial or need for additional documentation.

✅ Apply **appropriate interest penalties** on claims paid beyond the 30-day limit, as required by Health & Safety Code §1371 and §1371.35.

⚠️ **What This Means for You**

- Review and update your internal billing systems and clearinghouse settings to ensure timely, clean submissions.
- Ensure all claims include complete and accurate documentation.
- Monitor payment timelines and communicate with SHPS if a claim appears unpaid beyond the 30-day timeframe.

Questions? If you have questions regarding the new requirements or how they apply to your contracts, please contact our Provider Services Team at: providerrelations@scrippshealth.org

LANGUAGE ASSISTANCE PROGRAM

State and federal law requires that health plans establish a **Language Assistance Program for limited English proficient members.** 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 other member encounters by contacting the member's health plan.

To request interpreter or translation services for SHP members, contact SHP's Customer Service by calling (844) 337-3700 or TTY (888) 515-4065. Face-to-face interpreter service requests must be submitted at least five (5) days prior to an appointment. Should an interpreter not be available for face-to-face services, health plans can also arrange for telephone interpreting services. Scripps Clinic and Coastal providers also have access to interpreters through in-office Blue Phones or may contact their Operation's Supervisor for assistance.

For SHPS Managed Care members, you can contact SHPS Managed Care Customer Service at (888) 680-2273 for assistance.

ELIGIBILITY AND CLAIMS STATUS AUTOMATED PHONE SYSTEM FOR PROVIDERS

Our **automated phone system** allows for a quick check of claims status and Scripps Health Plan HMO eligibility status for one or more patients 24 hours a day, 7 days a week. Using this system saves you valuable time on the phone and offers a convenient self-serve option at any time of day. If you are in need to speak to a live agent, they are available Monday-Friday 8 a.m. – 5 p.m. SHP (844) 337-3700, SHPS (888) 680-2273.

To check **Scripps Health Plan HMO member eligibility**, please have the following information ready:

- Your Tax ID number
- Member ID number (example: SH012345601 – you will input numbers only 012345601)
- Member date of birth

The system will provide the following **eligibility information**:

- Medical Group and PCP
- Coverage Information
- Effective and Term dates
- List of copays
- Maximum out of pocket limit (met/not met)

To check **claims status** for any of our managed care members, please have the following information ready:

- NPI associated with the claim (vendor or rendering provider NPI)
- Member Date of Birth
- Date of Service associated with the claim
- Billed Amount associated with the claim
-

The system will provide the following **claims information**:

- Claim Status
- If claim paid: claim number, paid amount, patient responsibility, check number, and check date
- If claim denied: claim number, received date, and denied date
- If claim is pending: claim number and received date

SPOTLIGHT ON SHPS UTILIZATION MANAGEMENT – REFERRAL REQUESTS

Prior Authorization Guide

The following services do not require authorization:

- Emergency room services
- Family planning services (abortion, FDA approved contraceptive devices)
- STD services and testing
- Vasectomy services
- Basic prenatal care
- Preventative care (immunizations, annual physicals)
- Routine labs, x-rays
- FDA approved biomarker testing for members with stage III/IV metastatic cancer

All other services may be subject to prior approval. In network and out of network services are evaluated based on medical criteria. Utilization patterns are reviewed to guide prior authorization rule sets to ensure administrative efficiency is maintained.

Services should be scheduled and rendered after an approved referral is received (excludes emergent services).

REMINDER to Scripps Clinic Medical Group Providers: Scripps Clinic Medical Group (SCMG) offers a comprehensive range of specialty and ancillary services to address the diverse health needs of our members. Patients attributed to SCMG are directed to receive care within the group to ensure seamless coordination, high-quality outcomes, and a patient-centered experience across the continuum. This includes therapy services, which should be provided by SCMG based providers rather than outside contracted groups. Please be mindful of this when submitting referrals for SCMG patients.

Important reminders:

- **Referral requests should be made electronically through Epic or Scripps Care Link**. Do not fax referral requests unless necessary (e.g., system issues, waiting for Scripps Care Link access).
- **The Authorization Change Request form is no longer in use**
- **There are regulated timeframes for making referral decisions are below**:

CATEGORY	COMMERCIAL TIMEFRAMES	MEDICARE TIMEFRAMES
Routine	Within five (5) business days of receipt	Within fourteen (14) calendar days of receipt
Urgent	Within seventy-two (72) hours of receipt	Within seventy-two (72) hours of receipt
Routine Pharmacy	Within seventy-two (72) hours from the receipt of request	Within seventy-two (72) hours from the receipt of request
Urgent Pharmacy	Within twenty-four (24) hours from the receipt of request	Within twenty-four (24) hours from the receipt of request

- **Approved referrals cannot be modified** due to regulatory requirements. If you need to add a CPT code, please submit a new referral request.
- **Request a peer-to-peer meeting with a physician reviewer**. The physician reviewer name and direct telephone number are printed on all referral denial letters.
- **Physician reviewers are not financially incentivized**, motivated, or otherwise rewarded for issuing denials of requested health services and are not offered any financial incentives that would encourage underutilization of services.

- **Need help to coordinate language interpreter services?** Call our SHPS Customer Service department to assist at 888-680-2273 (MSO members) or 844-337-3700 (Scripps Health Plan members).
- **If you are unable to obtain a timely referral** to an appropriate provider for a member, you may contact the member's health plan for assistance (see the "Managed Care Grievance Process" section of this newsletter for plan contact information) or file a complaint with the Department of Managed Health Care. The department has a toll-free telephone number (888-466-2219) and a TDD line (877-688-9891) for the hearing and speech impaired, as well as an internet website www.dmhc.ca.gov

Genetic Counseling Services – Availability Update

To facilitate appropriate referral processing and requests, we want to ensure our teams are aware of the current availability of genetic counseling services across specialties:

Condition	SHPS Provider	Notes
Oncology	Scripps	All cancer/cancer risk diagnosis
Perinatology/Reproductive	UCSD	Scripps Perinatology: No genetic counseling provider currently available. LabCorp is being utilized; however, SHPS does not have a contract with LabCorp Genetics.
Cardiology	UCSD	
Complex Medical	Genome Health-(not contracted)	Example: Alzheimer's, Huntington's disease, Muscular dystrophies, Hemophilia, etc.

Pediatric Developmental Evaluation: Clarifying Referral Pathways – Ambulatory referral to Developmental Evaluations

Important Guidance for Providers: When referring patients for pediatric developmental evaluations, please follow these updated guidelines to ensure appropriate routing and timely care:

- Rady Developmental Evaluation Clinic

  - Behavioral Health Services Only: Rady provides behavioral health developmental evaluations.
  - Referral Process: Requests for behavioral health developmental evaluations should be directed to Rady.
  - Authorization: Must be obtained through the patient's behavioral health plan/provider.
    Note: SHPS does not authorize behavioral health services.

- Cortica

  - Medical Developmental Evaluations: SHPS is contracted with Cortica for medical developmental evaluations.
  - Referral Process: Direct referrals for medical development concerns (e.g., neurological, genetic, or complex medical conditions) to Cortica.

Postural Orthostatic Tachycardia Syndrome (POTS) Update: Referral Guidance & Provider Availability

Important Update for Providers Managing Patients with Suspected or Confirmed POTS

- UCSD Cardiology – Dr. Taub - Not accepting new POTS patients currently.
- UCSD and Scripps currently do not have designated POTS specialists.
- SHPS-Contracted Providers for POTS

SHPS is contracted with the following providers who evaluate and manage patients with POTS:

- North County Neurology Associates, aka The Neurology Center

Please refer patients to these contracted providers for evaluation and management of POTS. Ensure appropriate documentation and clinical rationale are included with the referral.

ACCESS TO CARE STANDARDS

Access Standards: As a contracted provider, you are required to comply with the regulatory standards regarding access to care and services for our 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 request.
Non-urgent appointments with Specialist physicians (SPC)	Must offer the appointment within fifteen (15) business days of request.
Urgent Care appointments that do not require prior authorization (PCP)	Must offer the appointment within forty-eight (48) hours of request. (Weekends and holidays included).
Urgent Care appointments that require prior authorization (such as an urgent appointment with a Specialist)	Must offer the appointment within ninety-six (96) hours of request.
Follow-up appointment with a non-physician mental health or substance use disorder (MHSUD) provider for those undergoing a course of treatment	Must offer the appointment within ten (10) business days following prior appointment.
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 request.

The timeframes for obtaining out-of-network specialty services if needed are consistent with the timeframes for obtaining in-network specialty services as outlined in the table above.
If you are unable to obtain a timely referral to an appropriate provider for a member, you may contact the member's health plan for assistance (see the "Managed Care Grievance Process" section of this newsletter for the plan contact information) or file a complaint with the Department of Managed Health Care. The department has a toll-free telephone number (888-466-2219) and TDD line (877-688-9891) for the hearing and speech impaired, as well as an internal website www.dmhc.ca.gov.

COMPLEX CASE MANGEMENT PROGRAM

Complex Care Management (CCM) is a team of highly trained registered nurses and care coordinators who help patients achieve health goals at no cost. We provide added support to address medical and social challenges, partnering with you and your patients to create individualized care plans, connect to community resources, offer education on complex conditions, and guide navigation of the health care system.CCM builds a one-to-one relationship with your patient through telephonic and video outreach. In addition to complex cases with co-morbid conditions and high utilization, the CCM team offers specialty focus areas including:

- Three (3) or more admissions within a 12-month period
- Two (2) or more emergency room visits in a 6-month period
- Re-admission within 30 days
- Poly-pharmacy utilization consisting of more than 5 prescriptions
- Cancer diagnosis requiring multiple treatment modalities with complex care coordination across multiple disciplines
- Major organ transplant/ Major trauma
- High Risk OB/ High Risk Pediatric
- Behavioral health needs, including depression, anxiety, substance use, or psychosocial challenges
- Complex medical needs that require close monitoring
- Non-adherence with medical recommendations and care plans

MATERNITY PROGRAM

The Maternity Program supports patients through pregnancy, birth, and beyond by coordinating care, providing specialized support for high-risk pregnancies, preparing families for a new baby, guiding postpartum recovery, offering compassionate help with pregnancy loss, assisting with family planning, connecting to breastfeeding resources, and recommending or linking with doula services.

Doula Services Now Available Scripps Health Plan offers doula services as part of our efforts to improve access to pregnancy care and to support a healthy outcome for parents and babies. Continuous doula support has been shown to lower cesarean rates, reduce interventions and complications, shorten labor, increase breastfeeding rates, and improve newborn Apgar scores.

With a referral, our members are eligible for the following doula services:

- One (1) initial visit with your doula.
- Up to eight (8) additional visits; these can be a combination of prenatal and postpartum visits.
- Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion or miscarriage.
- Up to two (2) three-hour postpartum visits.

Members can get doula services up to 12 months after the end of pregnancy. Providers can request services using the new ambulatory order **AMB Referral to Doula (REF771)** in Epic, in alignment with AB-904. which mandates health care coverage for doula support during pregnancy, labor, birth, and the postpartum period. Services are currently provided by **Mocha Capricorn Doula LLC**, with additional options under development.

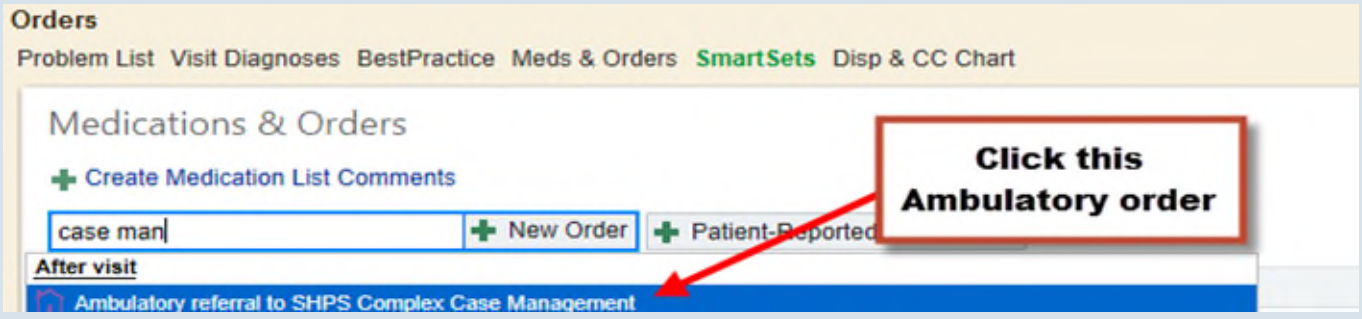
Maternal Mental Health

The law, as described in California SB 1207 and the Health and Safety Code Section 1367.625, requires that a licensed health care practitioner (provider) who provides prenatal or postpartum care for a patient shall ensure that all mothers are offered screening or are appropriately screened for maternal mental health conditions. Maternal mental health means a mental health condition that occurs during pregnancy or during the postpartum period and includes but is not limited to postpartum depression. As a contracted provider, you are required to comply with this regulation and encouraged to perform the screening, diagnosis, treatment, and referral to appropriate mental health services, including maternal mental health. Efforts of our maternal mental health program are designed to promote quality and cost-effective outcomes. Pursuant to California AB 1936, maternal mental health screenings shall consist of at least one (1) maternal mental health screening to be conduct during pregnancy, at least one (1) additional screening to be conducted during the first six (6) weeks of the postpartum period and additional postpartum screenings, if determined to be medically necessary and clinically appropriate in the judgement of the treatment provider.

How to Refer

Anyone can make a referral to Care Management, Maternity or Disease Management Programs for an evaluation including but not limited to a primary care practitioner, specialist, discharge planner, member, caregiver, case manager, appeals, grievances staff and/or any staff and other medical management programs.

Referrals can be made via: **Epic: Ambulatory Order #210 (Ambulatory referral to SHPS Complex Care Management)**



- Email: shpscmreferrals@scrippshealth.org
- Voicemail: 888-399-5678
- Fax: 858-260-5834
- CM Referral Form

PREVENTATIVE HEALTH & WELLNESS

Free benefits for our patients that make a difference
Our patient's health is our top priority. We encourage our practitioners to recommend our patients take advantage of the many preventive care services that are available to them at no additional charge when scheduled with an in-network provider.

- Well-baby and well-child (up to age 18) physical exams, immunizations and related laboratory services
- Well-adult physical exams, immunizations and related laboratory services
- Routine gynecological exams, immunizations and related laboratory services
- Screenings for: breast cancer, cholesterol, cervical cancer, colorectal cancer, depression, diabetes, hypertension, obesity, prostate cancer, sexually transmitted infections, tobacco and alcohol use/misuse
- Adult Immunization Schedule by Age | Vaccines & Immunizations | CDC
- Child and Adolescent Immunization Schedule by Age | Vaccines & Immunizations | CDC
- National Guideline Clearinghouse
- Autism Spectrum Disorder in Your Children: Screening

Wellness tips and resources

- https://www.scripps.org/health-and-wellness

You also have access to the wellness solution library by clicking on the link below.
The wellness solution library includes decision making aids that provide information about treatment options and outcomes. We encourage you to use these decision-making aids during the treatment decision process, including during discussions with your patients.

- https://scrippshealthib.staywellsolutionsonline.com/Library/Encyclopedia/

ASSEMBLY BILL (AB) 144 - COVERAGE OF PREVENTATIVE CARE SERVICES

On September 17, 2025, Governor Newsom signed AB 144. This bill codifies the federal recommendations in effect on January 1, 2025, and allows the California Department of Public Health (CDPH) to supplement those recommendations. Per AB 144, all plans must cover the CDPH-recommended immunizations without cost-sharing or utilization management. CDPH issued guidance regarding COVID-19, influenza, and RSV immunizations. Guidance can be found at CDPH and as follows:

COVID-19

- Children: All children 6-23 months; All children 2-18 years with certain risk factors; All children with close contact with others with risk factors; All children who choose protection.
- Adults: All adults age 65 years or older; All adults ages 18-64 years with certain risk factors; All adults with close contact with others with risk factors; All adults who choose protection.
- Pregnancy: All planning, pregnant, postpartum, or lactating.

Influenza

- Children: All children 6 months or older.
- Adults: All adults 18 years or older.
- Pregnancy: All planning, pregnant, postpartum, or lactating.

RSV

- Children: All children 8 months or younger; All children 8-19 months with risk factors.
- Adults: All adults 75 years or older; All adults 50-74 years with risk factors.
- Pregnancy: Pregnant between 32-36 weeks gestational age.

Please note, the FDA currently recommends COVID-19 immunizations only for people who are 65 years of age or older, or for younger people with at least one underlying condition that puts them at a greater risk for COVID-19. Notwithstanding the FDA's recommendation, per AB 144, plans must cover COVID-19 immunizations per CDPH's recommendations even if doing so could be considered "off label."

NONPHARMACOLOGICAL PAIN MANAGEMENT TREATMENT

Information regarding the benefits and uses of nonpharmacological pain management treatment is available at https://www.scripps.org/services/integrative-medicine/integrative-pain-management.

POTENTIAL QUALITY ISSUES (PQI)

A PQI is any suspected provider quality of care or service issue that has the potential to impact the level of care being provided to the enrollee/patient. Providers may include independent physicians, medical groups, hospitals, nurses, ancillary providers, and their staff as well as health plan staff.

Please see PQI Referral forms and PQI frequently asked questions below.

Scripps Health Plan : SHP PQI Referral Form SHP PQI FAQ
Scripps Health Plan Services: SHPS PQI Referral Form SHPS PQI FAQ

MANAGED CARE GRIEVANCE PROCESS

Scripps Health Plan Services is not delegated for grievances by any of the major health plans except for Scripps Health Plan (HMO) when we are the Plan. **Refer the patient to contact their health plan directly.**
Patient may file a complaint by call customer service, submit via mail, or use online grievance form. They can find the Health Plan contact information on the insurance identification card. (See below).

Health Plan Name	Phone Number	Link to Appeals and Grievances Form
Anthem Blue Cross	1-800-331-1476	https://www.anthem.com/ca/forms/
Blue Shield	1-800-393-6130	https://www.blueshieldca.com/bsca/bsc/public/member/mp/login
Cigna	1-800-997-1654	https://www.cigna.com/individuals-families/member-resources/appeals-grievances
Health Net	1-800-675-6110	https://www.healthnet.com/content/healthnet/en_us/members.html
United Healthcare	1-866-414-1959	https://www.uhc.com/member-resources/forms
SCAN	1-800-559-3500	How to Complete a Grievance (scanhealthplan.com)
Scripps Health Plan (HMO)	1-844-337-3700	www.scrippshealthplan.com Grievance and Appeal Process - Scripps Health Plan

COVID-19

For COVID-19 related information, including FAQs, testing, and vaccine information, visit Scripps Health's dedicated COVID-19 webpage.

CREDENTIALING AND RECREDENTIALING PROCESS FOR CONTRACTED PROVIDERS

As a provider, you have the right to:

- Nondiscrimination during the credentialing process
- Confidentiality of all information submitted during the credentialing process
- Be notified of information obtained during the credentialing process that varies substantially from what is submitted by you
- Review information submitted to support your credentialing application, except for references, recommendations and peer-review protected information
- Be informed of the status of your application upon request, you can email the Credentialing Department at SHPSCRED@scrippshealth.org
- Receive notification of the credentialing decision within 60 days of the SHP's decision
- Receive notification of your rights as a provider to appeal an adverse decision made by SHP
- Be informed of the above rights.

Credentialing and recredentialing is required for all contracted providers, practitioners and allied health care professionals (for example, physician assistants and nurse practitioners) and health delivery organizations providing services to SHPS members. The Quality Improvement staff, as part of the credentialing and recredentialing process, may perform site visits and medical record reviews. Providers will be contacted in advance if a site visit or audit is needed

Please review your Provider Manual or call your Provider Relations Specialist if you have any questions regarding the above.

Provider's Right to Notification and Corrections of Erroneous Information

SHP will notify you, the Provider, in writing, if SHP receives conflicting information. Areas where variation from information provided may occur include, but are not limited to, actions on a license; malpractice claims history or board certification. SHP is not required to reveal the source of information that was not obtained to meet verification requirements. A notification to you will identify the information in question and the apparent conflict.

You have the right to correct erroneous information within thirty (30) calendar days of receiving notification from SHP by submitting a written response to:

Scripps Health Plan
Attention: Credentialing 4S-300
10790 Rancho Bernardo Road
San Diego, California 92127

You are required to explain any discrepancy and include any proof that may be available in order to support your request. Please be advised that any failure to honestly, fully and completely provide information can be used to recommend and adverse credentialing decision, even if you correct your response. If you do not respond within thirty (30) calendar days of notification, your application will be considered withdrawn, and processing will be discontinued. Upon receipt of any response from you, SHP may re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the credentials file. You will be notified in writing of any correction has been made to the credentials file. If the primary source information remains inconsistent, the Credentialing Department will notify you.

COMPLIANCE PLAN

Providers can view the SHPS Compliance Plan on the SHP website under SHP Forms, Credentialing & Dispute Resolution and the SHPS website under SHPS Provider Resources.

HOW TO REPORT COMPLIANCE CONCERNS

There are multiple ways to report compliance concerns, including potential fraud, waste, and abuse incidents:

- Notify your supervisor or manager.
- Notify SHPS Compliance Department: SHPSCompliance@scrippshealth.org.
- Notify SHPS Chief Compliance Officer: Pantovic.Linda@scrippshealth.org or **858-927-5360.**
- Report via the Scripps Health Compliance and Patient Safety Alertline (online or by phone **1-888-424-2387**). You can also choose to report anonymously.

MEDICAL RECORD DOCUMENTATION STANDARDS

Consistent, current, and complete documentation in the medical record is an essential component of quality patient care. There are specific elements that reflect a set of commonly accepted standards for medical record documentation. Providers will be required to meet minimum documentation standards to continue participation in the SHPS network. This includes electronic medical record (EMR) documentation. SHPS conducts periodic audits and ongoing oversight of medical record documentation to ensure compliance with such standards. Medical record documentation audit activities are often directed to the PCP; however, audits of other practitioners and ancillary providers will be conducted as directed by the SHPS Compliance Department as a result of claims trends, suspected fraud, waste, or abuse, documentation issues, and/or as directed by any of its Scripps Health Plan Services Committees. Please refer to the "Medical Record Documentation Standards - Tip Sheet" available via the SHP and SHPS websites under SHP Forms, Credentialing & Dispute Resolution or SHPS Provider Resources.

STANDARDS OF CONDUCT – DOING THE RIGHT THING

Scripps Health Standards of Conduct serves as a primary education and communication tool that demonstrate how Scripps' mission and values influence patient care, conduct daily business, interact with each other and make everyday decisions. It is everyone's responsibility for upholding these guiding principles and for providing care and conducting business in a manner consistent with these standards. Scripps Health has relevant and specific compliance guidance for physicians, advanced practice clinicians, vendors, and third parties.

NOTICE OF AFFIRMATIVE ACTION STATEMENT – INCENTIVES

As a reminder, 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 upon current professionally recognized standards of practice, organizational policies and procedures, clinical guidelines, and the member's evidence of coverage.
- The organization does not financially incentivize, motivate, or otherwise reward providers or other individuals for issuing modifications and/or denials of requested health care services.
- The organization does not offer financial incentives that would encourage a decision that would result in underutilization or reduce or limit medically necessary care.
- UM decisions are impartial and shall never directly or circuitously impact nor influence the hiring, compensation, termination, promotion, or other economic interests of the organization's providers, employees, or vendors.

NON-DISCRIMINATION IN HEALTH CARE

SHPS requires providers to deliver services to members without regard to race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. 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). The Health Industry Collaborative Effort (HICE) has prepared Better Communication, Better Care: Provider Tools to Care for Diverse Populations. Provider guidance on civil rights is also available on the U.S. Department of Health and Human Services (HHS) website.

Providers are expected to disclose complaints of discrimination to SHPS. If you or a member believes that SHPS has failed to provide language services or has discriminated against an individual in another way, a grievance may be submitted to the SHPS Appeals & Grievances Department by mail, phone, fax, email, or online:

Scripps Health Plan Services
Attn: Appeals & Grievances Department
10790 Rancho Bernardo Rd., 4S-300
San Diego, CA 92127
Phone: (844) 337-3700 TTY: (888) 515-4065
Fax: (858) 260-5879
www.scrippshealthplan.com
Email: SHPSAppealsAndGrievancesDG@scrippshealth.org

The U.S. Department of HHS, Office for Civil Rights (OCR) also accepts complaints of discrimination electronically through the OCR Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by phone at (800) 368-1019 TDD: (800) 537-7697, or by mail at:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201