Newsletter

SEPTEMBER 2025 – 3RD QUARTER EDITION

PROVIDER DISPUTE RESOLUTION PROGRAM

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. 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.

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

For security purposes, please advise us when a staff person who has access to the portal is no longer employed by your group/facility. We will 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.

For access issues and status inquiries please use the new email Scrippscarelink@scrippshealth.org

For password resets and unlocking your account please call the IS Service Desk at 858-678-7500.

SHPS MATRICES

SHPS Institutional Matrix 2025 SHPS Professional Matrix 2025

PROVIDER OPERATIONS MANUALS

SHP Manual SHPS Manual

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. 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.

SENTATE 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 Demographic Update

CLAIMS SUBMISSION

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** 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.

Additionally, SHPS has received inquiries regarding the use of **Multiple Procedures modifiers (51 and 59)** and the **Bilateral Procedures modifier (50)**. Please keep the following in mind when coding:

- **CMS guidelines** may not require modifiers 51, 59, or 50, as their system logic is designed to automatically apply payment reductions for multiple and/or bilateral procedures.
  Therefore, manual inclusion of these modifiers may not be necessary unless specifically indicated by payer requirements or unique coding scenarios.

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

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

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.

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.

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 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

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
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 is printed on all referral denial letters.

Physician reviewers are not financially incentivized
denials of requested health services and are not offered any financial incentives that would encourage underutilization of services.

If you are unable to obtain a timely referral
the member's health plan for assistance (see the "Managed Care Grievance Process" section of this

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 _____

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

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

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.

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:

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 CARE MANAGEMENT

Complex Care Management (CCM) is a team of highly trained registered nurses and care coordinators who are available to assist you and your patients in reaching their health care goals. At no cost to your patient, we are here to provide that extra level of support to overcome health and social challenges. CCM partners with you and your patients to develop a customized care management plan of care, connection to available community resources, education on complex health conditions and help navigating through the health care system. CCM offers the extra level of support needed by developing 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 with the same or similar diagnosis or condition
Poly-pharmacy utilization consisting of more than 30 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
Minimum of one (1) complex condition with high risk for hospitalization or two (2) or more conditions expected to last at least 12-months.

MATERNITY PROGRAM

The Maternity Program helps you:

Get specialized care if you have a high-risk pregnancy.
Prepare for a new baby.

Offer support if you are dealing with a pregnancy loss.
Manage family planning decisions.
Learn about breastfeeding and resources.
Provide a recommendation for doula services.
Get connected with a **doula**.

Scripps Health Plan offers doula services as part of our efforts to improve access to pregnancy care. Our goal is a healthy outcome for parent and baby.

One of the other key aspects of a doula is to ensure mother and baby are supported in the social conditions that may affect their overall health, or their social determinants of health.

888-399-5678

Continuous doula support during the pregnancy journey may lead to improved health outcomes and offer additional social, emotional, and physical support for the pregnant and birthing person. Studies have demonstrated that support from non-clinical providers, such as doulas, is associated with lower cesarean rates, fewer obstetric interventions, fewer complications, lower use of pain medication, shorter labor, higher rates of breastfeeding and higher scores on the Apgar test.

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.

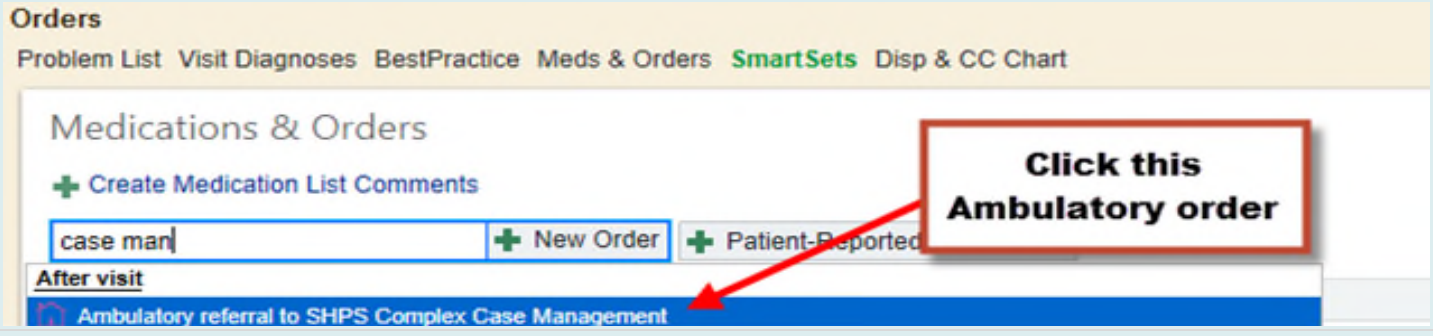
Members can get doula services up to 12 months after the end of pregnancy. A new ambulatory order, AMB Referral to Doula (REF771), is now available in Epic for providers to request doula services in alignment with AB-904, which mandates health care coverage for doula support during pregnancy, labor, birth, and the postpartum period. Mocha Capricorn Doula LLC, is currently contracted to provide doula services to our members, and we are actively exploring additional provider options

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.

Did you know that anyone can make a referral to our 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: shcmreferrals@scrippshealth.org
- Voicemail:
- 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 patient's 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/

NEW PROVIDER RESPONSIBILITIES UNDER AB 2843 FOLLOW UP CARE FOR SURVIVORS OF RAPE AND SEXUAL ASSAULT

Effective immediately, all contracted providers must comply with California Assembly Bill (AB) 2843, which ensures timely access to follow-up care for individuals who have experienced rape or sexual assault. This includes medical and surgical services without cost-sharing for up to nine (9) months following the initial treatment.

Key Requirements:

Provider Notification: Notify the health plan when emergency or follow-up care is rendered following rape or sexual assault (no legal report or conviction required). Options include but are not limited to:

- ✓ Phone: Customer Service 844-337-3700
- ✓ Email: shcmreferrals@scrippshealth.org
- ✓ Voicemail: 888-399-5678
- ✓ Fax: 858-260-5834
- ✓ CM Referral Form

- Provider Education: Understand definitions of "rape," "sexual assault," and "follow-up health care treatment" as outlined in Penal Code §§ 261, 261.6, 263, 263.1, 286, 287, and 288.7.
- Tracking Care: Help ensure enrollees receive appropriate follow-up care for the 9-month duration.
- Out-of-Network Access: Refer to out-of-network providers when necessary to avoid delays in care.
- Prohibited Requirements: Do not require enrollees to file police reports or press charges as a condition for care.

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

CREDENTIALING AND RECREDENTIALING PROCESS FOR CONTRACTED PROVIDERS

As a provider, you have the right to:

substantially from what is submitted by you

Review information submitted to support your credentialing application, with the exception of references, recommendations and peer-review protected information

Be informed of the status of your application upon request, you can email the

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

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, in the event that 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 SHPS Compliance Department: _____
Notify SHPS Chief Compliance Officer: _____
858-927-5360.

_____ or by

1-888-424-2387

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.

OIG/GSA/STATE EXCLUSION CHECKS

SHPS is prohibited from hiring, contracting, or making payments to any person or business that is excluded or debarred from federal health care programs. All applicable individuals and entities, including providers, are checked against the Office of Inspector General (“OIG”) and General Services Administration (“GSA”) federal exclusion lists and the consolidated State of California Medi-Cal Suspension Lists prior to hire or contracting, and monthly thereafter.

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 believe 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

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