Empire Healthcare IPA

Provider Operations Manual

All Care To You
Management Service Organization
Version 1.0 June 2022
Version 2.0 July 2025

Provider Operations Manual - Table of Contents

Section 1.0 – Empire Healthcare IPA Introduction

1.1 Welcome to Empire Healthcare IPA

As the Management Service Organization (MSO) for Empire Healthcare IPA (EHI), All Care To You (ACTY) would like to thank all providers within our network for partnering with us to provide exceptional care to Empire Healthcare patients. EHI provides exceptional healthcare that is patient centered, caring and compassionate.

1.2 Background

EHI owns and operates multi-specialty medical clinics, practices and urgent care centers in the Los Angeles and Inland Empire regions. EHI contracts with two medical groups through a professional services agreement to exclusively provide clinical services at EHI locations. EHI also operates a managed care division for the purpose of assuming professional risk-based contracts. Through the managed care division, EHI contracts with a downstream provider network to serve its patients outside of its clinics.

EHI contracts with ACTY for Management Services Organization (MSO) services. An MSO is a business that provides non-clinical and administrative services to providers, hospitals, or other healthcare practices. MSO's assist in growing the business side of healthcare by enhancing revenue, containing costs, and improving quality.

1.3 Mission

EHI exists to empower all people to ignite their most joyful & purposeful lives. That starts with our patients but extends equally to our providers and team members.

1.4 Important Contact Information

ACTY customer service inquiries include claims, grievances and appeals, utilization and care management, member eligibility, provider contracting and credentialing, ACTY portal support, provider network, and five-star quality.

Please call (949) 750-2058 or email the ACTY departments below:

Department	Department Group Email
Care Management (CM)	Caremanagement@allcaretoyou.com
Claims	Claims@allcaretoyou.com
Contracting	Contracting@allcaretoyou.com

Eligibility	Eligdept@allcaretoyou.com
Finance	Finance@allcaretoyou.com
MIS	EDIsupport@allcaretoyou.com
EDI	EDIsupport@allcaretoyou.com
ACTY Portal Support	Portalsupport@allcaretoyou.com
Provider Network	Providernetwork@allcaretoyou.com
Quality Team	5StarTeam@allcaretoyou.com

For after-hours emergency room visits and hospital admissions, please call (949) 750-2058, press 5.

1.5 Contracted Health Plans

Medicare Advantage HMO Plans
Aetna
Alignment Healthcare
Astiva Health Plan
Central Health Plan
Health Net
Imperial Health Plan
SCAN Health Plan

Dual Plans: MEDI-MEDI
Aetna
Alignment Healthcare
Astiva Health Plan
Central Health Plan
Health Net
Imperial Health Plan
SCAN Health Plan

Commercial
Aetna
Health Net

MEDI-CAL
Health Net

Section 2.0 – EHI Procedures

2.1 Provider Operations Manual

This Provider Operations Manual (POM) explains the policies and administrative procedures of EHI. You may use it as a guide to answer questions about claim submissions, authorizations, and many other issues. It should be used to clarify any requirements identified in your Provider Agreement with EHI. It is important that you familiarize yourself with this POM, so you understand how to work with EHI and their members.

2.2 Protected Health Information Violations

EHI Protected Health Information (PHI) can be inadvertently routed to providers and facilities by mail, fax, or e-mail, providers and facilities are required to immediately destroy any misrouted PHI and notify us of the disclosure by contacting (949) 750-2058.

2.3 ACTY Provider Portal

ACTY provides EHI providers to a secure online provider portal to obtain authorization for services and other important information, including but not limited to:

- Claims status
- Provider disputes
- Member eligibility
- Member referrals
- Member cases
- Secure messaging
- Resources and Document Library
- Cozeva

ACTY Provider Portal link: https://portal.allcaretoyou.com/ehi

Once you register for an account and receive your account access, please review the ACTY Portal Overview in the Document Library. The ACTY Portal Overview will provide guidance on how to navigate the ACTY Provider Portal.

Section 3.0 – EHI Members' Rights

As a member of EHI, individuals have the right to:

Be Treated with Respect

- Receive considerate, respectful, and culturally appropriate care, regardless of race, color, national origin, sex, age, religion, sexual orientation, gender identity, disability, or language.

Privacy and Confidentiality

- Have personal health information kept private and shared only as allowed by law.

Access to Care

- Get timely appointments, access to specialists, and medically necessary services.
- Receive emergency care when needed without prior authorization.

Information and Communication

- Receive understandable information about rights, health plan benefits, providers, and health care options.
- Request materials in alternate formats or languages.

Participation in Treatment Decisions

- Be actively involved in decisions about health care, including the right to refuse treatment.
- Discuss all treatment options, regardless of cost or coverage.

Complaints and Appeals

- File grievances or appeals without fear of losing health care services.
- Receive timely responses to grievances and appeals.

Choice of Providers

- Choose a primary care provider (PCP) within the network.
- Change providers within the plan's network as allowed.

Freedom from Retaliation

- Exercise rights without being penalized or subject to discrimination.

Advance Directives

- Create and use advanced health care directives.

Access to Medical Records

- Review and request copies of their medical records.
- Request corrections to inaccurate records.

Right to Disenroll

- Request disenrollment from the plan under permitted circumstances.

Section 4.0 – EHI Members' Responsibilities

As a member of EHI, individuals are responsible for:

Respecting Providers and Staff

- Treat providers, staff, and other members with courtesy and respect.

Using the Health Plan Appropriately

- Follow plan rules and procedures.
- Use emergency services only when appropriate.

Getting and Using Care

- Choose a PCP and build a relationship with that provider.
- Arrive on time for appointments and notify providers if unable to attend.

Sharing Information

- Provide accurate information about health history and current health status.
- Inform providers about any changes in health or medication.

Following the Treatment Plan

- Follow agreed-upon treatment plans.
- Ask questions if instructions or information is not understood.

Maintaining Health

- Take an active role in staying healthy (e.g., preventive care, screenings).
- Report any misuse of services or fraud to the health plan.

Notifying the Plan

- Inform EHI of address or phone number changes.
- Notify EHI of any other health insurance coverage.

Understanding Coverage

- Learn about benefits, covered services, and prior authorization requirements.
- Review member materials and contact Member Services with questions.

Section 5.0 – EHI Contracted Health Plans

5.1 Member Eligibility and Health Plan Verification

EHI contracts with the following health plans:

Health Plan	Web Address
Aetna	https://apps.availity.com/availity/web/public.elegant.login

Alignment Healthcare	www.alignmenthealthplan.com
Astiva Health Plan	https://providers.astivahealth.com/Identity/Account/Login
Central Health Plan	https://www.centralhealthplan.com/cpa/
Health Net	https://provider.healthnetcalifornia.com/
Imperial Health Plan	No Web portal
SCAN Health Plan	https://secure-pportal.scanhealthplan.com/scanprovider

If you have any questions, please contact our Eligibility Department via email at EligDept@allcaretoyou.com

The ACTY portal reflects the most recent eligibility we have received from our plan partners. ACTY electronically updates member eligibility following notification by our contracted health plan. Member eligibility may be reported to EHI retroactively. Before providing services to EHI members, providers must verify eligibility, check for copays and/or coinsurance amounts and determine if any other limitations apply. Covered benefits and services are subject to authorization requirements and utilization limits.

5.2 Benefits and Evidence of Coverage

EHI contracts with health plans that offer a wide array of benefits that are subject to

authorization requirements and utilization limits as described in each health plan's Evidence of Coverage (EOC). The EOC is available on each health plan website.

5.3 Coordination of Benefits

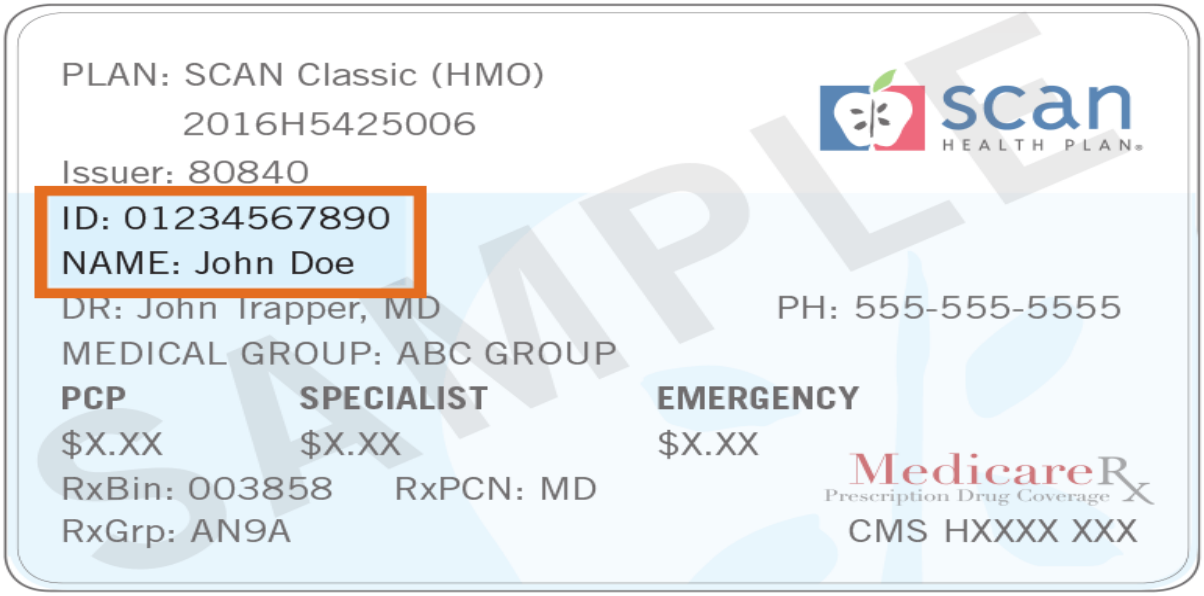
Coordination of Benefits (COB) is the procedure used to process health care payments for a Member with one or more insurers providing coverage. EHI, and delegated entities for claims payment, must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits. (See 42 CFR 422.108 and MMCM, Chapter 4, Section 130). If you are aware of other non-Medicare coverage (i.e. third-party liability coverage), it is important to provide this information on your claim form. Prior to claims submission, providers must identify other payers who have primary responsibility for payment and bill that payer prior to billing EHI (or its delegate). When a balance is due after receipt of payment from the primary payer, a claim may be submitted to EHI (or its delegated entity) for payment consideration. The claim should include information verifying the payment amount received from the primary payer as well as a copy of the primary payer's explanation of payment statement. Upon receipt of the claim, EHI (or its delegate) will review its liability using the coordination of benefits rules and/or the Medicare/Medicaid "crossover" rules —whichever is applicable. Please note that when EHI is not the primary payor, no prior authorization is required.

5.4 Health Plan Member ID Cards

Health plan	# of Digits	ID# Example	Suffix or Prefix Information
Aetna	10	W123456789	Always starts with a W

Alignment Healthcare	11	00000123456	None
Astiva Health Plan	12	900659412000	No prefix, No suffix
Central Health Plan	12	123456789101	Always ends with 01
Health Net	12	R12345678FM1	FM1, MM1, FS1, MS1, FD1, FD2, etc., MD1, MD2, etc.
Imperial Health Plan	9	90007440F	Always ends with 01
SCAN Health Plan	9	31012311101 or 40012311101 or 31112311901	Always ends with 01

Below is an example of a health plan member ID card ONLY



5.5 Carve Out Vendors

A carve-out vendor is a specialized service provider that manages specific healthcare services or benefits separately from a primary health plan or insurer. Examples of carve out services

include but are not limited to:

- Pharmacy benefit management (PBM)
- Mental health services
- Vision services
- Specialty care management

For a list of current carve out services, please contact ACTY at (949) 750-2058.

5.6 Division Of Financial Responsibility

EHI is financially responsible for paying for the majority of professional services. There are certain services dependent on the member's health insurance that are the financial responsibility of the health plan.

Services that are billed to but not the financial responsibility of EHI will be forwarded to the health plan for payment. This will be outlined on the claim Remittance Advice (RA). An RA contains information about your claims payments that Medicare Administration Contractors (MACs) send, along with payments to providers and to suppliers. The RA, which can either be in the form of an Electronic Remittance Advice (ERA) or a standard Paper Remittance (SPR), explains the payment (and any adjustment(s) Medicare made to it) during the claims adjudication process. RAs give itemized claims processing decision information regarding payments, deductibles and copays, adjustments, denials, missing or incorrect data, refunds and claims withholding due to Medicare Secondary Payer (MSP) or penalty situations. The RA gives justification for the payment, as well as input to your accounting system/accounts receivable and general ledger applications. The codes in the RA will help you identify any additional action you may need to take.

For any service that is the financial responsibility of the health plan, our Care Management (CM) team will coordinate with your office which facilities the procedure can be authorized to. If the health plan is contracted with the ambulatory surgery center or hospital where the procedure is being performed at, it may be authorized without issue.

5.7 Medi-Cal Managed Care Services

Managed care plans delegate certain authorization and claims processing to some of its contracted participating provider groups like EHI and Management Services Organizations (MSOs) like ACTY. Delegation is when an entity gives another entity the authority to carry out a function that it would otherwise perform, such as operating within the parameters agreed upon between the Managed care plan and EHI.

The National Committee on Quality Assurance (NCQA) holds managed care plans to the following requirements:

- Delegation Agreement - A mutual agreement between Managed care plan and EHI outlining specific delegated functions that meet NCQA standards.
- Oversight and Monitoring – Managed care plans must oversee the delegates to ensure that the delegates properly performing all delegated functions.

For more information on NQCA standards and functions, please visit their website at http://www.ncqa.org/AboutNCQA.aspx.

Medi-Cal Managed Care provides high quality, accessible, and cost-effective health care through managed care delivery systems. Medi-Cal Managed Care contracts for health care services through established networks of organized systems of care which emphasize primary and preventive care. Managed care plans, have been proven to be a cost-effective use of health care resources that improve health care access and ensure quality of care.

Section 6.0 – EHI Timely Access to Care Standards

While there is no mandate for professional standards for health care providers, EHI, Department of Managed Health Care Services (DMHC) and Centers for Medicare and Medicaid Services (CMS) require that members receive medically necessary services in a timely manner.

6.1 Appointment Access Standards

The table below details the minimum compliance standards for enrollee Accessibility and appointment times to primary, specialist, behavioral health, and ancillary care providers.

Service Accessibility Standards for Commercial and Medicare

CATEGORY	STANDARD
Preventive Care Appointments Access to preventive care with a PCP, Nurse Practitioner, or Physician Assistant at the same office site as a member's assigned PCP.	Within 30 calendars days

Regular and routine care PCP Access to routine, non-urgent symptomatic care appointments with a member's assigned PCP. The time standards must be met unless: the referring, treating, or health professional providing triage services determines that a longer waiting time will not have a detrimental impact on the enrollee or the appointment request is for preventive care services.	Within 10 business days
Regular and routine care SPC Access to routine, non-urgent symptomatic care appointments with a specialist. The time standards must be met unless: the referring, treating, or health professional providing triage services determines that a longer waiting time will not have a detrimental impact on the enrollee or the appointment request is for preventive care services.	Within 15 business days
Urgent Care Appointment Access to urgent symptomatic care appointments that do not require prior authorization with the PCP, specialist, covering physician, or urgent care provider. The time standard must be met unless: the referring, treating, or health professional providing triage services determines that a longer waiting time will not have a detrimental impact on the enrollee or the appointment request is for preventive care services	Within 48 hours
Urgent Care Appointment Access to urgent symptomatic care appointments requiring prior authorization. When a Practitioner refers a member (e.g., a referral to a specialist by a PCP or another specialist) for an urgent care need to a specialist and an authorization is required, the member must be seen within 96 hours or sooner as appropriate from the time the referral was first authorized. The time standard must be met unless: the referring, treating, or health professional providing triage services determines that a longer waiting time will not have a detrimental impact on the enrollee or the appointment request is for preventive care services	Within 96 hours
Ancillary Care Appointments Access to non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health conditions. The time standard must be met unless: the referring, treating, or health professional providing triage services determines that a longer waiting time will not have a detrimental impact on the enrollee or the appointment request is for preventive care services	Within 15 business days

Service Accessibility Standards for Medi-Cal

Specialist Urgent Care without prior authorization	Within forty-eight (48) hours of the request.
Specialist Urgent Care with prior authorization	Within ninety-six (96) hours of the request.
Specialist Routine or Non-Urgent Care	Within fifteen (15) business days of the request.
OB/GYN Specialty Care	Within ten (10) business days of the request
Non-urgent and routine follow-up visits with behavioral health non-physician practitioners	Within ten (10) business days of the request
Non-urgent and routine follow-up visits with behavioral health physicians	Within fifteen (15) business days of the request.
Behavioral Health Urgent Care Visits	Within forty-eight hours of the request.
Behavioral Health Non-life-threatening emergency	Within six (6) hours of the request.
Routine or Non-Urgent Care Appointment for Ancillary Services	Within fifteen (15) business days of the request.
Children's Preventive Period Health Assessments (Well-Child Preventive Care) Appointments	Within ten (10) business days of the request
After Hours Care	24 hours/day; 7 day/week availability
Initial Health Assessment for New members (under eighteen (18) months of age)	Within thirty (30) calendar days upon request (must be completed within 120 calendar days from when a member becomes eligible).
Initial Health Assessment for New members (over eighteen (18) months of age)	Within thirty (30) calendar days upon request (must be completed within 120 calendar days from when member becomes eligible) or within periodicity timelines established by the American Academy of Pediatrics (AAP).
Maternity Care Appointments for First Prenatal Care	Within ten (10) business days of the request.
Office Wait Time to be Seen by Physician (for a	Should not exceed thirty (30)

Type of Care and Service	Blue Shield Promise Health Plan Standard
Emergency Services	Immediately, 24 hours a day, 7 days a week.
PCP Urgent Care Services without prior authorization	Within forty-eight (48) hours of the request.
PCP (and OB/GYN) Urgent Care with prior authorization (including referrals made by a physician to another physician)	Within ninety-six (96) hours of the request.
PCP (and OB/GYN) Routine or Non-Urgent Care Appointments	Within ten (10) business days of the request

scheduled appointment)

minutes from the appointment time. ALL PCPs are required to monitor waiting time and adhere to this standard.

The waiting time for a particular appointment, including preventive care services may be extended by the referring or treating provider or the provider rendering triage and screening services. The provider must be acting within the scope of his/her license and consistent with professionally recognized standards of practice. The provider must determine and note in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member. When it is necessary for a provider or member to reschedule an appointment, the appointment shall be promptly rescheduled within a time that is appropriate for the member's health care needs and ensures continuity of care consistent with good professional practice.

6.2 Office Hours

Providers must be available for EHI members at least an equal number of hours to those offered to privately be insured or Medicare and/or Medi-Cal fee-for-service members. The provider must be available 24 hours a day by telephone or have an on-call answering service to take calls and route them accordingly. Office hours must be noticeably posted for members to see.

Section 7.0 – EHI Participating Providers

7.1 Credentialing Program

ACTY is responsible for the initial credentialing and subsequent re-credentialing process for all EHI providers. All new providers are subject to a rigorous credentialing process. Providers are required to participate in a required re-credentialing process every 36 months. All Credentialing Program policies are available upon request.

All new providers and those eligible for re-credentialing must return a signed California Participating Physician Application (CPPA) or provide an updated and attested CAQH number to ACTY, along with all required attachments, including, but not limited to, copies of the following documents:

- Current Medical License or Business License.
- Current Clinical Laboratory Improvement Amendments (CLIA) or Waiver, if applicable.
- Current Drug Enforcement Agency (DEA) License, if applicable.
- Documentation for National Provider Identifier (NPI) and Taxonomy Code.
- Professional Liability Insurance (malpractice) face sheet (required limits are $1,000,000 per occurrence/$3,000,000 annual aggregate).
- Signed Taxpayer Identification Form (W-9 new providers only).
- Curriculum vitae (with dates in MM/YYYY format)
- Hospital Privileges Status or Admitting Agreement
- New Provider Orientation Attestation (new providers only)

If a provider is a supervising provider for a mid-level provider, all new mid-level providers and those eligible for re-credentialing must return a signed CPPA, along with all required attachments and copies of the following documentation:

Please submit all documentation to:
Attn: **Provider Network Department**
Fax: 949-396-2614
Email: ProviderNetwork@allcaretoyou.com

7.2 Medi-Cal Certification is Required – Screening and Enrollment

In addition to EHI credentialing process, providers are required to complete screening and enrollment pursuant to the Department of Health Care Services (DHCS) guidelines.

7.3 Roles and Responsibilities

- Providers must follow all terms agreed to in the EHI Provider Services Agreement.
- Provide timely responses to reasonable requests by EHI for member medical information regarding services provided.
- Give information to the member or member's legal representative about the illness, course of treatment and recovery in layman's terms.
- Keep all member information confidential and secure, as required by HIPAA law.
- Providers must verify EHI eligibility and/or determine authorization status before providing care, except in emergencies.
- Verify the member's eligibility at each appointment, admission and immediately before giving non-emergency services, supplies or equipment (for example, a member verified to be eligible on the last day of the month may not be eligible the first day of the following month)
- Not intentionally segregate EHI members in any way from other persons receiving similar services, supplies or equipment, or discriminate against any members on the basis of race, color, creed, ancestry, marital status, sexual orientation, national origin, age, sex or physical or mental disability in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000(d), and rules and regulations promulgated thereunder. Members must not be discriminated against due to:
    - Medical condition (including physical and mental illness;
    - Claims experience;
    - Receipt of health care;
    - Medical history;
    - Genetic information;
    - Evidence of insurability; or
    - Disability
    - Gender, including gender identity or gender expression (Health and Safety Code Section (§)1365.5).
- Offer language assistance if needed.
- Allow members to participate actively in all decisions regarding their medical care, including, as limited by law, their decision to refuse treatment.
- Obtain signed consent prior to rendering care, except as limited by emergency situations.

7.4 Notification about Actions Taken Against Provider or Staff

Federal and state laws require that you notify us immediately by sending an email to credentialing@allcaretoyou.com of the following actions taken towards you or any providers on your staff:

- Revocation, suspension, restriction, non-renewal of license, certification, or clinical privileges.
- A peer review action, inquiry or formal corrective action.
- A malpractice action or a government action, inquiry or formal allegation concerning qualifications or ability to perform services.
- Formal report to the state licensing board or similar organization or the National Practitioner Data Bank of adverse credentialing or peer review action.

- Any material changes in any of the credentialing information.
- Sanctions under the Medicare or Medicaid programs.
- Placement on the Medi-Cal Suspended and Ineligible Provider list.
- Any incident that may affect any license or certification, or that may materially affect performance of the obligations under the agreement.

7.5 Emergency & Urgent Care Services

The law states that it is an emergency if you reasonably believe that it is an emergency. If waiting to get care could be dangerous to your life or a part of your body, it is an emergency. Health plans must cover emergency care, even if the patient does not go to a hospital in their plan's network. Any emergency room must treat a patient until they are well enough to be moved to a hospital in their health plan's network. No authorization is required for treatment of an emergency medical condition by in-network or out-of-network providers. In the event of an emergency, EHI members can EHI emergency services 24 hours a day, 7 days a week.

Urgent care is when a patient's condition, illness or injury is not life-threatening, but a patient needs medical care within 24 to 48 hours. Health plans must cover urgent care when a patient travels outside their plan's service area.

7.6 EHI Contracted Urgent Care Centers and Hospitals

Below is a list of our currently contracted urgent care centers as of the publication date of this manual. EHI is open to contract with your preferred urgent care centers. If you have any suggestions on additional urgent care centers, please let us know.

Hospitals	Website
Advanced Urgent Care of Beverly Hills	https://urgentmednetwork.com/advancedurgentcareofbeverlyhills/
Anaheim Urgent Care, Inc.	https://urgentmednetwork.com/anaheimurgentcare/
BlueDoor Urgent Care	https://www.bluedoorcares.com/
Endure Urgent Care	https://endureurgentcare.com/
Premiere Urgent Care Centers of California	• 284 E. Highland Avenue, Suite 100, San Bernardino, CA 92404. Tel: 909-883-1098 • 49305 Grapefruit Blvd, Suite 1, Coachella, CA 92236. Tel: 760—391-9062 • 82013 Dr Carreon Blvd, Ste G, Indio, CA 92201. Tel: 760-775-9500 • 9889 Magnolia Avenue, Ste A, Riverside, CA 92503. Tel: 951-542-3900
RainCross Urgent Cross	https://raincrossurgentcare.com/
Reliant Immediate Care Medical Group and Reliant Urgent Care	https://relianturgentcare.com/urgent-care
Santa Monica Urgent Care	https://urgentmednetwork.com/santamonicaurgentcare/
Venice Urgent Care	https://urgentmednetwork.com/veniceurgentcare/

West Point Medical Center	https://www.westpointmedicalcenter.com/
Hollywood Presbyterian Medical Center	1300 N. Vermont Ave. Los Angeles, CA 90027, Tel: 213-413-3000
Marina Del Rey Hospital	4650 Lincoln Blvd. Marina Del Rey, CA 90292, Tel: 310-823-8911
Providence Little Company of Mary, Torrance	4101 Torrance Blvd. Torrance, CA 90503, Tel: 310-540-7676
Southern California Hospital at Culver City	3828 Delmas Terrace Culver City, CA 90323, Tel:310-836-7001
St. John's Health Center	2121 Santa Monica Blvd. Santa Monica, CA 90404, Tel: 310-829-5511
Providence Little Company of Mary, San Pedro	1300 West 7th St. San Pedro, CA 90732, Tel: 310-832-3311

7.7 EHI Contracted Laboratory and Imaging Services

Some Laboratory and Imaging services require prior authorization and must be performed at a contracted facility.

Laboratory Servies

Please find a list of LabCorp locations and hours on their website.

Laboratory Servies	Website
LabCorp	https://www.labcorp.com/labs-and-appointments

Imaging Services

Please find a list of contracted imaging facilities below

Imaging Center	Website
Anaheim Advanced Imaging	https://msk.radnetimaging.com/msk-centers/anaheim-advanced-imaging
Breastlink Women's Imaging Center	https://breastlink.com/
Beverly Radiology Medical Group (BRMG)	https://www.beverlyradiologymedicalgroup.com/
Lakewood Open MRI	https://msk.radnetimaging.com/msk-centers/lakewood-open-mri
Los Coyotes Imaging Center Medical Group	https://msk.radnetimaging.com/msk-centers/los-coyotes-imaging
Lakewood Open MRI	https://msk.radnetimaging.com/msk-centers/lakewood-open-mri
MemorialCare Imaging Center	https://www.memorialcare.org/services/imaging-radiology

Saddleback Valley Radiology	https://www.radnet.com/orange-county/locations/waveimaging-saddleback
San Bernardino Advanced Imaging	https://www.radnet.com/inland-empire/locations/san-bernardino-advanced-imaging
Wave Imaging	https://waveimagingnetwork.com/
Wave Interventional Radiology & Imaging	https://www.radnet.com/orange-county/locations/wave-interventional-radiology-imaging-center
West Coast Radiology Center - Irvine	https://msk.radnetimaging.com/msk-centers/west-coast-radiology-irvine
West Coast Radiology Center – Misson Viejo	https://msk.radnetimaging.com/msk-centers/west-coast-radiology-mission-viejo

7.8 EHI Specialty Providers

EHI builds specialty networks for each primary care provider to minimize disruption to patient care and existing referral patterns. Please contact your provider relations representative if you would like any specialists added to your network. The current provider directory can be found in the ACTY portal. EHI also provides a virtual specialty network.

7.9 Oversight of Mid-Level Providers

All providers using mid-level providers must provide supervision and oversight of such Mid-level providers consistent with state and federal laws. The provider and the Mid-level provider must have written guidelines for adequate supervision, and all supervising providers must follow state licensing and certification requirements.

7.10 Members' Rights and Responsibilities

All providers shall actively support the Members' Rights and Responsibilities as written and provided in the EHI Provider Services Agreement.

7.11 Confidentiality

All providers shall prepare and maintain all appropriate records in a system that permits prompt retrieval of information on members receiving covered services from acute care hospitals and ancillary providers. Providers shall only make the members' information, including but not limited to medical records, available in accordance with applicable state and federal law. EHI may use aggregate patient information or summaries for research, experimental, educational, or similar programs if no identification of a member is or can be made in the released information.

7.12 Medical Records

Providers must make available to EHI all pertinent medical records for our members. EHI may request the provider to provide medical records or information for quality management or other purposes during audits, grievances and appeals, and quality review. Providers shall have procedures in place to provide timely EHI to medical records in their absence.

7.13 Language and Interpreter Services

EHI's contracted health plans provide a Language Assistance Program (LAP) for their

members. In addition, ACTY has Spanish and Vietnamese representatives are available by calling (949) 750-2058 during normal office hours Monday – Friday from 8:30 a.m. to 5 p.m. TTY/TDD services are available by dialing 711 for the California Relay Services.

7.14 Admission Notification

Acute care hospitals are required to report all EHI members requiring authorization to admit patients to an inpatient setting by calling EHI at (949) 750-2058. Hospitals shall report clinical reviews to the Care Management (CM) department within 24 hours prior to admission for nonemergency admissions. Hospitals shall report clinical reviews for emergency admissions the next business day, or as soon as reasonably possible.

7.15 Clinical Information

Acute care hospitals are required to provide clinical information in the time parameter outlined in Admission Notification to facilitate concurrent review, certify approved inpatient days, and expedite discharge planning and authorizations. If timely clinical information is not provided for post-hospital services, inpatient claims are subject to retrospective review. Assistance with discharge planning is provided, as needed, to facilitate and coordinate the timely transition of care when medically indicated.

7.16 Home Health Agencies

Sometimes we may need a little extra help to make us whole again. The purpose of home health is to provide medical care therapy and support services in the comfort and convenience of a patient's home when a medical doctor deems it necessary.

This involves a team of healthcare professionals, including nurses, therapists and other specialists who work together to provide medical care and support to patients in their home.

The goal of home health is to help patients recover from illness, injury, surgery, and manage chronic health conditions and improve their general health and well-being. Home health can include a range of services such as wound care, medication management, physical therapy, occupational therapy, speech therapy and more.

Appropriate use of home health care encourages safe discharge and may prevent re-admission to acute care. Authorized home health services should begin within 24 hours of the referral unless the provider orders an alternate period. Contact EHI before ordering home health services to ascertain benefit coverage and obtain prior authorization.

7.17 Durable Medical Equipment and Supplies

All durable medical equipment and medical supplies should be delivered as soon as possible to prevent any TOC issues for EHI patients.

Section 8.0 – EHI Claims Payment and Billing

This section identifies All Care To You's claims process for claims submittals for covered benefits and services provided to EHI members. All provider claims, electronic or paper, should be "clean", which means that providers should submit claims with all fields completed with valid HCPCS, CPT or Local Codes, etc.

8.1 Fee Schedule

Provider rates of reimbursement or compensation for serving EHI members is dependent upon the provider's EHI Provider Service Agreement and its specified reimbursement rates. For assistance with understanding the fee schedule, please email your questions to Contracting@allcaretoyou.com

8.2 Timely Filing of Claims

EHI will deny claims submitted by non-contracted providers for medical services when a provider does not receive authorization prior to services, except for emergency services.

Providers must submit claims in a timely manner. Claims received by EHI past the contracted filing limit will be denied. Call 949-750-2058 with questions regarding the completion of the CMS-1500 or UB-04 claim forms.

8.3 Electronic Data Interchange

EHI requires electronic billing or electronic data interchange (EDI).

EDI is a computer-to-computer transfer of information. EDI is a fast, inexpensive, and safe method for automating the claims business processes. The benefits of using EDI are:

- Reduces costs (saves on staffing, overhead, claim forms, mailing materials and postage)
- Full tracking (no claims "lost in the mail")
- Faster turnaround time
- Consistent processing (no data conversion errors)
- Data security and privacy (data exchange occurs in secure and private environments)

Providers can submit EDI claims electronically through a HIPAA approved billing system, software vendor or clearinghouse. Using a clearinghouse can streamline the provider's billing processes by using a single system. Clearinghouses are connected with numerous insurance payers including EHI. Electronic transactions must contain HIPAA required data elements in all fields to be successfully processed. A clearinghouse and/or EHI will return claims submitted with incomplete or invalid information for correction. Billing providers are responsible for working with their EDI vendor or clearinghouse to ensure that claims with errors are corrected and resubmitted. Many clearinghouses have web portals that allow for manual correction and resubmission. All provider claims must be submitted and accepted by their clearinghouse within the contracted filing limit to be considered for payment. EDI and claims are HIPAA compliant and meet federal requirements for EDI transactions, code sets, EHI will accept 5010 complaint 837 transactions directly from the provider. Implementation guides are available at http://store.x12.org/store.

EHI accepts the following HIPAA compliant claim formats:

- Professional Claim - ASCX12 5010 837P
- Institutional Claims - ASCX12 5010 837I

Enrollment is required and providers can enroll by emailing our EDI Department at EDIsupport@allcaretoyou.com. A direct EDI submission connection requires a 90 day turn around to build.

Providers can call (949) 750-2058 or by email at EDIsupport@allcaretoyou.com if their preferred clearinghouse is not listed.

Clearinghouse	PayerID	Support Phone#	Website
Office Ally	EHI01	(360) 975-7000 Opt. 1	http://www.officeally.com

If you are unable to send claims electronically, please email our Claims Team for additional assistance at Claims@allcaretoyou.com

8.4 Clinical Record Submission Request

EHI may request submission of clinical information before or after payment of a claim. We will use RA code 252 with a corresponding Remittance Advice Remark (RARC) code to explain why we are requesting medical records. Providers have 45 business days from the date on the Remittance Advice (RA) to submit the requested information.

8.5 Claim Items and Coding Guidelines

Itemizations are required for any inpatient stay where the complete length of stay (LOS) was not authorized.

- Itemization is not required as a regular billing practice; however, itemization may be required on a case-by-case basis.
- Itemizations must contain the total for the LOS (each DOS)
- Discharge DOS is not a payable fee.

Regardless of the method you use, all providers must bill using the appropriate claim form, with appropriate codes, and in a manner acceptable to us. All EHI claims submitted for payment need to include the current HIPAA- compliant code sets required by the state and federal government. Providers must use the following national guidelines when coding claims:

- *International Classification of Diseases, 10th Revision (ICD diagnostic and Procedure Codes)*: Applicable ICD procedure codes must be in Boxes 74(a-e) of the UB-04 form when the claim indicates a procedure was performed. Medi-Cal Local Only Codes (Local Only Codes): Use Local Only Codes until the state remediates the codes. Do not use Local Only Codes for dates of service after the remediation date. Local Only Codes billed after the remediation date are denied for use of an invalid procedure code.
- *Healthcare Common Procedure Coding System (HCPCS*): Refer to the current edition of HCPCS published by the Centers for Medicare and Medicaid Services (CMS).
- *Current Procedural Terminology (CPT) Codes*: Refer to the current edition of the Physicians' CPT manual, published by the American Medical Association.
- *Modifier Codes*: Use modifier codes when appropriate with the corresponding HCPCS or CPT Codes.
- *Local Only, HCPCS or CPT Codes*.

8.6 Checking Claim Status

Providers should be able to check claims status online. If the claim contains all required information, the claim will enter into EHI's claims system for processing. Providers will receive an RA when the claim is finalized. Providers may confirm receipt of their claims after 5 business days from the date the claim was submitted through the Provider Portal website at https://portal.allcaretoyou.com. Providers must first register to use the site by clicking on the registration link or by visiting ACTY, or the provider's contracted clearinghouse will return claims submitted with incomplete or invalid information for correction.

Billing providers are responsible for working with ACTY, their EDI vendor or clearinghouse to ensure that claims with errors are corrected and resubmitted. Many clearinghouses have web portals that allow for manual correction and resubmission.

8.7 Claims Appeals Process

EHI offers a claim appeal process for issues pertaining to processing of provider claims. Providers may submit one appeal (or dispute) per claim. Providers must submit their request for consideration in writing within 45 business days from the date of the provider's receipt of our Remittance Advice (RA). Providers may appeal a claim on the ACTY website at https://portal.allcaretoyou.com.

For a mailed appeal, the provider's submission must include a complete Claim Appeal/Dispute form, a copy of the original and/or corrected CMS 1500 or UB04 claim form, and supporting documentation not previously considered to:

Empire Healthcare IPA
c/o All Care To You
Attn: Claims Department
P.O. Box 4367
Orange, CA 92863

Please note that providers receive an RA with every claim, whether paid or denied. Claim appeals are reviewed on a case-by-case basis. EHI will acknowledge all provider claim appeals in writing within 15 calendar days of receipt and will send a written resolution notice 45 business days from receipt of the reconsideration request. If providers are dissatisfied with the resolution after exhausting the appeal process, refer to the dispute resolution process in the EHI participating Provider Agreement.

8.8 Claims Overpayment Recovery Procedure

EHI will recover all claim overpayments from the claim payee whom payable. When an overpayment is discovered, EHI initiates the overpayment recovery process by sending written notification of the overpayment to a provider, hospital, facility, or other health care professional (provider). Please return all overpayments to EHI upon the provider's receipt of the notice of overpayment.

If providers want to contest the overpayment, call (949) 750-2058. If you believe you received a recovery request in error, please send correspondence to the address on the overpayment notification.

If EHI does not hear from the provider or receive payment within 60 business days, the overpayment amount is deducted from future claims payments to the provider or referred to a collection service.

Section 9.0 – EHI Utilization Management

EHI's Care Management (CM) department consists of the Utilization Management (UM)

program and the Case Management program. It is designed to create a holistic approach to effectively manage patients' health conditions and achieve improved health outcomes. The UM program is a collaboration with providers to promote and document appropriate use of health care resources. To contact the Care Management (CM) department, call (949) 750-2058 from 8:30 a.m. to 5 p.m., Monday through Friday, excluding holidays.

For after-hours emergency room visits and hospital admissions, please call (949) 750-2058 option 0.

9.1 Utilization Management

UM is the process of influencing the continuum of care by evaluating the necessity and efficiency of health care services and affecting patient care decisions through assessments of the appropriateness of care.

The CM department helps to ensure prompt delivery of medically appropriate health care services to EHI members. In conjunction with providers, UM performs discharge planning and care management and authorizes services when indicated. EHI does not reward providers or other individuals conducting utilization review for issuing denials of coverage or service care and does not encourage decisions that result in under-utilization.

9.2 Continued Access to Care

Continued access to care is the process of authorizing the continuation of services with a terminating provider under specified conditions and for a limited period with a plan of care to transition the member to a network provider.

The medical conditions that qualify for continued access to care may include, but are not limited to:

- Terminal illness
- Surgery or other procedures authorized and scheduled to occur within 180 business days of the date of the contract's termination or within 180 business days of the effective date of coverage for a newly covered member.
- Degenerative and disabling conditions (a condition or disease caused by a congenital or acquired injury or illness that requires a specialized rehabilitation program, or a high level of care, service, resources, or continued coordination of care in the community)
- An acute condition or a serious chronic condition

EHI has an established UM multidisciplinary approach to provide health care services in the setting best suited for the medical and psychosocial needs of the member based on benefit coverage, established criteria and the community standards of care.

9.3 Availability of Care Management Team Members

EHI ensures the availability of CM team members at least eight hours a day during normal business days to answer care management-related calls.

9.4 Decision and Screening Criteria

Decision and notification of approval, deferral and denial periods are in alignment with contracts and applicable legislation.

EHI applies MCG and/or InterQual guidelines for Utilization Management screening and decisions. Application of the criteria is not absolute or completely relied on by EHI but is a factor in determining medical necessity along with the clinical information provided by the requesting

provider and the individual health care needs of the member.

9.5 Provider Authorization Process

Providers are responsible for verifying eligibility and obtaining authorization for non-emergent services prior to rendering the services. All prior authorization requests must be submitted within the ACTY Provider Portal at https://portal.allcaretoyou.com

A prior authorization review of certain procedures and services is required to ensure that services:

- Access the members medical benefits
- Are based on medical necessity
- Are rendered by the appropriate provider or facility

Obtaining prior authorization is not a guarantee that a payment will be made by EHI. Providers seeking reimbursement for unauthorized non-emergent services will be denied for lack of prior authorization.

Providers are responsible for verifying eligibility and authorization for non-emergent services prior to rendering the services. Prior authorization of certain procedures and services is required to ensure that services are based on medical necessity and benefit coverage and are provided by the appropriate providers.

Complete the online form by including current ICD and CPT code(s) with all supporting documentation. Requests submitted without appropriate documentation will automatically suspend the referral in a deferred status until further information is received. Identify and select one of three levels of priority for the request. The levels of priority are as follows:

- **Urgent** - Patient care must be expedited on an urgent basis.
  - The turnaround time is 24 to 72 hours.
- **Routine** - The patient can wait for the appointment. This level should be used for non-urgent/non-emergent requests. Do not make an appointment for the member without a referral.
  - The turnaround time is approximately 3-5 business days following submission of a complete request.
- **Retro** - This level may be used for services provided within the last 30 days and must include supporting documentation such as medical records.
  - Services that were provided beyond the last 30 days should be submitted as a claim.

Requests to non-contracted/out of network providers cannot be submitted to UM as an urgent request. Place in the notes section of the request that this is a non-contracted provider and needs immediate attention. Upon approval or denial, the authorization number will be available on the portal within the specified timeframe. The website must be checked at least daily as this is how you are notified of referral decisions. Providers can also receive email notifications alerting them that there is an update for your review. No PHI regarding the authorization will be sent in the email notification.

All services require prior authorization, except for the following services:

- Non-emergency inpatient admissions to non-participating hospitals, or

- Continued inpatient hospital stays at non-participating hospitals that are available at a participating network hospital.
- Preventative immunizations, routine x-rays, and routine labs.

Authorizations expire ninety (90) business days after the date of the decision. A written notification is sent to the member by mail within two business days of the decision.

- The requesting provider must print and file a copy of the approval or denial letter from the portal in the member's chart.
- The Medical Director will review all redirected requests and all medical necessity denials. If the provider disagrees with the decision, the provider may contact the CM department at (949) 750-2058 from 8:30 a.m. to 5 p.m., Monday through Friday, except for all major holidays or follow EHI's provider appeal process as indicated below in Section 12.0 - Provider Grievance and Appeals.
- Providers may reference Medicare D-SNP Timeliness Standards for line of business authorization timeliness standards.

It is EHI's responsibility to determine whether services are medically necessary.

All services below require prior authorization. This list is subject to change.

Service	CPT/Description
New and Established Consultations, Outpatient and Other Visits	99201-99205; 99211-99215
Diagnostic Radiology / X-Rays (***Except***: ***70170, 70992, 70336, 70350, 70355, 70371, 70373, 70390***)	**70030-70390** Radiography: Head, Neck, Orofacial Structures **70450** Radiography: Computed tomography, head or brain; without contrast material **71010-71130** Radiography: Thorax/Chest, Rib etc. **72192** Computed tomography, pelvis; without contrast material **73000-73085** Radiography: Shoulder and Upper Arm **73090-73140** Radiography: Forearm and Hand **73500-73550** Radiography: Pelvic Region and Thigh **73560-73660** Radiography: Lower Leg, Ankle, and Foot **74150** Computed tomography, abdomen; without contrast material **93571-93572** Coronary Artery Doppler Studies **93990-93998** Noninvasive Vascular Studies: Hemodialysis Access
Mammography	**77053-77057** Radiography: Breast

	76641 and 76642 Breast Ultrasound
Ultrasound (**Expect: 76831**)	**76813-76817** Ultrasound: Other Fetal Evaluations **76536-76800 76536-76800** Ultrasound: Neck, Thorax, Abdomen, Spine, Liver, Renal, Breast, Pelvic, Soft Tissue & Thyroid **76830-76873 76830-76873** Ultrasound: Male and Female Genitalia
Audiology	**92550** Hearing screening via audiometer (for Medicare AWV)
Biopsy & Dermatology	**19100-19101** Breast Biopsy Without Imaging Guidance **20200-20206** Muscle Biopsy **21550-21550** Soft Tissue Biopsy of Chest or Neck **21920-21925** Biopsy Soft Tissue of Back and Flank **23065-23066** Shoulder Biopsy **25065-25066** Biopsy Forearm/Wrist **27040-27041** Biopsy of Hip/Pelvis **27323-27324** Biopsy Femur or Knee **27613-27614** Biopsy Lower Leg and Ankle **27323-27324** Biopsy Femur or Knee **30000-30115** I&D, Biopsy, Excision Procedures of the Nose **37197-37202** Transcatheter Procedures: Infusions, Biopsy, Foreign Body Removal **49180-49180** Biopsy of Mass: Abdomen/Retroperitoneum
Gastroenterology	**0249T-0255T** Protoscopic Procedures **43201** EGD with injection **43231** Endoscopic ultrasound- upper W/o bx **43235** EGD **43239** EGD with bx **43242** Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound **43243** EGD with banding of varices **43249** EGD with dilatation **43251** EGD with hot snare **43255** EGD with control of bleeding **45341** Endoscopic ultrasound lower for cancer stagging **45378** Colonoscopy without bx **45380** Colonoscopy to control bleeding **45381** Colonoscopy with saline

	injection or tattoo to mark or lift a lesion. **45383** Colonoscopy with ablation **45385** Colonoscopy with biopsy and/ or to remove small polyp **45385** Colonoscopy with snare polypectomy of larger polyp **46600-46615** Anoscopic Procedures
General	**10060** Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single **10061** Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple **11042** Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less **11041** Debridement; skin, full thickness **20550** Injection(s); single tendon sheath, or ligament, aponeurosis (e.g., plantar "fascia")
Injections (Orthopedics, Pain Management & Rheumatology)	**20526** Injection, therapeutic (e.g., local anesthetic, corticosteroid), carpal tunnel **20551** Biceps tendonitis, media/lateral epicondylitis **20552** Trigger point injections (cervical/lumbar/ paraspinal injections) **20600** Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g., fingers, toes); without ultrasound guidance **20605** Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance **20610** Hip, knee, shoulder **20650** Trigger finger, plantar fasciitis, De Quervain’s tenosynovitis injections
Optometry	**92015** Refraction Screening
Orthopedics	**21310-21499** Care of Fractures/Dislocations of the Cranial and Facial Bones

	22325-22328 Open Treatment Vertebral Fractures: Posterior Approach **25500- 25695** Casting for fractures **27750-27848** Treatment of Fracture/Dislocation Lower Leg/Ankle
Spirometer	**94010-94799 (CPTS: 94010, 94060, 94200, 94014, 94015, 94016, 94070, 94620, 94621, 94011, 94012; HPCS: A9150-A9300, 3E0424-E0487)** **94010** Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation **94060** Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration **94200** Maximum breathing capacity, maximal voluntary ventilation **94014** Patient-initiated spirometry recording per 30-day period of time; includes reinforced education, transmission of spirometry tracing, data capture, analysis of transmitted data, periodic recalibration and review and interpretation by a physician or other qualified health care professional **94015** Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration) **94010-94799 (CPTS: 94010, 94060, 94200, 94014, 94015, 94016, 94070, 94620, 94621, 94011, 94012; HPCS: A9150-A9300, 3E0424-E0487), 94010** Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation **94060** Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration **94200** Maximum breathing capacity, maximal voluntary ventilation **94014** Patient-initiated spirometry recording per 30-day period of time; includes reinforced education, transmission of spirometry tracing, data

	capture, analysis of transmitted data, periodic recalibration and review and interpretation by a physician or other qualified health care professional **94015** Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration) **94016** Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional **94070** Bronchospasm provocation evaluation, multiple spirometric determinations as in 94010, with administered agents (e.g., antigen[s], cold air, methacholine) **94620** Pulmonary stress testing; simple (e.g., 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry) **94621** Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings) Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional **94070** Bronchospasm provocation evaluation, multiple spirometric determinations as in 94010, with administered agents (e.g., antigen[s], cold air, methacholine) **94620** Pulmonary stress testing; simple (e.g., 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry) **94621** Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)
Urgent Care/Minor Surgery, Lacerations	**10030-10180** Treatment of Fluid-filled Lesions: Skin and Subcutaneous Tissues **12001-12021** Suturing of Superficial Wounds

	12031-12057 Suturing of Intermediate Wounds **97597-97610** Treatment of Wounds
Vaccines (*Any vaccine covered by Medicare)	**90389** Tetanus Shot **90653, 90654, 90656, 90660-90662, 90672-90673, 90686, 90688** Influenza Vaccine **90670** Prevnar 13 Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use **90732** Pneumococcal Vaccine
Well Woman/Man	**81025** Pregnancy Test **88150, 88155 and 57410** Pap Smear/Pelvic Exam

Common ACTY Portal Referral Submission Errors and Solutions

Error	Solution
Authorizations left unassigned without documentation of requested provider	Document the full name of the provider in the notes. Please do not choose any provider and then ask to change the provider in the notes. Please use Unassigned
Incorrect Place of service. i.e., Using Office (POS 11) for an Ambulatory or Inpatient request.	Select the correct place of service on the authorization request form. If you are requesting a procedure that is performed at an Ambulatory Surgical Center, Outpatient, or Inpatient Facility you need to select the correct place of service as well as the facility.
Entering the incorrect rendering provider. i.e., assigning the hospital instead of the surgeon.	Use the provider who will render the service.
Duplicate authorizations	Always review the member's authorization history before entering a new request.
Requesting to change provider on an approved authorization.	We cannot change the provider on an approved authorization. A new request is required.
Entering a request for plain film x-rays.	No authorization is required for plain film x-rays.
Entering the incorrect rendering provider.	Use the provider who will render the

i.e., assigning the hospital instead of the surgeon.	service.
Entering surgeries and office visit follow ups on the same authorization	Submit separate authorizations for office visits and outpatient procedures. (In office procedures may be submitted on the same authorization.) Please note: Most major surgeries included follow-up visits within 90 days
No clinical information documented or documenting “see fax”.	Please document the basic medical indication for the request. If you need to submit additional typed consultation notes or radiology

9.6 Concurrent Review

Clinical reviews are required on all members admitted as inpatients in an acute-care hospital. The reviews are performed to assess whether the medical care rendered is medically necessary, and whether the facility and level of care are appropriate.

ACTY identifies members admitted to the inpatient setting by:

- Facilities reporting admissions.
- Providers reporting admissions.
- Members or their representatives reporting admissions.
- Prior authorization requests for inpatient care

The UM department completes concurrent inpatient reviews within 24 hours of receipt of the information necessary to make the determination. The hospital shall provide EHI with all clinical information necessary to make a Utilization Review determination as requested by EHI. UM nurses who perform concurrent review functions request clinical information from the hospital on the same day they are notified of the member’s admission. If the information provided meets medical necessity review criteria, the request is approved within 24 hours from the time of receipt of the information. When a request does not meet medical policy guidelines, the case is sent to a provider or medical director for review.

9.7 Admission Notification

Acute care hospitals are required to report to EHI all members in the group who are admitted to an inpatient setting by faxing the face sheet to (949) 396-2614 or by calling the CM department at (949) 750-2058. For after-hours, please press 0.

Prospective admissions should be reported no less than 24 hours prior to admission for nonemergency admissions and the next business day, or as soon as reasonably possible, for emergency admissions.

9.8 Clinical Information

Acute care hospitals are required to provide timely clinical information in the time parameter outlined in the admission notification in order to facilitate concurrent review, certify approved inpatient days, and expedite discharge planning and authorizations.

Assistance with discharge planning is provided, as needed, to facilitate and coordinate the

timely transition of care when medically indicated.

9.9 Deferral of Service

EHI sends an initial written notice to inform the member and the provider of the deferred status of the case and of the period for submission of additional information. If information is not received within the 14-calendar day period from the date of the request, EHI will provide notice to the provider via the portal and send a written notice to the members informing them that the request has been denied for lack of medical information. This deferral process does not apply to the concurrent review process.

9.10 Denial of Service

Only a medical or behavioral health provider who possesses an appropriate active professional license or certification can determine a denial of service (procedure, hospitalization, or equipment) based on a lack of medical necessity. When a request is determined to be not medically necessary, the requesting provider is notified of the opportunity for a peer-to-peer discussion of the case and is informed of the opportunity for an appeal.

Providers can contact EHI's physician clinical reviewer to discuss any UM decision by calling the Care Management (CM) department at (949) 750-2058.

9.11 Emergency Services

Out-of-network providers must notify EHI within 24 hours of an emergency encounter, as a condition of receiving payment for emergency services. The out-of-network provider must accept payments made in accordance with EHI.

No authorization is required for treatment of an emergency medical condition. In the event of an emergency, members can access emergency services 24 hours a day, 7 days a week.

All providers who engage in the treatment of a member share responsibility in communicating clinical findings, treatment plans, prognosis, and the psychosocial condition of such member with the member's providers to ensure coordination of the member's care.

9.12 Sensitive Services

Sensitive services include those services related to treatment for injuries resulting from sexual assault, drug or alcohol abuse treatment, pregnancy, family planning, HIV counseling and testing, pregnancy termination, outpatient mental health treatment and diagnosis, residential shelter services, intimate partner violence, and treatment of sexually transmitted infections (STIs) for minors aged 12 and older.

Sensitive services are defined as all health care services related to:

- Mental or behavioral health.
- Sexual and reproductive health.
- Sexually transmitted infections.
- Substance use disorder.
- Sender affirming care, and
- Intimate partner violence.

Sensitive services include services described in Sections 6924—6930 of the Family Code, and Sections 121020 and 124260 of the California Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the services.

9.13 Medicare DSNP Timeliness Standards for UM Referral Management

Type of Request	Decision	Notification Timeframes
Standard Initial Organization Determination (Pre-Service) *-No extensions allowed*	Within 5 working days of receiving the necessary information but no later than 14 calendar days	If the enrollee can be successfully contacted (voicemail or successful phone call) then the enrollee may be notified orally of the decision, but the written notification must be provided within 3 calendar days of the verbal notification. A written notification of any adverse decision must be provided to the member at least 10 calendar days prior to the date the service will be reduced, suspended, or stopped. - Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
Expedited Initial Organization Determination *-No extensions allowed* **Requested as Urgent appropriately** (See footnote)[1]	As soon as medically necessary, within 72 hours after receipt of request (including weekends & holidays).	Within 72 hours after receipt of request. **<u>Approvals</u>** - Oral or written notice must be given to the member and provider within 72 hours of receipt of request. - Document date and time oral notice is given. - If written notice only is given, it must be received by a member and provider within 72 hours of receipt of request. **<u>Denials</u>** - When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. - Document date and time of oral notice. If only written notice is given, it must be **received** by the member and provider within 72 hours of receipt of request.

[1] Note: Health Plans may have referral requirements that may impact timelines. When processing expedited requests, groups must factor in the time it may take to refer the request to the health plan in the total 72 hours to ensure that expedited requests are handled timely.

		- Use NDMC template for written notification of a denial decision.
Post-Service - All necessary information received at time of request (decision and notification is required within 30 calendar days from request) **Retro claim review**	Within 30 calendar days of receipt of request.	Within 30 calendar days after receipt of request. Within 30 calendar days after receipt of request. **Approvals** - Practitioner: Within 30 calendar days of receipt of request (for approvals). - Member: Within 30 calendar days of receipt of request (for approvals). **Denials** Within 30 calendar days of receipt of request
Translation Requests for Non-Standard Vital Documents - **Urgent** (e.g., pre-service pend or denial notifications with immediate medical necessity) - **Non-Urgent** (e.g., post-service pend or denial notifications)	***Requires consultation by an Expert Reviewer:*** Within 15 calendar days from the date of the delay notice. ***LAP Services Not Delegated:*** All requests are forwarded to the contracted health plan. - Request forwarded within one (1) business day of member's request - Request forwarded within two (2) business days of member's request	***Requires consultation by an Expert Reviewer:*** **Practitioner**: Within 15 calendar days from the date of the delay notice (for approvals). **Member**: Within 15 calendar days from the date of the delay notice (for approval decisions). ***Requires consultation by an Expert Reviewer:*** Within 15 calendar days from the date of the delay notice. ***LAP Services Delegated/Health Plan:*** All requested Non-Standard Vital Documents are translated and returned to members within 21 calendar days.
Urgent Concurrent (i.e., in-patient, ongoing/ambulatory services) Request involving both urgent care and the extension of a course of treatment beyond the period of time or number	Within 24 hours of receipt of the request.	Within 24 hours of receipt of the request. **Note:** If oral notification is given within 24 hours of request, written or electronic notification must be given no later than 3 calendar days after the oral notification.

of treatments previously approved and the request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments. **Exceptions:** If the request is not made at least 24 hours prior to the expiration of prescribed period of time or number of treatments, and request is urgent, default to ***Urgent Pre-service*** category. If the request to extend a course of treatment beyond the period of time, or number of treatments previously approved by the Health Plan/PMG/IPA does not involve urgent care, default to ***Non–urgent Pre-service*** category.		
Part B Drugs (Step Therapy Drugs) – *Standard/Routine*	Within 72 hours from date/time of receipt of request.	Within 72 hours from date/time of receipt of request. **NOTE**: No extensions allowed.
Part B Drugs (Step Therapy Drugs) – *Urgent*	Within 24 hours from date/time of receipt of request.	Within 24 hours from date/time of receipt of request. **NOTE:** No extensions allowed**.**

Type of Request	Decision	Notice of Medicare Non-Coverage (NOMNC) Notification	Detailed Explanation of Non-Coverage (DENC) Notification
Termination of Provider Services: - Skilled Nursing Facility (SNF)	The Health Plan or delegate is responsible for making the decision to end services no later than two (2) calendar days or 2 visits before coverage	The SNF, HHA or CORF is responsible for delivery of the NOMNC to the member or authorized	Upon notification by the Quality Improvement Organization (QIO) that a

- Home Health Agency (HHA) - Comprehensive Outpatient Rehabilitation Facility (CORF) **NOTE**: This process does not apply to SNF Exhaustion of Benefits (100-day limit).	ends: - Discharge from SNF, HHA or CORF services **OR** - A determination that such services are no longer medically necessary	representative - The NOMNC must be delivered no later than 2 calendar days or 2 visits prior to the proposed termination of services and must include: member name, delivery date, date that coverage of services ends, and QIO contact information. - The NOMNC may be delivered earlier if the date that coverage will end is known. - If the expected length of stay or service is 2 days or less, give notice on admission. **NOTE**: Check with Health Plan or delegate for delegated responsibility, as a Health Plan or delegate may choose to deliver the NOMNC instead of the provider.	member or authorized representative has requested an appeal: The Health Plan or delegate must issue the DENC to both the QIO and members no later than close of business of the day the QIO notifies the Health Plan of the appeal.

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
Hospital Discharge Appeal Notices (Concurrent)	Attending physician must concur with discharge decision from inpatient hospital to any other level of care or care setting. Continue coverage of inpatient care until physician concurrence obtained. Hospitals are responsible	Hospitals must issue the IM within 2 calendar days of admission, obtain the signature of the member or representative and provide a copy of the IM at that time. Hospitals must issue	Upon notification by the QIO that a member or representative has requested an appeal, the Health Plan or delegate must issue the DND to both the member and QIO as soon

	for valid delivery of the revised Important Message from Medicare (IM): 1) within 2 calendar days of admission to a hospital inpatient setting. 2) not more than 2 calendar days prior to discharge from a hospital inpatient setting. Health Plans or delegates are responsible for delivery of the Detailed Notice of Discharge (DND) when a member appeals a discharge decision. DND must be delivered as soon as possible but no later than noon of the day after notification by the QIO (Quality Improvement Organization).	a follow up IM not more than 2 calendar days prior to discharge from an inpatient hospital. **NOTE:** Follow up copy of IM is not required: ▪ If initial delivery and signing of the IM took place within 2 calendar days of discharge. ▪ When member is being transferred from in-patient to in-patient hospital setting. ▪ For exhaustion of Part A days, when applicable. If IM is given on day of discharge due to unexpected physician order for discharge, member must be given adequate time (at least several hours) to consider their right to request a QIO review.	as possible but no later than noon of the day after notification by the QIO. The DND must include: ▪ A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered. ▪ A description of any applicable Medicare coverage rules, instructions, or other Medicare policy, including information about how the member may obtain a copy of the Medicare policy from the MA organization. ▪ Any applicable Medicare health plan policy, contract provision, or rationale upon which the discharge

			determination was based. ▪ Facts specific to the member and relevant to the coverage determination sufficient to advise the member of the applicability of the coverage rule or policy to the member's case. ▪ Any other information required by CMS.

Section 10.0 – EHI Case Management

10.1 Case Management Program

The purpose of EHI Case Management program is to ensure that medical care is delivered in the most cost-efficient setting for members who require extensive or ongoing services. The program will be focused on the delivery of cost-effective, appropriate healthcare services for members with complex and chronic care needs. Members with complex needs can include individuals with physical or developmental disabilities, multiple chronic conditions and severe mental illness. Case managers assist in assessing, coordinating, monitoring, and evaluating the options and services available to meet the individual needs

of these members across the care continuum. Case Management is defined as "A collaborative process that assesses, develops, implements, coordinates, monitors, and evaluates care plans designed to optimize members' health care across the care continuum. It includes empowering members to exercise their options and EHI the services appropriate to meet their individual health needs, using communication, education, and available resources to promote quality outcomes and optimize health care benefits."

We will work with our members to develop an Individualized Care Plan (ICP) and provide you with updates to the plan after holding an Interdisciplinary Care Team (ICT) meeting with participants most appropriate to address individualized needs.

10.2 Case Management Referral Process

Providers, nurses, social workers and members or their representative may refer

members to Case Management:

- By calling the Care Management (CM) department (949) 750-2058.

10.3 Provider Responsibility

It is the provider's responsibility to participate in the case management process through information sharing (such as medical records) and facilitation of the case management process by:

- Referring members who could benefit from case management
- Collaborating with case management staff
- Providing medical information

Examples of member cases appropriate for referral include:

- Members with chronic conditions- DM, CHF, COPD
- Members on 10 or more medications
- Members with two or more hospitalizations and/or ER visits in the last 6 months
- Potential transplants
- HIV/AIDS

10.4 Role of the Case Manager

EHI case managers have an educational and experience-based background as registered nurses, licensed vocational nurse and/or social work case managers who:

- Facilitate communication and coordination between all members of the health care team, involving the member and family in the decision-making process to minimize fragmentation in the health care delivery system.
- Educate the members and all providers of the health care delivery team about case management, community resources, benefits, cost factors and all related topics so that informed decisions can be made.
- Encourage appropriate use of medical facilities and services, improving the quality of care and maintaining cost-effectiveness on a case-by-case basis.

Upon identification of a potential member for the Case Management program, the case manager contacts the referring provider and member and completes an initial assessment. The case manager develops an individualized care plan based on information from the assessment and with the involvement of the member, the member's representative, and the referring provider.

The care plan is re-assessed to monitor progress toward goals, any necessary revisions, and

any new issues to ensure that the member receives support and teaching to achieve care-plan goals. Once the member meets EHI's care goals or the member is unresponsive to the case manager's interventions, the member's case is closed.

10.5 Accessing Specialists

EHI Care Management (CM) team members are available to help Primary Care Providers EHI Specialists. For help locating a Specialist, call (949) 750-2058 or logon to https://portal.allcaretoyou.com

10.6 Advance Directives/POLST

Recognizing a person's right to dignity and privacy, members have the right to execute an Advanced Directive or POLST form to identify their wishes concerning health care services should they become incapacitated. Members may request that providers and/or office staff assist members in procuring and completing necessary forms. Providers should document their efforts to educate their patients on advance directives and should support patients in the completion of the POLST form.

10.7 Medi-Cal Initial Health Appointment (IHA) Requirements including Cognitive Health Assessment

An IHA consists of a history and physical examination that enables a provider of primary care services to comprehensively assess the Member's current acute, chronic and preventative health needs.

The health plans require that Dual Special Needs (DSNP) and Medi-Cal members have an Initial Health Appointment (IHA) within 120 calendar days of enrollment or all IHA elements were completed within the past twelve (12) months and documented for annual assessments.

- New members need the IHA done within 120 calendar days of enrollment.
- Continuing members need to have their IHA done annually.

For members under the age of 18 months:

- IHA also must be completed within 120 calendar days following the date of enrollment or within periodicity timeliness established by the American Academy of Pediatrics (AAP) for ages 2 or younger, whichever is less.

A Cognitive Health Assessment (CHA) is a screening or evaluation used to check for problems with thinking, memory, or concentration — especially in older adults or those at risk for cognitive decline (like dementia or Alzheimer's disease).

- The provider must complete the DHCS Dementia Care Aware cognitive health assessment training prior to conducting the brief cognitive health assessment.
- The provider can administer the annual cognitive health assessment as a component of an E&M visit including, but not limited to an office visit, consultation, or preventive medicine service (elements of the cognitive health assessment can be conducted by non-billing team members acting within their scope of practice and under the supervision of the billing Provider)

Link to DHCS Dementia Care Aware training: https://www.dementiacareaware.org/

A CHA must be completed along with the Initial Health Appointment (within 120 calendar days of enrollment) and then annually for Medi-Cal members 65 years and older.

Documentation Requirements for the IHA and CHA are as follows:

- The provider must make at least three (3) initial attempts to contact the member to schedule an IHA and CHA if applicable within 120 calendar days of enrollment. All attempts must be documented in the medical record.
- All new members must have a history and physical. Referrals for any abnormal findings must be documented.
- If the member misses the IHA, the provider needs to document the reason in their chart (e.g. Member/parent refusal or missed appt) and evidence of 2 outreach attempts (1 verbal and 1 written) to reschedule within the IHA timeframe (120 calendar days from

enrollment).

- Evidence must be documented in the medical record of follow-up within 60 days for identified risks.

Physical Exam requirements are as follows, and must be included in the IHA:

- A history of the Member's physical and mental health (i.e. Present and past illness (es) including hospitalizations and operations and medications.)
- An identification of risks;
- An assessment of need for preventive screens or services;
- Health education; and
- The diagnosis and plan for treatment of any diseases
- Physical exam needs review of all organ systems including but not limited to;
  - Height and Weight
  - Blood Pressure
  - General Appearance
  - BMI
  - Total serum cholesterol measurement
  - Clinical breast examination
  - Pap smear on all women determined to be sexually active, regular screening may be discontinued after age 65 who have regular screening with consistent results
  - Tuberculosis screening- all members receive TB testing upon enrollment and annual screening will be part of the annual H&P
  - Preventative services should we provided per the USPSTF Guide to Preventative Services (see attachment)
  - Mental Health and status evaluation
  - Diagnoses and plan of care

For members under 21 Years, physical exams requirements include but are not limited to:

- screenings for ACEs, development, depression, autism, vision, hearing, lead and SUD.
- Per APL 23-005: Requirement for coverage of EPSDT services:
  - Complete physical exam to include both physical and mental health development
  - Unclothed physical exam,
  - Appropriate immunizations,
  - Lab testing (including lead blood level assessment appropriate for age and risk factors)
  - Health Education (includes anticipatory guidance),
  - Vision Screen (Dx and treatment for defects in vision, including Rx eyeglasses),
  - Dental services,
  - Hearing Screen,
  - Lead Screen,
  - Referral to Substance Use Disorder if applicable

10.8 Medicare Advantage

An initial denial decision cannot be changed to an approval after an initial denial notice that was sent to the member, even with new information whether from a peer-to-peer discussion or receipt of additional clinical information. Any newly received clinical documentation should be

forwarded to the appropriate Health Plan within twenty-four (24) hours of receipt. It is up to the Health Plan to review the new documentation to render a reconsideration decision.

Section 11.0 – EHI Provider Grievance and Appeals

EHI facilitates a grievance and appeals process for adverse determinations.

11.1 Provider Appeals Regarding UM Clinical Decisions Medicare Advantage

An initial denial decision cannot be changed to an approval after an initial denial notice that was sent to the member, even with new information whether from a peer-to-peer discussion or receipt of additional clinical information. Any newly received clinical documentation should be forwarded to the appropriate health plan within twenty-four (24) hours of receipt. It is up to the health plan to review the new documentation to render a reconsideration decision.

11.2 Provider Appeals of Non-medical Necessity Claims Determinations

Submission of a first level Provider Dispute pertaining to a Medicare Advantage member must be filed in writing within a minimum of 120 calendar days after the notice of initial determination (i.e., RA's/ Letters). Appeals must include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement; and mail the reconsideration to the designated health plan. When necessary, documentation has not been submitted for review of the Provider Dispute, EHI will advise the provider to submit the required documentation. Requests can be made via phone outreach or in writing.

Section 12.0 – EHI Member Grievance and Appeals

12.1 Member Grievances or Complaints and Appeals

Members may file a grievance with their health plan if they are:

- Not satisfied with UM decision, such as grievances related to an appeal of a denied, delayed, or modified covered service.
- Not satisfied with any aspect of a provider's service or care, such as grievances relating to quality of care, access, attitude (e.g., practitioner or office staff behavior). Grievances going directly to the provider group are immediately forwarded to the respective health plans.

Members will be provided with their respective health plan's grievance form upon request. Participating providers and EHI participate in the resolution of grievances by cooperating with plans and supplying information and records. Plans make the final decisions.

Section 13.0 – EHI 5 Stars Quality

13.1 Cozeva

Cozeva is a best-in-class reporting and analytics platform that displays performance in clinical quality and risk measures. The platform gathers data from multiple sources and provides insights into opportunities to address care gaps for patients and improve performance.

How can Cozeva support my practice?

- Track measure rates using the Registries scorecard
- View patient-level detail on gaps in care

- Print face sheets to facilitate pre-visit planning
- Close data gaps instantly by uploading records

What can I expect?

- Cozeva displays up-to-date information on patient care gaps across a variety of measures, along with relevant supporting detail at both the overall panel and individual patient levels.

How do I gain access to Cozeva?

- Through single sign on access through your ACTY Portal account. Once logged into your portal account, please access the Resources module and select Cozeva. Cozeva will open a separate page which allows Users to work in both databases simultaneously.