
# NEMS MSO Provider Newsletter

**Quarter 2: June 2025**

*The Latest Updates for NEMS Medical Group!*

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## What's Inside:



## Provider Resource Links:

NEMS EZ-NET Provider Portal
Network Provider Update Form
NEMS MSO Contact Information
Interpretation Services
NEMS Provider Manual & Trainings

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## HEDIS Reminder: Well Child Visits

### Why Regular Well Child Visits Matter

Well Child Visits are a crucial component of preventive healthcare. These visits help ensure children receive the appropriate screenings, vaccinations, and developmental assessments, and allow providers to identify early health concerns, leading to earlier treatment and better outcomes.

We recommend following the AAP Guidelines to conduct Well Child Visits at each of the following milestones:

- Babies: 0 to 15 months (at least 6 visits)
  - Newborn
  - 1 month
  - 2 months
  - 4 months

    - 6 months
    - 9 months
    - 12 months
    - 15 months

- Toddlers: 15 to 30 months (at least 2 visits)
    - 18 months
    - 24 months / 2 years old
    - 30 months / 2.5 years old

- Children: 3 – 21 years old
    - Annually

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## Initial Health Appointment (IHA)

**IHAs Must Be Completed Within 120 Days of Enrollment**

Medi-Cal Managed Care members are required to complete an Initial Health Appointment (IHA) within 120 days of enrollment. An IHA is a comprehensive assessment to ensure the acute, chronic, or preventative health needs are met. An IHA must include all the following:

- History of the Member's physical and mental health
- Identification of risks
- Assessment of need for preventive screens or services
- Health education
- Diagnosis and plan for treatment of any diseases

IHAs must be performed by a provider in a primary care setting, in a culturally & linguistically appropriate manner, and be documented in the member’s medical

records.

For more information about IHA, please see DHCS's All Plan Letter 22-030, Initial Health Appointment. Please reach out to NEMS QI Team at MSO-QI@nems.org if you have specific IHA questions.

## NEMS Credentialing Program

**Credentialing Updates per NCQA**

NEMS Credentialing program follows federal, state, health plan and NCQA guidelines. The NEMS Credentialing program was accredited by NCQA in 2024. In order to maintain our accreditation, NEMS incorporates and updates policies in accordance with the most current NCQA standards.

Based on the July 1, 2025, NCQA Credentialing Standards update, NEMS has modified our credentialing process to ensure compliance. Some notable updates include:

- Initial and Re-Credentialing applications now have a 120-day timeframe (previously 180) to be completed and reviewed by the Credentials Committee.
- Providers and organizations will be notified within 30 days (previously 60) of the Credentials Committee's determination on an application

Please review your Credentialing Provider Rights and the NEMS MSO Provider Manual for more information. If there are any questions, please contact the Provider Network Operations team at 415-352-5186, Option 3 or at Provider.Relations@nems.org.

## NEW NEMS PACE Center: San Jose

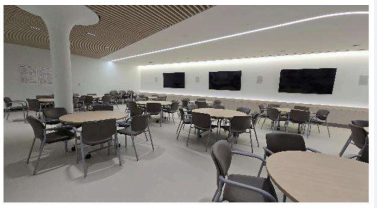
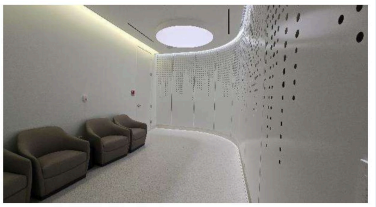
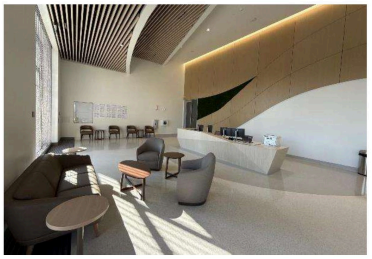
**New NEMS PACE Center Opens on July 1st**

NEMS is bringing our PACE program to Santa Clara County! The newest NEMS PACE center will be opening on Tuesday, July 1st at 939 Story Road in San Jose.

NEMS PACE offers comprehensive care services for older adults with chronic conditions, including primary and specialty medical care, rehabilitation, social activities, medications, homecare, transportation, meals and more. Services are customized based on each individual's specific needs, with the goal of supporting individuals to live safely in the community.

Providers in Santa Clara county are welcome to contact us to learn how to join the NEMS PACE provider network. Interested providers can submit an interest form or contact NEMS Provider Network Operations Team at provider.relations@nems.org.

If you have patients that would benefit from NEMS PACE services please contact the PACE team at (415) 333-8909 or at PACEReferral@nems.org.

## Prior Authorization Reminder

**Compliance for Timely PA Processing**
When submitting treatment authorizations, it is important that providers utilize the “Urgent” and “Routine” indicators properly.

Urgently needed care means health care for a condition which requires prompt medical attention and should not be used to expedite an appointment based on member convenience. Urgent/expedited requests based on scheduling convenience could delay care for other patients who truly have clinically urgent conditions.

A member must have an urgent condition when submitting an expedited prior authorization request, such that the member faces an imminent and serious threat to his or her health, including but not limited to, potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the member’s life or health, or could jeopardize the member’s ability to regain maximum function.

For urgent authorization requests, please allow for a 72-hour turnaround time. For routine authorization requests, our standard turnaround time is 5 business days, excluding holidays. The NEMS MSO UM Team will try to accommodate same day urgent authorization requests to the best of their abilities.

We recommend providers to refer to the NEMS MSO website for an overview of our UM policies and procedures and for a list of services requiring prior authorizations. Providers should review this PA list, based on the line of business (i.e., Medi-Cal Managed Care Plans, HealthNet/GBHP Medicare Advantage, etc.), to avoid any future disputes or claims denial.

NEMS UM staff are available to members and providers during regular business hours (Monday through Friday, 8:00am - 5:30pm) to discuss UM issues, including denial decisions. After normal business hours, UM staff can receive

secure voicemail, fax, and email and are returned within one business day. Our staff are identified by name, title, and organization name when initiating or returning calls regarding UM issues. Inquiries can be made via methods listed contact methods below:

- For Inpatient services: um-inpatient@nems.org
- For Outpatient services: um-outpatient@nems.org
- Fax: (415) 398-2895
- Phone: (415) 352-5186, option 1; TTY: (800) 735-2929

## PDR Reminder & Updated PDR Form

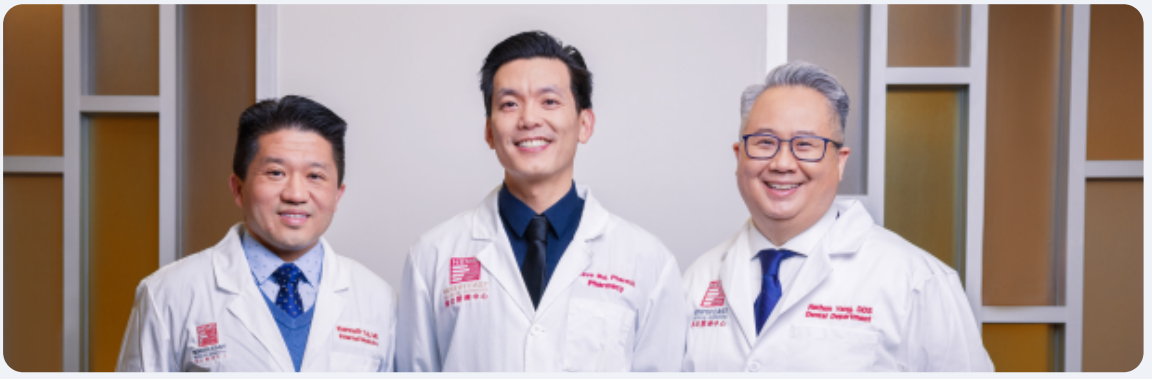
**PDR Eligibility Criteria Clarified**

NEMS MSO would like to remind providers that claims denied due to a claim submission error or omission (e.g., missing modifier, incorrect CPT / ICD-10, or place of service code, missing EOB/EOMB or requested invoice, etc.) **DO NOT** qualify for the Provider Dispute Resolution process. These claims should be resubmitted within the claim's submission timeframe as a corrected claim. Please include a brief explanation of the error either noted on the claim or as an attachment.

If a claim was denied due to a missing invoice, EOB, or clinical notes, this information can be faxed to NEMS MSO at 866-930-2290 within the claim's timely filing limits. Claim number and/or a copy of the NEMS MSO EOB must be provided with the submission of the missing item.

NEMS MSO has also updated their PDR request form. Utilizing this form to submit PDRs reduces the chance of omitting information required for us to process the request.

To read more about our PDR process and to download a copy of the updated PDR request form, please visit our webpage at: https://nemsmso.org/claims-pdr-mechanism/



## Coverage of HIV Preexposure Prophylaxis (PrEP)

**Billing & Coverage Guidelines for PrEP**

Since June 2019, the USPSTF has recommended that providers prescribe effective antiretroviral therapy to adults and adolescents weighing at least 77 pounds who are at increased risk of HIV. Effective antiretroviral therapy for

preventing HIV currently includes both daily oral PrEP and long acting injectables.

All FDA-approved PrEP medications are covered with no prior authorization or cost sharing. In addition to the antiretroviral drug itself, all integral services necessary for PrEP initiation and ongoing follow-up care and monitoring are also covered.

To prevent enrollees from being inadvertently charged cost-sharing for PrEP and/or services integral to the administration of PrEP, providers should follow the uniform coding guidelines consistent with ICD-10-CM and any updates. Billing guidelines for daily oral PrEP and Long-acting injectable PrEP are outlined in the DMHC APL 25-011. Please review to esnure your practice is billing appropriately for PrEP.

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## Hospice Services & Medi-Cal Managed Care

**Key Requirements for Hospice Services**

Medi-Cal managed care beneficiaries are eligible to start and receive hospice care services upon member election. Election of hospice care occurs when the Beneficiary or Authorized Representative voluntarily files an election statement with the hospice Provider. The hospice Provider is responsible for the coordination of hospice services and must submit the appropriate DHCS election form (Medi-Cal Hospice Program Election Notice) to the NEMS MSO within five calendar days of certification and election of hospice care.

Hospice coverage is provided in benefit periods: Two 90-day periods, beginning on the date of hospice election; followed by unlimited 60-day periods. A benefit period starts the day the Member receives hospice care and ends when the 90-day or 60-day period ends.

DHCS ALL PLAN LETTER 25-008 provides additional information including what services are and are not covered within the hospice services benefit, care coordination requirements, requirements for children transitioning to hospice care and billing guidelines. Please review this APL to ensure your practice understands the hospice benefit and how to appropriately bill for services.

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