NORTH EAST MEDICAL SERVICES

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MANAGEMENT SERVICES ORGANIZATION (MSO)

NEMS MSO Provider Manual

March 2026

This document contains general information and program requirements for multiple lines of business. ***Please make sure to distinguish the contents and apply the information to the program with which you are affiliated***. If you have any questions regarding the contents of the document, contact NEMS MSO Provider Network team at 1 (415) 352 – 5186, option 3.

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NEMS KEY CONTACTS

NEMS MSO	For general questions or inquires. **Hours of Operation:** Monday to Friday, 8:00am – 5:30pm **Phone:** 1(415) 352-5186, Option 4 **TDD/TYY:** 1-800-735-2929 **Email:** mso-info@nems.org **Mailing Address**: 1710 Gilbreth Road Burlingame, CA 94010
NEMS MSO Provider Network Operations	For questions or concerns about provider issues, network, contracting inquiries, and credentialing. **Hours of Operation:** Monday to Friday, 8:00am – 5:30pm **Phone:** 1(415) 352-5186, Option 3 **Email:** provider.relations@nems.org
NEMS MSO Claims	For questions or concerns about claims payment and other claims related inquiries. **Hours of Operation:** Monday to Friday, 8:00am – 5:30pm **Phone:** 1(415) 352-5186, Option 2 **Email:** mso-claims@nems.org **Paper Claims Mailing Address:** NEMS MSO Claim PO Box 1548 San Leandro, CA 94577
NEMS MSO Utilization Management	For questions or concerns about service authorizations (or TAR), covered medical services, and inpatient concurrent review. **Hours of Operation:** Monday to Friday, 8:00am – 5:30pm **Phone:** 1(415) 352-5186, Option 1 **Email:** MSO-UM@nems.org
NEMS MSO Case Management	For questions related to case management and care coordination. **Hours of Operation:** Monday to Friday, 8:00am – 5:30pm **Telephone:** 1(415) 352-5179 **Email:** casemanagement@nems.org

ABOUT NEMS

North East Medical Services (NEMS) was founded in 1968 in response to the lack of adequate health care services for uninsured and underprivileged Asians in San Francisco. For over five decades, NEMS has grown from a small primary care clinic to a large, comprehensive health care organization consisting of fourteen clinics located in San Francisco, San Mateo, and Santa Clara counties.

To meet the growing demands for its services and strengthen the partnership with managed care plans in the Bay Area, NEMS formed a Management Services Organization (MSO) in 1999 to provide administrative services for Medi-Cal managed care patients who have selected NEMS as the primary care clinic/provider. Since its inception, NEMS and its MSO department continue to grow to bring comprehensive, quality, culturally and linguistically appropriate care to individuals in the Bay Area. Currently, NEMS MSO manages Medicare Advantage and Medi-Cal members for national and local health plans. We partner with major hospitals in the bay area, as well as a large network of specialty care providers to ensure our members can access a full spectrum of care.

Our Mission

To provide affordable, comprehensive, compassionate, and quality health care services in a linguistically competent and culturally sensitive manner to improve the health and well-being of our community.

NEMS MSO Provider Manual

Our provider network is a critical component in serving our mission. We developed this manual to be a useful guide which will offer a general overview of information, tools, and guidance needed for you and your staff to facilitate care and services for NEMS MSO members. This provider manual also describes your responsibilities as a provider to our members and as a contracted partner with NEMS MSO. When utilizing this manual, please be sure to utilize the information that applies to your members, Medi-Cal, or Medicare. The Provider Manual is updated periodically, and updates are communicated with network providers through provider newsletters, bulletins, memorandums, or other communication methods. Copies of the latest NEMS MSO Provider Manual can be found on our website, https://nemsmso.org/provider-manual/. All contracted providers are required to fulfill the relevant specified responsibilities explained in this provider manual. If you have any questions about our provider network, provider manual, programs, covered services or member enrollment, please contact NEMS MSO Provider Network Team via email at provider.relations@nems.org or at 1(415) 352-5186 **Option 3**.

OUR PROGRAMS

NEMS MSO contracts with national and local managed care plans to provide Medicare and Medi-Cal services to our patients. Please see below for an overview of the programs NEMS MSO participates in.

Medicare Advantage

Medicare Advantage (MA) Plans is an alternative to original Medicare and covers Medicare Part A and Part B services through the MA Plan's network of providers. Individuals are eligible to enroll into MA plans if they are:

- Living in the service areas of the plan they want to join
- Eligible for Medicare Part A and Part B
- A U.S. citizen or lawfully present in the U.S.

Enrollment and disenrollment activities in Medicare must follow Centers for Medicare and Medicaid Services (CMS) policies. Individuals may enroll into an MA plan during the initial enrollment period or annually during the open enrollment period. Individuals may change their enrollment or disenroll from an MA plan during specific times of the year. See the chart below for more information.

Enrollment period:	Individual can:	Coverage starts:
Initial Enrollment Period (new to Medicare) Starts 3 months before you get Medicare and ends 3 months after you get Medicare.	Join any plan. • You need both Part A (Hospital Insurance) and Part B (Medical Insurance) to join a Medicare Advantage Plan. You need either Part A or Part B to join a Medicare drug plan.	Varies, depending on when the plan gets your request: • If you request to join a plan **before** your Medicare starts: Your plan coverage starts the same day as when your Medicare starts. If you request to join a plan **after** your Medicare starts: Your plan coverage starts the first of the month after the plan gets your request.
Initial Enrollment Period – New to Part B (only if you get Part B after your Part A coverage starts) The 3 months before your Part B starts.	Join any Medicare Advantage Plan with or without drug coverage.	The same day as when your Part B coverage starts.
Open Enrollment Period October 15-December 7.	Join, drop, or switch to another plan. (You can add or drop drug coverage.)	January 1 of the next year.
Medicare Advantage Open Enrollment Period (only if you are already in a Medicare Advantage Plan) • January 1-March 31.	• Switch to another Medicare Advantage Plan with or without drug coverage. • Drop your Medicare Advantage Plan and go back	First of the month after the plan gets your request.

Enrollment period:	Individual can:	Coverage starts:
• The first 3 months after you get Medicare, and you are in a Medicare Advantage Plan.	to Original Medicare. You can also join a Medicare drug plan	
Special Enrollment Period Varies. Only for certain situations that happen in your life, like you move to a new address, you lose or have a change to your current coverage, you have Medicaid or get Extra Help paying drugs costs, and more.	Varies. Generally, you can join or switch to another plan.	Varies. Generally, the first of the month after the plan gets your request.

Additionally, each MA plan may have different coverage requirements and optional benefits. For example, some plans may offer coverage for services like transportation to doctor visits, over-the-counter drugs, and services that promote your health and wellness. Plans can also tailor their benefit packages to offer these benefits to certain chronically ill enrollees. These packages will provide benefits customized to treat specific conditions.

Finally, newly enrolled MA members are encouraged to select a Primary Care Provider (PCP) as soon possible. If members do not choose a PCP, or if the selected PCP is not available within the NEMS MSO network, new members will be automatically assigned to a Medical Group or PCP near their home. The PCP selected must be within the NEMS MSO's Medicare Advantage network and must be located within 30 miles or 30 minutes from where the beneficiary lives or works. Members may change their PCP for any reason, at any time. To request a PCP change, please contact NEMS MSO Provider Network team via email at provider.relations@nems.org or at 1(415) 352-5186 **Option 3**.

Medi-Cal Managed Care

Medi-Cal provides free or low-cost health care coverage services to low-income adults, families with children, pregnant women, seniors, people with disabilities, children in foster care, or adults formerly in foster care up to age 26. For more information regarding Medi-Cal eligibility, please refer to the California Department of Health Care Services (DHCS) website at https://www.dhcs.ca.gov/services/medi-cal/Pages/DoYouQualifyForMedi-Cal.aspx.

Individual may apply for Medi-Cal benefits at any time during the year and can apply for Medi-Cal in person, online, via mail, or over the telephone – please see below.

- Apply online at https://www.healthcareoptions.dhcs.ca.gov/enroll/online/ or https://www.coveredca.com/
- Apply over the phone by calling Toll-free – 1-800-430-4263 (TTY 1-800-430-7077)
- By mail:

  CA Department of Health Care Services: Health Care Options
  P.O. Box 989009
  West Sacramento, CA 95798-9850

- In-person

San Francisco Human Services Agency SF Benefits Net	San Mateo County Human Services Agency	Santa Clara County Social Services Agency Assistance Application Center
1440 Harrison St. San Francisco, CA 94103 1235 Mission St. San Francisco, CA 94103 (415) 558-4700 (855) 355-5757 Toll Free	400 Harbor Boulevard, Building B Belmont, CA 94002 (800) 223-8383 Toll Free	1867 Senter Road San Jose, CA 95112 (408) 758-3800

There are several types of Medi-Cal coverage, including limited scope coverage (such as pregnancy related services only) and full scope coverage that is inclusive of primary, specialty, behavioral health, acute care services, vision, and dental. To check individual member coverage, please contact NEMS MSO Provider Network team via email at provider.relations@nems.org or at 1(415) 352-5186 **Option 3**.

New members are encouraged to select a Primary Care Provider (PCP) at the time of enrollment. When a PCP is not selected, the managed care plans will automatically assign members a PCP, taking into consideration the member's place of residence, primary spoken language, and other similar factors. Members who are auto assigned to a PCP may select another PCP. All members may change PCPs upon request if the PCP is accepting new patients. For Medi-Cal managed care, PCP Change requests made by the 15th day of the month will be effective on the first day of the following month. To request a PCP change, members can contact their respective Medi-Cal managed care plan or contact NEMS MSO Provider Network team via email at provider.relations@nems.org or at 1(415) 352-5186 **Option 3**.

Medi-Cal Waiver Programs

Medi-Cal waivers are programs that provide additional services to specific groups of individuals, limit services to specific geographic areas of the state, and provide medical coverage to individuals who may not otherwise be eligible under traditional Medicaid rules. Please review the below waivers to learn more.

- Genetically Handicapped Persons Program: Genetically handicapped persons program is a state-funded program that may provide additional care coordination and services for eligible persons aged 21 years old or older with genetically transmitted diseases such as hemophilia, cystic fibrosis, and sickle cell disease, as well as metabolic disorders such as Phenylketonuria (PKU). More information on how to apply for GHPP services and eligibility can be found at https://www.dhcs.ca.gov/services/ghpp/Pages/default.aspx.
- HIV/AIDS Waiver Program: HIV/AIDs program provides Medi-Cal recipients with a written diagnosis of symptomatic HIV or AIDS with case management, in-home skilled nursing care, home-delivered meals, and non-emergency transportation. Qualified persons cannot be simultaneously enrolled in either the Medi-Cal hospice or the AIDS Case Management Program.

For more information, call West Side Community Services at 1(415) 355-0311, Option 8 or https://westside-health.org/.

- Home and Community-Based Services for the Developmentally Disabled (HCBS-DDS): HCBS-DD provides in-home care and support to persons with disabilities. Services provided include homemakers for chores, home health aides and/or nurses, family training, vehicle adaptation, respite care, day habitation, transportation and more. For referral and eligibility review contact Golden Gate Regional Center at (415) 546-9222. For more information visit https://www.dhcs.ca.gov/services/ltc/Pages/DD.aspx.
- Multi-Purpose Senior Services Program (MSSP): MSSP provides in-home care to members as an alternative to placing them in an institution. The County's Department of Aging administers the program. Services are available to physically disabled or aged members over 65 years of age who would otherwise require care at skilled nursing facility (SNF) or intermediate care facility (ICF) level. A SFHP member who is eligible for MSSP services remains enrolled with SFHP, and the medical group and PCP maintain responsibility for coordination of services and for continued medical care.
    - The PCP or specialist submits appropriate medical records and the MSSP referral to:
      Institute on Aging for MSSP and Adult Day Health Care
      3626 Geary Boulevard, Second Floor
      San Francisco, CA 94118
      1(415) 750-4150 or 1(415) 750-5330
      https://www.ioaging.org/companioa/www.ioaging.org
- Nursing Facility Waiver: Nursing Facility Waiver services are provided to Medi-Cal recipients of any age who need in-home assistance with activities of daily living, protective supervision, private duty nursing, environmental adaptation, and case management. For more information, call 1(916) 552-9400 or visit their website at HCBS Waiver.

Dual Eligible

Dual eligible are those who enroll in Medicare Part A and/or Part B, and are also enrolled in full-benefit Medi-Cal. Although Medicare and Medi-Cal cover many of the same services, some services are covered under Medi-Cal but not Medicare, and vice versa. Medicare pays first for Medicare-covered services that are also covered by Medi-Cal because Medi-Cal is generally the payer of last resort. Medi-Cal may cover care that Medicare does not cover (such as a variety of long-term services and supports). All providers, including Medicare providers, must enroll in Medi-Cal for Medi-Cal claims review, processing, and payment of Medicare cost-sharing. See below for more information on Medi-Cal provider enrollment and Coordination of Benefits.

VERIFYING MEMBER ELIGIBILITY

How to Check Eligibility

When a NEMS MSO member seeks medical care, it is important that providers verify eligibility on the date of service. A member's eligibility and PCP/Medical Group assignment can change from month to month and beneficiaries will often not communicate or be aware of such changes. **Hence, it is important to verify eligibility:**

- To verify that the member is currently active
- To verify medical group or PCP affiliation
- To ensure that the member is assigned to you or that a referral is on file
- To ensure that you will be reimbursed for providing services to an eligible member

NOTE*: A referral or authorization does not guarantee member eligibility.*

Please refer to the chart below for eligibility verification information NEMS MSO is affiliated with. You may also request a copy of the member's Health Plan ID card.

San Francisco Health Plan (SFHP): Medi-Cal & Medicare Advantage	1) Check eligibility using the Secure Provider Portal at www.SFHP.org/providers/ and click on provider login. Please visit the SFHP website and create an account to access the provider portal.
Santa Clara Family Health Plan (SCFHP)	1) SCFHP Online Eligibility Verification: Please contact the SCFHP Provider Services Department at **(408) 874-1788** or providerservices@scfhp.com to obtain a password and instructions for obtaining online verification. Available 24/7. 2) SCFHP Automated Eligibility Verification: Phone system to verify eligibility for the current month as well as the past three months. Call 1(800) 720-3455 using a touch- tone phone. Available 24/7.
Anthem Blue Cross (ABC): Medi-Cal and Medicare Advantage	1) Check eligibility using Anthem's Availity Platform at https://apps.availity.com/availity/web/public.elegant.login For questions about account set up and access, contact Availity Help Desk at 1(800) AVAILITY (282-4548).
Golden Bay Health Plan (GBHP)	1) Check eligibility by using the Provider portal at www.healthnet.com/portal/provider/home.ndo 2) Call 1 (800) 431- 9007 to speak with a representative and verify member eligibility. Hours of operation may differ based on enrollment periods.
Alignment Health Plan (AHP)	1) Check eligibility using the AVA Provider self-service tool at https://avaprovidertools.alignmenthealth.com/verify-eligibility
SCAN Health Plan	1) Check eligibility using the SCAN Provider Portal at https://www.scanhealthplan.com/en/Providers/Joining-the-SCAN-Network/Medical-Group-Selection

PROVIDER RESPONSIBILITIES

Primary Care Provider (PCP) Responsibilities

The PCP is the overall coordinator of care for NEMS MSO members and is responsible for the following:

- Assuring reasonable access and availability to primary care services.
- Providing preventive care and CHDP/EPSDT required services in conjunction with other providers, as necessary.
- Completing an Initial Health Assessment/Staying Healthy Assessment within 120 days of member enrollment with NEMS MSO.
- Providing access to urgent care.
- Providing 24-hour coverage for advice and referral to care.
- Making appropriate specialty care referrals.
- Providing coordination and continuity of care after emergency care, outpatient, inpatient, and tertiary care referrals, including:
    - Providing referral, coordination, and continuity of care for members needing mental/behavioral health services, drug and alcohol detoxification and treatment services, or referrals for seriously medically impaired and seriously emotionally disturbed members to the appropriate behavioral health services.
    - Providing referral, coordination, and continuity of care for members requiring Direct Observed Therapy for uncontrolled tuberculosis (TB).
    - Providing referral, coordination, and continuity of care for members requiring services from California Children Service (CCS), Early Start, Golden Gate Regional Center (GGRC), and the Local Education Agency (LEA).
    - Providing referral, coordination, and continuity of care for members requiring hospice care
- Case managing members or referring members for case management services, as necessary.
- Requesting authorizations for specialty care or services as necessary from the medical group or outside the medical group's network, as necessary.
- Communicating authorization decisions to the member.
- Assisting the member in making appointments or other arrangements for specialty care or procedures.
- Closing the loop on referrals. This is done by tracking and conducting follow ups on member referrals. A referral from a PCP to a specialist resulting in a completed specialty appointment, with results available to the PCP, meets this requirement.
- Utilizing and maintaining results of a comprehensive risk assessment tool for all pregnant women that is comparable to American College of Obstetricians and Gynecologists (ACOG) and Comprehensive Perinatal Services program (CPSP) standards. PCP must have hospital admitting privileges with a network hospital.

Specialists Responsibilities

Specialists must coordinate care with the member's PCP and provide care in accordance with timely access standards. Specialists are required to communicate their assessments, care provided, and management recommendations to the member's PCP within one week of treating the referred patient.

Covered Services

NEMS Network Providers are responsible to know what services are covered for members. Covered services will be dependent on the members insurance plan but will always coincide with standard Medi-Cal and Medicare Covered services.

- Medi-Cal Covered Services: Medi-Cal currently provides a core set of health benefits, including doctor visits, hospital care, immunization, pregnancy-related services, and nursing home care. To review all covered services please visit the DHCS website here.
- Medicare Covered Services: Medicare offers Part A, B and D coverage options. Medicare Advantage plans may also include additional covered and supplemental services. To review Medicare coverage guidelines please visit the CMS website here.

Requirements for Reporting Provider Changes

NEMS MSO's Responsibilities. Prior to implementing material changes to terms of payment, credentialing, and other rules of participation, NEMS MSO will issue written notice by fax, e-mail, or mail to providers **thirty (30) days** in advance of the effective date.

Provider's Responsibilities. Providers changing or adding a new office location, changing tax identification information, or adding/terminating a provider within the practice, must submit written notification to NEMS MSO at least **ninety (90) days** prior to the effective date of the change.

Providers required to notify us within **thirty (30) days** of any change in status such as licensure, malpractice claims settlement, and hospital privileges. Prior to initiating a contract termination without cause, providers must submit a written notice to NEMS MSO at least **ninety (90) days** in advance of the requested date of the contract termination.

Timely Access Standards

NEMS MSO adheres to timely access and availability requirements set by regulatory agencies based on appointment or type of service. Providers must meet the following timely access and availability standards based on the provider's specialty, appointment type, and service type:

- Access to a PCP 24 hours a day, 7 days a week
- Non-urgent primary care appointments available within 10 business days of request
- Non-urgent specialty care appointments available within 15 business days of request
- Urgent primary and specialty care appointments with no prior authorization requirement available within 2 days of request
- Urgent primary and specialty care appointments with prior authorization requirement available within 4 days of request

For more information on timely access standards, please visit the Department of Managed Health Care (DMHC) website at https://www.dmhc.ca.gov.

Initial Health Appointment

Please note: This is a requirement for Medi-Cal lines of business.

An Initial health Appointment (IHA) is an initial comprehensive preventive clinical visit with a primary care practitioner. PCPs must complete an IHA with new NEMS MSO members within 120 calendar days of enrollment for all ages. The IHA, at a minimum, includes a history of the member's physical and

mental health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases. It enables the member's PCP to assess and manage the acute, chronic, and preventative health needs of the member.

When conducting an IHA, it must be performed by a provider in the primary care setting, provided in a way that is culturally and linguistically appropriate and documented in the Member's medical record. Please note, an IHA is not necessary if the Member's Primary Care Provider (PCP) determines that the member's medical record contains complete information that was updated within the previous 12 months.

Please contact NEMS MSO Provider Network team via email at provider.relations@nems.org or at (415) 352-5186 **Option 3** for question.

Annual Wellness Exam

Please note: This is a requirement for Medicare Advantage lines of business.

The Annual Wellness Exam provides an assessment of member's overall health and well-being by a PCP. The primary purpose is prevention – either to develop or update the member's personalized prevention plan. Medicare covers a wellness visit once every 12 months (11 full months must have passed since your last wellness visit), and you are eligible for this benefit after you have had Part B for at least 12 months.

During the Annual Wellness Exam, members will fill out a questionnaire called a "Health Risk Assessment." Responses to this questionnaire will help inform the members personalized prevention plan. The exam may also include review of medical and family history, review of providers/prescriptions, screening schedule for preventative services and advanced care planning.

Cognitive Health Assessment

Please note: This is a requirement for Medi-Cal lines of business.

Medi-Cal benefits include an annual cognitive assessment for Members, who are 65 years of age and older, if they are otherwise ineligible for a similar assessment as part of an annual wellness visit through the Medicare Program. An annual cognitive health assessment identifies whether the patient has signs of Alzheimer's disease or related dementias, consistent with the standards for detecting cognitive impairment under Medicare and the recommendations by the American Academy of Neurology.

In order to bill and receive reimbursement for conducting an annual cognitive health assessment, providers must complete the DHCS Dementia Care Aware cognitive health assessment training prior to conducting the cognitive health assessment. In addition, providers must administer the annual cognitive health assessment as a component of an E&M visit, properly document the screening in the member's medical record and use allowable CPT codes as outlined in the Medi-Cal Provider Manual.

Providers are required to provide the appropriate and necessary follow up services, based on assessment scores and may include, but are not limited to, additional assessment or specialist referrals.

For members under 65 years of age who are reporting symptoms or showing signs of cognitive decline, medically necessary and appropriate coverage of assessments, which may include but is not limited to cognitive health assessments, appropriate treatment services, and necessary referrals, billed through established practices, will be provided.

Sensitive Services

Please note: This is a requirement for Medi-Cal lines of business.

Sensitive Services are designated services by Medi-Cal as available to members (minors and adults) without a referral or authorization, in order to protect patient confidentiality and promote timely access. These services include, but are not limited to:

- Family planning/birth control (including sterilization).
- Pregnancy testing and counseling.
- HIV/AIDS prevention and testing.
- Sexually transmitted infections prevention, testing and treatment.
- Sexual assault care.
- Outpatient abortion services

Minors and adolescents (12 – 17 years old) have the right to access sensitive services without parental consent. **Medi-Cal members may go in and out of network for sensitive services without prior authorization.** Information and records related to sensitive services are strictly confidential and shall not be released to any third party without the consent of the member involved, including adolescents.

Sterilization Services. CA law requires that individuals who request sterilization (surgery that will end their ability to have children) complete a form (PM-330) attesting that they are giving informed consent for the procedure. Form must be completed and signed prior to the surgery and filed in the medical record. Medi-Cal members may not waive the 30-day waiting period. A copy of the form must be attached to the claim when submitted for payment.

Abortion Services. Medi-Cal members may self-refer for outpatient abortion services since such services are not subject to prior authorization, medical justification, or any other utilization management procedure. Authorization requirements for general anesthesia associated with abortion services will vary by health plan. Please reach out to NEMS MSO Utilization Management for more information.

Chaperones. Utilizing Chaperones is highly recommended for sensitive services and any other services in which the patient requests a chaperone. Having chaperones present provides reassurance to patients of the professional character of the exam, can help prevent misunderstandings between patient and provider and can often streamline services when providers utilize licensed chaperones.

All NEMS network providers are highly encouraged to utilize chaperones, especially those providing sensitive services. Chaperone best practices include, but are not limited to:

- Establishing a protocol and corresponding policy to ensure chaperones are available on a consistent basis for patient examinations. Policy should be communicated to all patients.
- All patient requests for chaperones must be honored
- An authorized health professional should serve as a chaperone whenever possible.

- Establishing clear rules about respecting patient privacy and confidentiality to which all chaperones must adhere.
- Arranging a separate opportunity for private conversation between the patient and the provider when appropriate, to clarify any patient questions about the chaperone policy. The provider should keep inquiries and history-taking, especially those of a sensitive nature, to a minimum during the course of the chaperoned examination.

Members may go to any Medi-Cal Provider of their choice for abortion services, at any time for any reason, regardless of network affiliation. However, there is no requirement for a Provider, health care provider, or person to perform or participate in the performance of an abortion, and no person refusing to perform or participate in performing an abortion is to be subject to penalty or discipline in any form for such a choice. Providers may refuse to provide abortion services. In such cases, NEMS MSO will help the Member find another Provider for the needed services.

After-Hours

All PCPs are required to have after-hours phone coverage 24 hours a day, 7 days a week. After-hours access must include triage for emergency care and direction to call 9-1-1 for an emergency medical condition. A provider or mid-level provider must be available for contact after-hours, either in person or via telephone. All after-hours member calls must be documented in the member's permanent medical records. If a provider who is not the member's PCP treats the member, the treating provider must forward documentation of services received to the member's PCP.

During after-hours or when a provider is not available, member may call their health plan directly. Health contact information including Nurse Advice Line may be found on the back of member's health insurance card.

Emergency Services and Urgent Care

An emergency medical condition is present when absence of immediate medical attention could result in one of the following situations:

- Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions,
- Serious dysfunction of any bodily organ or part,
- Any psychiatric emergency and related medical condition(s).

Emergency services include medical screening, examination, medical and psychiatric evaluation, as well as the provision of care, treatment, and surgery by a provider necessary to relieve or eliminate the emergency medical condition.

In all instances where a member presents with an emergency medical condition, a provider must take all necessary actions to mitigate or eliminate the emergency medical condition. A service authorization is not required for emergencies.

Provider Appointment Availability Survey

On an annual basis, NEMS MSO's contracted health plans administers the Provider Appointment Availability Survey (PAAS) to measure patient access to care against DMHC Access to Care Standards. The survey is conducted over the phone or via fax during the third and fourth quarter of the year. A random sample of primary care providers, specialists, and ancillary providers is selected to survey. Providers should complete the survey or transfer the call/fax to an alternate staff member who will complete the survey. Any non-response is considered non-compliant and will require a corrective action plan. Should NEMS contact a provider after a corrective action plan is issued, they are expected to provide a response within the specified timeframe.

If any provider data errors are identified via the survey, NEMS will correct these errors within one week following the discovery of an error(s). This corrects will be reported to contracted health plans and provider directory will be updated.

Patient Preferred Language

Providers must document member's primary language and need for language and/or interpretation services in the member's medical record. Additionally, providers are also required to:

- Document in the medical record if a member refuses professional interpreter assistance.
- Keep on file documentation of language proficiency for any office staff who communicates with members in non-English languages.
- Update NEMS MSO on any changes in your office's language capacity
- Communicate updates on our membership's population noting changes in language, ethnicity, age, and gender.

NOTE: ***NEMS is committed to providing quality healthcare to its culturally diverse membership and we highly discourage the use of adult family member, children, or friends as interpreters. Children cannot interpret unless there is a life-threatening emergency, and no qualified interpreter is available.***

The California Department of Health Care Services (DHCS) requires proper documentation in a member's medical record if a member declines interpreter service.

Provider Satisfaction Survey

NEMS MSO conducts an annual Provider Satisfaction Survey to measure provider satisfaction. Results of the survey and recommendations for improvements are shared with NEMS leadership team and Board of Directors. Providers must try their best to complete the provider satisfaction survey in a timely manner.

Non-discriminatory Practice

NEMS MSO providers shall not differentiate or discriminate in the provision of Covered Services to Enrollees because of race, color, national origin ancestry, ethnic group identification, religion, sex, gender, gender identity, marital status, sexual orientation, medical condition, age, mental disability, physical disability, genetic information, or because of any grievance or complaint filed by enrollees.

Providers shall render services to NEMS MSO members in the same manner, in accordance with the same standards, and within the same time availability, as offered to non-members consistent with existing medical, ethical, and legal requirements for providing care to any patient.

Health Needs of Diverse Populations

Services for Seniors and Persons with Disabilities. The following criteria must be met for American with Disabilities Act (ADA) compliance and is assessed during the facility site review:

- Wheelchair access
- Water availability
- Elevator with floor selection within reach
- Pedestrian ramps with a level landing at the top and bottom of the ramp
- Designated parking
- Access in waiting rooms, exam rooms and bathroom; and
- Exam table access

When providers are located at sites that do not meet the Americans with Disabilities Act requirements, NEMS MSO assists the provider and the member with special arrangements to allow access.

Specialty Mental Health Needs. After determining a member meets the needs for mental health care, such as through a Health Risk Assessment (HRA) that evaluates mental health needs, an appropriate referral should be made to a behavioral health provider. To identify where to direct a member for behavioral health services, please review the NEMS MSO Prior Authorization Guidelines. They can be found on the NEMS MSO website here.

Substance User Disorder Needs. After determining a member meets the needs substance use disorder services, an appropriate referral should be made to a behavioral health provider. To identify where to direct a member for behavioral health services, please review the NEMS MSO Prior Authorization Guidelines. They can be found on the NEMS MSO website here.

Intellectual and Developmental Disabilities. An intellectual or developmental disability can affect a person's understanding, memory, language, judgment, learning and related information processing and communication functions. These disabilities include individuals with intellectual disabilities, head injury, strokes, autism, Alzheimer's disease, and emotional disabilities.

Best practices for providing care to this population include:

- Offer information in a clear, concise, concrete, and simple manner.
- If you are not being understood, modify your method of communicating. Use common words and simple sentences.
- Allow time for people to process your words, respond slowly, or in their own way.
- Make sure the person understands your message.

Children and Youth with Special Health Care Needs (CYSHCN). Children with Special Health Care Needs (CSHCN) are "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional conditions and who also require health or related services of a type or amount beyond that required by children generally."

Medical groups and primary care physicians are responsible for ensuring that CSHCN are identified, assessed, receive care coordination or care management, receive all medically necessary follow-up services, and have timely access to specialties, subspecialities, ancillary providers, specialized equipment and supplies and community resources to address the member's special health care needs.

Disease Surveillance

Title 17, California Code of Regulation (CCR) Reportable Diseases and Conditions, requires health care providers to report known or suspected cases of disease or condition. Reporting disease or condition helps public health agencies identify outbreaks before they become epidemics and guide public health decision-making. Providers will report the case to the local health officer for the jurisdiction where the member resides by the required timeframe in accordance with Title 17, California Code of Regulation (CCR) § 2500, §2593, §2641.5-2643.20, and §2800-2812. Healthcare providers must report diseases even if the laboratory has already reported. A current list of reportable communicable diseases as well as reporting forms is available here.

Smoking Cessation

In accordance with DHCS APL 16-014, Medi-Cal managed care beneficiaries are entitled to comprehensive tobacco cessation services. When necessary, providers are required to provide:

- Initial and annual assessment of tobacco use for each adolescent and adult
- FDA-approved tobacco cessation medications (for non-pregnant adults of any age)
- Individual, group, and telephone counseling for beneficiaries (any age) who use tobacco products
- Prevention of tobacco use in children and adolescents by early education
- Identification of tobacco users via ICD-10 codes
- Track treatment utilization of tobacco users

NEMS encourages providers and/or other office staff to use the “5 A's"(Ask, Advise, Assess, Assist, and Arrange), the “5 R’s” (Relevance, Risks, Rewards, Roadblocks, Repetition), or other validated behavior change models when counseling beneficiaries.

The USPHS “Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update” should be utilized by providers, as it informs and educates clinicians regarding effective strategies and approaches for providing tobacco cessation treatment for all populations, including specific recommendations for pregnant people.

Specifically for pregnant beneficiaries, they should be asked if they are exposed to tobacco smoke and receive assistance quitting if they personally use it. For tobacco users, this includes offering at least one face-to-face tobacco cessation counseling session per quit attempt and referring them to a tobacco cessation quit line, such as Helpline. These counseling services must be covered for 60 days after delivery, plus any additional days needed to end the respective month. Providers should refer to the tobacco cessation guidelines by the American College of Obstetrics and Gynecology (ACOG) before prescribing tobacco cessation medications during pregnancy.

Additional Provider trainings and resources can be found on page 11 of the DHCS APL 16-014.

Medi-Cal EPSDT Requirements

EPSDT, or Early and Periodic Screening, Diagnostic, and Treatment, assures that children receive early detection and care to diagnose, avert, and treat health problems as early as possible, regardless of whether the service is covered under Medi-Cal, and when medically necessary.

Per state law and regulations, providers rendering services to Medi-Cal members under the age of 21 must inform, comply, and provide EPSDT services to these Medi-Cal beneficiaries. This includes sharing DHCS-approved material that informs beneficiaries about eligible services and additional resources EPSDT Services include but are not limited to:

- Screening Services (e.g., immunizations, physical and mental health exams, etc.).
- Vision Services.
- Dental Services.
- Hearing Services.
- Behavioral Health Treatment.
- Case Management and Care Coordination (e.g., transportation, scheduling assistance, etc.).

All network providers serving Medi-Cal beneficiaries under the age of 21 must review and complete EPSDT-Specific Training every two years and submit an attestation verifying their training completion.

Providers are encouraged to review the Recommendations for Preventive Pediatric Health Care put forth by Bright Futures and the American Academy of Pediatrics. These are recommendations for providers to access and does not serve as an exclusive course of treatment.

For more information about EPSDT, please see DHCS APL 23-005 and visit the EPSDT Webpage.

Medical Record Maintenance and Coding Requirements

Medical Record Maintenance. Each provider office is responsible for maintaining adequate medical records of member care and each member has a legible, detailed, well-organized, confidentially stored, and easily retrievable medical record. Records must be maintained in accordance with applicable federal and state privacy laws. All medical records must be maintained in a manner consistent with professional practices and prevailing community standards. Providers are required to maintain records for ten years after termination of an agreement, including the period required by the Knox-Keene Act and Regulations and Medicare and Medi-Cal programs.

Coding. To receive the payments, providers and billing staff should stay informed and seek educational opportunities about the appropriate codes to use from industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes.

Incentive Programs

Provider Programs. NEMS MSO participates in health plans' clinical quality improvement/incentive programs to improve clinical outcomes and ensure our providers meet the minimum performance levels in the Department of Health Care Services (DHCS) Managed Care Accountability Sets (MCAS) and the Centers for Medicare & Medicaid Services (CMS) Medicare Star Ratings.

Healthcare Effectiveness Data and Information Set (HEDIS) is one of health care's most widely used performance improvement tools created by the National Committee for Quality Assurance (NCQA). HEDIS measures performance with more than 90 measures across 6 domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Reported Using Electronic Clinical Data Systems

Patient Programs. In accordance with Federal and State regulations, NEMS and/or its health plan partners may offer nominal incentives to members for completing their preventive screenings and engaging with healthcare services.

To learn more about provider and patient incentive programs please reach out to the NEMS MSO Quality Improvement (QI) team at MSO-QI@nems.org or (415) 321-1927.

NEMS PROVIDER NETWORK SERVICES

NEMS MSO Provider Network (PN) team is the key liaison between NEMS MSO and our provider community. The PN team is responsible for the following key functions:

- Conduct provider credentialing and re-credentialing
- Conduct new and ongoing provider orientation, training, and education
- Assist providers with finding in-network providers
- Manage provider network data and reporting
- Create and disseminate provider communications on both a regular and ad hoc basis
- Ensure network adequacy by establishing provider networks with the appropriate provider types and ensuring these provides are in an acceptable time and distance from members

Provider Credentialing and Re-credentialing

All practitioners providing care to NEMS members and participating in the NEMS MSO network, including providers and non-provider medical practitioners (e.g., provider assistants, nurse practitioners, certified nurse midwives), must meet NEMS MSO enrollment and credentialing requirements. Credentialing standards are implemented in accordance with federal and state requirements, contractual obligations with health plans, and National Committee for Quality Assurance (NCQA) guidelines.

The credentialing cycle is every three (3) years for all providers, including Primary Care, Obstetrics and Gynecology, High Volume Providers, Ancillary Providers, and Organizational Providers. Providers must:

- Be qualified in accordance with current applicable legal, professional, and technical standards.
- Be appropriately licensed, certified, or registered.
- Maintain good standing in the Medi-Cal and Medicare programs. Providers terminated from either program or with unresolved sanctions cannot participate in the NEMS MSO network.

The credentialing process includes comprehensive screening against federal and state sanctions databases, verification of training and education, and assessment of quality indicators such as member complaints and facility site reviews. NEMS MSO also has ongoing procedures to monitor and address quality of care and service issues.

Providers receive periodic notifications before licensure, certification, and liability coverage expiration and must submit renewed documents. Failure to submit on time may result in termination from the NEMS MSO network.

NEMS MSO does not base credentialing or re-credentialing decisions on an applicant's age, gender, race, ethnic/national identity, sexual orientation, or the types of procedures performed. For details on credentialing policies or application status, contact the Provider Network team at provider.relations@nems.org or 1-415-352-5186 (Option 3).

For more information, including practitioner rights, visit the NEMS MSO website here.

Provider Training

All new providers that join the MSO network will receive new provider training within 10 days of being added to the network. The PNO team conducts provider training, education and reeducation. New provider training covers the following topics:

- NEMS MSO Provider Manual
- Information on contracted Health Plans and Programs
- NEMS Key Contacts Information
- Medi-Cal Programs & Benefits and Carved Out Services
- DHCS Waiver Programs
- Member Eligibility
- Timely Access to Care and Appointment Standards
- Referrals, Prior Authorizations, and Appeal to UM Decisions
- Member Rights, Complaints, Grievances, and Appeals
- Coordination of Care for Medi-Cal Members (Case Management, EPSDT Services, Closed loop referrals)
- Initial Health Appointment (IHA)
- Health Education Programs
- Claims and Provider Claims Dispute Resolution Mechanism
- General Compliance (Fraud, Waste, and Abuse; HIPAA/Privacy)
- Disease Surveillance
- Cultural and Linguistics / Interpreter Services
- Diversity, Equity, and Inclusion Training
- Health needs of:
    - Seniors and Persons with Disabilities Training
    - Members w/ chronic conditions
    - Members w/ Specialty Menta lHealth service needs
    - Members w/ Substance Use Disorder needs
    - Members w/ intellectual and developmental disabilities
    - Children w/ special health care needs
- Provider Data Collection and Reporting

- Social Determinants of Health
- Provider and Member Incentive Programs

NEMS network providers must complete retraining on the above topics at least biannually, every two (2) years.

Provider Data Management

NEMS MSO establishes and maintains a network of providers to serve our members and meet contractual obligations with our health plan partners. To ensure our provider information is comprehensive and accurate, NEMS MSO maintains a provider roster that will be updated and shared with our contracted health plans regularly. The provider roster includes, but is not limited to the following information:

- Name
- National Provider Identification (NPI) Number
- California License Number and Type
- Phone Number
- Address
- Hours of Operation
- Email Address (if available)
- Currently accepting new patients (yes/no)
- Provider Specialty (taxonomy) and/or practice area
- Board Certification
- Gender
- Languages spoken by the provider
- Languages spoken by qualified medical interpreters on the provider's staff
- Provider group or other affiliation
- Affiliated hospital and/or admitting privileges to a contracted hospital
- Subnetwork, Provider group or other affiliation

Providers are required to provide NEMS MSO the above data in its entirety and update NEMS MSO on any changes. In addition to reporting the above data to health plan partners, NEMS also ensures this data is accurate in the provider directory. Please see next section for instructions on how to report such changes and or updates.

Network Provider Update Form

In compliance with Senate Bill 137, Uniform Provider Directory Standards, NEMS MSO Network providers are required to update NEMS of any changes to their practice, which includes but is not limited to:

- Changes in practice location and/or practice contact information
- Changes in provider specialty, panel, and/or hospital privileges
- Changes in TIN and/or remittance information

Providers are encouraged to utilize the Network Provider Update Form to update their provider record, this can be found on our NEMS MSO website. Contact the Provider Network team at 415-352-5186, Option 3 or at Provider.Relations@nems.org, if you have any questions.

Ongoing Provider Communication

NEMS MSO primarily utilizes the MSO Provider Newsletter to communicate new policies and managed care regulations, provide education/training resources, reminders about NEMS resources and others. Contracted network providers should be reviewing these newsletters to ensure they are up to date with any and all changes. Administrative contacts from subdelegated groups are expected to share these newsletters with providers contracted with NEMS. If you are interested in receiving the provider newsletter, please contact the PR team at provider.relations@nems.org or at 1-415-352-5186, **Option 3**.
Outside of the MSO Provider Newsletter, network providers may be contacted via email, phone and/or fax with additional updates.

UTILIZATION MANAGEMENT

NEMS MSO Utilization Management (UM) Department oversees authorization requests and monitors services provided to members. The Utilization Management Department processes authorization requests timely and in accordance with federal and state requirements. It is the responsibility of the provider to establish coverage eligibility and medical group assignment prior to delivering services. This avoids the possibility of providers obtaining reimbursement denials for services already rendered. Authorizations are contingent upon the member's eligibility, benefit program, and are not a guarantee of payment.

NEMS MSO and its staff do not compensate, provide financial incentives, or reward individuals performing utilization review for issuing denials of coverage. Additionally, there are no financial incentives for UM staff, or independent medical consultants to encourage utilization review decision resulting in underutilization or denials. All UM decisions are based on appropriateness of care and services, the member's benefit coverage, and by applying clinical criteria to make evidence-based medical necessity determinations.

The below sections contain a summary of NEMS MSO UM processes, for additional information please see our NEMS MSO website at NEMSMSO.org.

UM Staff Availability

NEMS MSO 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 and request a copy of the UM criteria.

NEMS MSO UM
Tel: 1-415-352-5186, Option 1
(TTY: 1-800-735-2929)
Fax: 1-415-398-2895
Email: MSO-UM@nems.org

After normal business hours, members and providers can send secure voicemail, fax, and email to the UM department. Messages received are returned within one business day. NEMS provides language assistance for members whose primary language is not English.

UM Criteria

UM criteria are used to assist UM staff in determining the benefit coverage and medical necessity of requested services. NEMS MSO does not create UM criteria. Instead, NEMS MSO reviews and adopts criteria that are based on sound medical evidence and are regularly reviewed and updated.

UM Criteria are available to members and providers upon request to the NEMS MSO UM staff. Requests can be made by phone, fax, in writing, or email. UM staff mails the criteria to providers who do not have fax or email.

Medicare Advantage UM Criteria

NEMS MSO makes coverage determinations or prior authorization decisions for Medicare Advantage (MA) members based on the following criteria in this hierarchy order:

1. Medicare National Coverage Determinations (NCDs)
2. Medicare National Coverage Determinations (NCD) Manual
3. Medicare Local Coverage Determinations (LCDs)
4. Local Coverage Articles (LCAs) (Active/Retired)
5. Medicare Manuals (Internet Only Manuals)
6. State Laws, if applicable
7. Health Plan's national medical policies
8. MCG Health Guidelines
9. Other Evidenced-Based Clinical Criteria
10. Independent Medical Review

NEMS MSO uses current versions of the criteria, which must not be older than two years.

Benefit coverage follows Medicare coverage guidelines unless otherwise specified in the member's Evidence of Coverage (EOC), such as carve-outs that may apply for vision, acupuncture or dental. To be eligible for coverage under Medicare, all services must meet applicable criteria for medical necessity.

National Coverage Determinations (NCDs): To determine medical necessity, the UM team must first consult Medicare NCDs, which apply to Medicare members in all regions. NCDs are located on the Centers for Medicare and Medicaid Services (CMS) website at www.cms.gov and can be accessed by:

- Selecting documents to view
- Selecting the region in which the service is performed
- Searching by keyword, phrase, or procedure codes

Providers may use criteria from this page to state whether a specific request is a covered medical benefit or to support the medical necessity decision. If there is no documented NCD, providers must determine medical necessity by referring to the next step in the hierarchy, which is the NCD Manual.

Medicare Coverage Articles for Medicare under Federal oversight can also be used for determination.

National Coverage Determinations (NCD) Manual: The NCD Manual describes whether specific medical items, services, treatment procedures, or technologies are covered under Medicare. The manual is located on the CMS website at www.cms.gov. If a service is not specifically listed in the NCD Manual, providers must determine medical necessity by referring to the next step in the hierarchy, the LCDs.

Local Coverage Determinations (LCDs): LCDs are written coverage decisions of local Medicare Administrative Contractors (MACs) with jurisdiction for claims in the geographic area in which services are covered. Medicare LCDs apply to members in specific regions. Accompanying articles are used in conjunction with LCDs and are not meant to be used alone. LCDs are located on the CMS website at www.cms.gov and can be accessed by:

- Selecting documents to view.
- Selecting the region in which the service is performed.
- Searching by keyword, phrase, or procedure codes.

Providers may use criteria from this page to state whether a specific request is a covered medical benefit or to support the medical necessity decision. If a service is not specifically mentioned, providers must determine medical necessity via the next step in the hierarchy, evidence-based clinical criteria.

A MAC outside of the plan's service area sometimes has exclusive jurisdiction over a Medicare-covered item or service. In some instances, one Medicare Part A and Part B MAC processes all the claims for a particular Medicare-covered item or service for all Medicare beneficiaries around the country. This generally occurs when there is only one supplier of a particular item, medical device, or diagnostic test (for example, certain pathology and lab tests furnished by independent laboratories). In this situation, NEMS must follow the coverage requirements or LCDs of the MAC that enrolled the supplier and processes all the Medicare claims for that item, device, or test.

State Law, if applicable: When state requirements are more stringent than federal requirements, NEMS MSO follows the state requirements that are more stringent and extensive.

Health Plan's National Medical Policies: If providers do not find results from the NCDs, NCD Manual, or LCDs search, they should refer to the Health Plan's national medical policies. Updated policies feature a grid and instructions that outline what resources can help to determine medical necessity. Resources are listed in the order that they should be utilized. If a resource is blank, it may be because at the time of writing or revising the policy, no Medicare coverage criteria existed, in which case providers must conduct a more specific search of the NCDs, NCD Manual. or LCDs site.

MCG Health Guidelines: If no results appear or the results are vague in the NCDs, NCD Manual, LCDs, and Health Plan's national medical policies, providers may contact NEMS MSO for the MCG Health criteria. Currently, NEMS MSO has adopted the latest version of the MCG Health Guidelines.

Other Evidence-Based Clinical Criteria: In the case of no guidance from the above guidelines, Physician Reviewers may consider other evidence-based clinical guidance/guidelines:

- Reports from peer reviewed medical literature, where a higher level of evidence and study quality is more strongly considered in determinations
- Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment
- Nationally recognized drug compendia resources such as Facts & Comparisons®, DRUGDEX®, and The National Comprehensive Cancer Network® (NCCN®) Guidelines
- Medical association publications
- Government-funded or independent entities that assess and report on clinical care decisions and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), U.S. Preventive Services Task Force (USPSTF), etc.
- Published expert opinions
- Opinion of health professionals in the area of specialty involved
- Opinion of attending provider in case at hand

Medicare Part B Drug Reviews: For Medicare Part B drug review, NEMS MSO will follow the above hierarchy. If there is not a NCD or an applicable LCD, the UM team will search the appropriate Drug Compendia and/or relevant guidance from the FDA.

Note: Staff follow the guidelines in the MBPM Ch 15, Sect 50.4 regarding label and off label use and how to use compendia, particularly involving Anti-cancer Chemotherapy which allows for literature.

In the absence of any of the above criteria, the UM team will determine whether the service meets established medical necessity criteria by using criteria available on the Health Plan website including, but not limited to the below, in the following order:

- Health Plan Medical Policies
- Health Plan Clinical UM Guidelines
- AIM Guidelines MCG™ guidelines (IP) or InterQual® (IP) guidelines only

Independent Medical Review: If medical necessity is not addressed by the above guidelines or when UM guidelines are not appropriate, the UM team sends the case to an independent medical reviewer in the same specialty for review. The independent medical reviewer is a board-certified provider who has extensive knowledge about the requested service. NEMS physician reviewers review the recommendation and supporting documentation provided by the independent medical reviewer and make a decision to approve or deny the service.

Medicare Clinical Criteria – Behavioral Health

Continuum of Care: Continuum of care refers to a treatment system in which clients enter treatment at a level appropriate to their needs and then step up to more intense treatment or down to less intense

treatment as needed. NEMS uses CMS guidance[1] and American Society of Addiction Medicine (ASAM) criteria[2] to approach the BH continuum of care as below:

- Outpatient services
    - Early intervention are services for specific individuals who, for a known reason, are at risk of developing substance-related problems, or a service for those for whom there is not sufficient information to document a substance use disorder. Examples of early intervention services include conducting an Alcohol Use Disorder screening, providing education, etc.

      Outpatient services may include screening, evaluation, treatment, and ongoing recovery and disease management services. Such services are provided in regularly scheduled sessions and follow a defined set of policies and procedures or medical protocols. Services can also include counseling and psychosocial therapies for substance related and co-occurring disorders offered by professionals who specialize in addiction care or by other health care and mental health professionals.
- Inpatient services
    - Inpatient BH services – inpatient services provided at a hospital or an inpatient psychiatric facility, which may include freestanding, certified psychiatric hospitals, and psychiatric units in acute care hospitals.
- Partial hospitalization/Intensive outpatient services
    - Intensive outpatient psychiatric care through active treatment but requiring less than 24-hours a day. Partial hospitalization/intensive outpatient services meet the following criteria:
        - Active treatment includes individual Plan of Care (POC) with coordinate services designated for patient's needs
        - POC treatment include physician-directed multi-disciplinary team care approach certifying patient's partial hospitalization therapeutic services minimum need of 20 hours per week
        - Patient requires comprehensive, highly structured, scheduled, multi-modal individualized POC requiring medical supervision and coordination because mental disorder severely interferes with multiple areas of daily life (social, vocational, Activities of Daily Living [ADL]/instrumental ADLs, and educational functioning)
        - Patient can cognitively and emotionally participate in the active treatment process and tolerate its intensity

For BH services, NEMS shall apply criteria and guidelines that are standards in the industry, per requirements under California Health & Safety Code Sec. 1374.721 and contractual requirements, including, but not limited to, the following:

- American Association for Community Psychiatry (AACP) Level of care Utilization System for Psychiatric and Addiction Services (LOCUS)

[1] Centers for Medicare and Medicaid Services. Medicare Mental Health. March 2022. https://www.cms.gov/files/document/mln1986542-medicare-mental-health.pdf.

[2] American Society of Addiction Medicine. ASAM Criteria: What is the ASAM Criteria. N.d. https://www.asam.org/asam-criteria/about-the-asam-criteria.

- World Professional Association for Transgender health (WPATH) Standards of Care
- American Society of Addiction Medicine (ASAM) Criteria

Use of Clinical Practice Guidelines for Members with Complex Healthcare Needs: NEMS MSO has a comprehensive approach to managing patients with complex healthcare needs, where clinical practice guidelines and nationally recognized protocols may need to be adjusted to fit the unique needs of vulnerable members. When complex needs are identified, NEMS MSO's UM team will refer the member to the Case Management team. The Case Management team then works closely with the member's Primary Care Provider (PCP) to create a patient-centered care plan that aligns with the patient's specific needs and goals. If the standard guidelines are not suitable for a vulnerable patient, the team will discuss how to modify or adapt them to improve care. This patient-centered approach ensures the care plan addresses specific challenges, such as cognitive impairments, mobility issues, or socio-economic factors that may affect the patient's ability to follow conventional care protocols.

NEMS MSO also provides education and support to members and caregivers. This may include offering resources to help members better manage their conditions or explaining any changes made to care protocols. Additionally, NEMS MSO ensures that members have access to the appropriate services, such as home health care, mental health support, or social services, which are essential for those with complex needs.

Medi-Cal UM Criteria

For Medi-Cal UM prior authorization determination, UM staff follow the clinical criteria in this hierarchy order:

1. Federal/State mandates (CMS/Medicare/Medi-Cal) criteria;
2. State law - When state requirements are more stringent and extensive than federal requirements;
3. Contracted health plan's adopted guidelines (e.g., San Francisco Health Plan, Santa Clara Family Health Plan, Anthem Blue Cross – the AIM Radiology Guidelines, Anthem Medical Policy, and Anthem UM Clinical Guidelines;
4. MCG Health and other evidence-based guidelines;
5. Independent Medical Review – NEMS MSO physician reviewers review the evidence in consultation with relevant external, independent specialty expertise when there are no available criteria.

For further information on NEMS MSO UM policies and procedures or general questions regarding UM, please contact NEMS MSO UM via **email at MSO-UM@nems.org, or 1-415-352-5186, Option 1**.

Prior Authorization

Prior authorization (PA) requests must be submitted to the NEMS MSO UM Department. The UM staff reviews prior authorization requests and makes decisions based on eligibility criteria, benefit criteria, and medical necessity of the requested service. UM staff may request additional information from the requesting provider if the information submitted is not sufficient to make a decision. Most denials involve non-covered services, and unless specifically indicated, NEMS MSO does not authorize or pay for services that are not covered by Medi-Cal and/or Medicare, including cosmetic services, infertility

treatment, and experimental and investigational procedures. Per state regulations, **a prior authorization is not required for emergency services and sensitive services (e.g., family planning, sexually transmitted disease services, HIV testing).**

Please visit the link below to access the authorization grid for the listing of procedures requiring prior authorization: https://www.nemsmso.org/prior-authorizations/

All requests for PA can be submitted online using the provider portal or by submitting via fax with all supporting clinical documentation/ medical records to the Utilization Management

- By fax: 1-415-398-2895
- By EZ-Net Provider Portal link (https://eznet.nems.org/EZ-NET60/Login.aspx)

EZ-Net Portal is a web-based administrative tool for providers to communicate information with NEMS MSO and perform tasks via the internet without compromising security. Providers may use the Portal to submit Prior Authorization Requests, inquire about claims and authorization status, and download explanation of benefits (EOB). For additional information on how to create an account for the NEMS MSO Provider Portal, visit our website and follow the instructions for requesting access.

Prior Authorization Turnaround Time

All PAs require written notification of the decision to approve, deny, defer, or modify the authorization depending on the request type (urgent, routine, retrospective).

Medi-Cal Members

The standard turnaround times for processing prior authorizations for Medi-Cal members are as follows:

- Routine requests – seven (7) calendar days
- Urgent/concurrent requests – within seventy-two (72) hours of receipt
- Retroactive requests – thirty (30) calendar days from date of receipt
- Drug requests – within twenty-four (24) hours of receipt

Medicare Members

The standard turnaround times for processing PA requests for Medicare members are as follows:

- Routine requests – seven (7) calendar days
- Urgent/concurrent requests – within seventy-two (72) hours of receipt
- Retroactive requests – thirty (30) calendar days from date of receipt*
- Part B drugs (urgent requests) – within twenty-four (24) hours of receipt
- Part B drugs (routine requests) – within seventy-two (72) hours of receipt

Retroactive Authorization

NEMS MSO UM may issue a retroactive authorization for services already rendered when the following criteria are met:

- The service was medically necessary and appropriate at the time the service was provided.
- The service was required on an urgent basis outside of NEMS MSO normal business hours, and documentation includes justification for the urgent nature of the service.
- The service is related to ensure continuity of care.

Retrospective authorization requests must be submitted no later than thirty (30) calendar days from the date of service. All retrospective authorization requests are subject to review using established medical necessity criteria. Requests received more than thirty (30) calendar days after the date of service will be denied.

*Effective April 1, 2026, NEMS MSO UM will begin reviewing retrospective authorization requests for Medicare Advantage members.

Concurrent Review

Concurrent review is the ongoing evaluation of clinical information to determine medical necessity during a member's inpatient stay. This process also supports discharge planning coordination and the identification of potential quality-of-care concerns.

Notification Requirements: Hospitals are required to notify the NEMS Utilization Management (UM) team within 24 hours of admission, or by the next business day for admissions occurring on weekends, for the following services:

- All inpatient hospitalizations
- Skilled nursing facility (SNF) admissions
- Inpatient rehabilitation admissions
- Inpatient hospice services
- Emergency room admissions

Timely notification of inpatient admissions for NEMS MSO members facilitates prompt claims payment, minimizes retroactive admission reviews, and allows NEMS UM to monitor member care concurrently. Failure to provide timely notification may result in delays in processing service requests and potential denial of payment.

Required Admission Information: When reporting an inpatient admission, hospitals and providers must submit the following information:

- Member name
- Subscriber identification (ID) number
- Attending and admitting physicians' first and last names, and contact information
- Admission date and time
- Admission type (e.g., emergency, elective, or urgent)
- Facility name and contact information
- Level of care
- Admitting diagnosis code
- CPT procedure code, if available
- Facility medical record number
- Participating provider's authorization number
- For obstetrical (OB) delivery admissions: newborn sex, birth weight, Apgar score, time of birth, and medical record number
- Discharge date, if applicable
- Other insurance information, if applicable

Authorization Approval/Denial

The NEMS MSO UM department reviews all PA requests to ensure all requests meet eligibility criteria, benefit criteria, and medical necessity of the requested service. The UM staff may request additional information from the requesting provider if a determination cannot be made from the information submitted.

Upon approval of the authorization, NEMS MSO UM department will generate an approval letter for each specific request, and send a copy of the approval letter to the following individuals on the next business day:

- Requesting provider
- Member's PCP
- Member

For routine PA requests with an extension, such as those requiring additional clinical information or consultation by an expert reviewer, the decision may be deferred and the decision time limit is extended to fourteen (14) calendar days from the date of receipt. The member and practitioner will receive notification of decision to defer, in writing, within seven (7) calendar days of receipt of the request. The referring practitioner will have fourteen (14) calendar days from the date of receipt of the original request to provide the additional information requested. If after fourteen (14) calendar days from the receipt of the request for prior authorization, the practitioner still has not complied with the request for additional information, NEMS will provide the member and provider a notice of denial.

For denials, the requesting provider receives notification of the decision via the provider portal or facsimile, and the reference number for the case is provided. The member will also receive notification of the routine prior authorization denial, and a signed copy of the denial letter will be sent to the member within two (2) business days, not to exceed three (3) calendar days of the denial decision. The member will receive notification of the urgent prior authorization denial, and a signed copy of the denial letter will be sent to the member within twenty-four (24) hours of the denial decision, not to exceed seventy-two (72) hours from the receipt of the request for service. The denial notification also includes an explanation of the denial, and it provides guidance to the member of the appeal process.

Appeal of UM Decisions

Providers may appeal authorization denials for clinical services that do not meet administrative policy requirements, medical criteria, or other reason(s), and were denied by the NEMS MSO Medical Director or designated physician. Contracted and non-contracted providers have the right to appeal the authorization review determination, except in the following instances:

- The appeal is submitted more than 90 calendar days following the date of the Notice of Action (NOA).
- The denial was based on untimely notification for inpatient admission.
- The service is not covered by Medi-Cal (under the evidence of coverage) at the time of the authorization request.

Provider appeals will be submitted to NEMS' contracted health plans for review and resolution. For further information on how to submit provider appeal, please contact NEMS MSO UM via **email at MSO-UM@nems.org, or 1-415-352-5186, Option 1.**

Carved Out Services

At the discretion of our health plan partners, there are some services that may be carved out of the health plan's coverage and provided through another entity. Example of carved out services include, but are not limited to:

- Behavioral Health
- Dental
- Vision

To verify what services are carved out and who the appropriate entity is to direct your authorization request please visit the below links to review PA guidelines for each NEMS MSO line of business.

- Medi-Cal Managed Care Plan Authorization Requirements (All Plans)
- Medicare Advantage Authorization Requirements: Health Net/GBHP
- Medicare Advantage Authorization Requirements: Anthem Blue Cross
- Medicare Advantage Authorization Requirements: Alignment Health Plan

In the bottom right corner, you will see the list of carved out services for the respective plan and the entity to contact for those services.

CASE MANAGEMENT SERVICES

NEMS Case Management strives to assist patients and families navigate through the managed healthcare system. NEMS MSO Nurse Case Managers and Care Coordinators provide advocacy for patients and interact with healthcare team members to find solutions in providing effective, quality, and efficient care. The objectives are to facilitate timely discharges, coordinate care across the continuum, prompt and efficient use of resources, and quality improvement activities that lead to optimal patient outcomes. Case management should be used as a resource for members with chronic conditions to address their unique needs.

Our Case Management Program includes, but is not limited, to the following activities:

- Assessment/reassessment and Care Plan development
- Care coordination and medical interpretation at critical appointments
- Patient education of disease process; coaching of self-management
- Medication reconciliation
- Home visit after hospital discharges
- Assistance in accessing community resources, e.g., Paratransit, CCS, LEA, IHSS, GGRC

Basic Care Coordination

Basic care coordination is the organized and intentional support provided to help patients navigate their health care across different providers, services, and settings. It includes scheduling appointments, connecting patients to community resources, promoting health education, advocating for their needs, facilitating communication among care team members, and reducing gaps in care to ensure a more seamless and effective health care experience.

Basic care coordination also includes screening members for additional health-related needs and barriers that may affect their care. Members are then referred to the appropriate programs and services to ensure they receive the resources and the right level of case management support needed.

Complex Case Management

The primary goal of complex case management is to help members regain optimum health or improved functional capability in the right setting. Complex Case Management involves comprehensive assessment of the member's medical condition; determination of available resources and benefits; and development and implementation of a case management plan with assessments, performance goals, monitoring and follow-up. The Complex Case Management Program is an optional service and NEMS members can decline to participate at any time.

Complex Case Management staff collaborate with other members of the healthcare team, including the Primary Care Provider, Specialist Providers, and Discharge Planners at the affiliated hospitals, and Utilization Management staff at NEMS MSO.

Providers may refer patients with complex medical needs to the NEMS MSO Case Management team by **email to CaseManagement@nems.org or by phone at 1-415-352-5179.**

CLAIMS

For all questions or issues related to claims and payments, please contact NEMS MSO Claims at 1-415-352-5186, **Option 2.**

The below sections contain a summary of NEMS MSO claims processes and requirements, for additional information please see our NEMS MSO website at https://nemsmso.org/claims-pdr/

Claim Requirements

To be considered a valid claim, each claim must be submitted within the timely filing period and meet the following criteria*:

1. Appropriate type of insurance coverage (box 1 of the CMS-1500).
2. Billing provider tax identification number (TIN), address and phone number.
3. Billing provider National Provider Identifier (NPI).
4. Bill type (institutional) and/or place of service (professional).
5. Original submission is indicated with a 1 in claim frequency box or resubmission code (box 22).
6. Codes 7 and 8 should be used to indicate a corrected, void or replacement claim and must include the original claim ID.
7. Patient name, health plan subscriber identification (ID) number, address, sex, and date of birth must be included.
8. Other health insurance information and other payer payment, if applicable.
9. Patient or subscriber medical release signature/authorization.
10. Accept assignment (box 13 of the CMS-1500).
11. Referring/Ordering provider name and NPI.
12. Check if lab work was performed outside the physician's office and indicate charges by the lab (box 20 on CMS-1500).
13. Rendering/attending provider NPI (only if it differs from the billing provider) and authorized signature.
14. Primary diagnosis code and all additional diagnosis codes (up to 12 for professional; up to 24 for institutional) with the proper ICD indicator (only ICD 10 codes are applicable for claims with dates of service on and after October 1, 2015).
15. Diagnosis pointers are required on professional claims and up to four can be accepted per service line.
16. Diagnosis codes, revenue codes, CPT, HCPCS, modifiers, or HIPPS codes that are current and active for the date of service. Claims with incomplete coding or having expired codes will be contested as invalid or incomplete claims.
17. Authorization, if applicable, should be sent in the 2300 Loop, REF segment with a G1 qualifier for electronic claims (box 23 for CMS-1500 or box 63 for UB-04).
18. Referral information, if applicable.
19. Inpatient institutional claims must include admit date and hour and discharge hour (where appropriate), as well as any Present on Admission (POA) indicators, if applicable.
20. Inpatient professional claims must include admit and discharge dates of hospitalization.
21. Admission type code for inpatient claims.
22. Admitting diagnosis required for inpatient claims.
23. Outpatient claims must include a reason for visit.
24. Statement from and through dates for inpatient.

25. Service line date required for professional and outpatient procedures.
26. National Drug Code (NDC) for drug claims as required.
27. Universal product number (UPN) codes as required.
28. Accommodation code is submitted in Value Code field with qualifier 24, if applicable.
29. Charges for listed services and total charges for the claim.
30. Days or units.
31. Early Periodic Screening, Diagnosis, and Treatment (EPSDT)/family planning indicators (box 24 in CMS-1500).
32. Name and address of service location.

*This is not meant to be a fully inclusive list of the claim form required elements. Additional fields may be required, depending on the type of claim, line of business and/or state regulatory submission guidelines.

To avoid possible denial or delay in processing, the above information must be correct and complete. Any claim(s) that does not meet the required criteria listed under claim requirements will be rejected, and a letter indicating the reason for the rejection will be sent to the provider along with the original claim.

Timely Filing Timeframes

All claims must be submitted timely for consideration of payment. Claims submitted after the appropriate filing deadline, prior to the actual date of service, and/or prior to delivery of supplies will be denied. Please refer to your contract to review the timeframe that applies to your practice but in general:

- Contracted or in-network providers must submit all claims (inpatient and outpatient) 90 days post service. Post service is defined as after the date of service.
- Non-contracted providers or out-of-network providers must submit claims within 180 days post service.

Claims submitted outside of the timely filing timeframes will be subject to timely filing denials. NEMS MSO policy requires that providers check eligibility to ensure that the member does not have primary insurance coverage with another health insurance provider. If it is determined that the member has a different primary coverage, providers are required to bill the member's primary health insurance prior to billing NEMS MSO.

NOTE: *The timely filing period and claims processing time is the same for both electronic and paper claims.*

Claim Submission

Claims may be submitted on paper or electronically.

- By paper: All medical paper claims for **NEMS MSO** must be submitted to the following address:

NEMS MSO Claim
PO Box 1548
San Leandro, CA 94577

- By electronically (preferred method): NEMS MSO offers providers the speed, convenience, and lower administrative costs of electronic claims filing via Electronic Data Interchange (EDI), which is a powerful tool used for communicating claim information that was traditionally submitted on paper. Claims can be submitted electronically via anyone of the partner clearing housed listed on the NEMS MSO Website. It is preferred that all claims be submitted electronically.

General Claims Processing Guidelines

- Acknowledgement of Claims. NEMS MSO acknowledges receipt of electronic claims, whether the claims are complete, within two (2) business days; paper claims acknowledgement occurs within fifteen (15) business days. The same manner and timeframe noted above applies for claims received from a provider's clearinghouse, and the claims acknowledgment is sent directly to the clearinghouse.
- Claim Processing Time. All clean claims will be processed and paid within forty-five (45) business days of receipt for Medicare Advantage lines of business and thirty (30) calendar days for Medi-Cal lines of business.
- Clean Claim. A claim submitted for payment that contains all necessary information in the required fields, including attachments if required for the claim, and any documentation required to determine payer liability.
- Unclean Claim. Any claim lacking sufficient information to pay or deny, resulting in the Claims Staff requesting additional information to adjudicate the claim will be rejected and returned to the provider.
- Interest on Claims. NEMS MSO will calculate and automatically pay interest, for Medicare claim, NEMS MSO follows the rate and formulae determined by the Treasury Department on a 6-month basis, effective January and July 1st, to all providers within 31 days after the receipt of their clean claim for contract providers and 61 days for non-contracted providers. For Medi-Cal claims, in California, the interest rate is 15% to all providers within thirty (30) business days after the receipt of their clean claim. The interest period begins on the day after payment is due and ends on the day of payment.

  NEMS MSO does not pay interest on the following:
  - Claims for which no payment is due.
  - Claims denied in full.
  - Claims for which the provider is receiving Practice Improvement Program (PIP) funds

- Misdirected Claims. Claims incorrectly sent to NEMS MSO but are the responsibility of the health plan for payment, will be forwarded back to the provider within ten (10) business days from date of receipt.
- Billing Members. State law prohibits the provider from billing the member for any sums owed by NEMS MSO or managed care plans. Providers may not seek reimbursement from the member for a balance due for covered services, open bills, balances in any circumstance, including when a claim is denied.
- Checking Claims Status: Providers with access to the NEMS MSO Provider Portal may check claims status online 24/7. All non-rejected claims posted in EZCAP are automatically attached to a status code:

Status	Description	Representation
1	Release to A/P	Claim is newly posted, pending for review and adjudication.
2	System Hold	Claim has hit certain system rule, e.g. elg, duplicate, etc.
3	Manual Hold	Claim placed on hold by an Examiner pending further research.
5	A/P – Hold	Claim is adjudicated and ready for check run.
6	A/P - Pay	Claim is included in an initiated check run, waiting for check printing.
7	Repriced Paid Claim	Claim went through a system reprice for payment adjustment.
9	Paid	Claim is Paid. Check # and EOB date is located in Claim Master screen.

Balance Billing

The state and federal law, along with the Health Plan, and NEMS policy prohibit balance billing to eligible members. Balance billing occurs when a participating provider bills a member for fees and surcharges beyond a member's copayment and coinsurance responsibilities for services covered under a member's benefit program, or for claims denied by NEMS MSO. Participating providers are prohibited from initiating or threatening to initiate a collection action against a member for non-payment of a claim for covered services. Participating providers agree to accept reimbursement from NEMS MSO for services as payment in full and final satisfactory, except for applicable copayments, coinsurance, or deductibles. Participating providers may bill a member for non-covered services when the member is notified in advance that the services to be provided are not covered and the member, nonetheless, requests in writing that the services be rendered. Participating providers who exhibit a pattern and practice of billing members will be contacted by NEMS MSO and subject to disciplinary action.

Billing Medicare-Medi-Cal Members Prohibited. Providers are prohibited from collecting Medicare Parts A and B deductibles, coinsurance, or copayments from members enrolled in the qualified Medicare beneficiaries (QMB) program, which exempts members from Medicare cost-sharing liability. Providers can either accept the NEMS MSO payment as payment in full or bill the state for applicable Medicare cost-sharing for members who are eligible for both Medicare and Medicaid.

This prohibition applies to all Medicare Advantage providers, not only those that accept Medicaid. In addition, balance-billing restrictions apply regardless of whether the state Medicaid agency is liable to pay the full Medicare cost-sharing amounts.

Denial of Claims

For Medi-Cal claims, NEMS MSO notifies the rendering providers in writing of a denied claim no later than thirty (30) calendar days after receipt of the claim. For Medicare claims,
NEMS MSO notifies the rendering providers in writing of a denied claim no later than thirty (30) calendar days after receipt of the claim for all clean non-contracted providers and no later than sixty (60) calendar days after receipt of the claim for all unclean non-contracted/contracted providers.

he denial date is the day when the denial is transmitted electronically or by U.S. mail.

A denial notice contains the following elements:

- Date of denial notice
- Member name
- Provider name
- Specific service denied
- Date of service
- Denied amount
- Member responsibility amount
- Information regarding the providers' appeal rights with health plan. Include plan name, address, and telephone number for appeals

The Centers for Medicare & Medicaid Services (CMS) approved Integrated Denial Notice - Notice of Denial of Payment (IDN-NDP) letters must be sent to members when the claim denial results in any member financial liability. The IDN-NDP letter includes the denial notice page, accompanying member appeals language and Notice of Non-Discrimination and multi-language insert.

For both the denial notice and appeals page, NEMS MSO is not permissible to omit any standardized language, nor alter the template, including font size, without contracted health plan and CMS approval. Minor changes to the denial notice page that do not affect the intent of the document may be allowed upon approval from the Medicare Compliance Department. NEMS MSO shall not send denial notices to capitated members if they are not financially liable for the services.

Information required in the space reserved for the explanation of a denial must specify the reasons for the denial, as required under 42 CFR 422.568 (e)(2). For Medicare Advantage providers, the CMS-approved Industry Collaboration Effort (ICE) standardized Single Service Claim Denial Letter and Multiple Services Claim Denial Letter are located under Approved ICE Documents on the ICE website at www.iceforhealth.org/library.asp. Additional information is available on the CMS website at www.cms.gov or from the ICE website at www.iceforhealth.org .

Contested Claims

A contested claim is one that NEMS MSO cannot adjudicate or accurately determine liability because additional information is required from either the provider, the claimant, or the third party.

For Medi-Cal claims, NEMS MSO notifies the provider of service in writing of a contested claim no later than thirty (30) calendar days after receipt of the claim.

For Medicare claims, NEMS MSO notifies the provider of service in writing of a contested claim no later than 30 calendar days for clean non-contracted providers and no later than sixty (60) calendar days for all unclean non-contracted/contracted providers.
The contested date is the date when the contest was transmitted electronically or by U.S. mail.

You may contest incomplete claims or claims requiring additional information in writing to NEMS MSO in the form of an Explanation of Payment/Remittance Advice (EOP/RA). NEMS MSO may send, in some circumstances, additional written communication within the timeframes noted above. Each EOP/RA

includes instructions on how to submit the required information to complete the claim if NEMS MSO has contested it. Each EOP/RA reflecting a denied, adjusted, or contested claim includes instructions on how to file a provider dispute, including the web link to procedures for obtaining provider dispute forms and the mailing address for submission of the dispute.

Overpayment and Recoupments

Overpayments can happen for several reasons, including but not limited to the following:

- Processing error
- Services paid by another third party (i.e., COB)
- Retroactive change to member eligibility
- Duplicate payment

A provider who has identified an overpayment should send a refund with supporting documentation to the following address:

NEMS MSO
Claims Refunds
1710 Gilbreth Road
Burlingame, CA 94010

If NEMS MSO identifies an overpayment, a notice will be sent to the provider with the following information:

- Member's name and ID number
- Provider's account number
- Claim number
- Date of service
- Overpayment amount
- Date of payment
- Detailed explanation for the refund request

The provider has thirty (30) days from receipt of payment to submit a written explanation contesting the overpayment notification. If the overpayment request is not contested within thirty (30) days of receipt of the overpayment notice, and a full refund is not received within forty-five (45) days from the overpayment notification, NEMS MSO will recoup the amount of the overpayment on future claims.

Coordination of Benefits (COB)

Coordination of benefits is the practice of two or more plans coordinating their provision of health benefits to members who have multiple coverage. Coordination of benefits is used to determine the order of payment responsibility when more than one health plan or insurer covers a NEMS MSO member. Federal laws require practitioners to bill other health insurers prior to billing NEMS MSO for Medi-Cal coverage. Since all other coverages are primary for eligible Medi-Cal members, NEMS MSO is always the payer of last resort for Medi-Cal members.

All claims must be submitted to NEMS MSO within ninety (90) days from the date of payment on the primary payer's Explanation of Benefits (EOB) form, and a copy of the EOB must accompany the claim. Under the secondary payer COB rules, NEMS MSO will pay the lesser of the following amount for covered services:

- The amount that would pay if another coverage did not exist.
- The actual charge from the provider, less the amount paid by the other coverage.
- If primary insurance payment exceeds the allowed contracted rate, neither NEMS MSO nor its member are financially responsible for additional payment.

Currently, all the health benefits provided for NEMS members are subject to COB provision.

Provider Dispute Resolution Mechanism

A provider claim dispute is a written notice to dispute a claim decision (paid, adjusted, contested, or denied) or disputing a request for reimbursement of an overpayment of a claim. The disputing provider must submit a written request, using the Provider Dispute Resolution (PDR) form within 365 calendar days or 120 calendar days from the receipt of claim decision for Medi-Cal or Medicare claims, respectively. The dispute must be submitted with any relevant and supporting documentation. NEMS MSO ensures that punitive action is not taken against providers who either submit disputes or support a member's appeal.

Providers wanting to dispute a claim payment or denial can submit a written dispute to the following address:

North East Medical Services MSO
Attn: Provider Claims Dispute
1710 Gilbreth Road
Burlingame, CA 94010

All supporting documentation submitted with the dispute must be legible and include the following information:

- Claim number from NEMS MSO's Explanation of Benefit/Payment
- Provider's NPI, Name, Contact Information, and Tax ID Number
- Copy of original claim being disputed
- Reason for dispute and explanation of the basis that provider believes the payment amount, adjustment, denial, or request for reimbursement is incorrect
- Identification of disputed item(s)/service(s)
- Copy of medical records if disputing for medical necessity
- Other pertinent documentation supporting the appeal or copies of all correspondence to and from NEMS MSO documenting timely follow-up

Claims denied due to the provider's submission error or omission (e.g., missing modifier, incorrect CPT/ICD-10/ revenue codes, place of service) do not qualify for the provider claim dispute resolution mechanism. Such claims must be resubmitted within the specified timeframe for claim submission as a "corrected claim," with a brief explanation of the error noted either on the claim or as an attachment. Failure to submit a claims dispute within the specified timeframe will result in denial of the dispute.

Medi-Cal Specific Claim Dispute Policy

For Medi-Cal claim disputes, NEMS MSO will acknowledge receipt of the PDR within fifteen (15) working days of receipt of the dispute, and will issue a written determination, including a statement of the pertinent fact and reasons, to the provider within forty-five (45) business days after receipt of the claim dispute.

Medicare Advantage Specific Claim Policies

Non-Contracted Provider Appeals (Waiver of Liability). In accordance with CMS regulations, non-contracted providers with a Medicare Advantage organization may file a standard appeal for a claim denied completely or in part, but only if they submit a completed **Waiver of Liability Statement** (page 33). If provider completes a Waiver of Liability Statement, provider waives the right to collect payment from the member, except for any applicable cost sharing, regardless of the determination made on the appeal.

Appeals are not processed by NEMS MSO and should be sent to the health plan directly. Appeals submitted to NEMS MSO will be forwarded to the member's plan. The health plan's appeal address are listed below:

- **Alignment Healthcare** | Attn: Provider Appeals and Disputes | PO Box 14012, Orange, CA 92863
- **Anthem Blue Cross** | Attn: Grievances and Appeals | Mailstop: OH 0205-A537 | 4361 Irwin Simpson Rd. Mason, OH 45040
- **Wellcare by Health Net** | Attn: Provider Appeal | PO Box 3060, Farmington, MO 63640-3822
- **SCAN Health Plan** | Attn: SCAN Claims Provider Disputes | P.O. Box 21543, Eagan, MN 55121
- **San Francisco Health Plan** | Attn: Claims | PO Box 194247, San Francisco, CA 94119

Non-Contracted Provider Disputes. Non-contracted providers have the right to dispute and submit request for reconsideration of claim payments when the providers believe that the payment amount received for a service is less than the contractual amount. Examples of non-contracted provider claim disputes include bundling issues or down coding.

Provider disputes must be submitted within 120 days from the date of the initial payment decision and must include complete documentation to the following address:

NEMS MSO Claims Dispute
1710 Gilbreth Road
Burlingame, CA 94010

NEMS MSO will review the dispute and provide a determination in writing within thirty (30) calendar days from the time we receive the dispute.

- If we agree with provider's position, we will pay the correct amount including any due interest.
- If necessary, documentation is missing for review of the provider dispute, NEMS MSO may request for such information via phone or in writing to the provider.
- If the requested information is received within the fourteen (14)-calendar day deadline, we will consider the evidence before making and issuing the final determination.
- If the requested information is not received within fourteen (14)-calendar days from date of the request, review of the dispute will be conducted based on available information in the file.
- We will send the determination in writing if we deny the payment dispute, stating the reasons for the determination.

NEMS MSO may dismiss the dispute as untimely filed if the dispute request is not received within the 120-days timeframe. The dismissal must be issued in writing to the provider, explaining the reason for dismissal, and the non-participating provider has up to 180 calendar days from the date of dismissal notice to provide additional documentation for compelling cause for late filing. If the decision is to uphold the dismissal after reviewing the additional documentation, NEMS MSO will issue a letter or EOB to the provider explaining that compelling cause has not been established.

Providers that have exhausted the NEMS MSO internal dispute process and insist services were not reimbursed fairly will be informed about their right to file a Second Level dispute with the Managed Care Plan directly. If a provider decides to submit a Second Level dispute to the Managed Care plan, NEMS MSO will forward all related materials including, but not limited to, the original claim's denial, and the written determination of the original dispute to the Health Plan upon receiving a written notice from the Plan.

NEMS MSO is required to retain copies of the provider disputes and the determinations, including all notes, documents, and other information that were used to reach the decision, for a period of not less than ten (10) years.

NEMS MSO WEBSITE AND PROVIDER PORTAL

NEMS MSO Website

NEMS MSO maintains a user-friendly website with information and tools for members, providers, and the community. Providers should check our website for the latest versions of this manual and other required training materials. In addition, provider should utilize the NEMS website for the following:

- Review PA Requirements
- Update Contact and Practice Information via the Provider Update Form
- Request Interpretation Services
- Search the Provider Directory for In-network providers and their contact information

Visit our website at www.nemsmso.org

EZ-NET Provider Portal

The NEMS EZ-NET provider portal is an efficient and secure way for providers and their staff to perform multiple functions that include the following:

- Submit prior authorizations online.
- Check status of authorizations.
- Check claims status.
- Download and print authorization letters.
- Download and print remittance advice (RA).
- Confirm and/or retrieve member contact information

NEMS MSO requires that providers and their staff complete the Provider Portal Form to obtain access to the NEMS secure provider portal. To download the provider portal form, visit the links section in our NEMS EZ-NET home screen listed below, and select "download the Provider Portal Form."

The MSO Systems Team will validate your account and information submitted on the form, and if granted access, will provide you with the username and password selected via email. Every person accessing the provider portal is required to have their own username, and we discourage sharing passwords and username information. Please note, after 6 months of inactivity accounts will be disabled. To reactivate an account, please submit a new Provider Portal Form.

Navigating the provider portal is simple! New users can find step-by-step guides for all portal functions, including submitting TARs. Additionally, if you need assistance, the Provider Network Operations team is available to provide personalized training sessions upon request. To request, please email provider.relations@nems.org or call 415-352-5186 Option 3. For more information and to Log In to the portal, please visit: https://eznet.nems.org/EZ-NET60/Login.aspx.

LINGUISTIC SERVICES

Interpretation Services

All NEMS members have the right to receive culturally competent care, including interpretation services. Professional interpretation services are offered by NEMS and our health plan partners to members at no cost. NEMS discourages the use of friends, family members, or minors as interpreters.

The responsibility to provide interpretation services varies among the different NEMS networks. Please review the table below to identify who should be contacted to provide services.

Health Plan Network	Interpretation Services Provided by	Contact Information
Alignment Health Plan (AHP)	NEMS MSO	Please make a request for interpretation services via one of the following methods: 1) NEMS MSO Website: Interpretation services may be requested by completing the request form at https://nemsmso.org/interpretation-services/ 2) Over the Phone: By calling NEMS Provider Network Operations at 415-352-5186, option 3 during regular business hours.
San Francisco Health Plan (SFHP) Care Plus: D-SNP		
San Francisco Health Plan (SFHP): Medi-Cal		
Anthem Blue Cross (ABC) Medi-Cal & MA	Anthem Blue Cross	Please call ABC at 800-677-6669 to access an interpreter on behalf of the member.

Golden Bay Health Plan (GBHP)/Health Net (HN)	Health Net	Please call HN at 866-563-1259 to access an interpreter on behalf of the member. 1. Select 5 for Medicare HMO 2. Select 1 for Spanish, 2 for other. 3. If you selected "other," an agent will connect with you and ask for the requested language. 4. Agent will connect you to the interpreter.
Santa Clara Family Health Plan (SCFHP)	Santa Clara Family Health Plan	Please call SCFHP at 800-260-2055 to access an interpreter on behalf of the member.
SCAN C-SNP	SCAN	Please call SCAN at 877-778-7226 to access an interpreter on behalf of the member.

NEMS MSO will provide interpretation services for appointments that occur during our regular business hours, Monday to Friday from 9:00am – 5:00pm, excluding holidays.

Requests for routine appointments and in-person interpreters, including sign language interpreters, should be submitted to NEMS MSO at least 5 business days prior to the appointment during regular business hours. Please note that in-person interpretation is available in limited capacity. For urgent appointments, please reach out to us as soon as possible to schedule interpretation services.

Cultural Competency and Linguistic Training

To assist providers in better communicating with patients that are limited in their English proficiency (LEP), NEMS MSO provides cultural and linguistic training as part of the provider orientation and on an as needed basis.

To request additional information or cultural and linguistic training, please contact NEMS MSO Provider Network team at provider.relations@nems.org or at 1(415) 352-5186 **Option 3**.

DIVERSITY, EQUITY, AND INCLUSION TRAINING

DEI training aims to enhance cultural competency and humility among NEMS staff and NEMS network providers, ensuring that healthcare services are responsive to the diverse cultural and linguistic needs of Medi-Cal members. The training focuses on:

- Data Collection and Stratification: Gathering accurate data on race, ethnicity, disability, language, sexual orientation, and gender identity to identify and address health inequities.
- Workforce Diversity and Cultural Responsiveness: Developing a workforce that reflects the diversity of the Medi-Cal population and provides culturally and linguistically appropriate care.

- Eliminating Health Disparities: Reducing disparities within the Medi-Cal population and supporting policies to address health-related social needs.

DEI training is tailored to the demographics of members, covering aspects such as sensitivity, diversity, cultural competency, cultural humility, and health equity, in alignment with the National Committee for Quality Assurance (NCQA) Health Equity Accreditation Standards.

Providers will be trained upon initial credentialing and retrained during re-credentialing. The training will also be distributed to the entirety of the NEMS Provider Network annually. Training with be implemented in accordance with the timelines set forth in the DHCS All Plan Letter (APL) 23-025.

To request additional information or training, please contact NEMS MSO Provider Network team at provider.relations@nems.org or at 1(415) 352-5186 **Option 3**.

HEALTH EDUCATION RESOURCES

NEMS Health Education Resources Library

NEMS offers an extensive Health Education Resources Library that is available for providers and members. Most training materials are available in a variety of language and cover a vast array of health topics. The NEMS Health Education Resources Library can be found on our website at https://nems.org/resources/health-education-resources/.

If providers or members have any questions about the materials, please reach out to the Case Management Team at CaseManagement@nems.org or by phone at 1-415-352-5179.

PROVIDER COMPLIANCE

NEMS' compliance standards and guidelines apply to all business arrangements between NEMS and providers, vendors, hospitals, and other persons which may be impacted by federal or state laws relating to fraud and abuse, reimbursement, and health care delivery. This includes compliance with all laws and regulations applicable to NEMS, such as laws related to fraud, waste, and abuse.

Fraud, Waste and Abuse

At NEMS, we are deeply committed to acting ethically and responsibly in a culture of compliance, ethics, and integrity. NEMS MSO cooperates with federal and state agencies as well as contracted managed care plans to identify fraud, waste, and abuse (FWA).

Abuse: Activity that is inconsistent with sound fiscal, business, or medical practice standards and results in unnecessary cost or reimbursement. It also includes any act that constitutes abuse under applicable federal law (as defined in Title 42, Code of Federal Regulations Section 455.2) or state law.
Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal (as defined in Title 42, Code of Federal Regulations Section 455.2) or state law.
Waste: The consumption of resources (products or services) due to mismanagement, inappropriate actions, or inadequate oversight. Waste is not typically the result of criminal actions.

False Claims Act (Federal – 31 U.S.C. § 3729-3733; California – C.G.C. § 12650-12656): The California and Federal False Claim Acts (FCAs) make it illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent.

Member FWA Examples

- A person using someone else's Member ID Card
- Deliberately providing misinformation to retrieve services
- Selling and/or forging prescriptions

Provider FWA Examples

- Provider submitting claims for services not rendered
- Sending member a bill after the plan had made payment

- Soliciting or receiving kickbacks

Filing false claims may result in fines of up to three times the programs' loss plus $11,000 per claim.

Under the civil FCA, no specific intent to defraud is required. The civil FCA defines "knowing" to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Further, the civil FCA contains a whistleblower provision that allows private individuals to file a lawsuit on behalf of the United States and entitles whistleblowers to a percentage of any recoveries.

There also is a criminal FCA (18 U.S.C. § 287). Criminal penalties for submitting false claims include imprisonment and criminal fines.

Suspicious activities may be reported by phone, in writing, or in person to the NEMS MSO Compliance Team.

NEMS MSO Compliance
1710 Gilbreth Road
Burlingame, CA 94010
415-352-5139
MSO-Compliance@nems.org

If you have questions about Compliance efforts, please contact NEMS MSO Provider Network team at provider.relations@nems.org or at 1(415) 352-5186 **Option 3**.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that contains national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

Providers must manage medical information in a manner that protects member rights and complies with HIPAA requirements. This includes all patient health information (PHI) in any form, including electronic, paper, or verbal. PH includes information about:

- Common identifiers, such as name, address, birth date, and SSN
- The patient's past, present, or future physical or mental health condition
- Health care you provide to the patient
- The past, present, or future payment for health care you provide to the patient

As part of HIPPA, the Privacy Rule requires providers to:

- Notify patients about their privacy rights and how you use their information
- Adopt privacy procedures and train employees to follow them
- Assign an individual to make sure you're adopting and following privacy procedures
- Secure patient records containing PHI, so they are not available to those who do not need to access
- Ensure all PHI transmitted to other providers in the member's care team is sent in a secure manner

For more information on HIPAA requirements please visit https://www.hhs.gov/hipaa/for-professionals/index.html.

MEMBER RIGHTS & RESPONSIBILITIES

NEMS MSO members have specific rights and responsibilities pursuant to applicable state regulations and policies. This information is made available to all NEMS members and posted to our NEMS MSO website.

NEMS MSO members have the following rights:

- To be treated respectfully, with dignity, no matter what your gender, culture, language, appearance, sexual orientation, race, disability, and transportation ability is, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about the plan, our services, including Covered Services, our practitioners and providers and your rights and responsibilities.
- To be provided information about all health services available to them, including a clear explanation of how to get them.
- To be able to choose a primary care provider within the Contractor's network.
- To participate in decision making regarding their own health care, including the right to refuse treatment.
- To be able to have candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- To voice complaints or grievances, either verbally or in writing, about the organization or the care received.
- To receive care coordination.
- To request an appeal of decisions to deny, defer, or limit services or benefits.
- To receive oral interpretation services for their language
- To receive free legal help at their local legal aid office or other groups.
- To formulate advance directives.
- To have access to family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and Emergency Services outside the Contractor's network pursuant to the federal law.
- To request a State Hearing, including information on the circumstances under which an expedited hearing is possible.
- To have access to, and where legally appropriate, receive copies of, amend or correct their Medical Record.
- To disenroll upon request, beneficiaries that can request expedited disenrollment include, but are not limited to, beneficiaries receiving services under the Foster Care, or Adoption Assistance Programs, and members with special health care needs.
- To access Minor Consent Services.
- To receive written member informing materials in alternative formats (including braille, large-size print, and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with W & I Code Section 14182 (b)(12).

- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand.
- To receive a copy of your medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how the Contractor, providers, or the State, treats you.
- To make recommendations regarding our member rights and responsibilities policy.
- Right to oral interpretation at no cost to the member.

NEMS MSO members have the following responsibilities:

- Carefully read all NEMS MSO or our contracted health plans' materials immediately after you are enrolled so you understand how to use your benefits.
- Ask questions when needed.
- Follow the provisions of your membership as explained in member welcome letter or communications.
- Be responsible for your health, understand your health problems, and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Follow the treatment plans your provider develops for you and consider and accept the possible consequences if you refuse to follow with the treatment plans or recommendations.
- Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.
- Make and keep medical appointments and let your provider know ahead of time when you must cancel.
- Communicate openly with your provider so you can develop a strong partnership based on trust and cooperation.
- Offer suggestions to improve NEMS MSO operation.
- Help NEMS MSO and your providers maintain accurate and current medical records by providing information promptly about changes in address, family status, other health plan coverage, and information needed to provide you with care.
- Notify NEMS MSO as soon as possible if you are billed inappropriately or if you have any complaints.
- Treat all NEMS MSO staff and health professionals respectfully and courteously.
- As required by Medi-Cal Program, pay any premiums, co-payments, and charges for non-covered services on time.
- You may refuse, for personal reasons, to accept procedures or treatment recommended by your medical group or primary care provider. If you refuse to follow a recommended treatment or procedure, your medical group or primary care provider will let you know if he or she believes that there is no acceptable alternative treatment. You may seek a second opinion. If you still refuse the recommended treatment or procedure, then NEMS MSO has no further responsibility to provide any alternative treatment or procedure that you seek.
- Using your ID cards properly. Bring your Medicare or Medi-Cal ID card and a photo ID with you when you come in for care.

- Telling us if you receive care at a non-NEMS contracted facility/provider.
- If you require an interpreter, you should request an interpreter in advance prior to your appointment.

For any questions or issues regarding member rights and responsibilities, please contact NEMS MSO Provider Network team via email at provider.relations@nems.org or at 1(415) 352-5186 **Option 3**.

Member Grievances

All NEMS managed care members have the right to file a grievance if they are unhappy with any aspect of their care. Members can file a grievance directly with their respective health plan. Please direct NEMS members to the following health plan contacts if they would like to file a grievance.

Health Plan Member Grievance Contacts			
Health Plan	**Hours (if applicable)**	**Contact Number**	**Address**
San Francisco Health Plan: Medi-Cal & Medicare Advantage	Monday through Friday, 8:30am to 5:30pm	Customer Service: • 800-288-5555	7 Spring Street, San Francisco, CA 94104
Anthem Medi-Cal Plans		Medi-Cal Customer Care Center: • 800-407-4627 (outside L.A. County) • 888-285-7801 (inside L.A. County)	Grievance and Appeal Department Anthem P.O. Box 60007 Los Angeles, CA 90060-0007
Anthem Medicare Advantage Plans		Member Services: • Phone Number located on back of member ID card	Medicare Complaints, Appeals and Grievances (MCAG) Attention: Member Grievance Unit Mailstop: OH0205-A537 4361 Irwin Simpson Road Mason, Ohio 45040
Santa Clara Family Health Plan		Customer Service: • 800-260-2055, or TTY 711 • Fax: 408-874-1962	Attn: Grievance and Appeals Department Santa Clara Family Health Plan PO Box 18880 San Jose, California 95158
Alignment Health Plan	8 am-8 pm, seven days a week (except Thanksgiving and Christmas) from Oct.	Member Services: • English: 866-634-2247 (TTY: 711) • Spanish: 877-399-	Alignment Health Plan Attn: Member Services Department 1100 W. Town and

	1 - March 31 8 am-8 pm, Mon-Fri (except holidays) from April 1 - Sept. 30	2247 (TTY: 711)	Country Road, Suite 300 Orange, CA 92868
WellCare/HealthNet		Member Services: • 800-522-0088	PO Box 9103 Van Nuys, CA 91409-9103
PACE		Quality Improvement Coordinator: • 800-508-4578	NEMS PACE Attention: Quality Improvement Coordinator 728 Pacific Ave, Ste. 200 San Francisco, CA 94133 Fax: (415) 240-4352
SCAN Health Plan	Hours are 8 a.m. to 8 p.m., seven days a week from October 1 to March 31. From April 1 to September 30, hours are 8 a.m. to 8 p.m. Monday through Friday.	Member Services: • 800-559-3500 (TTY: 711)	SCAN Health Plan Attention: Grievance and Appeals Department PO Box 22644 Long Beach, CA 90801-5644

SOCIAL DETRIMENTS OF HEALTH

Social Determinants of Health (SDOH) are non-medical factors influencing health, such as conditions in which people are born, grow, live, work, and age. Key categories include:

- **Economic Stability**: Employment, income, and financial security.
- **Education**: Literacy, language, and access to quality education.
- **Health Care Access**: Insurance, primary care, and health literacy.
- **Neighborhood and Environment**: Housing, transportation, and healthy food access.
- **Social Context**: Support systems, discrimination, and community ties.

Addressing SDOH improves health outcomes and equity. Key reasons:

1. **Health Impact**: SDOH influence chronic disease, mental health, and life expectancy.
2. **Equity**: Reduces disparities among vulnerable groups.
3. **Care Efficiency**: Guides personalized treatment and referrals.
4. **Cost Savings**: Reduces hospital readmissions and emergency visits.

Documenting SDOH in Medical Records:

1. **Gather Information**:
    - Use open-ended questions or screening tools (e.g., PRAPARE).
    - Focus on housing, employment, transportation, and food security.
2. **Record Findings**:
    - Use EHR fields for SDOH (e.g., ICD-10 Z codes).

- Include patient-reported and observed factors.

3. **Plan and Address**:
    - Document referrals to social services.
    - Note patient engagement with interventions.
4. **Collaborate**:
    - Share SDOH insights in care team discussions.
    - Highlight factors affecting care plans.