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NETWORK MEDICAL MANAGEMENT

Managed IPA's: Allied Pacific, Access Primary Care Medical Group, Accountable Health Care, Advantage Health Network, Alpha Care Medical Group, Beverly Alianza, Emanate Health, Community Family Care, Greater Orange Medical Group, La Salle Medical Associates

Purpose

As a regulatory requirement, provider offices must attest to doing an annual review of UM policies, updates, clinical criteria, and other programs outlined in this presentation.

The IPA and its contracted providers are assessed yearly for compliance by our partner Health Plans, CMS, and DHCS. This presentation will outline these updates and programs. Your office will be required to provide a signed attestation confirming the office staff has been educated and trained on an annual basis.

Provider Offices

IPA Contracted Providers include

- Primary Care Physicians
- OB/GYNs and all other specialty providers

Primary Care Physician Office

Initial Health Assessment (IHA) and Individual Health Education Behavioral Assessment (IHEBA)

- ❖ NMM complies with the Department of Health Care Services (DHCS) requirement that Primary Care Physicians (PCPs) complete an IHA for all new Medi-Cal members.

- ✓ As the Member's PCP, you are held responsible for coordinating care for the needs of your members.
- ✓ On your provider portal, a list of you new members is available for your office to contact the members and schedule their initial visit. *Document all out-reach attempts your office conducts.*
- ❑ New Members
  - IHA should be completed within **120 days for Medi-Cal members (60 Days for members < 18 months)** of being eligible to receive services **.**
  - IHAs should be completed within **90 Days** for Covered California Members of being eligible to receive services .
  - IHAs should be completed for CMC and Medi-Medi members within **90 days** of being eligible to receive services.
- ❑ Current Members
  - Current members who have not completed an updated SHA must complete it during the next preventive care office visit (well-baby, well-child, well-woman exam), according to the SHA periodicity table.

*MMCD Policy Letter APL 16-014

Coordination of care, Language Assistance, Mental Health and Substance abuse

- ❑ Coordinating the member's care with a specialist provider
  - If the member missed their appointment, please follow up with the member.
  - Document all work-up and treatments done and include with your request for authorization.
- ✓ URGENT REQUESTS
  - We encourage your office to submit urgent requests only if there is a need for medical care or services where application of the time frame for making routine or non-life-threatening care determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.
- ❑ For the geriatric population and/or terminally ill: Please document assessment and wishes
  - End of life discussions related to advanced directives, palliative care and or hospice.
  - Medi-Cal members 18 year and above with a terminal disease have an End-Of-Life option that is covered as a Fee For Service under Medi-Cal that the member may wish to enroll in. The member will need to select a Fee For Service Provider to manage his future care.
- ❑ Cultural and Linguistics: Language Assistance Program
  - This information is to be reviewed yearly. Health plans send yearly updates which is available on your provider portal or the NMM website.
- ❑ Mental Health and Substance Abuse
  - Please assess at each visit and document assessment.

Open Authorization Tracking

- ✓ **Open authorizations: approved referrals that have not been used by the member.**
- ➢ **What action do we need to take?**
- ❑ A list of your members open authorizations is on your portal for you to review and follow up with the member to determine if the member no longer requires the referral and or if he needs to be reassessed.
- ❑ If the member was seen, please contact the specialist for the consult notes.

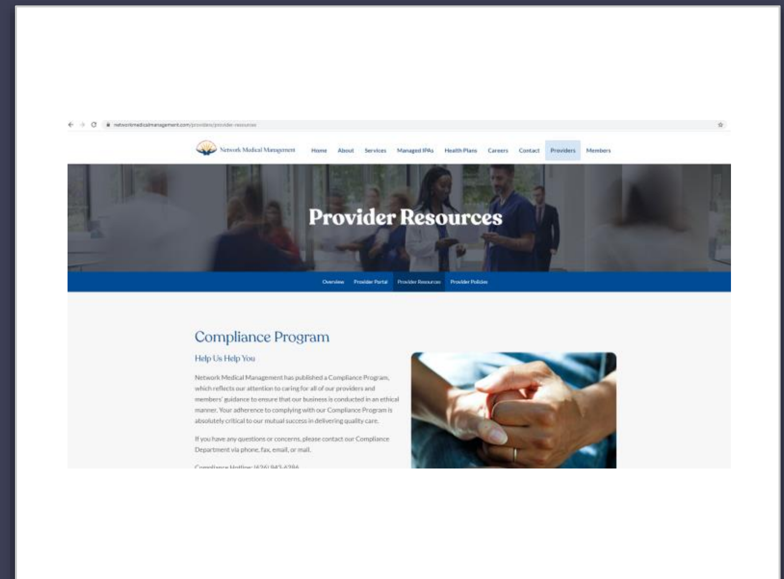
❖ **As a standard requirement under Medi-Cal, please document that you have received/read the consultation notes from the specialist and document any outreach to the member and/or specialist provider.**

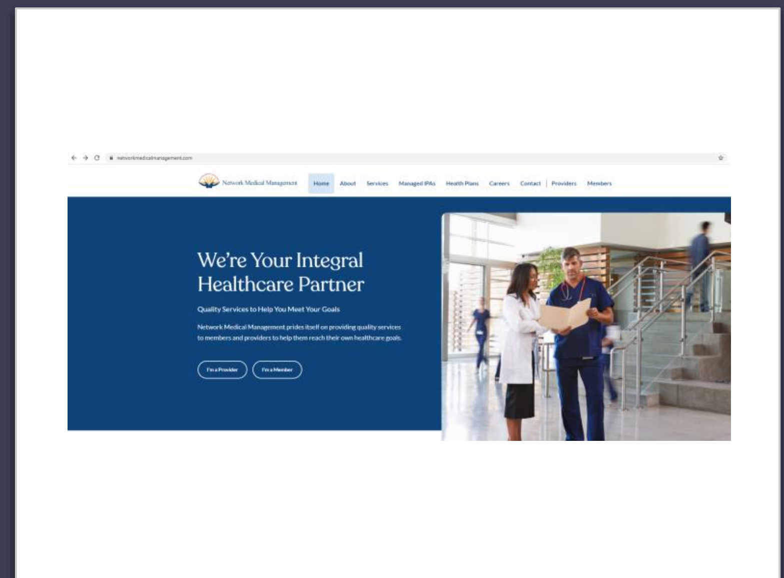
PROVIDER ANNUAL TRAINING

- Available online www.Networkmedicalmanagement.com
- "Providers" tab
- Provider Resources

(click + to expand list)

- ✓ Fraud, Waste, and Abuse
- ✓ General Compliance
- ✓ Model of Care (per Plan)
- ✓ General Provider Training
  - ✓ Access to Care
  - ✓ Cultural Competency
  - ✓ Language Assistance Programs
  - ✓ HIPAA

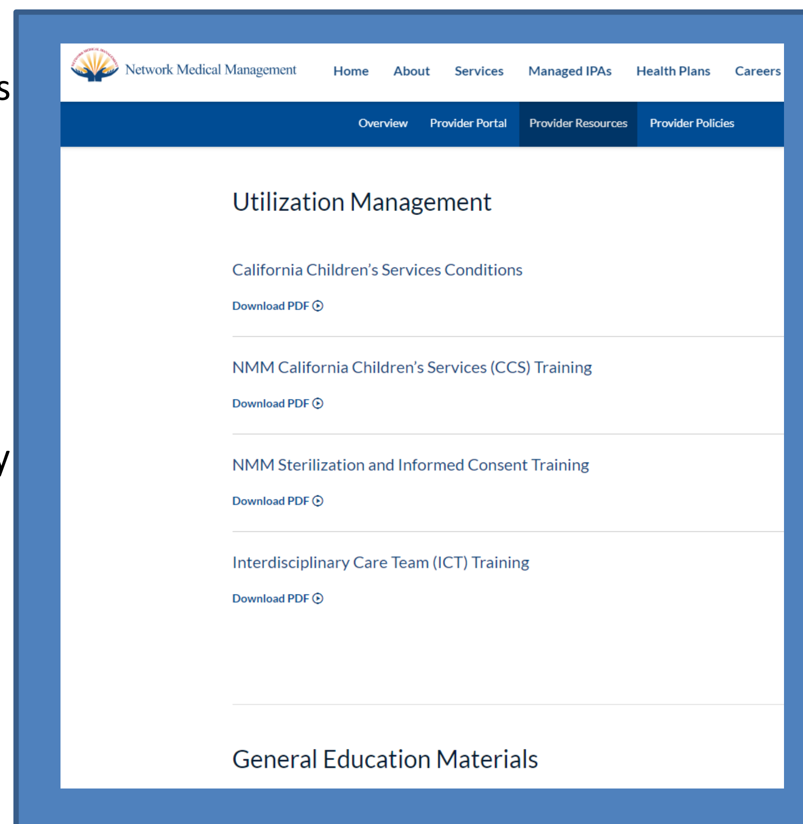




Programs/Materials for Annual Review

Updates/Guidelines

- ❑ Initial Health Assessment (IHA)
- ❑ Contracted provider (PCP / SPC) responsibilities
- ❑ Contracted specialist requirements
- ❑ NMM Standards of conduct
- ❑ UM Provider Updates
- ❑ California Children's Services (CCS)
- ❑ Child Health and Disability Prevention Program (CHDPP)
- ❑ Comprehensive Perinatal Service Program (CPSP)
- ❑ Early Start, Early Intervention, Developmentally Disabled (ES/EI/DD)
- ❑ Specialty Referral Tracking
- ❑ Standing Referral requirements
- ❑ Sterilization: PM330 and DHCS Education Booklet requirement
- ❑ Advance Directives
- ❑ Language Assistance Program (LAP)
- ❑ Screening, Brief Intervention and Referral to Treatment (SBIRT)
- ❑ Hospice / Palliative Care
- ❑ Behavioral Health Therapy (BHT)



*Audit guidelines under Medi-Cal/DHCS

Resources/Programs (Medi-Cal)

- WOMEN, INFANT AND CHILDREN'S (WIC) PROGRAM Supplemental nutritional options for children 5 and under and or your pregnant members
- CALIFORNIA CHILDREN SERVICES (CCS). For members 21 years and under. For members with catastrophic or congenital conditions to have enhanced coordinated services with specific providers.
    - If NMM Is notified that a member has CCS, we will notify your office.   If your member has CCS please document this in the chart at each visit.
- *REGIONAL CARE CENTERS: Services for members with Developmental Disabilities present prior to age18*
    - LA Care Health Plan will send a monthly list of any Regional Care Center Members. If your member is on this list, we will send you a notification of this to place in the chart.   Document this information at each visit.
  - If your office refers a member to one of the programs discussed, please document this in your member's chart.
  - Websites with additional information on the Medi-Cal Programs.
    - http://www.dds.ca.gov/rc/listings
    - http://www.publichealth.lacounty.gov/cms/ccs.htm

IPA Policies and Clinical Criteria

Quality Management Program & Policies

Quality Management Program, Policies and Procedures are available upon request to members and providers by calling our Customer Service department at (877) 282-8272 Opt. 1, Monday-Friday between 9:00 AM to 5:00 PM PT.

Financial Incentive Attestation

Network Medical Management's procedures for reviewing appropriateness of care are aimed at promoting quality of care and efficiency within the health care delivery process. We recognize the need for concern about the potential for under-utilization and appropriately review, which includes, but is not limited to bed day reports, lengths of stay reports, pharmacy usage reports and data on member concerns regarding access to services.

As a matter of policy, associates who make utilization management coverage decisions for Network Medical Management may not be compensated or given other incentives to make denial decisions. Utilization decision making is based only on appropriateness of care and services.

Utilization Management Policies

Procedures and Criteria are disseminated to members and provider upon request by calling our Customer Service department at (877) 282-8272 Opt.1, Monday through Friday between 9:00 AM to 5:00 PM PT. For the hearing impaired, please call our TTY telephone at 877-735-2929, Monday through Friday between the hours of 8:30 AM to 5:00 PM PT.

A requesting practitioner may call Network Medical Management to discuss a denial, deferral, modification, or termination decision with the physician (or peer) reviewer at (877) 282-8272 ext. 6195; Monday through Friday between the hours of 9:30 AM to 2:30 PM PT. All calls will be returned within 24 hours.

- Financial Incentive Attestation
- Quality Management (QM)
- Utilization Management (UM)