GREATER TRI CITIES

IPA

Independent Physicians - Providing Personal Care

Provider Training Manual

GREATER TRI CITIES IPA

Independent Physicians – Providing Personal Care

Dear Greater Tri Cities IPA Provider,

Welcome to Greater Tri Cities IPA! We would like to briefly review with you the many functions that the IPA is responsible for and your role in this important process. The IPA holds contracts with several HMO's or "Health Plans." The Health Plans give the IPA a portion of the monthly premium they collect for each member assigned to the IPA. The IPA is then responsible to provide health care services to these members. In order to do that, the IPA must contract with a network of PCP's, specialists, and other ancillary providers such as out patient surgery, home health, PT, radiology, pathology, and many others. The IPA is also delegated by the Health Plans for credentialing, utilization, management, quality improvement, claims and capitation payment.

The responsible use of healthcare resources is maintained by authorizing services according to current medical necessity guidelines, and since we only have access to the information you provide us with your authorization request, your active participation in this process is crucial. It is very important that you provide complete information when submitting a request so it can be reviewed and either approved or denied appropriately.

Both authorizations and claims payment are subject to the patient's eligibility at the time of service. A patient has the right to change their IPA at any time, so it is important that you check the patient's eligibility before each visit. You may obtain current eligibility by contacting the patient's health plan directly. We use an online portal, www.aerialcare.com for authorization request and tracking in addition to claims submission and tracking. A user name and password can be requested directly from Aerial Care at 800-864-8160. We also accept electronic claims through Aerial Care or Office Ally (866-575-4120). When calling one of those providers, give them our Payer ID of PDT01 to get set up.

Our objective is to manage the use of healthcare resources responsibly without impeding our provider's ability to deliver appropriate, quality healthcare. If you have any questions, please feel free to contact me at 760-941-7309 ext. 130

Sincerely,

Itzel Romero

iromero@pdtrust.com
Provider Relations Specialist

PHYSICIANS DATATRUST

INTEROFFICE MEMORANDUM

TO: PCP, SCP, Clinical Services and Administrative Staff

FROM: Lisa Serratore, Chief Executive Officer

CC: Evelyn Jimenez, IPA Manager, CVPG
Renee LaMarsh, IPA Administrator, GTCIPA
Mary Beltran, IPA Administrator, Noble AMA IPA; Interim IPA Manager, GPMG
Leesa Johnson, VP of IPA Operations, St. Vincent IPA

DATE: January 11, 2023

RE: Affirmative and Impartiality Statements

AFFIRMATIVE STATEMENT

As a utilization management organization, Physicians DataTrust on behalf of Citrus Valley Physicians Group, Golden Physicians Medical Group, Greater Tri Cities IPA, Noble AMA IPA, and St. Vincent IPA, ensures that all decisions are made based on the available medical information at the time of the request. Should a member ask to see the criteria utilized to make a medical decision; the statement below is attached to that guideline, as required by the National Committee for Quality Assurance (NCQA):

Decisions regarding requests for medical care are based on the medical necessity of the request, the appropriateness of care and service and existence of coverage. There is no monetary reward for non-approval of services. Compensation for individuals who provide utilization review services does not contain incentives, direct or indirect, for these individuals to make inappropriate review decisions.

Utilization review criteria, based on reasonable medical evidence and acceptable medical standards of practice (i.e. MCG and/or applicable health plan guidelines) are used to make decisions pertaining to the utilization of services. Review Criteria are used in conjunction with the application of professional medical judgment, which considers the needs of the individual patient and characteristics of the local delivery system.

IMPARTIALITY STATEMENT

All participating practitioners are ensured independence and impartiality in making referral decisions which will not influence hiring, compensation, termination, promotion or any other similar matters.

These statements are also on our websites: www.cvpg.org, www.gpmedicalgroup.com, www.gtcipa.com, , www.nobleamaipa.com, and www.stvincentipa.com, along with other valuable information for our contracted providers and our members, and can be printed, if needed. Our business hours are Monday through Friday, 9:00a.m. to 5:00p.m. and Administrative staff can be reached at (760) 941-7309 or (800) 458-2307 during business hours. Should you have a question for the Utilization Management Department after hours, you may call (760) 941-7309 or (800) 458-2307 and leave a message for someone to call you back the next business day.

GREATER TRI CITIES IPA

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Greater Tri Cities IPA
New Provider Orientation

Provider Name: _____ Contract Effective Date: _____

Is the Provider(s) **PCP, SCP**, or **Ancillary**? (Circle one)

I acknowledge that our office has been oriented on the following Greater Tri Cities IPA policies and procedures and has received and reviewed the provider manual's topic areas:

1. Staff Directory and Phone Tree
2. Contracted Health Plans
3. Contracted Urgent Cares and Radiology
4. Referral Process
5. Member Add Request
6. Claims Submission and Payment Process
7. Affirmative Statement
8. Compliance Training/IPA Attestation-required within 30 days of contract date
9. Access to Care Standards
10. Cal MediConnect Training
11. Provider Marketing Guidelines
12. Cal MediConnect Model of Care/SNP Training
13. Blue Shield Promise CMC Training Attestation (required within 30 days of contract date)

For additional resources and training tools, please visit our website: gtcipa.com

GTC Representative	Signature	Date
Provider Office Representative	Signature	Date

GREATER TRI CITIES IPA

Independent Physicians – Providing Personal Care

STAFF DIRECTORY

IPA Operations

Renee LaMarsh, IPA Administrator	(800) 458-2307 ext. 134
Itzel Romero, Provider Relations Specialist	(800) 458-2307 ext. 130
Cesar Delgado, Risk Supervisor	(800) 458-2307 ext. 116
Katharine Nunez, Quality Manager	(800) 458-2307 ext. 103
Caroline Begins, Quality Coordinator	(800) 458-2307 ext. 227

Utilization Management

Dr. Mark O'Brien, GTC Medical Director	
Cheryl Souza, Vice President of Clinical Services	(800) 458-2307 ext. 118
Jehiel Elad, Clinical Services Nurse	(800) 458-2307 ext. 140
*Iselda Gentry MSN, FNP-BC	(800) 941-7309 ext. 106

Referral Authorizations:

- Phone Number	(800) 458-2307 opt. 2 then opt. 3
- Fax Number	(760) 941-7332
- Provider Portal for referrals	(800) 864-8160

www.aerial.carecoordination.medecision.com

Claims

Claims, including encounter data, that cannot be submitted electronically via Cerecons or Office Ally can be submitted on a CMS 1500 form and mailed to the P.O. Box listed below.

- Claims Phone Number (800) 458-2307 opt. 2 then opt. 2

Claims Mailing Address

Greater Tri Cities IPA
P.O. Box 5059
Oceanside, CA 92052

**Diabetic Education/Home Visit-send referral through Aerial*

GREATER TRI CITIES IPA

Independent Physicians - Providing Personal Care

This is a reminder to please update the phone number you have on file for Greater Tri Cities IPA to the number below. This number is dedicated to GTC members and providers.

Main Line: 1-800-458-2307

The following shortcuts will allow you to easily navigate our phone system options:

❶ Member
- ① Claims Department
- ② Clinical Services Department
- ③ General Information (Hours, Mailing Address, etc)

❷ Provider
- ① General Information (Hours, Mailing Address, etc)
- ② Claims Department
- ③ Clinical Services Department
- ④ Credentialing Department
- ⑤ Risk Adjustment Department
- ⑥ Provider Relations Department
- ⑧ Health Net Community Care

❹ Assistance in Spanish

** At any point, you can return to the previous menu by pressing * (star)

We encourage our providers to continue to utilize Aerial Care to submit any authorization requests, check eligibility, authorization and claim status.

If you encounter any issues with getting ahold of someone and/or are on hold for an unreasonable amount of time, please reach out to Audrey at aburton@pdtrust.com or x185.

GREATER TRI CITIES
IPA
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GREATER TRI CITIES IPA
CONTRACTED HEALTH PLANS

Aetna - Commercial and Medicare Advantage plans
Phone: 800-624-0756
http://www.aetna.com

Alignment-Medicare Advantage Only
Phone: 866-634-2247
https://alignmenthealthplan.com/

Astiva-Medical Advantage Only
Phone: 866-688-9021
https://astivahealth.com/

Brand New Day- Medicare Advantage Only
Phone: 866-255-4795
https://bndhmo.com/

Blue Cross - Commercial and Medicare Advantage plans
Phone: 800-677-6669
https://provider2.anthem.com

Blue Shield - Commercial and Medicare Advantage plans
Phone: 800-424-6521
Http://www.blueshieldca.com

Blue Shield Promise- Only Cal MediConnect-effective 1/1/2021
Phone: 800-605-2556
Http://www.blueshieldca.com

Cigna - Commercial plan only
Phone: 800-882-4462
http://www.cigna.com

CleverCare-Medicare Advantage Only
Phone: 917-545-5439
https://clevercarehealthplan.com/

Health Net – Commercial and Medicare Advantage
Phone: 800-641-7761
http://www.healthnet.com

Humana- Medicare Advantage only
Phone: 800-448-6262
http://www.humana.com

Sharp- Commercial and Medicare Advantage
Phone: 800-359-2002

http://www.sharphealthplan.com

United Healthcare-Commercial and Medicare Advantage plans
Phone: 800-542-8789
http://www.uhcwest.com

Contact health plan for access to their secure web site.

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Urgent Care Locations

Please be aware that the Urgent Care is not to be used as a substitute for calling your PCP's office for an appointment, as the Urgent Care visit may not be covered.

Optum Urgent Care
Thunder Drive Location
145 Thunder Drive
Vista, CA 92083
(760) 941-9002
Hours: M-F, 3:00 pm-9:00 pm
Saturday, 9:00 am to 4:00 pm
Sunday, 10:00 am to 3:00 pm
*Open Dec 23rd 9-3, Closed Thanksgiving, Christmas Eve, Christmas, New Year's Eve, New Year's Day.

828 Urgent Care
4171 Oceanside Blvd., #109
Oceanside, CA 92056
Phone: (760) 216-6253
Hours: 8 am – 8 pm everyday
*Holidays-normal hours

Concentra Urgent Care

Carlsbad Site
5810 El Camino Real, Suite A
Carlsbad, CA 92008
Phone: (760) 929-8269
Fax: (760) 929-8556
Hours: M-F, 7:00 am to 6:00 pm
Closed Christmas and New Year's Day

Escondido Site
860 West Valley Parkway, Suite 150
Phone: (760) 740-0707
Hours: M-F, 8:00 am to 3:30 pm
Closed Christmas and New Year's Day

Oceanside Site
3910 Vista Way, Suite 106
Phone: (760) 941-2000
Hours: M-F, 7:00 am to 7:00 pm
Sat-8am-2pm
Closed Dec 23-25th and 30th-Jan 1st.

Pediatrics

Rady Children's Urgent Care Escondido
625 W. Citracado Parkway, Suite 100
Escondido, CA 92025
(760) 739-1543
Hours: M-F, 4:00 pm-10:00 pm
Sat/Sun, 1:00 pm to 10:00 pm
Christmas Eve, Christmas Day, New Year's Eve, New Year's Day 4pm-10pm

Rady Children's Urgent Care Oceanside
3605 Vista Way, Suite 172
Oceanside, CA 92056
(760) 547-1000
Hours: M-F, 4:00 pm-10:00 pm
Sat/Sun 1:00 pm to 10:00 pm
Christmas Eve, Christmas Day, New Year's Eve, New Year's Day 4pm-10pm
(no x-ray machine)

GREATER TRI CITIES IPA

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Contracted Radiology Providers

Carlsbad Imaging
6010 Hidden Valley Rd Ste 125
Carlsbad, CA 92011
760-730-3536

Cypress Imaging
3230 Waring Ct Ste I
Oceanside, CA 92056
760-931-1200

Imaging Healthcare Specialists (multiple locations)
3601 Vista Way Bldg A Suite 101
Oceanside, CA 92056
858-658-6500

San Diego Imaging (multiple locations)
3909 Waring Rd Suite C
Oceanside, CA 92056
760-630-0014

Valley Radiology
255 North Elm St #102
Escondido, CA 92025
760-739-5400

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Tri City PET
902 Sycamore Ave #120
Vista, CA 92081
760599-9940

Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056
760-940-7470

REFERRAL FORM A – PCP

TRACKING NUMBER
IPA USE ONLY

Greater Tri-Cities IPA
Fax: (760) 941-7332 Phone: (760) 941-7309

Date of Referral Request: ____/____/____ ☐ **Routine** ☐ **Urgent** ☐ **Emergent**
☐ **Member Request**

Patient Name: (First, Last) _____

Address: _____ City: _____ Zip: _____

Date of Birth: ____/____/____ Phone: _____

Health Plan: _____ Patient ID#: _____

Referred To: **ICD-10:**

Specialty Type: _____

Referred By: (PCP) **Diagnoses:**

PCP office Contact : _____

PCP Phone: _____

PCP Fax: _____

SIGNATURE OF PCP:
(MANDATORY – WILL NOT BE PROCESSED WITHOUT MD SIGNATURE) _____

Procedures/services requested:	CPT CODE:
	CPT CODE:
	CPT CODE:
	CPT CODE:

Reason for REFERRAL: _____

Attachment(s)	
Notes:	
Lab:	
EKG/EEG:	
X-Ray	
Other:	

Place of Service: ☐ **Office** ☐ **Out-Patient** _____ ☐ **In-Patient** _____

FOR USE BY GREATER TRI CITIES IPA UM STAFF ONLY

☐ Authorize Date: _____ ☐ Pending Date: _____ ☐ Modified Date: _____

☐ Denied Date: _____ ☐ Not a covered benefit. ☐ T P L

Comments/Remarks: _____

UM Signature: _____ **Date:** _____

Date PCP Notified: _____ ◊**Please notify member today of referral status.**

Certification does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions. This certification is good for sixty (60) days from approval date

FRM 022
Revised 090106

GREATER TRI CITIES

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REFERRAL TURNAROUND TIME STANDARDS

Greater Tri Cities IPA follows or exceeds these national standards for referral turnaround time.

- **Routine referrals** have a 5 business day decision time frame from the time a completed and signed referral has been received in IPA office. The IPA must notify the PCP office within 24 hours of that decision via FAX, e-mail or telephone.

- **Urgent referrals** have 72 hours.

- **Emergent referrals** must have a **24 hour turnaround time** during business hours (8:00am – 5:00pm).

- Referrals received at the end of a business day (after 4:00pm) will be processed as received on the next business day.

- **Pended routine referrals** – can pend 45 days for commercial members or 14 days for senior members. Once we receive the requested information, we have five (5) business days to make a decision.

- **Pended urgent referrals** – can pend 48 hours, then a decision must be made within 24 hours.

GREATER TRI CITIES IPA

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Instructions for Aerial Care Start Up

Greater Tri Cities IPA provides a Web Portal for On Line Referrals & Claims Submission through Aerial Care, a managed care software system. If you have internet access in your office simply follow the steps below to easily set up your on line referral process for your Greater Tri Cities IPA patients.

1. Call Aerial Care customer service department at **1-800-864-8160**, to obtain your login and password.
2. Go to the IPA website: www.gtcipa.com
3. Click on the "Aerial Care" button at the top of the page. This will take you to the Greater Tri Cities IPA Aerial Care web portal.
4. Enter your login name and password. The first time you log on, you will be asked to change your password. (You will be asked to change your password every 30 days. Be aware that when that happens, you *may* reuse the same password.) After entering your new password, you will be taken into the site.
5. The screen you will first see is called the "*dashboard*". At the top and middle of the screen, under "*Group Information*", you will see any Provider notices we have posted, as well as documents for common use.

To access the Aerial Care Training information:

1. Click on the word *Training* at the top of the screen.
2. If you would like to download written documentation, on the left side of the screen under Documentation click on Provider. Then click *Physicians Training*. The training materials will open up in Adobe Reader. You can then print the information or save the document to your computer.
3. If you would like to access an online training video, on the right side of the screen under *Training Videos* click Provider. Then click Provider Dashboard. The training video will then open for you to review. Note: You must have speakers on your computer to hear the audio on the training video.

To enter a referral:

1. Click on "Submit Online Referrals", which you will find in the far left column on your screen.
2. You may search for the patient using the ID#, Name, SSN, or DOB. We have found that the name or DOB are the easiest search options. Please note that the patient will show up with the name and DOB *that the health plan believes they have.* For this reason, if you have trouble finding the patient, you should look at their ID card to see if the health plan knows them by a different name or DOB. (Note: if the plan has any of the patient's information noted incorrectly, the patient must contact the plan to have that corrected.) If you do not find the patient at all, please verify their eligibility with the health plan.

3. If the patient is newly effective with Greater Tri Cities IPA, please use the *"Member Add Request Form"* (which can be found on the dashboard under Group Information) to report the new patient to us. We will add the patient to our system and they will soon be available to you on Aerial care.

4. Once the correct member has been located, take note of the icon to the left of their record on the screen. If it is red, they are ineligible according to the last information provided to us by the health plan. If this is incorrect and they are still eligible under this health plan, use the *"Member Add Request Form"* to have the patient updated by us. If the icon is green, they are eligible, and a purple "refer" button will appear to the right of their record on the screen. Click on the "refer" button to proceed with submitting a referral.

5. A referral form will come up on the screen. You will fill in the fields using a combination of typing and drop down menus. *All fields in red must be completed*, including CPT and ICD-10 codes. If you do not know a code, you can type in a description, and the system will provide a drop down menu of choices to select from.

6. You will see 2 boxes; Clinical Symptoms and Proposed Treatment. **Please provide complete information on the patient's condition** including pertinent test results. This will allow us to make a decision and respond to your request quickly.

7. Once you have completed the form, click on the "submit" button at the bottom of the screen.

8. Any applicable questions will come up on the next screen. Complete them and click on the "submit" button. (If you want to change anything on your referral, this is your last chance – click the "edit referral" button.)

9. The next screen will tell you either that your referral has been received and is being processed, or that your referral was approved. You have the chance to attach any notes or test results here, by clicking on the statement below that says "click here to add attachments".

To look up the status of a referral that you previously submitted:

1. Click on the "eligibility" tab near the top of your dashboard.
2. Enter the patient's first and last name, or DOB. Click "submit".
3. If there is more than one patient that comes up, identify the correct patient. To the far right of their record, you will see two icons. The "paper with the blue arrow" icon is the one you want to click to open the patient's record.
4. This will bring up the patient's demographic information. You will see two buttons at the top of the page. To look at their referrals, click the "member referrals" button. (The small number to the right of the button represents how many referrals are on record for this patient.) Any referrals on file for this patient will come up on the next screen. You may click on the "paper with the blue arrow" button on the far right to open the referral details.

GREATER TRI CITIES IPA

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Member Add Request Form

Complete all fields below and fax this form to (760) 477-2951.

Please Note that this form is for non urgent Member Adds only. If you have a patient who requires a medically urgent referral, please fax the referral directly to the UM Department for expedited processing. Requests will be processed within 3 business days.

You may submit Member Add requests electronically, by logging into Cerecons and selecting "Create a New Member Inquiry" under the Eligibility Tab

** All fields must be completed for your request to be processed.

Provider Name:			
Contact Name		Contact Phone#	
Contact Fax#			
Purpose for this Request:	☐ New Member ☐ Health Plan Change ☐ Update Member information (Member information is received from the Health Plan. Member must notify their Plan of any necessary updates.) ☐ Date of Birth ☐ Address ☐ Sex ☐ Other :		
Health Plan		Health Plan Member ID	
Member First Name		Member Last Name	
Member Date of Birth		Member Gender	
Member Address			
Member Phone Number			
Comments			

To Be Completed by IPA:

Response:

☐ Member has been added or updated; Changes will be reflected in next month's capitation report.
☐ Member is not eligible with IPA Name / PCP
☐ Form Incomplete / Information Submitted can not be verified with Health Plan
☐ Other:

Aerial Care

Claim Submission Options:

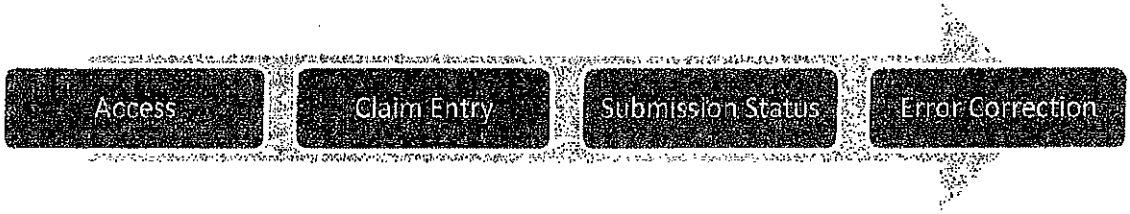
There are 2 options for claims submission via Aerial Care:

- File upload, which allows for the upload of an ANSI837 Professional Claim file.
- Online Claim Entry, which is claim submission via manual entry into an Online CMS1500 Claim form.

Claim Submission Process:

Access: Contact Medecision / Aerial Care for access at (800) 864-8160. Select the option for "Aerial Care Coordination".
Test File Submission: You must first submit a Test file before actual claims can be submitted. To upload a Test file, contact Support at (800) 864-8160 and select the option for "Aerial Care Coordination". A representative will assist you to ensure a successful Test File upload.
Claim File Submission: Once you have successfully submitted a Test file, you can submit a Claim file by clicking the Upload Claim Batches option, which is listed under Quick Links on the left side of your Aerial Care dashboard screen.
Submission Status: You can check the status of any submitted batch by clicking the Submitted Claim Batches option under Quick Links on the left side of your Aerial Care dashboard screen.
Error Correction: From the Submitted Claim Batches screen you can open any batch that has 1 or more listed in the Err field, meaning there are Errors. You can open the claim record and make the corrections on the online claim form.

Online Claim Entry:



Access: Contact Medecision / Aerial Care for access at (800) 864-8160. Select the option for "Aerial Care Coordination".
Claim Entry: Click the Submit Online Claims option, which is listed under Quick Links on the left side of your Aerial Care dashboard screen. Enter the information on the search screen to locate the correct member. Click the Claim icon to create an online claim. Enter all applicable values. If you have only 1 claim to submit, click Submit Single Claim. If you have multiple claims to submit click Save in New Batch. Once all claims have been created and saved, click Submit Batch.
Submission Status: You can check the status of any submitted batch by clicking the Submitted Claim Batches option under Quick Links on the left side of your Aerial Care dashboard screen.
Error Correction: From the Submitted Claim Batches screen you can open any batch that has 1 or more listed in the Err field, meaning there are Errors. You can open the claim record and make the corrections on the online claim form.

Other Important Information:

- Member and Provider information in Aerial Care is updated nightly.
- Claims successfully submitted via Aerial Care are received by the IPA the following business day.
- Only Professional Claims or Encounters may be submitted via Aerial Care.

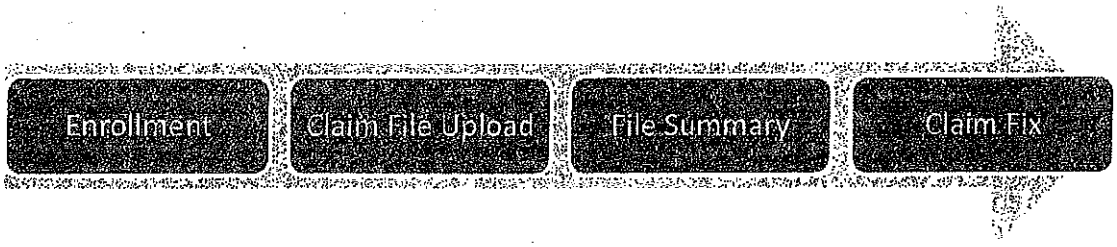
Office Ally

Claim Submission Options:
There are 2 options for claims submission via Office Ally:

- File upload, which allows for the upload of an ANSI837 Professional or Institutional Claim file, either via web portal or SFTP.
- Online Claim Entry, which is claim submission via manual entry into an Online CMS1500 or UB04 Claim form.

Payer ID: PDT01

Claim Submission Process:



Enrollment: Contact Office Ally for enrollment and access at (360) 975-7000. Select option 1. Or visit https://cms.officeally.com/Register/Register.aspx to complete the Enrollment Form online.
Claim File Upload: Log onto officeally.com. Hover over the Upload Claims option on the left side of the screen. Select Upload HCFA, to upload a Professional Claim file, or select Upload UB04 to upload an Institutional Claim file. Click Select File. Browse for your file and click Open. Click Upload. You will receive an upload confirmation page with your File ID number. Alternately, Office Ally does offer an option for SFTP file submission. Contact Office Ally at (360) 975-7000, option 1 to request SFTP. You will need to be prepared to provide the following information: Office Ally User Name, Contact Name, Email, Software Name, Format being submitted and whether you would like to receive 999/277s.
File Summary: Within 24 hours, your file summary will be available. This report is the receipt of the claims submitted. To view the available reports, select Download File Summary under Download listed on the left side of the screen. Dates listed with a pink background are dates that have reports that have not yet been viewed. Click on the date to view the available reports for that date. Click on the View link to review the report. Then click Open.
Claim Fix: If a claim receives an error and cannot be processed it will be made available in Claim Fix. You can view any claims in Claim Fix by selecting the Claim Fix option on the left side of your screen then clicking "Repairable Claims". Click on any date which has a pink background. Click the Correct link to view and fix the data on the claim. Click Update to save the changes and resubmit the claim. Once all of your claims for a specific date have been corrected the background for that date will change to white.

Online Claim Entry:

Enrollment: Contact Office Ally for enrollment and access at (360) 975-7000. Select option 1. Or visit https://cms.officeally.com/Register/Register.aspx to complete the Enrollment Form online.
Claim Entry: To view a detailed video which will walk you through the process, log onto the Office Ally Website at www.officeally.com. Click on Training Videos on the Menu Bar and then select the "Online Claim Entry" video under Service Center. To submit your claim(s) via Online Claim Entry, click the Online Claim Entry option under Claims, on the left side of your Office Ally screen, after you have logged onto the site.

Claim Batching: After online claims are submitted they will be "Awaiting Batch". Claims can take 1-3 hours to be reviewed and batched. While a claim is in this status you can view, edit or delete the claim by selecting Claims Awaiting Batch under the Online Claim Entry option on the left side of the screen.
File Summary: Within 24 hours, your file summary will be available. This report is the receipt of the claims submitted. To view the available reports, select Download File Summary under Download listed on the left side of the screen. Dates listed with a pink background are dates that have reports that have not yet been viewed. Click on the date to view the available reports for that date. Click on the View link to review the report. Then click Open.
Claim Fix: If a claim receives an error and can not be processed it will be made available in Claim Fix. You can view any claims in Claim Fix by selecting the Claim Fix option on the left side of your screen then clicking "Repairable Claims". Click on any date which has a pink background. Click the Correct link to view and fix the data on the claim. Click Update to save the changes and resubmit the claim. Once all of your claims for a specific date have been corrected the background for that date will change to white.

Other Important Information:

- Member and Provider information on Office Ally is updated weekly.
- Claims submitted via Office Ally are received by the IPA the business day after successful submission and processing by Office Ally.
- Office Ally offers to Print and mail any claims that can not be submitted electronically. If you are interested in this service contact Office Ally or access the "Update Printing Option Form" available on the Office Ally website under Resource Center, Office Ally Forms & Manuals then Account Management.
- Technical Support is available at (375) 975-7000, option 2.
- Office Ally offers Free Training. To utilize this service contact Office Ally at (360) 975-7000 Option 5.

Smart Data Solutions

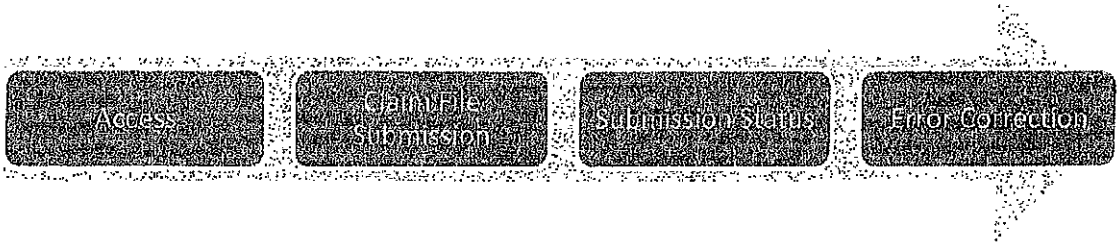
Claim Submission Options:

There are 2 options for claims submission via Smart Data Solutions:

- File upload, which allows for the upload of an ANSI837 Professional or Institutional Claim file.
- Online Claim Entry, which is claim submission via manual entry into an Online CMS1500 or UB04 Claim form.

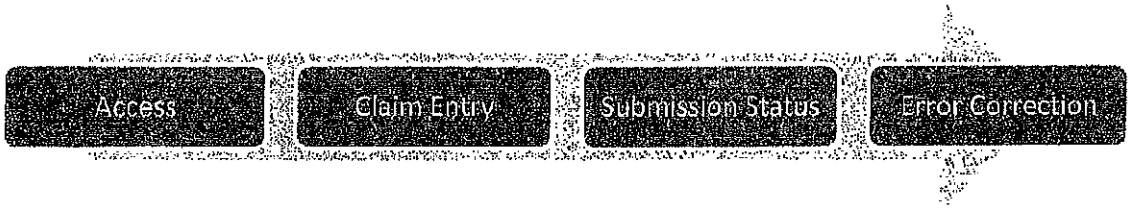
Payer ID: PDT01

Claim Submission Process:



Access: Contact Smart Data Solutions (855)297-4436 to obtain access.
Claim File Submission: Once you have access to the SDS Quick Claim Portal, you can submit a Claim file by clicking the Upload New File option.
Submission Status: You can check the status of any submitted batch by clicking on Batch History on the Main screen.
Error Correction: From main screen you can click on View Rejected documents, to review and correct any claims that were rejected.

Online Claim Entry:



Access: Contact Smart Data Solutions (855)297-4436 to obtain access.
Claim Entry: Once you have access to the SDS Quick Claim Portal, you can submit a Claim online by clicking the Key New Claim option. Enter your claim information and click Save.
Submission Status: You can check the status of any submitted batch by clicking Batch History on the Main screen.
Error Correction: From main screen you can click on View Rejected documents, to review and correct any claims that were rejected.

Other Important Information:

- Member and Provider information with Smart Data Solutions Aerial Care is updated every Friday.
- Claims successfully submitted via Smart Data Solutions are received by the IPA the following business day.
- Both Professional and Institutional Claims can be submitted via SDS.

InstaMed®
Healthcare Payments Simplified

GREATER TRI CITIES IPA

May 23, 2018

Attention: Action Requested
New Payment Process for Greater Tri Cities IPA

Dear Billing Manager:

Greater Tri Cities IPA has partnered with InstaMed, the leading healthcare payments network, to offer a **free** solution to deliver your payments as Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT). You can register to receive Greater Tri Cities IPA ERA/EFT payments today at www.instamed.com/eraeft.

ERA/EFT is a convenient, paperless and secure way to receive claim payments. Funds are deposited directly into your designated bank account. The benefits of ERA/EFT include:

- Accelerated access to funds with direct deposit into your existing bank account
- Reduced administrative costs by eliminating paper checks and remittances
- No disruption to your current workflow – there is an option to have ERAs routed to your existing clearinghouse

You have two simple options to register to receive Greater Tri Cities IPA payments as *free* ERA/EFT transactions:

1. **Online:** visit www.instamed.com/eraeft
2. **Paper:** complete the enclosed Network Funding Agreement and fax it to (877) 755-3392

Please do not hesitate to contact us directly at (866) 945-7990 or connect@instamed.com with any questions.

Sincerely,

Richard M. Croswell
Senior Vice President
InstaMed

1880 John F. Kennedy Blvd. • 12th Floor • Philadelphia, PA 19103
Tel: (866) 945-7990 • Fax: (877) 755-3392
www.instamed.com

Payer Payments

InstaMed®
Healthcare Payments Simplified

The InstaMed Payer Payments solution enables providers to receive claim payments via electronic remittance advice (ERA) and electronic funds transfer (EFT). ERA/EFT is a convenient, paperless and secure way to receive claim payments. Funds are deposited directly into your designated bank account and include the TRN Reassociation Trace Number, in accordance with CAQH CORE Phase III Operating Rules for HIPAA standard transactions.

Additional benefits include:

- **Accelerated access to funds with direct deposit into your existing bank account**
- **Reduced administrative costs by eliminating paper checks and remittances**
- **No disruption to your current workflow – there is an option to have ERAs routed to your existing clearinghouse**

To register for free InstaMed Payer Payments, visit www.instamed.com/eraeft.

Frequently Asked Questions

Is Online Registration secure?

Yes. InstaMed places the highest importance on data integrity, security and compliance. InstaMed meets the highest industry standards for compliance and security, including Payment Card Industry (PCI) Level One and verification processes to prevent fraud. For details about InstaMed compliance standards, visit www.instamed.com/about/compliance-and-security.

What information is needed during Online Registration?

- Tax ID
- Email Address
- Legal Business Name
- Business Address/Phone
- Principal Name (primary decision maker)
- Billing NPI Number
- Bank Name
- Bank Routing Number

How will I receive my ERAs?

You have multiple options to receive your ERAs. Upon registering for InstaMed, you will receive access to InstaMed Online, a free, secure provider portal that will allow you to access payment details 24/7 and view and print remittances. You also have the option to have ERAs routed to your existing clearinghouse. Finally, you have the option to have an SFTP folder set up. Please contact InstaMed at connect@instamed.com or (866) 945-7990 with any questions on ERA delivery.

Will I still receive paper EOBs in the mail?

No. Once your register for ERA/EFT, you will stop receiving paper checks and mailed EOPs.

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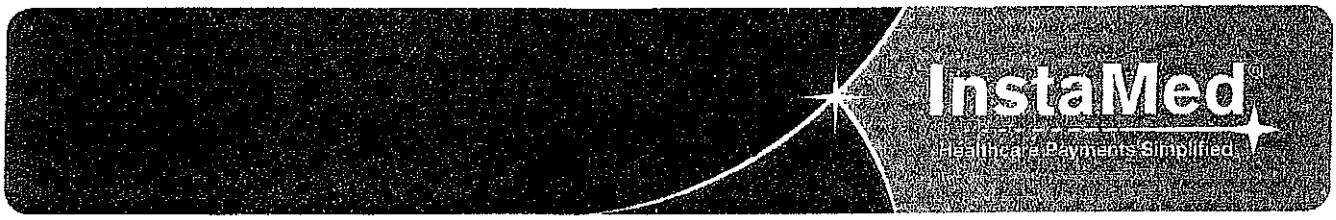
InstaMed is a registered ISO of Wells Fargo Bank, N.A., Walnut Creek, CA.; a registered ISO of U.S. Bank, N.A.; and a registered MSP/ISO of Elavon, Inc. Georgia



How will I know when I get paid?

You will receive email alerts to notify you when a payment is made, so you can easily track all payments. Additionally, you will have 24/7 access to reporting with InstaMed.

Which NPIs do I provide?

Please enter your Type 2 NPI(s) during Online Registration since they are used for billing claims.

What if I have multiple Tax IDs?

Once you register, you may add additional Tax IDs to your account.

Who is the contact vs. the principal?

The principal is the primary decision maker, i.e., director or owner. The contact is the person who will be the administrator on the account. The contact may be the principal or an authorized representative of the organization.

Which email address should I enter during Online Registration?

InstaMed will send an email to this address to confirm registration, so this should be an email address you want to use for your InstaMed account.

Why do I need to enter details about my business during Online Registration, including date established?

In order to prevent fraud, we use this information to verify your organization.

What is the turnaround time between registering online and receiving payments?

After you register online, someone from InstaMed will reach out to you to verify your account. You will also have access to online training materials. It takes about 8 to 10 business days to receive your first payment, because InstaMed completes a thorough verification process to ensure your bank account information is secure.

I'm a billing service. Why should I register?

We work directly with you, the billing service, enabling you to manage payments for your providers as you do today, but with tools to make your processes more efficient. Plus, you manage all of the payments and reports for providers all in one place, and enhance your offering to providers by enabling them to receive the payments faster.

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InstaMed is a registered ISO of Wells Fargo Bank, N.A., Walnut Creek, CA.; a registered ISO of U.S. Bank, N.A.; and a registered MSP/ISO of Elavon, Inc. Georgia

InstaMed – Online Registration

What is Online Registration?

Online registration is a way for provider's to conveniently join the InstaMed Network for the following services:

- Payer Payments (ERA/EFT)
- Member Payments

InstaMed Packages:

- Payer Payments (ERA/EFT Only)
- Standard (ERA/EFT + Member Payments)

InstaMed Registration Sites:

- https://register.instamed.com/eraeft

Page 1 – Landing Page – Getting Started

InstaMed®
Healthcare Payments Simplified

InstaMed Healthcare Payments Account

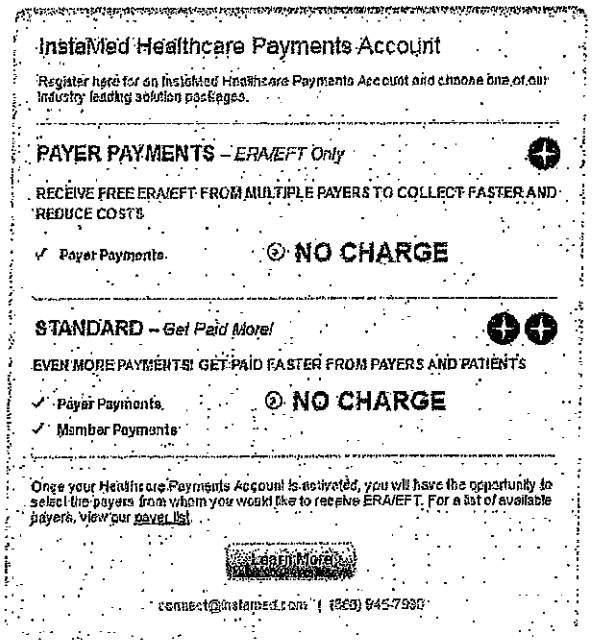
Register for your InstaMed Healthcare Payments Account and get paid!

Email *

Tax ID *

Registration Code
OPTIONAL

Get Started


InstaMed Healthcare Payments Account

Register here for an InstaMed Healthcare Payments Account and choose one of our industry leading solution packages.

PAYER PAYMENTS – *ERA/EFT Only*

RECEIVE FREE ERA/EFT FROM MULTIPLE PAYERS TO COLLECT FASTER AND REDUCE COSTS

✓ Payer Payments ⓘ NO CHARGE

STANDARD – *Get Paid More!*

EVEN MORE PAYMENTS! GET PAID FASTER FROM PAYERS AND PATIENTS

✓ Payer Payments ⓘ NO CHARGE
✓ Member Payments

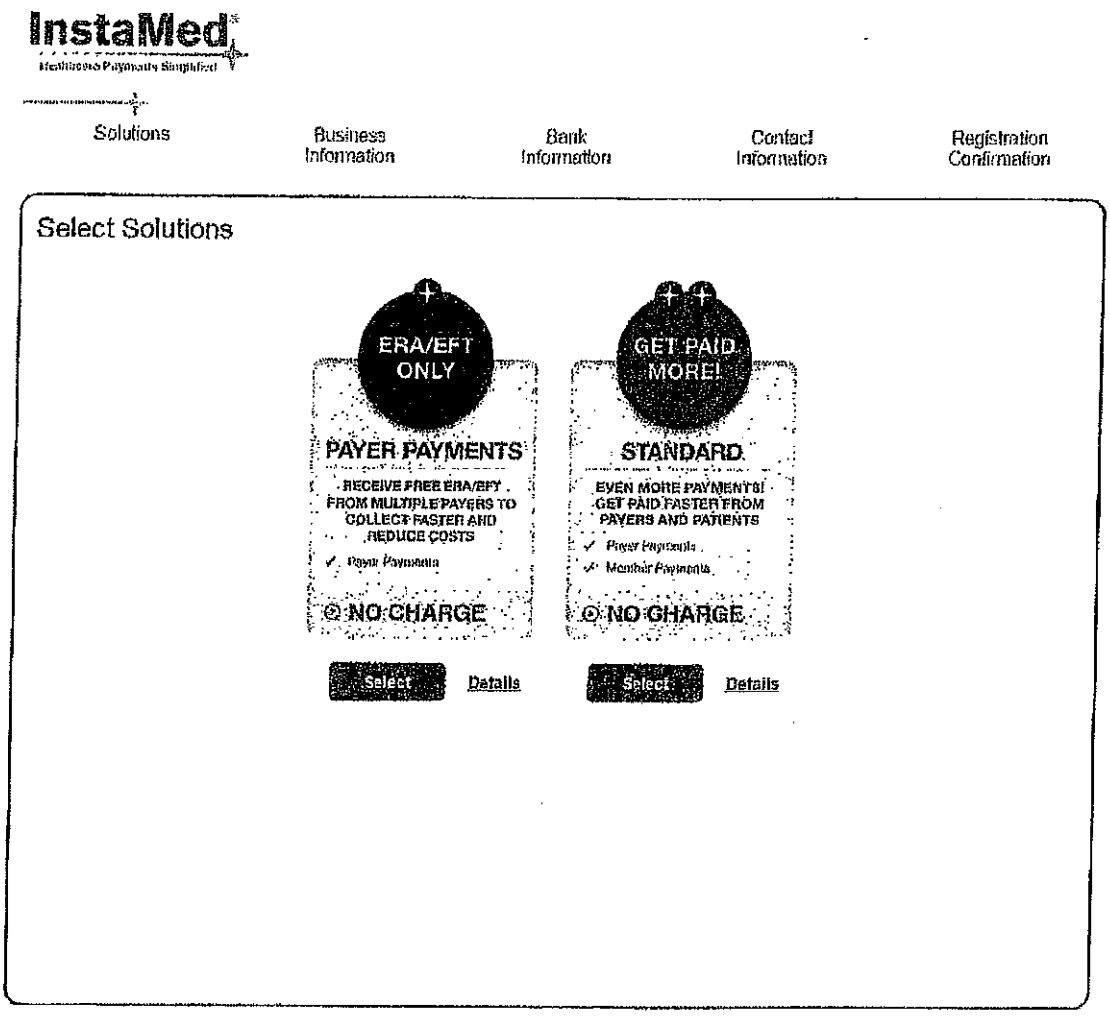
Once your Healthcare Payments Account is activated, you will have the opportunity to select the payers from whom you would like to receive ERA/EFT. For a list of available payers, view our payer list.

Learn More

connect@instamed.com | (866) 945-7930

Q: I am an existing InstaMed customer and just want to add solutions. How do I start this process?
A: From the Getting Started page, enter the Tax ID associated with your account and your email address. If your Tax ID already exists on the InstaMed Network, you will be redirected to a new screen that will prompt you to log in to add solutions.

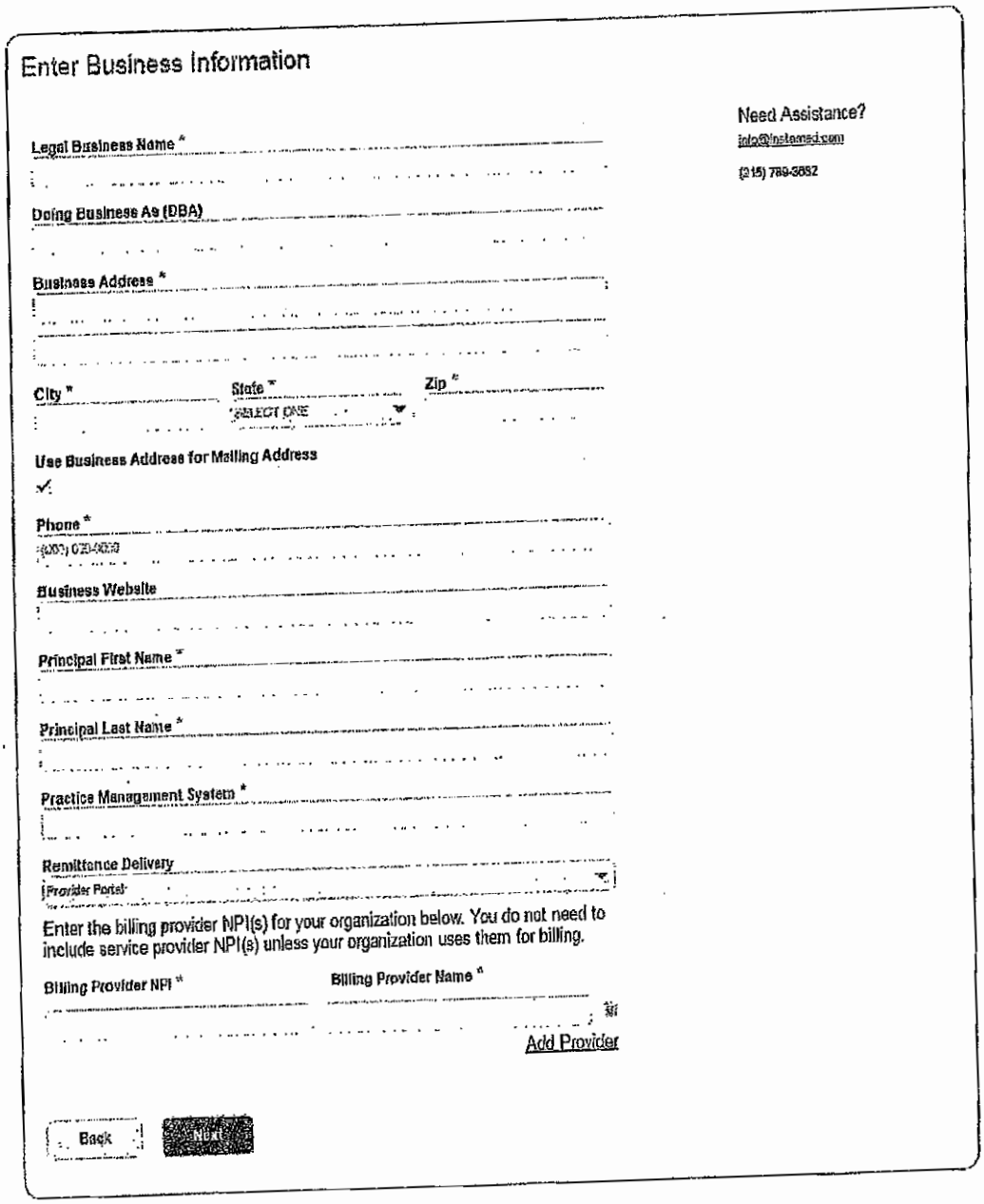
Page 2 – Solutions



Q: I received the link to register online from [PAYER], how do I register for ERA/EFT from [PAYER]?

A: By registering for the Payer Payments solution, you will automatically receive Integrated ERA/EFT® from [PAYER] as well as our list of Integrated ERA/EFT® payers. There are no fees to you for this service. Once your account is activated, you will be able to elect to receive ERA/EFT from additional payers. The Payer Payments Payer List is available here: http://info.instamed.com/payer-payments-payer-list.

Page 3 – Business Information



Enter Business Information

Need Assistance?
info@instamed.com
(215) 789-3852

Legal Business Name *

Doing Business As (DBA)

Business Address *

City * State * Zip *

SELECT ONE

Use Business Address for Mailing Address

Phone *

Business Website

Principal First Name *

Principal Last Name *

Practice Management System *

Remittance Delivery

Provider Portal

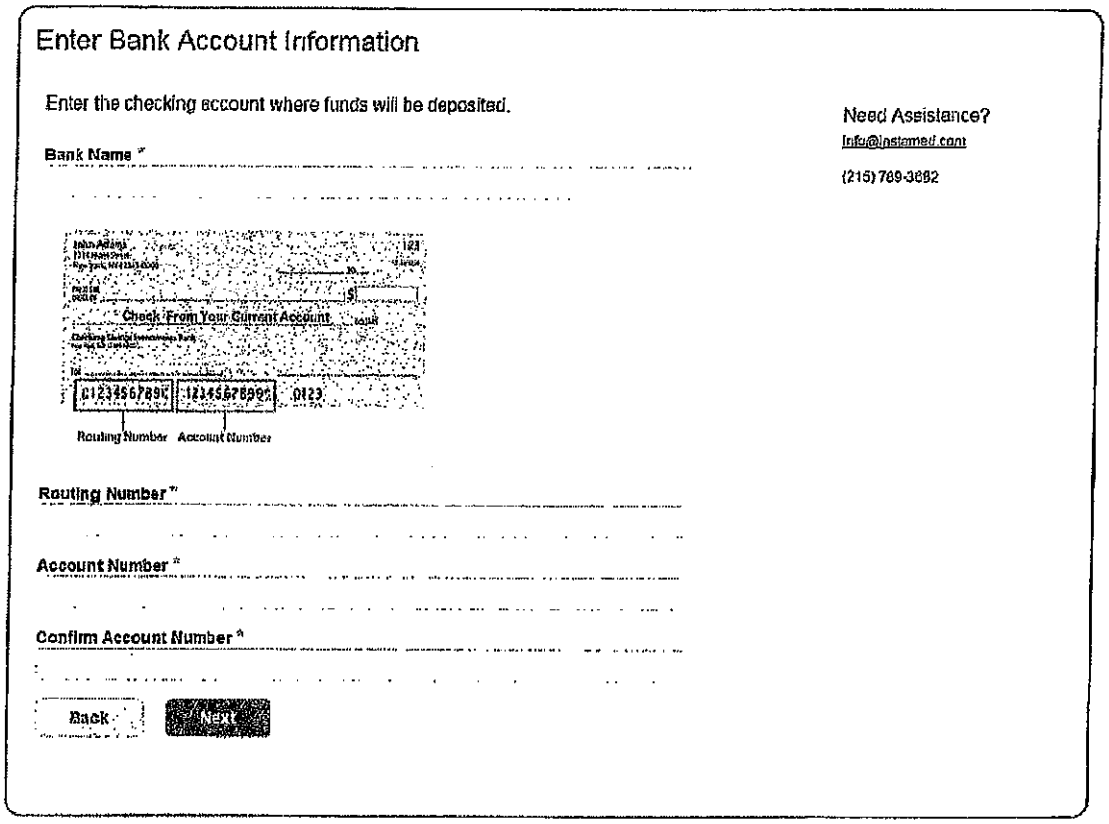
Enter the billing provider NPI(s) for your organization below. You do not need to include service provider NPI(s) unless your organization uses them for billing.

Billing Provider NPI * Billing Provider Name *

Add Provider

Back Next

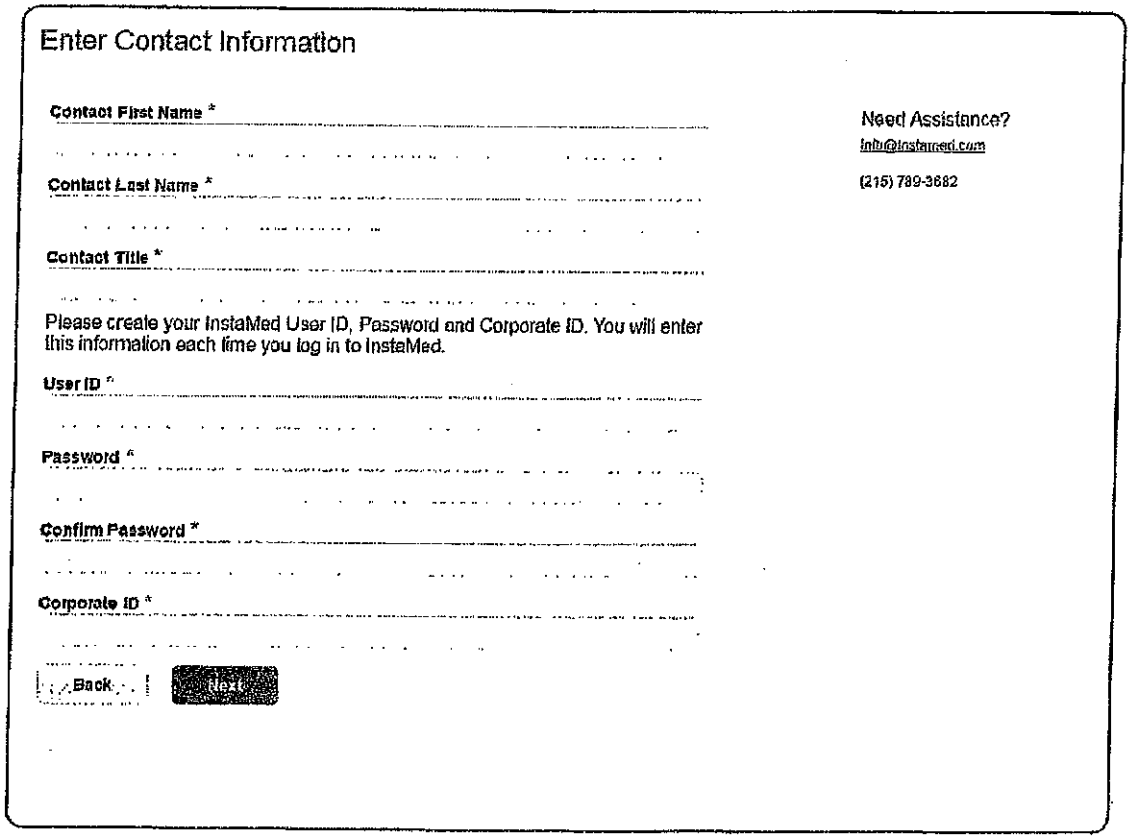
Page 4 – Bank Account Information



Q: Can I add multiple bank accounts for separate NPIs?
A: InstaMed's Online Registration only supports one bank account per Tax ID. But if the customer would like to go through our paper enrollment process, we can support multiple bank accounts.

Q: Is my bank account information secure?
A: InstaMed meets the highest industry standards for compliance and security, including verification processes to prevent fraud. InstaMed is the first company to achieve both EHNAC healthcare and financial accreditations. (EHNAC = Electronic Healthcare Network Accreditation Commission) InstaMed is also fully HIPAA Compliant, PCI Level 1 Certified and we have successfully completed the Statement of Standards for Attestation Engagements No 16 type II (SSAE16) (formerly SAS70).

Page 5 – Contact Information



Q: Whose contact information should be entered?
A: The person filling out the form should fill out their own contact information. The Principal name for the business has already been collected on the Business Information page.

Q: What if my business needs to have multiple users created?
A: Once your account is activated, you will be able to add users and customize user rights for each user.

Q: Why do I need a Corporate ID?
A: You will enter your Corporate ID, along with your User ID and Password, each time you log in. If you create multiple users, they will all use the same Corporate ID.

Page 6 –Registration Confirmation

Confirm Registration

You already have payments ready to be deposited!
The payments below were mailed to your organization but can be directly deposited into the bank account entered in the previous page. Learn More

Need Assistance?
info@instamed.com
(215) 789-3682

Payment Type	# Cards	Total
Payer Payments	1	$437.76

Select Yes Below to have these payments directly deposited

Yes No

Almost there! Click "Register" below to register for the following package:

InstaMed Healthcare Payments Account Payer Payments Details

INSTAMED TERMS AND CONDITIONS

The InstaMed Terms and Conditions (the "**Agreement**") is an agreement between you ("**Customer**") and InstaMed Communications, LLC ("**InstaMed**") and applies to Customer's use of the Services (as defined in Section 1 below).

1. **Services.**

a. Description. InstaMed shall provide to Customer, through the use of the Application Services, one or more of the following services that Customer has elected to receive during Registration: (i) a means by which to transmit (A) Customer's healthcare claim and other transaction data to, and to receive healthcare claim and other transaction data from, certain health insurance, health plan and other third-party payers and intermediaries which may, from time-to-time, elect to receive and transmit such data by means of InstaMed's system; (B) Customer's patient bills, patient communications and other transaction data to, and to receive payment transaction data, communications and other transaction data from, patients which may, from time-to-time, elect to receive and transmit such data by means of InstaMed's system; and (C) Customer's patient demographic and other transaction data to, and to receive address analysis, address verification, identity analysis, identity verification, consumer credit analysis and other demographic and financial information from, certain consumer financial service providers, credit bureaus and other third-party data sources which may, from time-to-time, elect to receive and transmit such data by means of InstaMed's system (collectively, the "**Healthcare Transaction Services**"); and (ii) a means by which to transmit payment transaction data to, and to receive payment transaction data from, certain payment networks, banks and other financial entities which may, from time-to-time, elect to receive and transmit such data by

Save Print

IMPORTANT: By checking the box "I accept the terms and conditions above" and clicking the button "Register," Customer acknowledges that Customer has read this Agreement, understands it and agrees to be legally bound by its terms.

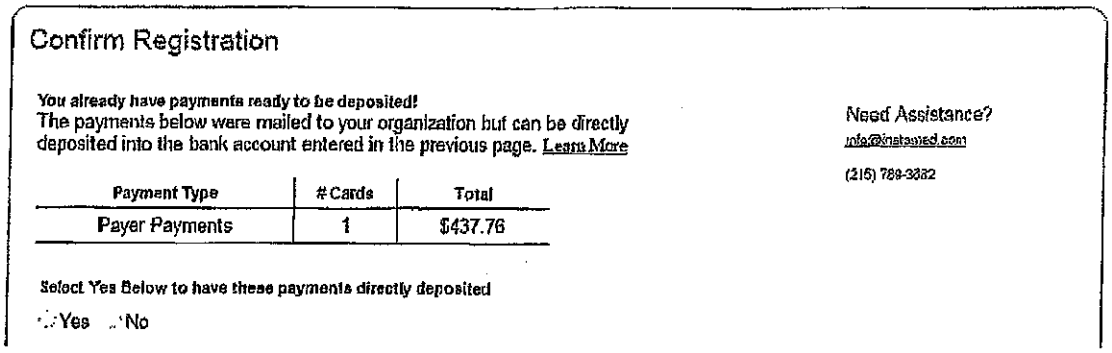
Please print and keep a copy of this agreement for your records.

I accept the terms and conditions above.

Back Register

Q: Why am I receiving a $0.01 deposit and withdrawal from my bank account?
A: We deposit $0.01 into the bank account you provider during Registration in order to validate your bank account. This $0.01 deposit will appear on your bank statement as INSTAMED. The penny is yours to keep. Additionally, if a provider registers for Payment solutions, we will withdraw a $0.01 from the bank account.

Q: What about outstanding Claim Payment Cards that I cannot process?
A: Underneath the 'Confirm Registration' text at the top of the page, you should see a message stating that "You already have payments ready to be deposited!". Simply click 'yes' to have the funds on the card reissued as free EFTs. This process should take around 8-10 days.



Confirm Registration

You already have payments ready to be deposited!
The payments below were mailed to your organization but can be directly deposited into the bank account entered in the previous page. Learn More

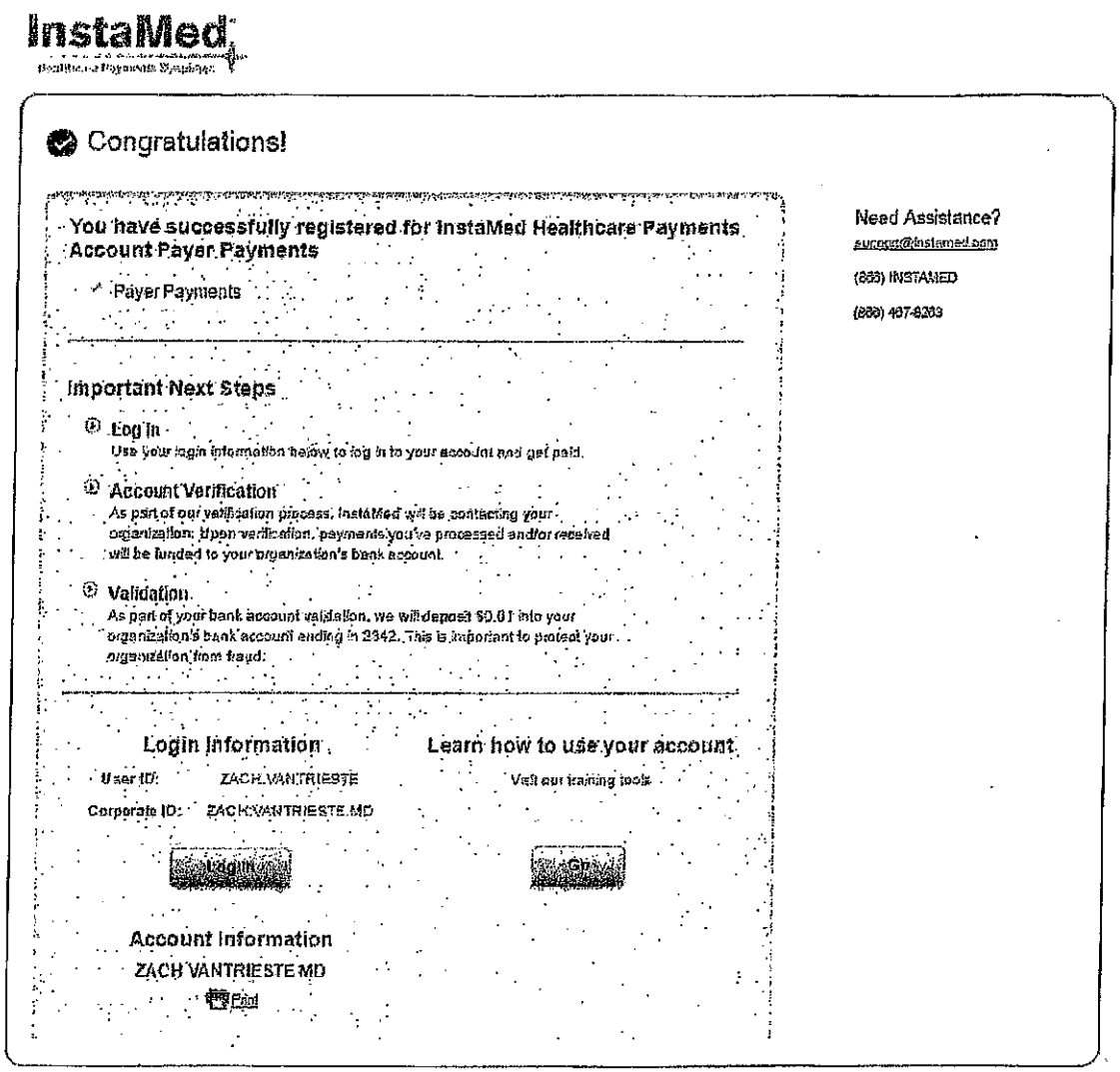
Need Assistance?
info@instamed.com
(215) 789-3382

Payment Type	# Cards	Total
Payer Payments	1	$437.76

Select Yes Below to have these payments directly deposited

Yes No

Page 7 – Confirmation Page



The "Go!" button will direct the user to the InstaMed training material and videos. It is strongly recommended that all new users read the training materials and watch the videos before starting to use InstaMed Online.

The "Log In" button will direct the user to log in to InstaMed online.

Q: Where can I receive training on my InstaMed Payer Payments account?
A: Visit http://www.instamed.com/online-registration/training/payer-payments.pdf for quick tips to get started and additional resources for using your InstaMed Payer Payments Account

PHYSICIANS
DATATRUST

INTEROFFICE MEMORANDUM

TO: PCP, SCP, Clinical Services and Administrative Staff

FROM: Lisa Serratore, Chief Executive Officer

CC: Evelyn Jimenez, IPA Manager, CVPG
Karly Haugh, IPA Manager, GPMG
Renee LaMarsh, IPA Administrator, GTCIPA
Mary Beltran, IPA Administrator, Noble AMA IPA
Leesa Johnson, VP of IPA Operations, St. Vincent IPA

DATE: January 15, 2022

RE: Affirmative and Impartiality Statements

AFFIRMATIVE STATEMENT

As a utilization management organization, Physicians DataTrust on behalf of Citrus Valley Physicians Group, Golden Physicians Medical Group, Greater Tri Cities IPA, Noble AMA IPA, and St. Vincent IPA, ensures that all decisions are made based on the available medical information at the time of the request. Should a member ask to see the criteria utilized to make a medical decision; the statement below is attached to that guideline, as required by the National Committee for Quality Assurance (NCQA):

Decisions regarding requests for medical care are based on the medical necessity of the request, the appropriateness of care and service and existence of coverage. There is no monetary reward for non-approval of services. Compensation for individuals who provide utilization review services does not contain incentives, direct or indirect, for these individuals to make inappropriate review decisions.

Utilization review criteria, based on reasonable medical evidence and acceptable medical standards of practice (i.e. MCG and/or applicable health plan guidelines) are used to make decisions pertaining to the utilization of services. Review Criteria are used in conjunction with the application of professional medical judgment, which considers the needs of the individual patient and characteristics of the local delivery system.

IMPARTIALITY STATEMENT

All participating practitioners are ensured independence and impartiality in making referral decisions which will not influence hiring, compensation, termination, promotion or any other similar matters.

These statements are also on our websites: www.cvpg.org, www.gpmedicalgroup.com, www.gtcipa.com, , www.nobleamaipa.com, and www.stvincentipa.com, along with other valuable information for our contracted providers and our members, and can be printed, if needed. Our business hours are Monday through Friday, 9:00a.m. to 5:00p.m. and Administrative staff can be reached at (760) 941-7309 or (800) 458-2307 during business hours. Should you have a question for the Utilization Management Department after hours, you may call (760) 941-7309 or (800) 458-2307 and leave a message for someone to call you back the next business day.

GREATER TRI CITIES IPA

Independent Physicians - Providing Personal Care

2022 DOWNSTREAM ATTESTATION

This attestation documents your organization's adherence to compliance and privacy requirements, as well as plan-specific training requirements. These requirements are further described in the training materials and other resources accessible at pdtrust.com/compliance.

1. **Standards of Conduct and/or Compliance Policies**
   All workforce members and downstream entities are provided the PDT Code of Conduct (or equivalent) within 30 days of hire or contracting, annually thereafter, and upon revision.
2. **General Compliance Training & Fraud, Waste and Abuse ("FWA") Training**
   All workforce members and downstream entities complete General Compliance and FWA training within 30 days of hire or contracting and annually thereafter.
3. **Privacy & Security (HIPAA) Training**
   All workforce members and business associates complete privacy and security training upon onboarding, annually thereafter, and upon revision.
4. **OIG/GSA Exclusion Screenings**
   All employees and downstream entities are screened against the OIG and GSA exclusion lists prior to hire or contracting and monthly thereafter. Resolution of potential matches is documented.
5. **Offshore Operations**
   Our organization does not engage in offshore operations involving the receipt, processing, transferring, handling, storing or accessing of PHI. This includes work performed offshore by a US-based business.
6. **Subcontractor Oversight**
   Our organization conducts sufficient oversight to ensure that downstream entities and business associates meet all compliance and privacy program requirements.
7. **Cultural Competency & Language Assistance Program (LAP)**
   Providers and staff complete cultural competency, sensitivity, and diversity training consistent with national Culturally and Linguistically Appropriate Services (CLAS) standards.
8. **Health Plan Required Training**
   Providers and staff complete SNP MOC, CMC, QI, and any additional training required by Blue Shield Promise, Brand New Day, and Health Net health plans.
9. **Critical Incident Reporting**
   Providers, staff, and downstream entities are informed of the obligation and methods to report suspected Critical Incidents. In turn, our organization reports applicable incidents to the IPA.
10. **Document Retention and Evidence Requests**
    Our organization and our subcontractors save all documentation pertaining to IPA business for a minimum of ten years, including evidence of the above requirements. Our organization agrees to produce this documentation upon request, or face corrective actions.

OVER →

GREATER TRI CITIES IPA

Independent Physicians - Providing Personal Care

2022 DOWNSTREAM ATTESTATION

Signature of Organization's Authorized Representative	Date
Organization's Authorized Representative Name	Title
Organization Name	Tax ID
Organization Email Address	Phone Number

Return this completed attestation via email, fax, or SignNow. Please contact us if you have any questions.

PHONE: 800-458-2307 **EMAIL:** gtcipapr@pdtrust.com **FAX:** 760-407-6611

ACCESS TO CARE STANDARDS

Primary Care Physician (PCP)	Standard
Emergency (Serious condition requiring immediate intervention)	Immediately (office, UCC, ER)
Urgent (Condition that could lead to a potentially harmful outcome if not treated)	*Within 48 hours (office, UCC)
Non-Urgent (routine) *(visit for symptomatic but not requiring immediate diagnosis and/or treatment)	*Within 10 business days
Adult or Pediatric Health Assessment / Physical *(Physical: periodic health evaluation with no acute medical problem) *(Preventive: for prevention and early detection of disease, illness, condition)	Within 30 calendar days, unless more prompt exam is warranted
**IHA (18 months and older) **IHA (under 18 months)	Within 120 days of enrollment Within 60 days of enrollment
Waiting Time in physician office	Less than 30 minutes
After hours Access	Answering Service or service w/ option to page Provider
• Enrollee with life threatening medical problem must have access to health care twenty-four (24) hours per day and 7 days per week. • After hours answering system or voice mail should instruct members that if they feel they have a serious acute medical condition, to seek immediate care by calling 911 or going to the nearest Emergency Room. • **Member must be assured that a Health Care Professional (Dr., Advice Nurse, PA, NP) will communicate with them within 30 minutes.	
**Telephone Triage and Screening (urgent and routine) • Telephone triage is available 24 hours a day and 7 days a week	**Within 30 minutes

Specialty Care Provider (SCP)	Standard
**Urgent referral (includes Behavioral Health)	Within 96 hours
*Non-Urgent / routine (includes Behavioral Health)	*Within 15 business days from time of PCP request

Behavioral Health Provider (based on Plan contracts)	Standard
Urgent	*Within 96 hours
Routine	*Within 15 business days
**Non-physician BH	** 10 business days

**Ancillary Services	Standard
Urgent (for diagnosis and treatment)	Within 96 hours
Routine (for diagnosis and treatment)	Within 15 business days

*Revised Standard 2011 ** New Standard 2011 Compliance = 80%


Cal MediConnect Training

What is Cal MediConnect?

- Cal MediConnect (CMC) is a program created to better serve beneficiaries who are eligible for both Medicare and Medi-Cal. The CMC program, an all-in-one health plan, covers medical care, prescription drugs, mental and behavioral health care, and long-term services and supports.

Member Rights and Responsibilities

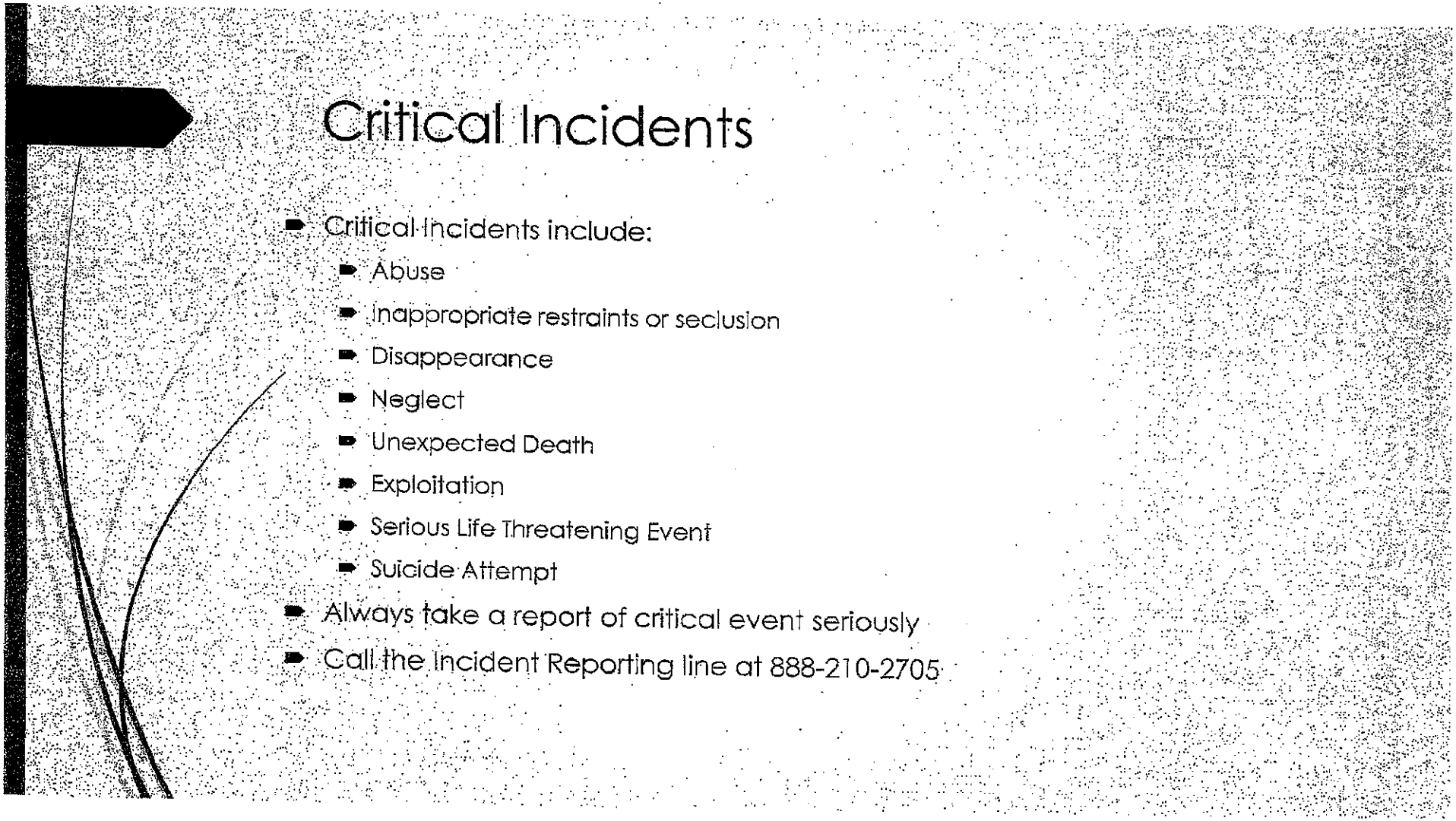
- Members have a right to get information in a way that meets their needs
- Members are treated with respect, fairness, and dignity at all times
- Members must receive timely access to covered services and drugs
- Member's personal health information must be protected
- Access to information about our plan, our network providers, and your covered services
- Network providers cannot bill our Members directly for covered services.
- Members can elect to leave our Cal MediConnect plan at any time
- Members have the right to make decisions about their health care. This includes the right to full disclosure of health care information, the right to actively participate in health care decisions and the right to say what they want to happen if they are unable to make health care decisions themselves.
- Members have the right to initiate complaints and to request Blue Shield Promise to reconsider decisions we have made

Member Rights and Responsibilities

- For additional information on **member rights and responsibilities, including:**
  - **Grievances and Appeals**
  - **Advanced Directives**
  - **Balance Billing**

Please go to the Blue Shield Promise Website and reference the Member Handbook, or click the link below:

https://www.blueshieldca.com/bsca/bsc/public/common/PortalComponents/sites/StreamDocumentServlet?fileName=BSP_2021_2021_CMC_EOC_BSCPromise_SD_EN.pdf


Critical Incidents
Critical Incidents include:
Abuse
Inappropriate restraints or seclusion
Disappearance
Neglect
Unexpected Death
Exploitation
Serious Life Threatening Event
Suicide Attempt
Always take a report of critical event seriously
Call the Incident Reporting line at 888-210-2705

Federal and State Statutes

- For more information regarding applicable Federal Statutes please go to: https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html
- For more information regarding applicable State Statutes please go to: http://www.dhcs.ca.gov/formsandpubs/laws/Pages/LawsandRegulations.aspx

PHYSICIANS DATATRUST

CMS MARKETING GUIDELINES FOR PROVIDERS

Physicians DataTrust, and all contracted JPAs, comply with CMS requirements. The training herein is an overview of CMS guidelines. For comprehensive CMS Marketing Guidelines visit: www.cms.gov. Last update 08/06/2019.

2020

Introduction

CMS Compliance Concerns and Limitations

- CMS has expressed concern with providers participating in marketing activities because
  - Providers may not be aware of all plan benefits and costs.
  - It may confuse beneficiaries if they perceive providers as acting as an agent or plan representative.
  - Providers may face conflicting incentives when acting on a Plan Sponsor's behalf.

PHYSICIANS DATA TRUST

Physicians DataTrust, and all contracted IPAs, comply with CMS requirements. The training herein is an overview of CMS guidelines. For comprehensive CMS Marketing Guidelines visit: www.cms.gov. Last update 08/06/2019.

Definitions

- **Communications:** Activities and materials to provide information to current and prospective enrollees, including their caregivers and other decision makers.
- **Marketing:** A subset of communications. Includes activities and materials with the intent to draw a beneficiary's attention to a plan or plans and to influence a beneficiary's decision-making process when selecting a plan for enrollment or deciding to stay enrolled in a plan (that is, retention-based marketing). Additionally, marketing contains information about the plan's benefit structure, cost sharing, measuring, or ranking standards.

PHYSICIANS DATA TRUST

Physicians Data Trust and all contracted IPAs comply with CMS requirements. The training herein is an overview of CMS guidelines. For comprehensive CMS Marketing Guidelines visit: www.cms.gov. Last update 08/06/2019.

2020

Definitions

- To identify marketing activities and materials, CMS will evaluate both the **intent and content** of the activities and materials to determine if the definition of marketing is met.
  - A flyer reads "Swell Health is now offering Medicare Advantage coverage in Nowhere County. Call us at 1-800-SWELL-ME for more information." Marketing or Communication? Communication. While the intent is to draw a beneficiary's attention to Swell Health, the information provided does not contain any marketing content.

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Definitions

- A billboard reads "Swell Health Offers $0 Premium Plans in Nowhere County" Marketing or Communication? Marketing. The advertisement includes both the intent to draw the viewer's attention to the plan and has content that mentions zero-dollar premiums being available.
- A letter is sent to enrollees to remind them to get their flu shot. The body of the letter says, "Swell Health enrollees can get their flu shot for $0 copay at a network pharmacy..." Marketing or Communication? Communication. While the letter mentions cost sharing, the intent is not to steer the reader into making a plan selection or to stay with the plan, but rather to encourage existing enrollees to get a flu shot. The letter contains factual information about coverage and was provided only to current enrollees.

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Providers Must

- Providers must remain neutral when assisting patients with information about their Medicare plan options.
- Any communications by providers to patients must come from the provider or medical group and not the agent or health plan in a misleading way.
- Be aware of agent or health plan engagement in marketing events and ensure they are within the scope of CMS guidelines.

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Providers May

- If providers allow plan marketing materials to be available in their common areas, then:
  - Provider must allow **ALL** contracting plans to participate.
- Display posters or other materials announcing plan affiliations.
- Direct patient to plan materials in common areas.
- Refer patients to other sources for more information, such as:
  - CMS/Medicare.gov website, HICAP/SHIP office, etc.
- If **patient initiates** request, provider may refer to plan or plan marketing representatives (brokers or agents.)

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Providers May

- Provide names and contact information of Health Plans they contract with and any factual, publicly available information about plan benefits and formularies.
  - Example: Information from *Medicare and You* or *Medicare Options Compare.*
- Provide information and assistance to patients applying for Low Income Subsidy (LIS/Extra Help.)
- Display plan marketing materials (but **not** enrollment forms) in waiting rooms.

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Providers May NOT

- Provide an endorsement or testimonial for a health plan
- Mislead or pressure patients into participating in presentations.
- Use health screenings as a marketing activity.
- Offer anything of value to induce beneficiaries to enroll in a particular plan or set of plans.
- Provide list of Medicare eligible patients to an agent or health plan representative.
- Conduct marketing, sales, or enrollment activities in areas where patients receive or wait to receive care:
  - Example: Exam rooms, waiting rooms, etc.

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Providers May NOT

- Distribute/display marketing materials in an exam room.
- Distribute sales agents' business cards to patients (unsolicited.)
- Make available/distribute, help complete, or accept completed enrollment applications.
- Offer or assist with Scope of Appointment Forms, lead cards and/or business reply cards.
- Make phone calls or distribute materials in an attempt to steer, direct, urge or persuade beneficiaries to enroll in a specific plan or set of plans.
- Mail marketing materials on behalf of a plan or agent.
- Accept compensation directly or indirectly from a plan for enrollment activities.

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Promotional Activities

Nominal Gifts, any items offered to attendees of promotional activities, must:

- Be of nominal value – no more than $15, with a maximum aggregate of $75/person, per year.
- Be offered to all people regardless of enrollment and without discrimination.
- Not be items considered to be a health benefit, covered item or service.
- If the nominal gift is one large gift (e.g., concert, raffle, drawing, etc.) the total value must not exceed the nominal per person value based on attendance.
    - Example) For 10 attendees, the gift may not be worth more than $150.

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Promotional Activities

Nominal Gifts, any items offered to attendees of promotional activities, may not:

- Be in the form of cash or other monetary rebates, including gift cards or certificates that can be readily converted to cash, even if it is worth $15 or less.
- Be in the form of a meal, unless the event meets the CMS definition of an educational event and complies with the nominal gift value.

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Marketing Unsolicited Contacts

Unless an individual has agreed to receive communications, providers may not initiate direct contact with non-patients for marketing purposes in the following forms:

- Telephonic outreaching including voice and text messaging.
- Electronic solicitation/electronic messaging via direct messaging on social media platforms.
- Approaching beneficiaries in common areas (e.g., parking lots, hallways, lobbies, etc.)
- Door-to-door solicitation including leaving flyers at residences or cars.

Marketing purposes pertains to health plan listings and benefit information. This does not extend to current patients, conventional mail, or other print medias.

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Marketing Unsolicited Contacts

Providers may not make unsolicited telephone calls to prospective enrollees expect for the following specific telephonic activities:

- Call current enrollees, including those in non-Medicare products, to discuss plan business
  - Calls to enrollees aging into Medicare from commercial products offered by the same organization
  - Calls to existing Medicaid/MMP plan enrollees to talk about its Medicare products
- Call former enrollees to conduct disenrollment surveys for quality improvement purposes (may not include sales or marketing information)
  - Call to market plans or products to former enrollees who have disenrolled, or to current enrollees who are in the process of voluntarily disenrolling;

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Marketing Unsolicited Contacts

Providers may not initiate Electronic Communication, including voicemail or direct messages, for marketing purposes unless an individual has agreed to receive those communications.

- If an individual likes or follows on social media, this does not constitute agreement to receive communication outside a public forum.
  - Providers may respond to questions or statements initiated by the beneficiary but only in the scope of the question.
- Providers may contact via email but must provide an opt-out process for recipients.

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Thank You

For a comprehensive understanding of CMS Marketing Guidelines visit:
https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html

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Promise Health Plan

Cal MediConnect
Newly Contracted Provider Training Attestation

To operate in full compliance with the Contract and all applicable Federal and State statutes and regulations, BSCPHP delegated entities must ensure that Network Providers receive provider training **within thirty (30) working days** after placing a newly contracted provider on active status.

Note: Before BSCPHP assigns members under this Contract, the Delegated Business Partner is responsible for providing Network Provider education specific to the delegated entity's processes (unless it is a health plan requirement) and the CMC program. **Please check the boxes below to confirm that you have received training as it relates to CMC services (including, but not limited to) and has access to the following:**

☐ Cal MediConnect Program
- Rights and Responsibilities pertaining to Grievance and Appeals procedures and timelines,
- Advance Directives,
- Care Coordination Benefit:
  - Methods for sharing information among Contractor/Non-Contractor, Network Provider, Enrollee and/or other healthcare professionals.
- Information on all Enrollee rights:
  - Including the right to full disclosure of health care information and the right to actively participate in health care decisions,
- Clinical protocols, evidence-based practice guidelines,
- Methods for sharing information among delegated entity, Network Provider, Enrollee, and/or other healthcare professionals,
- Cultural Competency:
  - The training covered information about the identified cultural groups in the Provider's Service Areas, such as the groups' beliefs about illness and health; methods of interacting with providers and the health care structure; and language and literacy needs, including limited English proficiency; and diverse cultural and ethnic backgrounds, and
- Developed cultural awareness and sensitivity:
  - The training covered the health needs specific to the population that utilizes various educational strategies, including but not limited to posting information on websites and other methods of educational outreach to Network Providers.

☐ Except as otherwise required or authorized by CMS, DHCS, or by operation of law, the newly contracted understands that the delegated entity must ensure that Network Providers receive a thirty (30) days advance notice in writing of policy and procedure changes and maintain a process to provide education and training for Network Providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect.

☐ Access to Policies and Procedures (P&Ps) that cover the following:
- Services (e.g., Provider Education, Panel Status Changes, etc.)
- Policies (e.g., Prior Authorization, Pre-Natal Services, Member Satisfaction, etc.)
- Procedures (e.g., DHCS Recommended Care Standards, Continuity of Care, Special Needs Plan (SNP), etc.)
- Any modifications to existing services, policies and/or procedures.

☐ Compliance/Standards of Conduct,

☐ Training, Fraud, Waste and Abuse Training, and

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Cal MediConnect
Newly Contracted Provider Training Attestation

☐ Access to Provider Manual(s). The Provider Manual is a comprehensive online reference tool for the Provider and their staff. It should be used as a point of reference regarding (but not limited to) administrative, prior authorization, and referral processes, claims and encounter submission processes, continuity of care requirements, and plan benefits; In addition, the Provider Manual shall also address clinical practice guidelines, availability and access standards, care management programs, and Enrollee rights.

I, , have completed the Newly Contracted Provider Training on with on the subjects listed above and have access to the provider manual as stipulated by the California Department of Health Care Services (DHCS) contractual requirements.

Newly Contracted Provider Signature **Date**

NPI# **Contract Effective Date**

I, , attest that the applicable subjects from the Newly Contracted Provider Training have been conducted with the office staff.

Office Manager Signature **Date**

Note: *If you do not have an office manager, please provide the name and title of who conducted the training for the office staff.*

I, , attest that the newly contracted provider and office staff have completed the required CMC training stipulated by the California Department of Health Care Services (DHCS) contractual requirements. I further attest that ongoing provider training and/or updates to Compliance, Fraud, Waste and Abuse training, Clinical Protocols and guidelines, the organization's policies, and procedures, etc., will be conducted/provided to the newly contracted provider named above.

PPG/MSO/IPA Rep Signature:_____ **Date:** _____

PPG/MSO/IPA Rep Title:_____

PPG/MSO/IPA Name: _____

Note: *Please return this attestation, including the evidence of training and completed documentation pertaining to Newly Contracted Provider Training to: BSCProviderTraining@blueshieldca.com.*