L.A. Care

Direct Network
A Direct Partnership for all of L.A.

Contracted Provider

Reference Guide

LA4163 04/24

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Welcome

Participating Contracted Provider

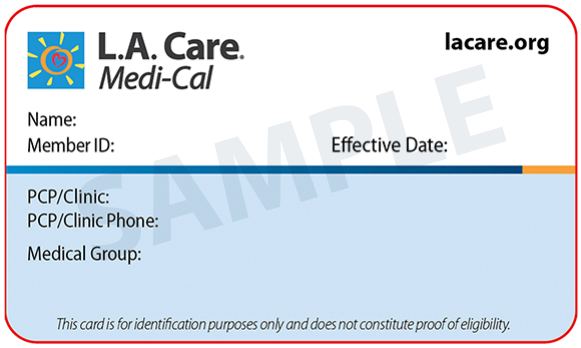
Welcome Participating Contracted Provider

L.A. Care Health Plan's (L.A. Care's) first directly contracted provider network aims to:

- Enhance Medi-Cal Members' ability to access care
- Allow Los Angeles County Providers the ability to have a direct relationship with L.A. Care
- Assure Member's continuity of care with Provider of choice
- Reduce the complexity of serving Medi-Cal Members and increasing healthy outcomes through closer relationships with participating providers directly

As a provider contracted to participate in the exclusive closed subnetwork within L.A. Care's Medi-Cal Provider Network, please be aware that our members may be assigned to, or can always choose a Primary Care Physician (PCP) within L.A. Care's Direct Network in accordance with the member assignment and PCP change rules outlined in the **Medi-Cal Member Handbook Evidence of Coverage**. Medi-Cal Members will receive primary care from their PCPs who then will coordinate all specialty services from physicians, facilities, hospitals, and other network providers contracted in the Direct Network. Contracted PCPs will receive monthly membership reports identifying each member assigned to the PCP/Group available for view and download on the Provider Portal.

Member ID Card Example:



Helpful Resources

To view a list of helpful resources, please refer to the **Resources at a Glance** section in this guide. There you would find contact information, forms, and more.

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Covered Medi-Cal Benefits

All covered benefits are free to the Member:

- Doctor visits
- Dental and Mental Health Services*
- Vision Care
- Hospital care and emergency room care
- Prescription drugs (covered by Medi-Cal Rx, a Medi-Cal FFS program), shots (immunizations), and more

* Dental services and specialty mental health services are carved out from L.A. Care required benefits. However, Topical Fluoride Varnish is not part of the Dental carve out. Topical Fluoride Varnish is included in the Early and Periodic Screening, Diagnostic and Treatment Medi-Cal benefit.

To learn more about covered Medi-Cal benefits visit **https://www.lacare.org/health-plans/medi-cal/benefits-guide**

Community Based Adult Services (CBAS)

For information on CBAS, please refer to **Chapter 17 of the Universal Provider Manual (UPM)**.

Long Term Care (LTC)

For information on LTC, please refer to **Chapter 17 of the Universal Provider Manual (UPM)**.

Referrals for CBAS & LTC

- PCP needs to complete a written order.
- Fax the completed CBAS or LTC authorization request form **with** the physician order to the appropriate number.
- All Authorization Forms are available at **https://www.lacare.org/priorauth**
- CBAS and LTC Authorizations are managed by L.A. Care's Utilization Management department.

In Home Supportive Services (IHSS)

For information on IHSS, please refer to **Chapter 17 of the Universal Provider Manual (UPM)**.

The Managed Long Term Services and Supports (MLTSS) Department Assists Members with IHSS by:

- Coordinating the assessment and re-assessment process
- Initiation of the IHSS application
- Resolving IHSS-related issues
- Understanding DPSS grievances process
- Understanding the IHSS appeals process
- Coordinating requests for expedited assessments
- Providing temporary services to fill in assessment gaps

It is the provider's responsibility to complete the IHSS Health Care Certification form (SOC 873).

Members who need IHSS can be referred directly to the DPSS IHSS Application Line **(1.888.944.4477)** or to the MLTSS Department for assistance.

Multipurpose Senior Services Program (MSSP)

For information on MSSP, please refer to **Chapter 17 of the Universal Provider Manual (UPM)**.

The MLTSS Department Assists Members with MSSP by:

- Referring to MSSP site
- Applying and assisting with MSSP process
- Following up with MSSP to ensure services are being provided, and to identify service gaps
- Coordinating MSSP benefits with other plan benefits
- Arranging for MSSP-like services if Member is MSSP eligible, but there are no open slots
- Navigating the MSSP grievance and appeals process

Members who need MSSP can be referred to L.A. Care's MLTSS Department. L.A. Care is financially responsible and oversees this program.

For information on MLTSS, please refer to **Chapter 17 of the Universal Provider Manual (UPM)**.

Behavioral Health Services

For information on Behavioral Health Services, please refer to **Chapter 19 of the Universal Provider Manual (UPM)**.

Pharmacy Services

For information on Pharmacy Services, please refer to **Chapter 16 of the Universal Provider Manual (UPM)**.

Care Management (CM)

All Members in the Direct Network who require additional assistance with their health and social needs are eligible to receive care management provided by L.A. Care's Care Management team. Coordination of medical or behavioral health care, referrals, services, and supports are provided by clinical care managers to Low Risk, Medium Risk, High Risk, and Complex Case Members.

The Care Management team will work with providers to help Direct Network Members:

- Understand their health conditions.
- Get the care they need to live safely and more independently.
- Decrease unwanted emergency room and hospital visits.
- Connect with benefits and resources the Member may be eligible for, such as transportation to medical office visits, caregiver assistance, or behavioral health services.

Care Management Contact Information

- The CM Referral Form is available on the L.A. Care website at: **https://www.lacare.org/sites/default/files/files/la4310_cm_referral_form_202212.pdf**
- Fax the completed CM Referral Form to the CM department, Secure Fax: (213) 438-5077

For questions regarding the program, please contact Care Management at:

- By Phone: (844) 200-0104
- By Email*: **cmreferral@lacare.org**

***Note:** Emails containing Member Personal Health Information (PHI) must be securely encrypted.

Enhanced Care Management (ECM)

Enhanced Care Management (ECM) aims to provide a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Members. ECM services are provided by organizations contracted with L.A. Care to work directly with high-need Members in-person and/or in the field.

ECM Contact Information

- The ECM Referral Form: **https://www.lacare.org/sites/default/files/pl1744_la_mcp_ecm_referral_form_202310.pdf**

Fax the completed ECM Referral Form to the ECM department.

- By Secure Fax: (213) 438-5694
- Or submit through the E-Form on L.A. Care's Provider Portal

For questions regarding the program, please contact ECM via email at:

- Email*: **ECMMembership@lacare.org**

***Note:** Emails containing Member Personal Health Information (PHI) must be securely encrypted.

Transitional Care Services (TCS)

Providers in the Direct Network will receive an L.A. Care faxed notification whenever there is information that one of their assigned members has been discharged from a hospital or skilled nursing facility.

Following a hospital or facility admission, members should be seen by their Providers within 30 days of discharge to evaluate new needs and complete a medication reconciliation. Because this period following an admission can often be a difficult time of adjustment for members, L.A. Care offers additional post-discharge support to members identified to need it.

Members who experience a hospital or facility admission can be referred to the Transitional Care Services (TCS) Program for rapid assistance. Members will receive coordination and support from a TCS Care Manager or Community Health Worker to ensure all needed resources and services are received at home.

Refer members for TCS support within 30 days of discharge by contacting the TCS Program:

- By Phone: (888) 524-4832
- By Email*: **TCS_Program@lacare.org**

***Note:** Emails containing Member Personal Health Information (PHI) must be securely encrypted.

Transportation

For information on Transportation, please refer to **Chapter 4 of the Universal Provider Manual (UPM)**.

Retail Clinics

L.A. Care has partnered with MinuteClinic™ to provide alternative access to urgent care through their retail clinic locations. MinuteClinic™ has locations in select CVS pharmacies around L.A. County.

MinuteClinic™ locations are staffed by nurse practitioners and/or physician assistants. Services can be provided to treat the following symptoms:

- Cold, flu, fever, ache
- Rashes
- Infections (skin, eye, ear, urinary tract infection (UTI))
- Wheezing, cough
- Stomach pain, vomiting, diarrhea
- Minor injuries, burns, sprains

To find a retail clinic near you, visit **www.cvs.com/minuteclinic** and enter your ZIP code.

Nurse Advice Line

The Nurse Advice Line is a service available to L.A. Care members 24 hours a day, 7 days a week. Nurses can answer health care questions and can help choose where to get care. Members may also choose to listen to information about a health issue through the health education audio reference library by calling the Nurse Advice Line and selecting the option "Listen to a Health Topic." The Nurse Advice Line can be reached by calling 1-800-249-3619. For more information, please visit **https://www.lacare.org/members/getting-care/nurse-advice-line**.

Telehealth Services

L.A. Care has partnered with Teladoc™ Health, Inc. to provide telehealth services for our members as another alternative for urgent care. Teladoc™ delivers care wherever you are by phone or video conferencing.

Services can be provided to treat the following symptoms:

- Cold, flu, fever, ache
- Rashes
- Infections (skin, eye, ear, urinary tract infection (UTI))
- Wheezing, cough
- Stomach pain, vomiting, diarrhea
- Minor injuries, burns, sprains
- Seasonal allergies

If you use Teladoc™ services, you have the right to access your resulting medical records, and those records will be shared with your primary care provider, unless you object. To access care through Teladoc™:

- Visit **www.teladoc.com** – click "Sign In" or "Register Now"
- Call Teladoc™ at 1.800.835.2362
- Contact L.A. Care Member Services at 1.888.839.9909 (if you are deaf or hard of hearing)

Teladoc is free for L.A. Care Medi-Cal members. Pre-approval is not needed.

Please note that Medi-Cal Members who have additional Medicare coverage may not be eligible, such as Full Dual CCI – Partial Dual Part B members. Members should check with their Medicare plan if they have access to telehealth benefits.

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Referrals and Prior Authorizations

Health Care Services: (never require Prior Authorization)

- Total OB/GYN Care
- Amniocentesis (Women 35 years or older)
- Initial treatment of fractures
- Mammogram
- Musculoskeletal x-rays
- PAP Smears
- Pacemaker Function Surveillance
- Preventive Health Services
- Routine laboratory studies

Note: Direct Referrals shall follow the recommended guidelines, with the exception of OB/GYN services, which are defined in policy Direct Referral OB/GYN policy. To see which services require Prior Authorization, please use our Online **Prior Authorization Tool** which can be located on the L.A. Care website at **https://www.lacare.org/priorauth**.

When Does a Direct Referral Apply:

General Office Visits to in-network specialists are to follow the Referral Process outlined on the Prior Authorization Form.

Prior authorization is not required for referrals to in-network providers. Mark the "Referral Form" box in the Prior Authorization Form. Fax this referral along with clinical notes to the in-network servicing provider.

Standing referrals may be needed for members with a condition that requires specialized care over an extended amount of time. Prior authorization is also not required for standing referrals to in-network providers. Mark the "Referral Form for Standing Referrals" box in the Prior Authorization Form. Fax this referral along with clinical notes to the in-network servicing provider *and* to L.A. Care.

Procedures performed during office visits may require Prior Authorization. Please use the online **Prior Authorization Tool** to verify if Prior Authorization is required. Reminder: Out-of-network services always require Prior Authorization, with a few exceptions outlined in the benefits section.

Procedure Code	External Description
99201	Office or other outpatient visit for the evaluation and management of a new patient (10 minutes)
99202	Office or other outpatient visit for the evaluation and management of a new patient (20 minutes)
99203	Office or other outpatient visit for the evaluation and management of a new patient (30 minutes)
99204	Office or other outpatient visit for the evaluation and management of a new patient (45 minutes)
99205	Office or other outpatient visit for the evaluation and management of a new patient (60 minutes)
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician (5 min)
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem-focused history, a problem-focused examination, and straightforward medical decision-making (10 min)
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history, an expanded problem-focused examination, and medical decision making of low complexity (15 min)
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history, a detailed examination, and medical decision-making of moderate complexity (25 min)
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history, a comprehensive examination, and medical decision-making of high complexity (40 min)
99241	Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making (15 min)
99242	Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making (30 min)
99243	Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity (40 min)
99244	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity (60 min)
99245	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity (80 min)

L.A. Care Direct Network Prior Authorization (PA) Rules

OUTPATIENT CARE:

- PA required for contracted providers for outpatient hospital-based, ambulatory surgery center and office-based procedures unless for Sensitive Services (which includes services related to the following: family planning, pregnancy, sexual assault, sexually transmitted diseases (STDs) for Members 12 years of age and older, if sexually active, and substance or alcohol abuse), preventive care or a procedure specifically outlined below
- PA required for non-contracted providers for outpatient hospital-based, ambulatory surgery center and office-based procedures unless only related to sensitive services
- PA required for all contracted and non-contracted hospice services
- PA required for all contracted and non-contracted DME (i.e. supplies, equipment, orthotics, prosthetics)
- PA required for all contracted and non-contracted home health services (i.e. Registered Nurses (RN),Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathologist (SLP))
- PA required for all contracted and non-contracted ancillary services (i.e. chiropractic care, acupuncture and OP rehab services (speech therapy, occupational therapy, physical therapy, cardiac rehab, pulmonary rehab, etc.)
- PA required for all contracted and non-contracted CBAS services
- PA required for all contracted and non-contracted services classified as experimental, investigational or unknown (EIU)
- PA required for all contracted providers for complex laboratory or complex radiology regardless of place of service (see below for specific codes)
- PA required for all non-contracted providers for ALL laboratory and radiology regardless of place of service
- PA required for some contracted providers for infusions/injections/Physician Administered Drugs (PAD) drugs (see below for specific codes)
- No PA required for contracted providers for basic laboratory or basic radiology services regardless of place of service (see detailed listing attached for specific codes)
- No PA required for all contracted and non-contracted Sensitive Services with correct ICD-10 and Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) Codes combinations
- No PA required for all contracted preventive health services (i.e. vaccines, colonoscopies) if billed with screening code and/or modifier 33
- No PA required for contracted community providers for specialty office visits (POS 11 + CPT 99201-99205, 99211-99215, 99241-99245)

INPATIENT CARE:

- PA required for contracted and non-contracted providers for all elective and emergency room inpatient admissions/surgeries except routine labor and delivery, both vaginal and C-section, if billed with ICD-10 O60.1-O60.23X9 or Z37-Z38.8
- PA required for contracted and non-contracted providers for admissions to Skilled Nursing Facilities (SNF)/Long Term Care (LTC), Rehabilitation, Long-Term Acute Care (LTAC) Facilities, Congregate Living (CLHF) and Recuperative Care.

- PA required for contracted and non-contracted Tertiary-Quaternary referrals (see Tertiary-Quaternary referral policy)
- No PA required for contracted and non-contracted providers required for professional services when performed within POS 21, 31,32,33,51, 54, 56 and 61

EMERGENCY ROOM & URGENT CARE:

- No PA Required for contracted and non-contracted providers for both facility and professional services for Emergency or Urgent Care services
- No PA required for contracted and non-contracted providers for all emergency room admissions to observation level of care (if REV CODE 450 on the claim)
- No PA required for Professional services for contracted or non-contracted Providers when performed within POS 19, 20, 22, 23, 24

DIALYSIS:

- No PA required for contracted and non-contracted dialysis services both professional and facility

NON-PARTICIPATING PROVIDERS AND SERVICES:

- PA required for ALL non-contracted services unless specifically mentioned above

You will need to submit an Authorization for:

- Acupuncture
- Audiology
- Behavioral Health Therapy for children with Autism; (all other services handled through Carelon Behavioral Health)
- Chiropractic services
- Durable Medical Equipment (DME)
- Hearing Aid
- Home Health
- Home Infusion
- Hospice
- NEMT Transportation (PCS form can specify up to a year)
- Occupational and Physical Therapy
- Out-of-Network services (except Emergency Room and Urgent Care Services)
- Prosthetics / Orthotics
- Sleep Study
- Some specialty office test and procedures
  - Please use **Prior Authorization Tool** at **https://www.lacare.org** under the Provider Forms tab to see a codified list
- Surgeries (Inpatient and Outpatient)

Services that *DO NOT* Require Prior Authorization

Note: This is not an all-inclusive list. Other restrictions may apply.

- Emergency medical screening and stabilization services as allowable under applicable rules and regulations and evidence of coverage.
- Health education and counseling necessary to understand contraceptive methods and make informed choices related thereto.
- Follow-up care for complications associated with contraceptive methods.
- Laboratory tests as part of the decision-making process for choice of contraceptive methods.
- Family Planning services (including tubal ligation, vasectomies, and abortion, except inpatient abortion). Preventive health services (including immunizations and influenza and pneumococcal vaccinations). Well women care (including annual cervical cancer screening, pelvic exams, and mammography screening at intervals specified in the U.S. Preventive Services Task Force Guidelines).
- Basic prenatal care, including in-network Obstetric (OB) referrals and consults.
- Certain sensitive and confidential services including HIV testing, and STD diagnosis and treatment and sexual assault services.
- Initial behavioral assessments.
- Physical exam when members are admitted for inpatient mental health/behavioral health treatment.
- Dialysis, both in-network and out-of-area
- Admissions for routine (uncomplicated) vaginal and routine (uncomplicated) C-section deliveries.
- Admissions for observation level of care
- Urgent Care visits
- Routine radiology tests such as x-rays, ultrasounds, echocardiograms, EKGs, etc.
- Routine lab services, preparations and tests: CBC, metabolic panels
- Non-Medical Transportation (NMT)
- Health education services provided by L.A. Care's Health Education Team including the Medically Tailored Meals program and Doula services.

Pre-Service Authorizations

Inpatient Request vs. Outpatient Request

- **Inpatient Request**
  - All Non-Emergent Hospital Stays
  - Skilled Nursing Facilities
  - Essentially anything that may require the member to stay overnight
- **Outpatient Request**
  - Durable Medical Equipment
  - Home Health
  - Ambulatory surgery
  - Medical Supplies

Concurrent Review

- Must be requested either via fax at 877.314.4957 or phone at 1.877.431.2273
  - Please submit face sheet and all supporting clinical documentation for admission via fax.
  - A UM nurse will contact the facility if necessary

Retrospective Authorizations

- Must be requested either via fax at 213.438.5777 or phone at 1.844.361.7272
  - Request must include clinical records justifying need for service or supplies requested.

Non-Urgent/Routine vs Urgent/Expedited

- Non-Urgent/Routine Requests are requests for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the Member or the Member's ability to regain maximum function and would not subject the Member to severe pain.

- Urgent/Expedited Requests are requests for medical care or services in instances where a Provider indicates or L.A. Care or its delegate determines, that the standard request time frame may seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function.

For information on UM, please refer to **Chapter 5 of the Universal Provider Manual (UPM)**.

Utilization Management Decision Timeframes

- **Pre-Service Routine**
  - 5 business days from receipt of the request for service
- **Pre-Service Expedited / Urgent**
  - 72 hours from the receipt of the request for service
  - An urgent/expedited authorization in which the Provider indicated/determines that the standard time frame could jeopardize the Members' life or health or ability to attain, maintain or regain maximum function.

- **Retrospective / Post Authorization Review**
  - Within 30 calendar days of the request
  - Service occurred without prior authorization

How to Submit an Authorization Request via Fax

- Use the Direct Network Form and tools posted at **https://www.lacare.org/priorauth**
- Confirm service(s) require Prior Authorization using our Direct Network Provider Authorization Tool. **https://www.lacare.org/providers/provider-resources/prior-authorization-search**
- Print the Direct Network Prior Authorization Fax Request Form. **https://www.lacare.org/sites/default/files/la4168_dn_prior_auth_form_202210.pdf**
- Mark Routine or Urgent
- Complete the Member demographic information section
- Complete the Specialist information section
- Complete clinical and diagnosis sections
- Attach all applicable clinical data
- Submit the Form via Fax

How to Submit an Authorization Request via e-Form

- Confirm service(s) require Prior Authorization using our Direct Network Provider Authorization Tool.
- Log in to the Provider portal: **L.A. Care Provider Central | L.A. Care Health Plan (lacare.org)**
- Select "Forms"
- Select "New Service Authorization Request e-Form"
- Check Member Status - Enter the Member ID and Date of Birth to Begin Your request
- Enter the Prescribing Providers Information
- Attach Applicable Prescription(s) and/or Doctor's Orders
- Select Request Priority: Routine, Urgent or Retro Request
- Select the Servicing Provider. When Identifying your Servicing Provider ensure they are part of the Direct Network – **Medi-Cal: L.A. Care Provider Portal (lacare.org)**
- Complete clinical and diagnosis sections
- Attach all applicable supporting clinical data
- Complete Applicable Social Drivers of Health (SDOH) section
- Sign the Form
- Submit the Form
- Confirm the Email Confirmation Receipt that includes a Unique ID for Tracking

Direct Network UM Customer Service: 1.844.917.7272 or 1.866.522.2736 (both numbers route to the same team)

California Children's Services (CCS)

Utilization Management at L.A. Care is now screening every service authorization request for members under the age of 21, for California Children's Services eligibility. L.A. Care is developing a Pediatric Utilization Management (UM) Team that includes a Pediatric Medical Director with extensive insight on CCS nuances. Once identified, our UM Team will then refer members to our Care Management (CM) Team with CCS information in the request, for a warm hand-off to an assigned Pediatric Care Manager. Led by our Pediatric Medical Director, UM, CM and other team members can participate in an interdisciplinary care team meeting specifically aimed at addressing members' care coordination needs.

Providers are expected to:

- Perform appropriate baseline health assessments and diagnostic evaluations which provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS-eligible medical condition.
- Initiate referrals of Members with CCS-eligible conditions to be made to the local CCS program by telephone, same-day mail or fax.
- Continue to provide all medically necessary covered services until CCS eligibility is confirmed (for Members whose eligibility for the CCS program is not yet established).
- Provide all medically necessary covered services that are not authorized by CCS (for Members whose eligibility for the CCS program is established).
- Coordinate care with CCS specialty providers and the local CCS program.

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Provider Portal

Provider Portal Quick Reference Guide

The Provider Portal Reference Guide is a unique tool created to assist in the daily navigation of the frequently performed tasks on the Provider Portal, including checking member eligibility, claim(s) status, member reporting and other valuable information to help you serve the L.A. Care Community.

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Getting Started

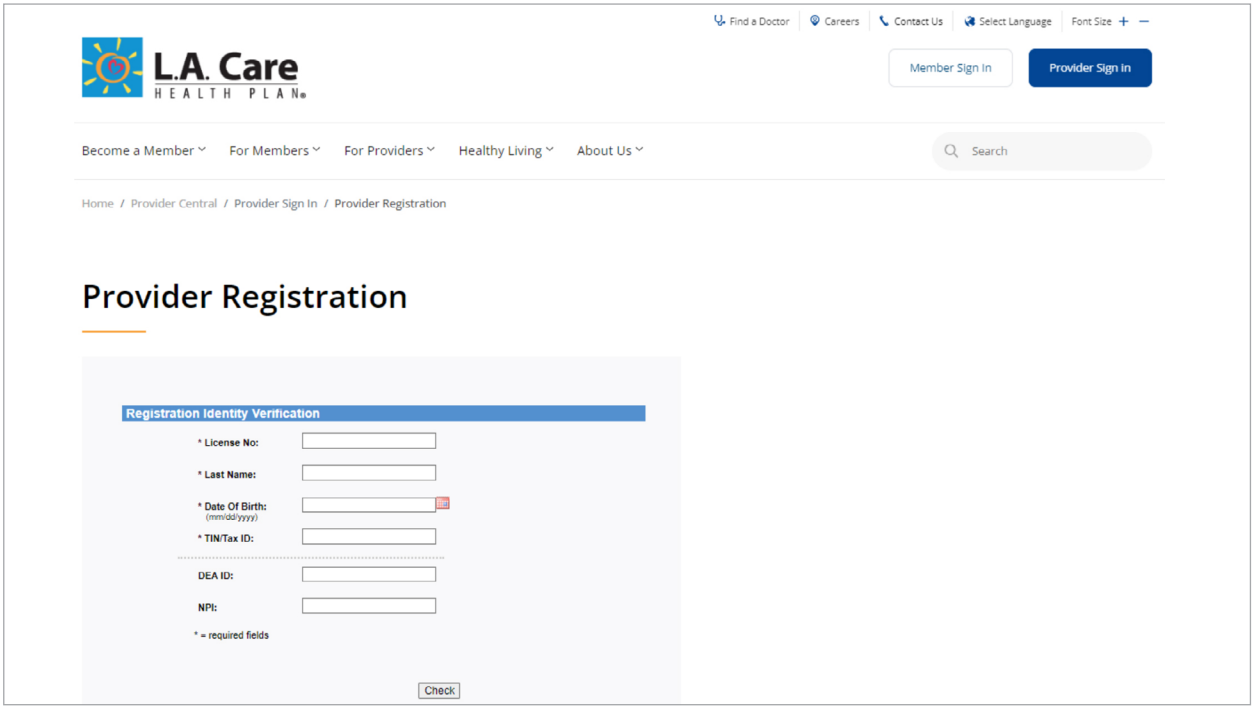
Registering a New User

A. All contracted physicians, specialists, and other medical administrative staff may self-register at **https://www.lacare.org/providers/provider-sign-in/provider-registration.**

Fields marked with an asterisk are required in order for the request to be processed. See Figure 1 below.

* License Number
* Last Name of the Physician/Specialist
* Date of Birth for Physician/Specialist
* Tax Identification Number for the Physician/Specialist

Figure 1



B. Please note all Provider Portal registration requests will be processed within **3-5 business days.**

C. Once access has been granted to the Provider Portal, an email notification will be sent to the new user. In this email, a confirmation link will be provided to confirm registration.

The activation link is valid for **72 hours**.

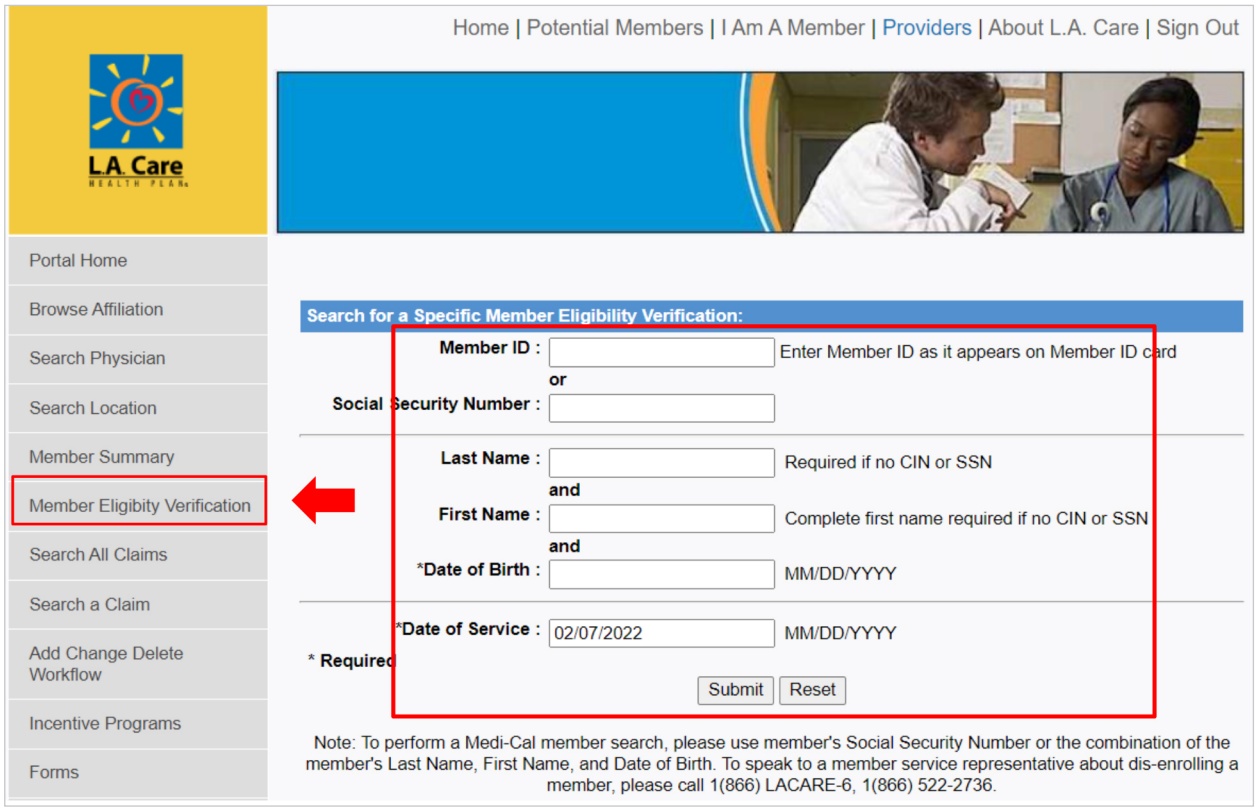
* If the new user does not confirm the user's access within the timeframe allowed, the registration process will have to be repeated. Please contact Provider Relations via email at **DirectNetwork@lacare.org** or further assistance.

Check Member Eligibility

A. Log on to the **Provider Portal** and select **"Member Eligibility Verification."**

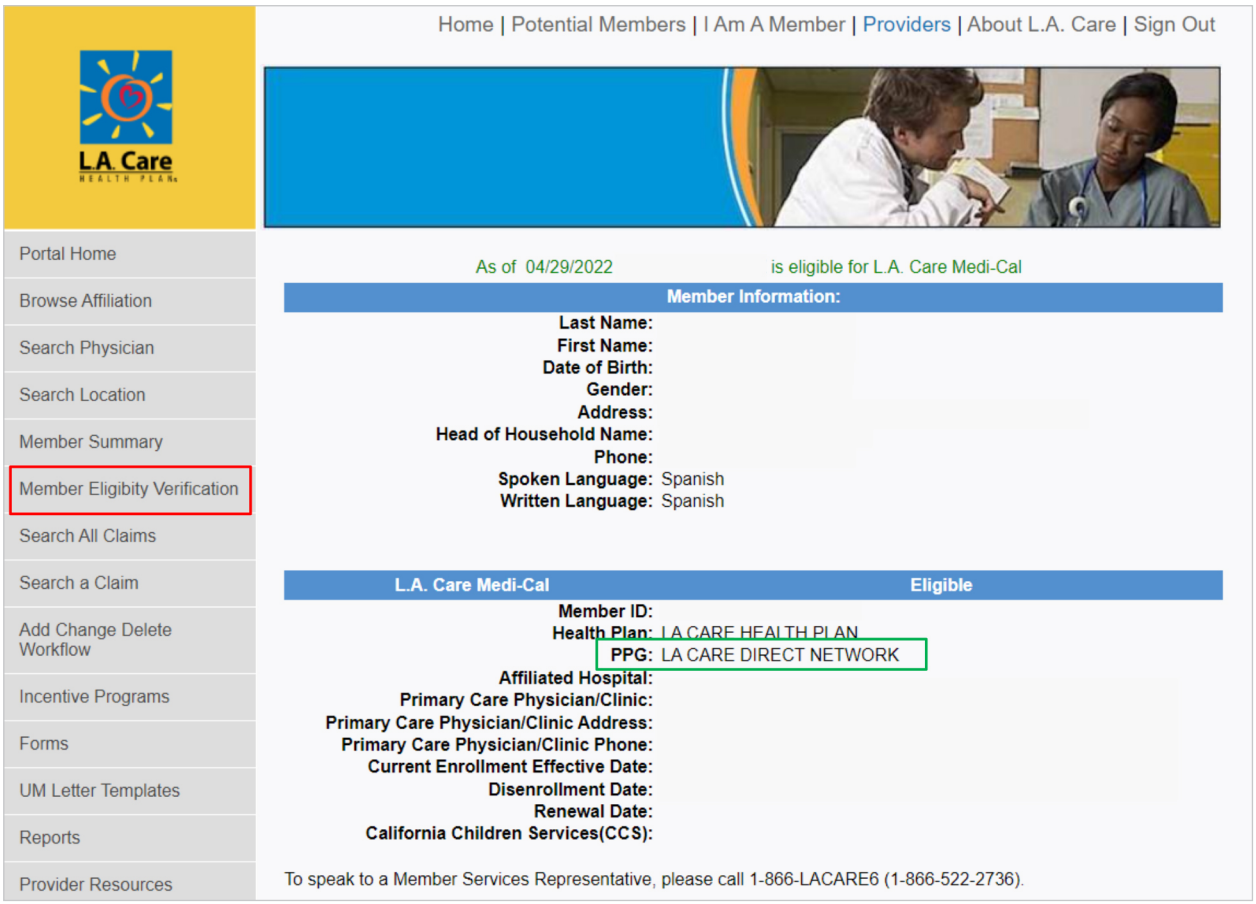
B. Fields marked with an asterisk are required in order for the request to be processed. Please provide additional available information and press submit when complete. See Figure 2A below

Figure 2A



C. See figure 2B example of how to verify the member is assigned to the Direct Network

Figure 2B



Claim(s) Search

A. To search for claims, log on to the Provider Portal and select the left-tabbed option **"Search a Claim"** or "**Search All Claims."** With a single claim number and patient account number, details of the claim can be viewed under the "Search a Claim" tab. If the claim number is not known, you will be provided with a list of claims by selecting the "Search All Claims" tab. See Figures 3 and 4 below.

If you are unable to locate a claim, please contact Provider Relations via email at **DirectNetwork@lacare.org** for further assistance.

Figure 3 - If you have the claim number available

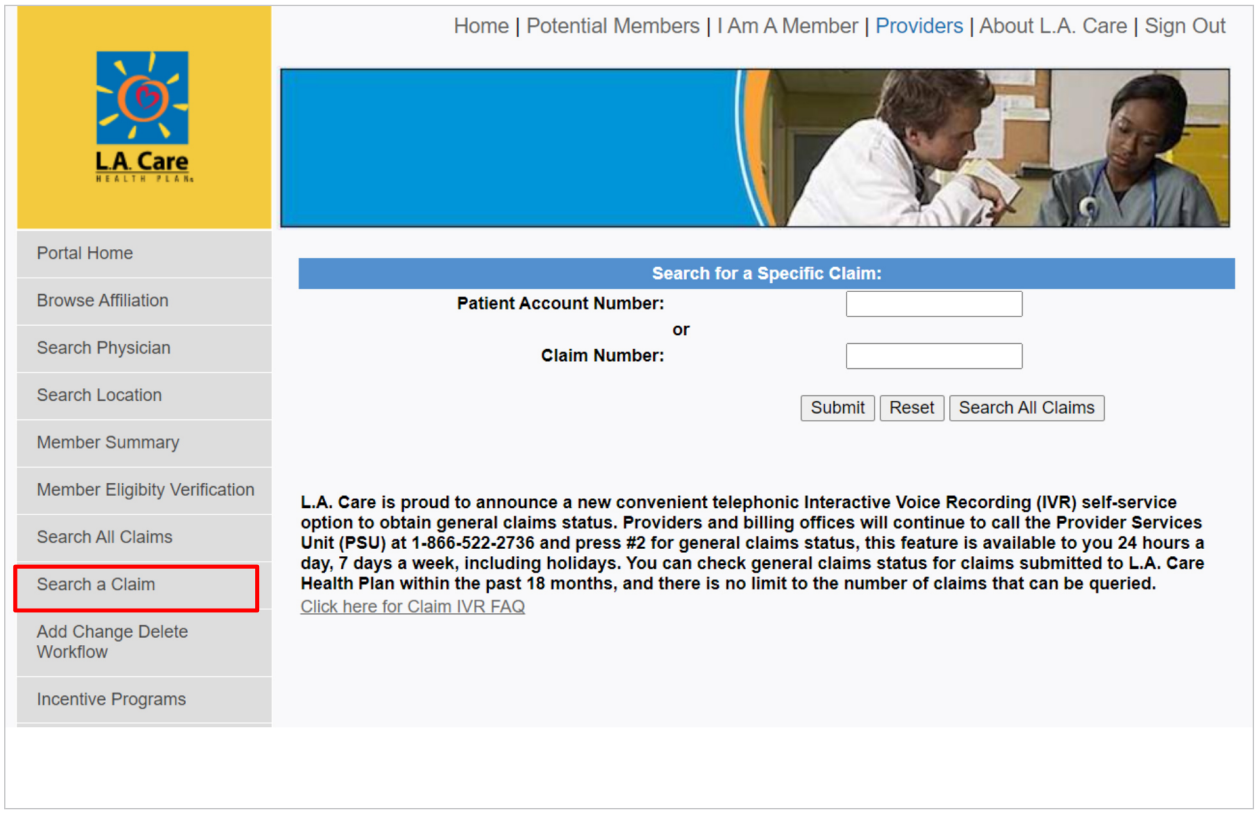
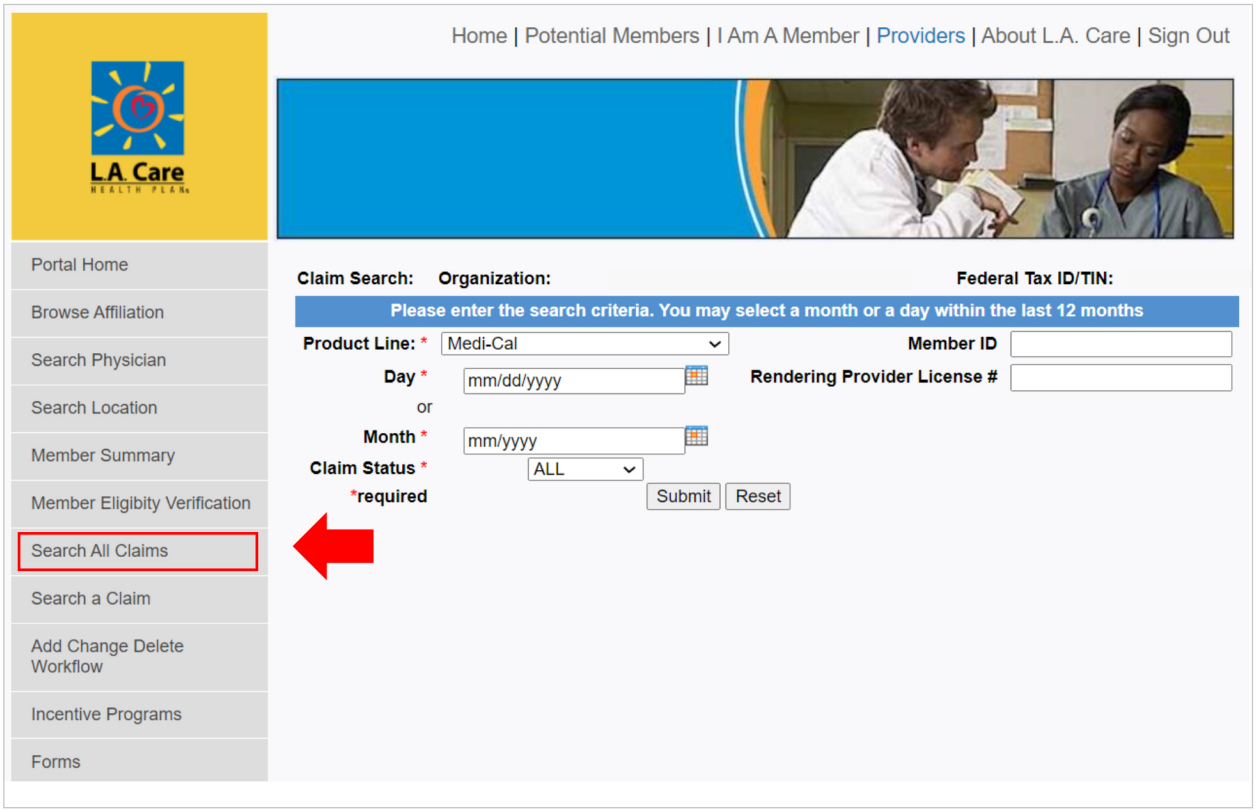


Figure 4 - If you do not have a claim number available



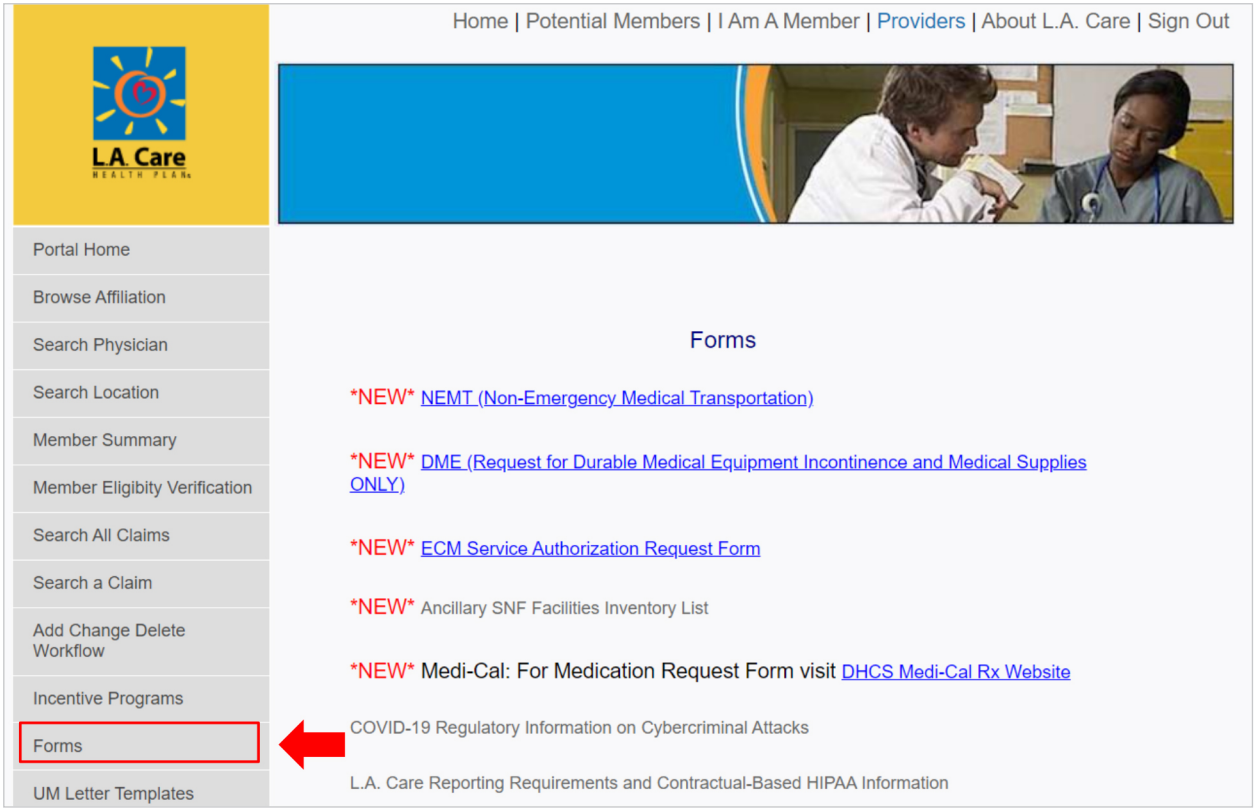
Forms

L.A. Care offers a number of forms for providers to view and download through the Provider Portal.

To view the selection of forms that are available for providers, log on to the Provider Portal and select the left-tabbed option "Forms." See Figure 5 below.

If you have any questions about the forms that are provided, or if you are unable to find a form you need, please contact Provider Relations via email at **DirectNetwork@lacare.org** for further assistance.

Figure 5



Incentive Program for Direct Network Providers

L.A. Care's Direct Network Pay-for-Performance (P4P) Program provides financial rewards for practices that provide high quality care for members in L.A. Care's Medi-Cal line of business, and is an opportunity to receive significant bonus revenue. Eligible providers have received annual incentive payments up to $8.00 per member per month (PMPM) for outstanding performance. Performance is based on a provider's improvement and/or benchmarking against other providers on key clinical quality indicators, including HEDIS, Utilization Management, Capitated Claims/Encounters and/or Member Experience measures.

- Providers with 10 or more L.A. Care Direct Network Medi-Cal Members are eligible to receive incentives through the Direct Network P4P Program. For more information, please refer to the Direct Network P4P Program Manual.

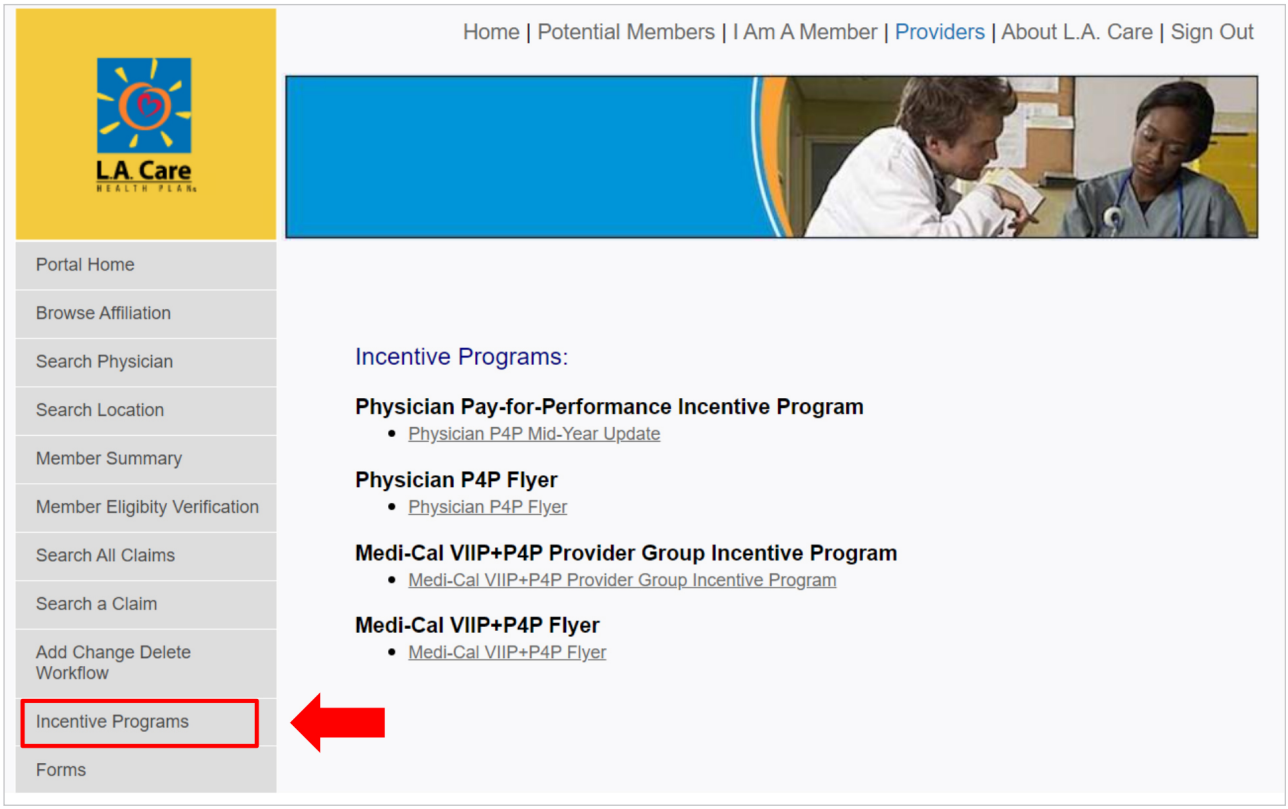
Please note: Medical records are not reviewed as part of the Direct Network P4P program. Providers and their employers must submit claim and encounter data through their normal reporting channels to receive credit.

To view current program offerings, log onto the Provider Portal and select the left-tabbed option **"Incentive Programs."** See Figure 6 below.

For questions regarding the Provider Portal, please contact Provider Relations via email at **DirectNetwork@lacare.org**.

For more information about current incentive program offerings, please contact your designated L.A. Care Direct Network Account Manager.

Figure 6



Reporting

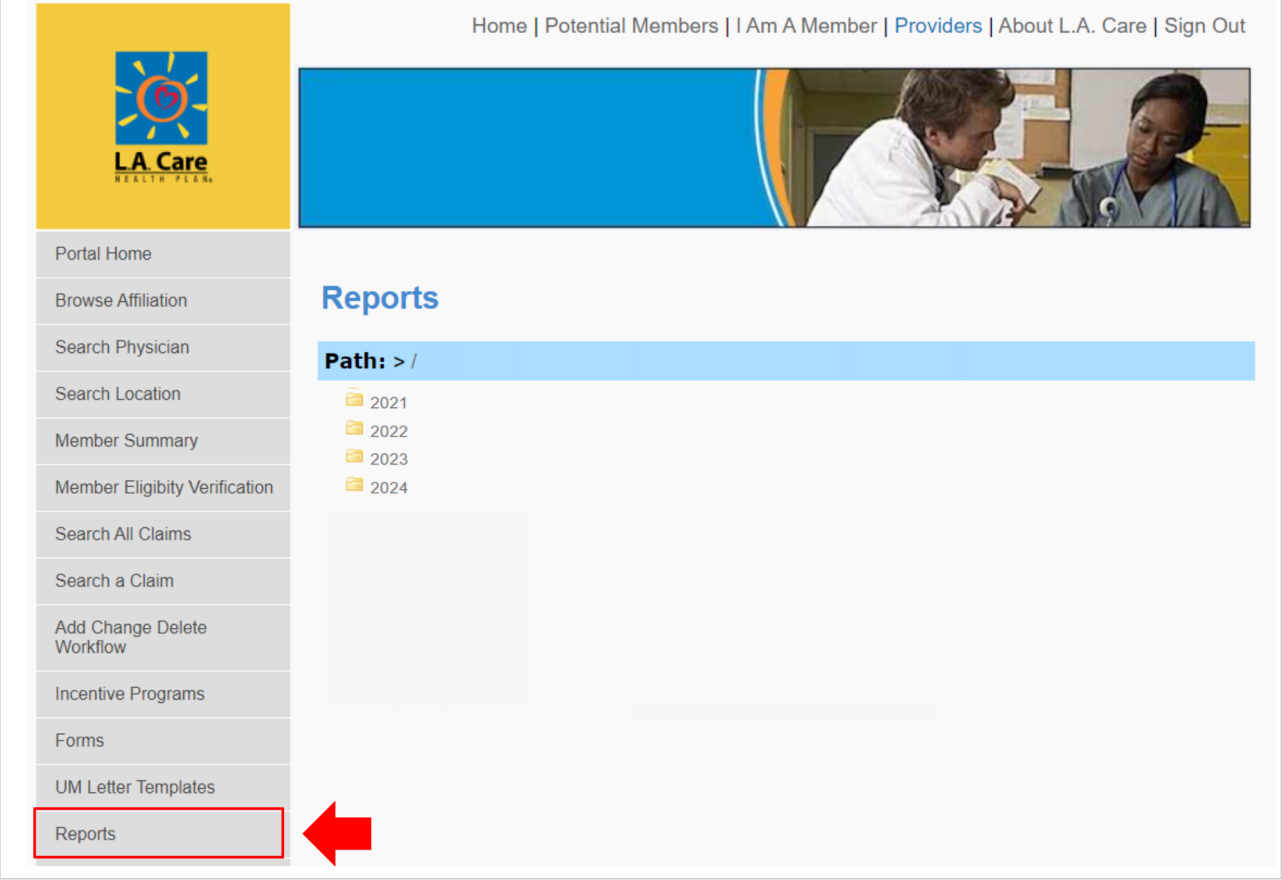
L.A. Care offers a number of reports for providers to view and download through the Provider Portal.

Figures 7, and 8 are examples of what reports are available for Providers to view. If you have questions about a particular report, or need more information about reporting, please contact **DirectNetwork@lacare.org** for further assistance.

A. To view the selection of reports that are available for providers, log on to the Provider Portal and select the left-tabbed option **"Reports."** See Figure 7 below.

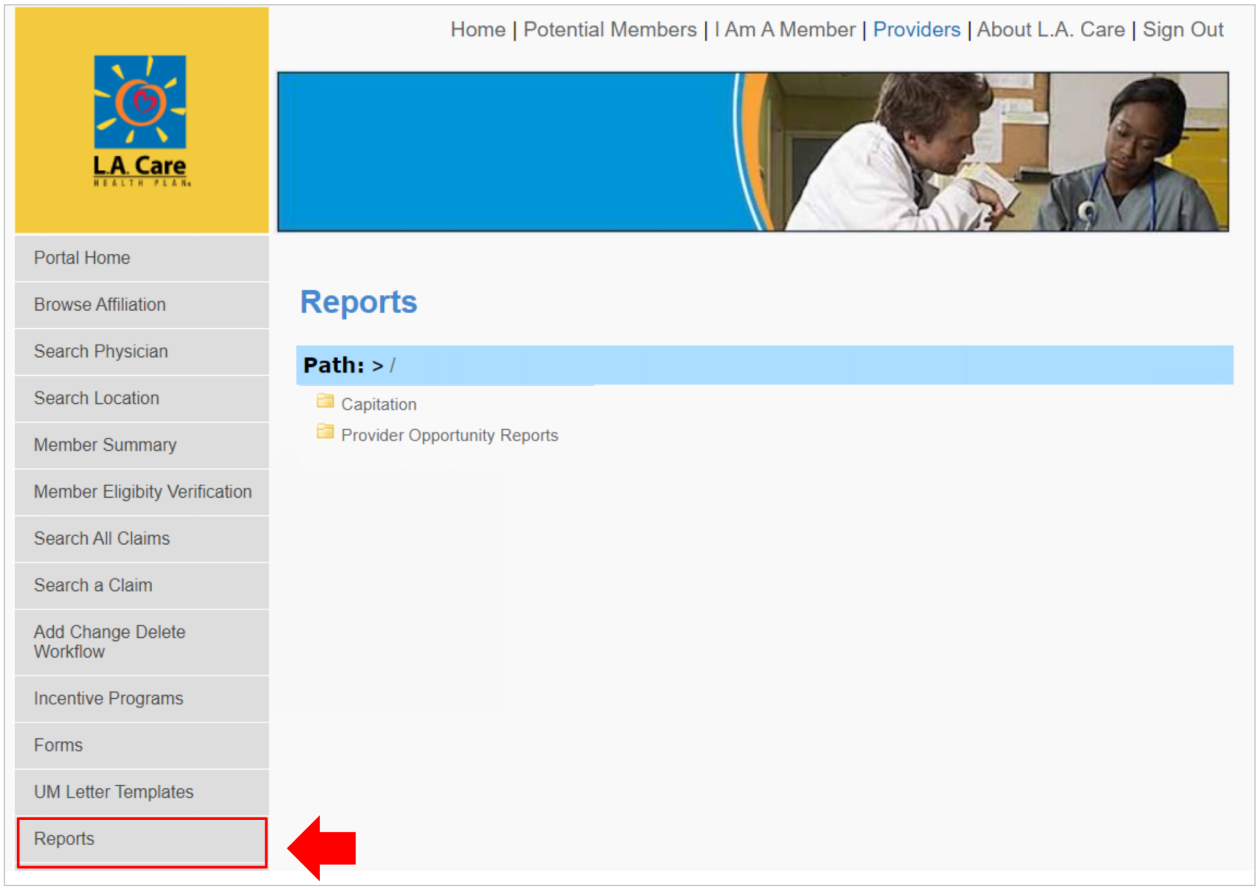
B. Next, select the reporting year related to your inquiry.

Figure 7



C. From the list of reports displayed, select the report you would like to view. See Figure 8 below.

Figure 8



Patient Safety Program

Patient Safety monitoring ensures the protection of welfare for those receiving care. L.A. Care patient safety monitoring effort is accomplished through identifying and reporting of risk and events from the Potential Quality of Care Issue (PQI) investigation, peer review process and critical incident (CI) review process. Providers shall report any quality concern with a potential or suspected deviation from accepted standards of care to the L.A. Care QI Department by submitting a referral for further investigation. Provider's responsibilities include the following:

1. Providers shall provide, ensure, and monitor the safety and quality of services provided to L.A. Care Members
2. Providers shall have a policy and procedure for collecting and providing information on safety and quality
3. Providers shall report any quality concern with a potential or suspected deviation from accepted standards of care to the L.A. Care QI Department by submitting a PQI referral to the email at **PQI@lacare.org** for further investigation
4. PQI referral forms can be found here: **https://www.lacare.org/sites/default/files/la2138_referral_quality_care_issues.pdf**

Critical Incidents

A critical incident is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a person. L.A. Care has a process in place to report Member critical incidents related to an adverse event. Critical Incident cases are referred to the Provider Quality Review (PQR) team for clinical evaluation, investigation, and tracking.

Critical Incident Reporting
Providers serving Members shall be vigilant in listening and watching for evidence of Critical Events/ Incidents, and reporting them appropriately to the authorities and L.A. Care as soon as they are identified, and within 48 hours of the incident. Definitions of critical events can be found on page two (2) of the Critical Incident Report form at the link below.

Categories of Critical Events/Incidents for which reporting is required are:

- Abuse (CI001)
- Neglect (CI002)
- Exploitation (CI003)
- Life-threatening Event (CI004)
- Disappearance (CI005)
- Suicide Attempt (CI006)
- Unexpected Death (CI007)
- Restraint or Seclusion (CI008)

The Critical Incident Report form can be found here:
https://www.lacare.org/sites/default/files/la2139_critical_incidents_report_form.pdf

Disruptive and Threatening Members

Primary care providers may request that Disruptive or Threatening members be transferred to another provider. The criteria for member transfer are outlined in L.A. Care Policy CSCMS-045, "Disruptive and Threatening Member Resolution (DTMR)."

The criteria for approval are situations where:

1. Members disrupt the operation of the provider's office or clinic.
2. Members threaten to harm the provider or provider's staff.

Non-compliance with medical advice, appointment no-shows, and the filing of complaints do not qualify for transfer.

If a DTMR request meets criteria, L.A. Care will arrange for a transfer of the member's care to another provider. The Plan will contact the member after the transfer to assess for ongoing needs. Providers should adhere to professional standards of care when responding to requests for release of information and for transfer of records.

If a DTMR request is not approved, L.A. Care will notify the provider within five (5) business days. L.A. Care specialists in Behavioral Health, Social Services, and Care Management are available for consultation about these cases.

- For Behavioral Health consultation: **BehavioralHealth_OD_Mailbox@lacare.org**
- For Social Services consultation: **SocialWorkDept_Mailbox@lacare.org**
- For Care Management consultation: **CMTriageCoordinators_DL@lacare.org**

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Claims & Reimbursement

Urgent Claim Reminder to ALL Contracted Providers

In accordance with the mandatory language in the Direct Network Contract and/or Addendum, **ALL SERVICES provided** (including services covered under PCP Capitation) **must be submitted** to L.A. Care for processing. Claims submitted by PCPs must satisfy contractual and regulatory requirements and will be processed according to contract specifications. ALL capitated and non-capitated services performed by any PCP or Specialist must be submitted. All claims should be submitted within 60 calendar days of rendered service date.

Benefits to Submitting Your Claims via Electronic Data Interchange (EDI)

Electronic Data Interchange (EDI) provides an efficient and secure way to submit your claim information to L.A. Care electronically. Billing paper claims through the mail is a time consuming practice that does not offer the same security and/or expedited payment option as EDI.

Additionally, EDI can help reduce administrative costs by eliminating manual labor associated with preparing and mailing paper claims. EDI also provides access to real-time verification of claim submissions, allowing visibility into correctable errors and rejections to facilitate resubmissions in real-time. Additional benefits include:

- Improved accuracy of billing and posting of information.
- Faster claim processing.
- Improved cash flow.
- Submit Coordination of Benefit Claims electronically. You can now submit your coordination of benefits (COB) claims electronically without the need to submit the primary Payers Explanation of Benefits (EOB).
- Audit trail of claim submission
- Improved security for protected information.

How to Enroll to Submit Your Claims Electronically

All EDI transmissions must be submitted to L.A. Care through our third-party clearinghouse partner Change Healthcare. L.A. Care does not accept direct electronic submissions from providers. To setup for EDI, you will need to do one of the following:

- Contact your Billing Service/Software Vendor to add L.A. Care to your practice management system to allow real-time electronic transmissions to Change Healthcare. Please reference L.A. Care's Payer Id "LACAR".
- If you do not have access to Real Time transactions via a software vendor or a billing service, please contact Change Healthcare Customer Support at: **1.877.363.3666** or visit their website at **https://support.changehealthcare.com/customer-support-portal** for more information on other options that may be available for direct submission to Change Healthcare.

Electronic Eligibility Verification

The Eligibility/Benefit Inquiry and Response (270/271 EDI) transaction set is used to provide information about healthcare policy coverage for a specific member or any of its dependents seeking medical services. To take advantage of electronic eligibility verification, you must:

- Have the ability to create a 270 Eligibility Request and Receive a 271 Eligibility Response. The EDI 270/271 are common transactions in healthcare data exchange and are available through your practice management system and/or billing service. If you do not have access to create a 270/271 transaction, please contact your software vendor/billing service for additional information.
- Have the ability to electronically submit a 270 Eligibility Request to Change Healthcare. L.A. Care contracts with Change Healthcare (clearinghouse) to receive and respond to all electronic eligibility requests on our behalf. If you do not have the ability to submit an EDI transaction to Change Healthcare, please contact your software vendor and/or billing service to add L.A. Care to your practice management system for submission to Change Healthcare.
- If you do not have the ability to submit using your current practice management system, please contact the Change Healthcare customer support line at 1.877.363.3666 for alternative options that may be available to your practice.

If you have any questions, or need additional information regarding any of the EDI services available to your office, please contact the L.A. Care EDI team via email at: **EDI_Shared_Services@lacare.org**.

Electronic Funds Transfer (EFT) & Electronic Remittance 835

Electronic funds transfer (EFT) allows your claim payments to be electronically deposited into your bank account. Setting your practice for EFT, allows you to receive your payments faster and minimizes the risk of lost checks. Furthermore, when you setup for EFT, you will also be enrolled to receive your remittance advice electronically in the **ANSI X12 835** EDI transaction. The 835 allows you to post your remittance advice electronically into your practice management system saving time by eliminating data entry and reducing errors associated with manual posting of your checks. It is important to note that only those providers that setup for EFT have the option of receiving an electronic 835. If you need additional information on setting up your system to post via the 835, contact your software vendor and/or billing service. Other benefits include:

- Improved cash flow because you receive your reimbursement faster.
- Secure transaction
- Reduced administrative fees by eliminating the need to go to the bank
- No more lost checks
- Capitation and incentive payments (commencing in 2024) can be directly deposited too!

How to enroll with Electronic Funds Transfer (EFT)

Enrollment in Electronic Funds Transfer (EFT) – First Time Users

To enroll in EFT, you will first have to register with our business partner PaySpan Health. If you are a first-time user with PaySpan, you will need a registration code before you can complete the registration process. You can request a registration code in one of the following 3 ways:

- By website: **https://www.payspanhealth.com**
- By phone: **1.877.331.7154**, Select Option 1
- By email: **providersupport@payspanhealth.com**

Once you have received your registration code, you can register by visiting https://www.payspanhealth.com and using your National Provider Identifier (NPI), Tax ID and Billing ZIP Code. The process will require you to:

- Provide your personal information
- Setup your banking information
- Confirm your PaySpan account for electronic payments

If you need additional assistance, contact a PaySpan Health Provider Service Specialist by phone **1.877.431.2273** or email.

Enrollment in Electronic Funds Transfer (EFT) – Existing PaySpan Users

If you have already registered with PaySpan Health, you may add L.A. Care as a new payer by following these simple steps:

1. Login into your existing account at PaySpan
2. Request a new registration code
3. PaySpan Health will send you an automated email with your new registration code
4. Once you receive your registration code, go to **http://www.payspanhealth.com**
5. Select "Your Payments"
6. Select "Add New Reg Code"
    A. Enter the Registration Code
    B. Provider Identification Number
    C. Tax Identification Number
    D. National Provider Identifier
7. Begin Registration

If you need additional assistance, contact a PaySpan Health Provider Service Specialist by phone **1.877.431.2273** or email **providersupport@payspanhealth.com**.

Additional Information You Need to Know

- If you do not setup up for EFT, you will receive funds via a paper check.
- It is important to note that if you have multiple Provider IDs, you will need to register all your provider IDs separately to ensure all your payments are sent electronically.
- EFT payments are typically deposited into your specified bank account within three business days following the claim date of process. This means that for any claims that complete processing day one (e.g., 3/1/17), an electronic remittance is available day two (3/2/17), and the electronic funds transfer will typically be deposited in your bank account on day three (3/3/17).
- EFT checks have a different number sequence than your current paper checks.
- The daily electronic remittance file will be your office's notification of the payment that is posted to the account. Additional notification of checks and amounts received into the accounts should come from your bank. Contact your bank for their notification procedures.

Hard Copy (Paper) Claim Submissions by Mail

You can also submit claims on the CMS 1500 (Professional) and UB04 (Institutional) standard forms. All hard copy claim forms should be mailed to:

L.A. Care Heath Plan
Attention: Claims Department
P.O. Box 811580
Los Angeles, CA 90081

Provider Dispute Resolution (PDR)

Provider Manual: Chapter Claims

A Provider has a right to file a dispute in writing to L.A. Care within **365 calendar days** from the claim paid date or the most recent action date if there are multiple actions. A Provider dispute is a written notice to L.A. Care challenging, appealing or requesting reconsideration of a claim such as the following:

- Payment of a claim
- Denial of a claim
- Adjusted
- Contested
- Seeking resolution of a billing determination
- Seeking resolution of another contract dispute
- Disputing a request for reimbursement of an overpayment to a claim

The following information is required for a Provider Payment Dispute Notice:

1. Provider Name, TAX ID under which services were billed and contract information
2. If the payment dispute concerns a claim or a request for reimbursement or overpayment of a claim – a clear identification of the disputed item using:
    A. L.A. Care's original claim number
    B. The date of service
    C. Member first and last name
    D. Member date of birth, and
    E. A clear explanation of the basis upon which the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is disputed.
3. If the payment dispute is not about a claim, a clear explanation of the issue and the Providers' position on the issue.
4. Second Level Disputes must state "Second Level Dispute" and include a copy of the first level dispute filing and determination.

Provider Disputes and Cap Deduct Disputes can be submitted via mail or fax.

- Mailed disputes are acknowledged within 15 days of received date. Faxed disputes are acknowledged within 2 days of received date.

  L.A. Care Health Plan
  Attn: Provider Disputes
  P.O. Box 811610
  Los Angeles, CA 90081
  Fax: 1.213.438.5057

- Written determination stating outcome of decision is issued within 45 working days after the receipt of a clean dispute

✓ At this time, PDR status is not available via portal. PDR status is available through Provider Service Unit **1.866.522.2736**.

✓ Claims and PDR

- Claims Customer Service: **1.866.522.2736**

✓ Claims only

- Provider Portal: **https://www.lacare.org/providers/provider-central/la-care-provider-central**

✓ Contact Account Manager

- Claims Customer Service: **1.866.522.2736**

Claims Payment Integrity

Providers must follow proper billing and submission guidelines. L.A. Care or its vendor(s), may conduct Pre-Payment or Post-Payment Reviews of a Providers' services rendered to L.A. Care Members. L.A. Care or its vendor(s) may also conduct Post-Payment Reviews of Claims as required or allowed by applicable law, and may request medical records, itemized bills, invoices, or other substantiating documentation to support payment of the Claim and to avoid Overpayment.

When L.A. Care verifies an Overpayment, an Overpayment Demand Letter is sent to the Provider, within 365 days of the date of payment, for review. The letter identifies the Claim, the name of the Member, the date of service, and an explanation of the basis upon which the amount paid on the Claim was in excess of the amount due.

The Provider has the following options, which are outlined in the letter:

- Provide a written notice within 30 working days stating the basis upon which the Provider believes that the Claim was not overpaid. L.A. Care will then process the contested notice of Overpayment of a Claim as a Provider Dispute.
- If the Provider does not contest the notice of reimbursement of the Overpayment of a Claim, the Provider shall reimburse L.A. Care within 30 working days of the receipt by the Provider of the notice of Overpayment of a Claim.
- If the Provider fails to respond to the Overpayment Demand Letter within 30 working days, L.A. Care will withhold the overpaid amount against future Claims payments.

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Resources at a Glance

With this reference guide, L.A. Care is confident that you will be equipped with the information you need to provide our members with care. Listed below are some additional resources that you may find helpful.

RESOURCE	CONTACT INFORMATION		
Provider Information	Phone: **1.844.361.7272**		
Member Services Line	Phone: **1.888.839.9909**		
Online Prior Authorization Tool	**Prior Authorization Tool**		
Utilization Management	**L.A. Care Direct Network - Authorization Fax Request Form:** **https://www.lacare.org/priorauth** Phone: **1.866.LACARE6 (1.866.522.2736)**		
Case Management	**Provider Referral Form:** **https://www.lacare.org/sites/default/files/files/la4310_cm_referral_form_202212.pdf**		
Specialty Services	**Call The Car** English: **1.626.817.9211** Spanish: **1.866.529.2142**	**Vision Service Plan (VSP)** Phone: **1.800.852.7600** TTY/TDD: **1.800.428.4833**	
	Managed Long Term Services & Supports E-mail: **MLTSS@lacare.org** Phone: **1.855.427.1223** Fax: **213.438.4877**	**Nurse Advice Line (24/7)** Phone: **1.800.249-3619** TTY: **711**	**Medi-Cal Dental Services** Phone: **1.800.322.6384** TTY: **1.800.735.2922**
Behavioral Health	**Non-Specialty Services** *Carelon Behavioral Health* Phone: **1. 877.344.2858** *L.A. Care Behavioral Health Services* Phone: **1.844.858.9940** Email: **behavioralhealth@lacare.org**	**Specialty Mental Health Services** *Department of Mental Health* Phone: **1.855.854.7771** *Specialty Substance Use Disorder Department of Public Health* Phone: **1.844.804.7500**	
Member Programs	**Health Education** Phone: **1.855.856.6943**	**Interpreting Services:** Telephonic interpreting: **1.855.322.4034** In-person Interpreting: **1.888.839.9909**	
Claims Department	**Claims Forms: Submitting a Claim | L.A. Care Health Plan (lacare.org)** :: Fee-For-Service PCP and Specialists – CMS 1500 Form Required :: Provider Disputes Resolution (PDR) **Electronic Claims Submission: Using Electronic Data Interchange (EDI) | L.A. Care Health Plan (lacare.org)** **Electronic Payment: https://www.payspanhealth.com/providerportal/registration**		
	Claims Submission Mailing Address: **L.A. Care Claims Department** **PO Box 811580** **Los Angeles, CA 90081**	**Provider Disputes Resolution** Mailing Address: **L.A. Care Claims Department** **Attn: Appeals and PDR Unit** **PO Box 811610** **Los Angeles, CA 90081** Fax: **213.438.5793**	
Facility Site Review (FSR)	**RequestFSR@lacare.org**	**For information on FSR, please refer to Chapter 3 of the Universal Provider Manual (UPM).**	
Population Health Management (PHM)	**phm@lacare.org** **For more information about Initial Health Appointments contact:** **IHA@lacare.org**	**For information on PHM, please refer to Chapter 3 of the Universal Provider Manual (UPM).**	

Direct Network Provider Tools & Resources

Your frequently asked questions can be conveniently answered through our Self-Service Tools

Log into our Online Self-Service Portal at:
https://www.lacare.org/providers/provider-central/la-care-provider-central

Resource Name	Resource Description	Link
Physician & Direct Network Pay-for-Performance Programs	These programs offer performance-based incentives to L.A. Care's Direct Network contracted physicians and Community Clinics that provide high-quality preventive and chronic care to our members.	https://www.lacare.org/providers/provider-central/provider-programs/quality-care-initiatives/p4p-program Incentive_Ops@lacare.org
Elevating the Safety Net	Launched in July 2018, Elevating the Safety Net is a $31 million initiative to address the physician shortage in Los Angeles County. Programs under the initiative include the Provider Recruitment Program, Provider Loan Repayment Program, Medical School Scholarship Program, Residency Support Program, and IHSS + Home Care Training Program, among others. Initiative to address the physician shortage in Los Angeles County that includes: • Provider Recruitment Program (up to $125,000 per provider) • Provider Loan Repayment Program (up to $5,000 per month for 36 months) • Medical School Scholarship Program • Residency Support Program • IHSS + Home Care Training Program	https://www.lacare.org/providers/provider-central/elevating-safety-net Find the right team to contact online at www.lacare.org/elevateproviders
Provider Recruitment Program	This program provides grant funds that will allow contracted entities within L.A. Care's Medi Cal network to better compete with practices outside of the safety net. Applicants may request up to $125,000 per provider. Funds can be used for salary and benefits subsidies, sign- on bonuses, and/or relocation costs. The five eligible provider types include Family Medicine, Internal Medicine, OB/GYN, Pediatrician and Psychiatrist.	https://www.lacare.org/providers/provider-central/elevating-safety-net/provider-recruitment-program
Provider Loan Repayment Program	This program provides loan repayments of up to $5,000 per month for 36 months, with an opportunity to extend for an additional two years. Eligible primary care specialties include Family Medicine, Internal Medicine, Pediatrics, Obstetrics/Gynecology, and Psychiatry.	https://www.lacare.org/providers/provider-central/elevating-safety-net/provider-loan-repayment-program

Resource Name	Resource Description	Link
Cozeva	Cozeva is a reporting and analytics platform that allows providers to better monitor and take action on performance gaps for quality and risk measures. Providers can sign up for free. Email lacare@cozeva.com for more information.	N/A
Prop 56 Funds	California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increased the excise tax rate on cigarettes and electronic cigarettes. The revenue was allocated to 5 health programs: Physician Services Supplemental Payments, Family Planning Supplemental Payments, Hyde Reimbursements (Medical Pregnancy Termination), Developmental Screening Services and Adverse Childhood Experiences Screening Services.	**https://www.dhcs.ca.gov/services/pages/dp-proposition56.aspx** **Be connected with the appropriate team for any question on Prop 56 funds**
Quality Improvement Webinar Training Series	An ongoing series of webinars which cover a wide range of quality improvement topics, ranging from diabetes care to data submission. Some sessions offer the opportunity to earn CME or CE credits.	**https://www.lacare.org/providers/provider-central/provider-programs/classes-seminars/** **Quality@lacare.org**
Provider Continuing Education Program	L.A. Care Provider Continuing Education (PCE) program is an accredited educational program that consists of Continuing Medical Education (CME) activities for Physicians (MDs, DOs, PAs) and Continuing Education (CE) activities for NPs, RNs, LCSWs, LMFTs, LPCCs and LEPs, and other healthcare professionals.	**https://www.lacare.org/providers/provider-central/provider-programs/classes-seminars/** **ProviderContinuingEducation_Mailbox@lacare.org**
Cultural and Linguistic Training	The Cultural and Linguistic Unit offers no-cost workshops available online for network providers. Available workshops include Cultural Competency, Disability Sensitivity and Unconscious Bias.	**https://www.lacare.org/providers/provider-central/provider-programs/classes-seminars/** **CulturalandLinguisticServices_Mailbox@lacare.org**
Cultural and Linguistic Training (C&L) Resources	C&L also has additional resources available on **http://healtheducation.chi.v6.pressero.com/login:** • C&L Toolkit (PDF version **https://www.lacare.org/providers/provider-resources/tools-toolkits/health-education-tools**) • Language poster (19 languages) • Member language brochure (11 languages) • Telephonic interpreting card **Order through the L.A. Care Materials Portal**.	**http://healtheducation.chi.v6.pressero.com/login** **CulturalandLinguisticServices_Mailbox@lacare.org**

Resource Name	Resource Description	Link
Health Education Services and Resources	L.A. Care offers health education services and resources including: • Printed health education materials • Health education group appointments and individual phone counseling • Medically Tailored Meals program • Doula services • Self-paced online wellness programs Providers can refer patients to Health Education using the correct online referral form: • **Health Education Referral Form** • **Medical Nutrition Therapy (MNT) Referral Form** • **CS Medically Tailored Meals Referral Form**	**https://www.lacare.org/providers/provider-resources/tools-toolkits/health-education-tools** **HealthEd_Info_Mailbox@lacare.org**
HEDIS Resources	Free HEDIS reference guides for all HEDIS measures that L.A. Care reports. These are designed to help practices provide the best quality care and how to properly submit data.	**https://www.lacare.org/providers/provider-resources/tools-toolkits/hedis-resources** **HEDISOps@lacare.org**
Clinical Practice Guidelines	Clinical Practice Guidelines are available for providers to use for evidence-based practice for various medical and behavioral conditions.	**https://www.lacare.org/providers/provider-resources/tools-toolkits/clinical-practice-guidelines** **Quality@lacare.org**
Preventive Health Guideline Brochures	Preventive health guideline brochures available for free for providers and their offices. Brochures are for Child/Adolescent, Adult and Older Adult.	**https://www.lacare.org/providers/provider-resources/tools-toolkits/clinical-practice-guidelines** **Quality@lacare.org**
L.A. Care Community Link	**L.A. Care Community Link** - A tool for addressing the Social Determinants of Health. It is a site where you can search for help with free or low-cost food, bills, job training, legal aid, and more.	**https://communitylink.lacare.org/**
Provider Toolkits	Over a dozen free toolkits for providers on topics ranging from medical and mental health to serving diverse populations.	**https://www.lacare.org/providers/provider-resources/tools-toolkits/toolkits**

Resource Name	Resource Description	Link
Patient Experience Tips	Tips available to L.A. Care providers to help them increase patient satisfaction and maximize financial payout.	**https://www.lacare.org/providers/provider-resources/tools-toolkits/quality-improvement-program/tips** **Quality@lacare.org**
Online Provider Portal	L.A. Care offers two provider portals: one for Contracted/ Participating Providers and one for Non-Contracted/ Non-Participating Providers. The Non-Participating Provider portal only has eligibility and claims status lookup. Eligibility is only for same day queries. No historical eligibility data is available. Additionally, no forms are available for download, no reports, no eligibility coverage history, and no other tools available.	**https://www.lacare.org/providers/provider-central/la-care-provider-central** **ProviderRelations@lacare.org**
Pharmacy Services	L.A. Care's Pharmacy Services offers several resources and guidelines to assist you with prescribing medications to our members. There is a list of covered drugs, outlined steps to improve medication adherence and prescription drug prior authorizations.	**https://medi-calrx.dhcs.ca.gov/home** L.A. Care Provider Solutions Center: **1.866.522.2736**
Provider News and Advisories	Stay up-to-date with the latest information about policy and regulatory changes, education and training opportunities, as well as updates on clinical best practices in a bi-monthly email newsletter and quarterly print newsletter.	**https://www.lacare.org/providers/provider-central/news**
Forms and Manuals	One-stop shop for L.A. Care provider manuals and commonly used forms.	**https://www.lacare.org/providers/provider-resources/forms-manuals**
Quality	Email inbox managed by the L.A. Care Quality Improvement Clinical Initiatives team. Providers can reach out with questions.	**Quality@lacare.org**
Provider Opportunity Report	These reports contain year-to-date compliance rates for HEDIS and member gaps in care. Download them and other reports from the provider portal.	**Make an account from L.A. Care Provider Central** **Incentive_Ops@lacare.org**
Transform L.A. Program	Practice Coaching - A practice coach partners with your practice to provide customized on-site and virtual technical assistance focused on EHR optimization, workflow efficiencies, population health management, and quality improvement.	For questions, please contact our Coach Team via email at **transformLA@lacare.org**

How to Contact an Account Manager

The L.A. Care Direct Network Account Manager is responsible for all aspects of the L.A. Care provider contracting and relationship management. Please reach out to your Account Manager if you have questions regarding

- Contract questions, as well as new protocols, policies, and procedures
- Operational issues
- Payment questions
- Escalated provider inquiries

Please contact the L.A. Care Direct Network Help Line at **1.213.694.1250** ext. **4297** or e-mail **DNProviders@lacare.org**. You may also contact your L.A. Care Direct Network Account Manager.

Access to Care - Provider Requirements

L.A. Care regularly monitors and audits the appointment and access standards identified in this chapter. This helps to evaluate the Provider's level of service to its Members. If requested by L.A. Care, the Provider must make any changes requested by L.A. Care to meet established provider service and access requirements in compliance with applicable states rules, regulations, and guidance. From time to time, L.A. Care may also request an inventory of services. Providers are responsible for responding to any appointment and access deficiencies identified. Providers shall submit confirmation of these changes to their Provider Network Account Manager or L.A. Care's Provider Network Management (PNM) department.

For more information on Access to Care Quick Tips, please visit: **https://www.lacare.org/sites/default/files/LA25730919ProviderQuickTipsClean2023.pdf**.

Provider Appointment Availability and After-Hours Survey

Providers are required to participate in L.A. Care's annual Provider Appointment Availability and After-Hours Survey to ensure regulatory access standards are being met. Providers are audited for the required after hours call system during the annual survey.

After Hours Call System standards:

- **Access:**
  - Recording or answering service must state emergency instructions to address medical emergencies.
  - Recording or answering service must provide a way of contacting the Provider.
- **Timeliness:**
  - Recording or answering service must state that Provider will call back within 30 minutes.

Results for each measurement year are presented at the Access and Availability Workgroup as well as various quality committees. Non-compliant Providers are monitored on a quarterly basis via the Quality Improvement's Appointment Availability & After-Hours Oversight and Monitoring (O&M) Workbooks.

Timely Access Standards

L.A. Care conducts an annual Access to Care webinar to inform Providers about Timely Access Standards as prescribed by the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), and other regulatory agencies. Providers must follow the Timely Access Standards below:

Standard[1]	Medi-Cal
Primary Care Provider (PCP) **Accessibility Standards**	
Routine Primary Care Appointment (Non-Urgent) Services for a patient who is symptomatic but does not require immediate diagnosis and/or treatment.	< 10 business days of request
Urgent Care Appointment - Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.	< 48 hours of request
Preventive Health Examination (Routine)	< 10 business days of request (Pediatrics) < 30 calendar days of request (Adults)
First Prenatal Visit - A periodic health evaluation for a member with no acute medical problem.	< 10 business days of request
Specialty Care Provider (SCP) **Accessibility Standards:**	
Routine Specialty Care Appointment (Non-Urgent) (including Behavioral Health Physician)	< 15 business days of request
Urgent Care Appointment - Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.	< 96 hours, if prior authorization is required
After-Hours Care Standards:	
After Hours Care - Physicians (PCPs or covering physicians) are required by contract to provide 24 hours a day, 7 days per week coverage to members. *Clinical advice can only be provided by appropriately qualified staff, e.g., physician, physician assistant, nurse practitioner or RN.	• Automated systems must provide emergency 911 instructions. • Automated system or live party (office or professional exchange service) answering the phone must offer a reasonable process to connect the caller to the PCP or covering practitioner. • Offer a call-back from the PCP covering practitioner or triage/screening clinician within 30 minutes. If process does not enable the caller to contact the PCP or covering practitioner directly, the "live" party must have access to a practitioner or triage/screening clinician for both urgent and non-urgent calls.
Practitioner Telephone Responsiveness:	
In-Office Waiting Room Time - The time after a scheduled medical appointment a patient is waiting to be taken to an exam room to be seen by the practitioner.	< 30 minutes
Missed Appointments - The time after a missed appointment that a patient is contacted to reschedule their appointment.	< 48 hours

For More Information

For questions or concerns regarding the information provided here, please contact the Access to Care Team via email at **ATC@lacare.org**.

L.A. Care
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