L.A. Care

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

Contracted Provider
Reference Guide

October 2022

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Welcome
Participating Contracted Provider

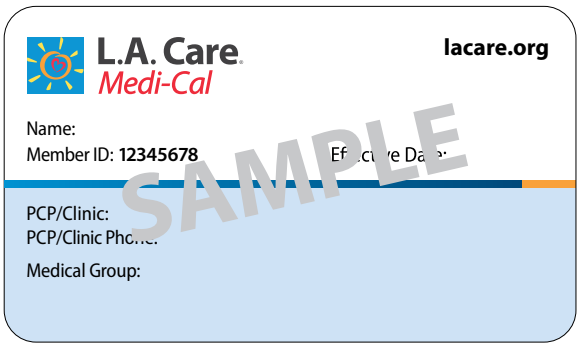
Welcome Participating Contracted Provider

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 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:



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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.

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

Community Based Adult Services (CBAS)

Core Services:

- Professional nursing and medication management
- Therapeutic activities
- Social services and/or personal care services
- One meal offered per day

Additional services include: physical, occupational or speech therapy, mental health services, registered dietitian services, and transportation to and from the center to a patient's residence.

Long Term Care (LTC)

Long-Term Care (LTC) is for patients who are at risk in the home or community that need ongoing care in a skilled nursing facility.

- Patients receive medical, social and personal care services for the purpose of assisting them with their activities of daily living rather than continued medical or skilled needs.
- Tracheostomy care, colostomy care, g-tube feedings, wound care
- Walking, bathing, dressing, feeding, toilet-use, preparation of special diets, and supervision of medications
- For Medi-Cal beneficiaries, professional care services and facility costs included

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)

- IHSS is a program that provides home care services to low-income seniors and people with disabilities. This allows them to continue living safely at home. IHSS services are assessed for and authorized by the Department of Public Social Services (DPSS) County IHSS Social Workers.
- Services available through IHSS include:
  - Personal Care such as bathing and grooming, dressing and feeding
  - Domestic Services such as housecleaning and chores, meal preparation and clean-up, laundry and grocery shopping
  - Paramedical Services such as assistance with medications, bowel and bladder care and catheter insertion
  - Other Services such as accompanying patients to their medical appointments, yard hazard abatement and protective supervision

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)

MSSP is an intensive case management program for seniors, 65 and older, who are certified for nursing home placement, but wish to remain at home.

- Six MSSP sites serve nearly 3,000 individuals in L.A. County with social and health care management services such as:
  - Case management
  - Supplemental chore and personal care assistance
  - Respite care (in & out of home)
  - Housing assistance / Minor home repairs
  - Personal Emergency Response System (PERS)
  - Adult day care / Support Center referrals
  - Meal services, transportation and social services
  - MSSP services are assessed for and authorized by MSSP Sites Nurse Case managers and Social Workers.

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.

MLTSS Contact Information

- The MLTSS Referral form is available on the L.A. Care website at **https://www.lacare.org/sites/default/files/la2562_mltss_referral_form_202005.pdf**
- Fax the completed MLTSS Referral form to the MLTSS department, Secure Fax: **213.438.4866**

If Providers have questions about the programs, or would like to consult on options for a member, please contact MLTSS at:

Phone: **1.855.427.1223**

Email*: **MLTSS@lacare.org**

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

LA Care

Managed Long Term Services and Supports (MLTSS) Referral Form

Phone: 855.427.1223 • Fax: 213.438.4866

Email: mltss@lacare.org (send via secured email only)

Referral Source: _____ Date of Referral: ___/___/___

Internal to L.A. Care:

☐ Case Management ☐ Utilization Management ☐ TOC ☐ Social Worker ☐ Disease Management

☐ Member Services ☐ Other (specify): _____

External:

☐ Member/Family/Caregiver ☐ Provider ☐ Hospital ☐ SNF ☐ Pharmacy ☐ PPG/IPA: _____

☐ Other (specify): _____

Referred by: _____ Phone and extension: _____

Member is currently: ☐ In a nursing facility under skilled care ☐ Acute hospital ☐ N/A

- Referral MUST be completely filled out or referral will be declined and returned to referral source.
- If need is for LTC Nursing Facility, complete the Long Term Care Authorization Request Form

SECTION I: Member Information

Member Name: _____ Gender: ☐ M ☐ F D.O.B: ___/___/___ Age: ___

CIN: _____ Current Address: _____ Language: _____

LOB: _____ City: _____ Zip: _____ Phone: _____

Authorized Representative: _____ Consent to speak to AR: ☐ Yes ☐ No Phone: _____

SECTION II: Clinical Information

Diagnosis: _____

Currently enrolled in internal CM or TOC program: ☐ Yes ☐ No Case Manager: _____ Ext. _____

Has member recently been admitted to:

☐ Emergency Room ☐ Hospital ☐ SNF ☐ Discharge Date: ___/___/___

Member's general condition (check all that apply):

☐ Ambulatory ☐ Ambulatory with assistance ☐ Maximum assist with all ADLs/IADLs ☐ Confined to bed

☐ Confined to wheelchair ☐ Incontinent ☐ Other (specify): _____

Current Social Supports (check all that apply):

☐ None ☐ Lives alone, but has outside support ☐ Lives with Partner/Spouse/Family

☐ Resides in group home/RCFE/Assisted Living/Senior Living/Etc. ☐ Has unpaid caregiver assistance

☐ Receives IHSS ☐ Other (specify): _____

Summary of member issue(s), need(s), and concern(s): _____

LAC_2018_0031_MLTSS Referral.com

Behavioral Health Services

Non-Specialty (Members with mild to moderate needs)

Beacon Health Options, delegated vendor for L.A. Care, provides the services listed below to ALL of our Members:

- Individual, group, and family mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring medication and treatment
- Outpatient laboratory, medications, supplies and supplements
- Psychiatric consultation

For Non-Specialty services, please contact: **Beacon Health Options at 1.877.344.2858**

Specialty Mental Health and Substance Abuse Treatment

Specialty mental health services and substance abuse services are carved out from L.A. Care Medi-Cal Benefits.

For referral to specialty mental health services for people with severe persistent mental illness or severe functional impairment due to a mental health condition please call **1.800.854.7771**.

For referral to substance abuse services please call **1.844.804.7500**.

L.A. Care's Behavioral Health Department

For more information or questions regarding behavioral health, please contact the Behavioral Health Department at **1.844.858.9940**.

Pharmacy Services

- The pharmacy benefit is carved out to the Department of Health Care Services (DHCS) through Medi-Cal Rx and is managed by Magellan, DHCS' pharmacy benefit manager (PBM). Providers can visit this website for additional resources: **https://medi-calrx.dhcs.ca.gov/home.**

Transportation

Non-Emergency Medical Transportation (NEMT)

NEMT is covered when a member requires medically necessary Medicare and/or Medi-Cal services, when prescribed life sustaining treatment, and when the members' medical and physical condition does not allow travel by public or private conveyance (DHCS All Plan Letter (APL) 22-008).

Modes of transportation include:

- Ground Ambulance (Basic Life Support, Advance Life Support, and Specialty Care Transport) – Provided for members who require continuous intravenous medication, medical monitoring, observation, or oxygen.
- Air Ambulance – Only if ground transportation is not feasible.
- Litter Van – Provided when the member must be transported in a prone or supine position because the member is incapable of sitting for the period of time needed to transport and requires specialized safety equipment.
- Wheelchair Van – Provided when member is incapable of being in passenger car or public transportation during transport, has a disabling physical or mental limitation, and/or requires specialized safety equipment.

Non-Medical Transportation (NMT)

NMT is covered when services are for routine medical or other eligible non-medical appointments.

NMT services does not include transportation of the sick, injured, invalid, infirm, convalescent or incapacitated. Modes of transportation include passenger car, rideshare, taxicab, bus, train, or any other form of public or private conveyance.

Product Line	Transportation Type	Benefit	Authorization Responsibility
Medi-Cal (MCLA)	**Emergency Medical**	Unlimited	Authorization not required
	***NEMT:** Advance Life Support (ALS)/Basic Life Support (BLS)/Critical Care Transport (CCT), Gurney/ Litter Van and Wheelchair Van	Unlimited	*L.A. Care provides authorization
	NMT	Unlimited	Authorization not required to eligible location

- In accordance with the All Plan Letter (APL) 22-008, L.A. Care requires a Physician Certification Statement (PCS) form and Prior Authorization for all NEMT services before transport can be arranged.
- In efforts to avoid unnecessary delays, a member or provider is not required to obtain Prior Authorization at the time of the reservation for NEMT services if the member is being transferred from an emergency room to an inpatient setting, or from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility or imbedded psychiatric health facilities, or any other appropriate inpatient acute psychiatric facilities.
- However, the PCS form must be submitted within 24 hours after transportation has been rendered.
- As a reminder, the PCS form is not required for NMT.

Link to the PCS Form for NEMT Click here
(https://www.lacare.org/sites/default/files/pl0598_pcs_form_201909.pdf)

Who Can Prescribe NEMT?

- Physicians
- Physician Extenders
- Mental health or substance use treatment providers
- Dentists
- Podiatrists

Utilization Management (UM) Review

- L.A. Care's UM department is responsible for reviewing the Prior Authorization request and PCS form (form must be completed and signed) for NEMT services.
- L.A. Care's UM department must approve the authorization before NEMT can be coordinated – review turn-around time is up to five (5) business days.
- Depending on the type of covered services, the authorization and PCS form will be approved for up to one year.

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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. 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
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 Beacon Health Options (Beacon))
- 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

Prior Authorization Exemptions

- **Specialty Visits**
  - Referral to any in-network medical specialist / provider for consults or follow-up visits
- **Routine Care**
  - Routine radiology tests such as x-rays, ultrasounds, echocardiograms, EKGs, etc.
  - Routine lab services, preparations and tests: CBC, metabolic panels
  - Non-Medical Transportation (NEMT requires a PCS form)
  - Urgent Care visits
- **Well Woman / OB Care / Family Planning**
  - Well woman care (including annual cervical cancer screening, pelvic exams and mammography screening at intervals specified in the US Preventive Services Task Force Guidelines
  - Basic prenatal care including in-network Obstetric (OB) referrals and consults
  - Family Planning services (including tubal ligation, vasectomies and outpatient abortion)
  - Lab tests as a part of the decision-making process for choice of contraceptive methods
  - Health education and counseling necessary to understand contraceptive methods and make informed choices
  - Follow-up care for complications associated with contraceptive methods
  - Certain sensitive and confidential services including HIV testing, STD diagnosis and treatment and sexual assault services
- **Inpatient Services**
  - Emergency medical screening and stabilization services
  - Admission for Observation level of care
  - Admission for routine (uncomplicated) vaginal or routine (uncomplicated) C-section deliveries
- **Mental Health**
  - Initial behavioral assessments
  - Physical exam for admission for inpatient mental health/behavioral health treatment
- **Preventive Health Services and Education**
  - Preventive health services including immunizations, influenza and pneumococcal vaccinations
  - Health Education services provided by L.A. Care's Health Education team
- **Dialysis, both in-network and out-of-area**

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.

Standard Authorization Timeframes

- **Pre-Service Routine**
  - 5 business days from receipt of the information necessary to make the decision, not to exceed 14 calendar days from receipt of the request
- **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

iExchange

From June 1, 2020 to October 31, 2022, L.A. Care used Medecisions' iExchange platform to submit authorization requests electronically. As of November 1, 2022, this option is no longer available, and requests must be made by phone or fax as described below.

How to Submit an Authorization Request

- 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**.
  - Download or print Direct Network Prior Authorization Fax Request Form November 2022
  - 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

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

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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**.

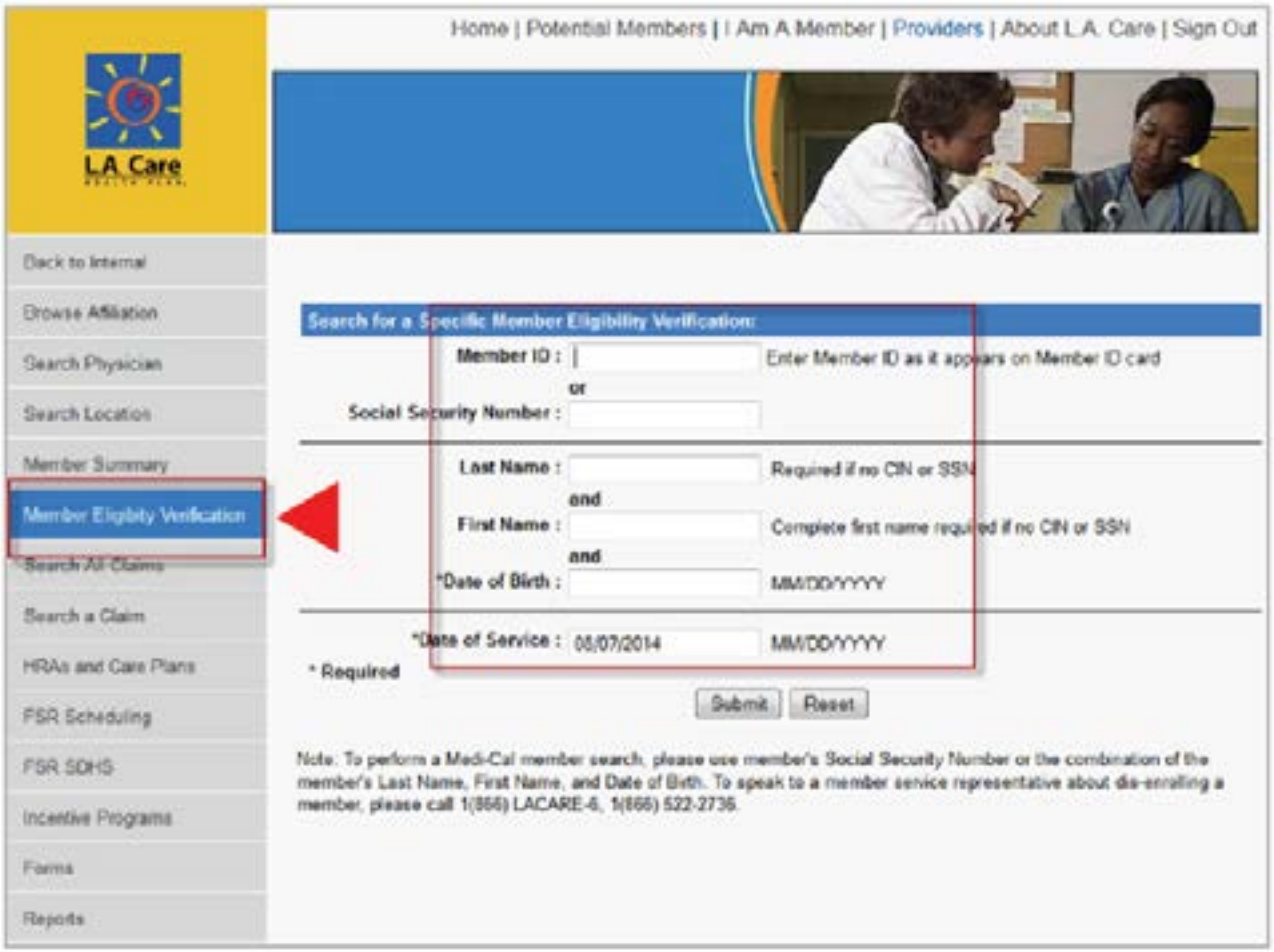
* If the new user does not confirm the user's access within the timeframe allowed, the registration process will have to be repeated. Please contact Provider Relations via email at **DNProviders@lacare.org** for further assistance.

Checking 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 **DNProviders@lacare.org** for further assistance.

Figure 3 - If you have the claim number available

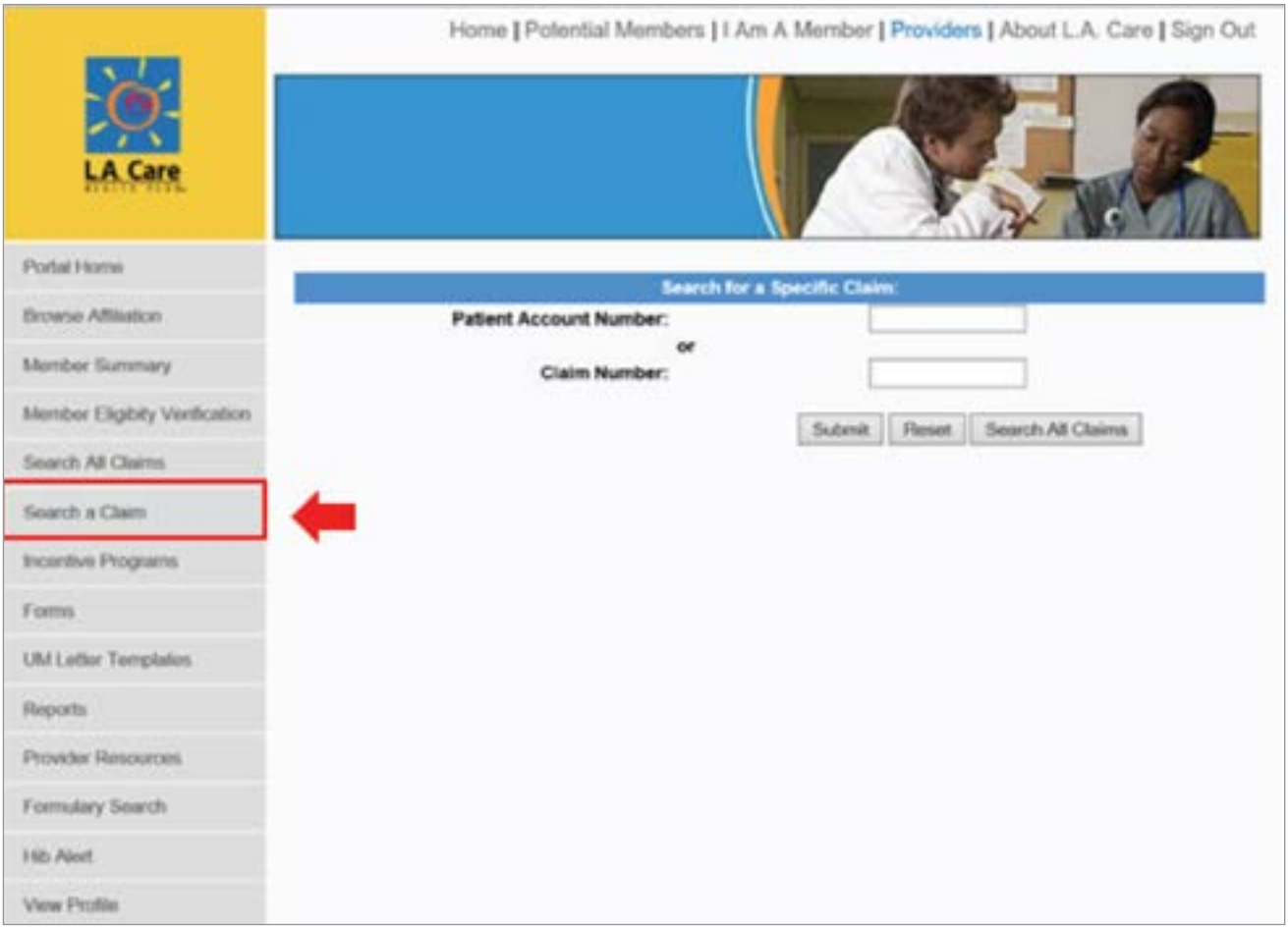
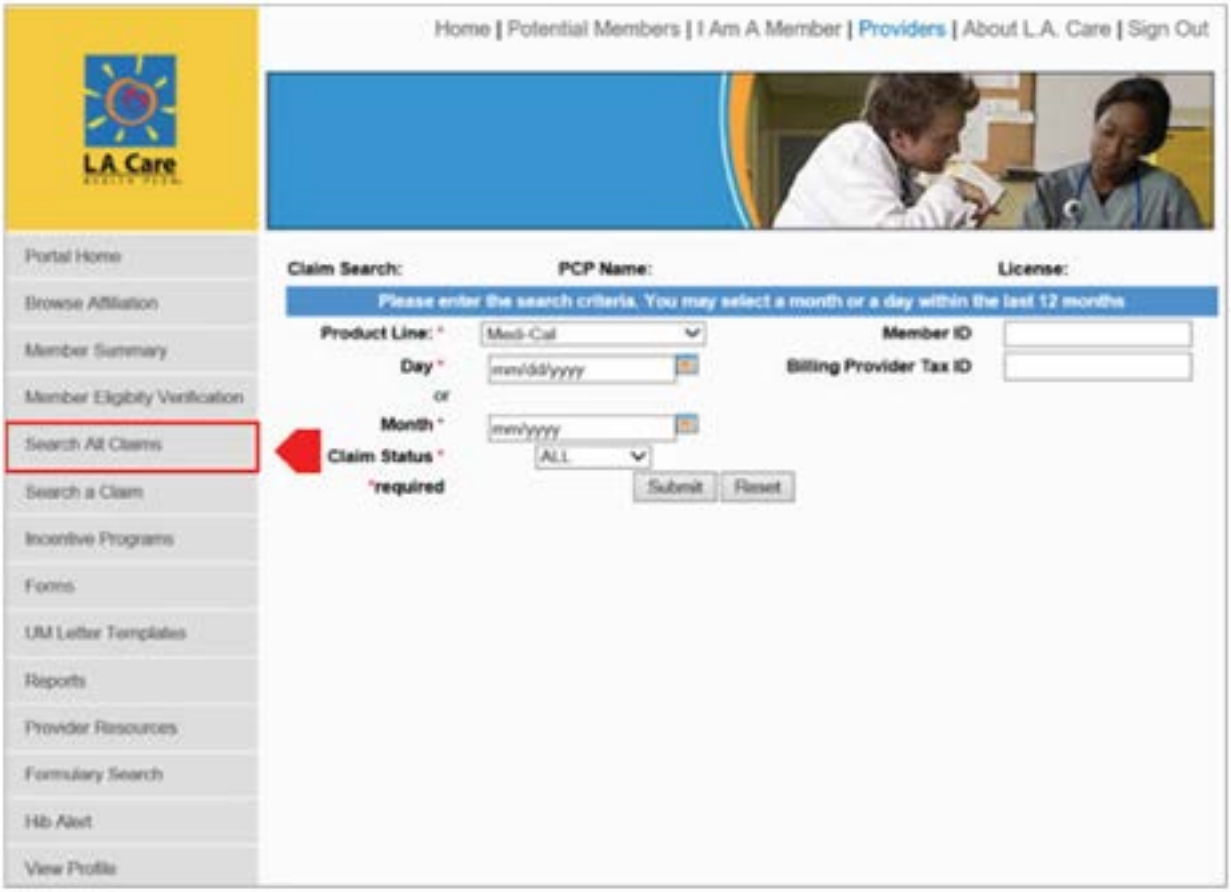


Figure 4 - If you do not have a claim number available



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 **DNProviders@lacare.org** for further assistance.

Figure 5

Incentive Programs

L.A. Care offers a number of incentive programs for providers. Ask your L.A. Care Direct Network Account Manager for more information about the current program offerings.

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

If you have any questions, please contact Provider Relations via email at **DNProviders@lacare.org** for further assistance.

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 **DNProviders@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**

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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 180 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 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/requestRegCode/**
- 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.

- Paper disputes are acknowledged within 15 days of received date. Electronic disputes are acknowledged within two (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-providercentral**

✓ Contact Account Manager

- Claims Customer Service: **213.694.1250 x4297**

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 over paid. 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: **1.877.431.2273**		
Case Management	**Provider Referral Form:** https://www.lacare.org/sites/default/files/caremanagement-referral-form-0916.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** *Beacon Health Options* 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:** https://www.lacare.org/providers/claims-edi/submittingclaim • Fee-For-Service PCP and Specialists – CMS 1500 Form Required • CHDP Services – PM160 Form Required • Provider Disputes Resolution (PDR) **Electronic Claims Submission:** http://www.lacare.org/sites/default/files/universal/office_ally_pm160.pdf **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**	

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
(Below resources will be on a table in final design guide)

Resource Name	Resource Description	Link
Physician & Direct Network Pay-for-Performance Programs	These programs offer performance-based incentives to L.A. Care 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**
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.	**https://www.lacare.org/providers/provider-central/elevating-safety-net**
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**
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**

Resource Name	Resource Description	Link
Quality Improvement Webinar Training Series for IPAs Providers	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/**
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/**
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/**
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	**http://healtheducation.chi.v6.pressero.com/login**
Health Education Services and Resources	L.A. Care offers health education services and resources including: health education and C & L materials; health education group appointments and individual phone counseling; and various self-paced online programs. Providers can refer patients to Health Education via the online referral form.	**https://www.lacare.org/providers/provider-resources/tools-toolkits/health-education-tools**
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**
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**
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**

Resource Name	Resource Description	Link
L.A. Care Community Link	L.A. Care Community Link is a site where providers can search for help with free or low-cost food, bills, job training, legal aid, and more. It's fast, free, and easy to use. Just enter the zip code in the search box and select the type of help that is needed.	**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**
Patient Satisfaction 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**
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**
Pharmacy Services	L.A. Care's Pharmacy Services for Medi-Cal members are carved out to California Department of Health Care Services (DHCS) through Medi-Cal Rx and is managed by Magellan, DHCS' PBM.	**https://medi-calrx.dhcs.ca.gov/home**
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**

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/providers/provider-resources/tools-toolkits/hedis-resources** under Access and Availability

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:

Type of Service	Timeframe	MCLA
Primary Care Provider—Routine Care	Within 10 business days	●
Primary Care Provider—Urgent Care	Within 48 hours	●
Specialist—Routine Care	Within 15 business days	●
Specialist—Urgent Care	Within 96 hours	●
Preventive Health Exams—Adults	Within 30 calendar days	●
Preventive Health Exams—Pediatrics	Within 10 business days	●
Routine Ancillary	Within 15 business days	●
Initial Prenatal	Within 14 calendar days	●
Normal Business Hours—Call Back	Within 30 minutes	●
Missed Appts—Call Back (Rescheduling)	Within 48 hours	●
Behavior Health—Routine Care (MD)	Within 15 business days	●
Behavior Health—Routine Care (Non-MD)	Within 10 business days	●
Behavior Health- Routine Care Follow- Up (Non-MD, Substance Use Disorder Providers)	Within 10 business days	●
Behavior Health - Urgent Care	Within 48 hours	●
Emergency Care and After-Hours Care	24 hours a day, seven (7) days a week	●

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**.

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