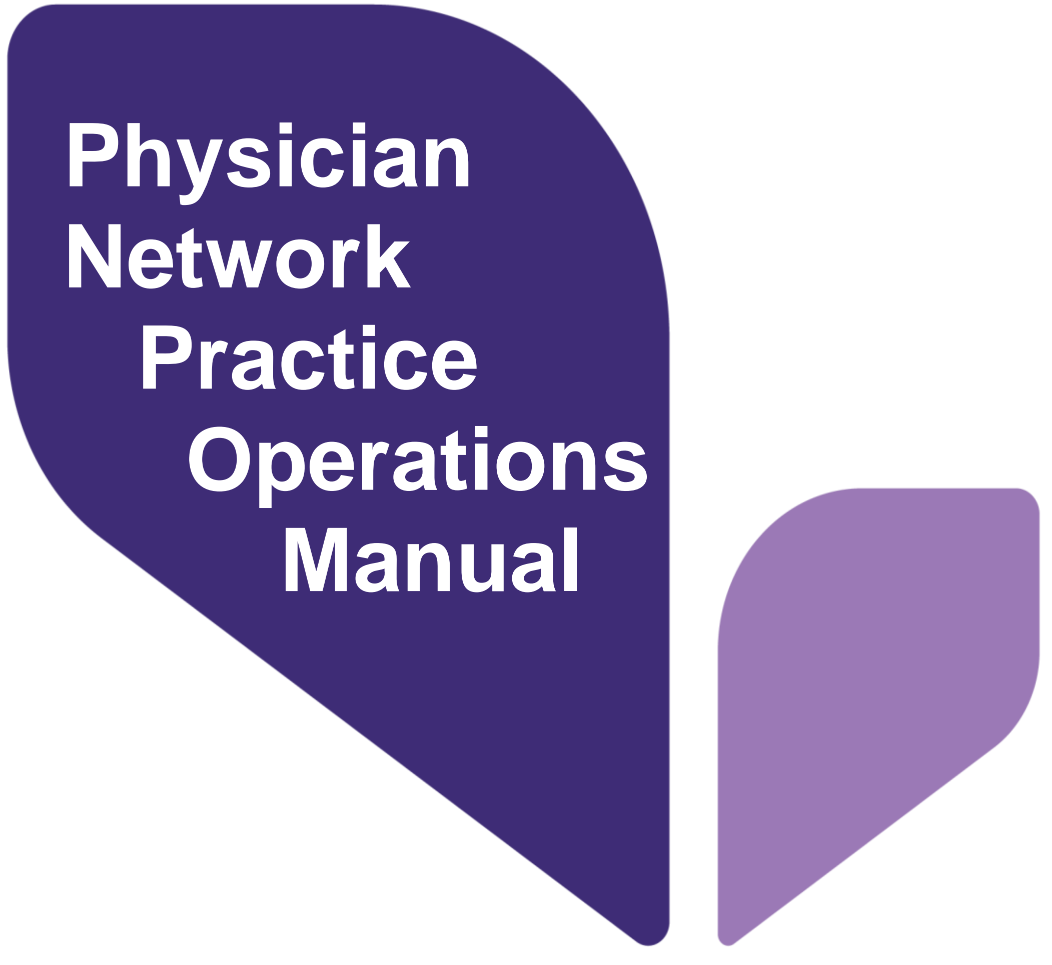

April 2025

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SECTION 1: INTRODUCTION AND OVERVIEW

It is a pleasure to welcome you as a contracted provider (Provider) with John Muir Health Physician Network (JMHPN). This Practice Operations Manual was created to help guide our Providers through some of our system operations, policies and procedures and provide you with information and necessary forms.

If you have any questions about the information contained in this Practice Operations Manual, please reach out to our Customer Service Department at (925) 952-2887.

ABOUT US

JMHPN contracts with Commercial HMO Health Plans and Medicare HMO (Medicare Advantage) Health Plans (collectively Health Plans) to provide or arrange for high-quality professional, ancillary, and ambulatory care for Health Enrollees (Enrollees). JMHPN fulfills this commitment by maintaining a contracted network of high-quality, accessible providers covering a broad array of clinical specialties.

Health Plans delegate a variety of administrative services to JMHPN, including Provider Credentialing, Eligibility Determinations, Claims Administration, Quality Assurance, Utilization Management, Care Management, Provider Relations, and Customer Service. Delegated services typically do not include marketing, benefit design, or member enrollment as those functions are retained by the health plans.

SECTION 2: KEY CONTACTS

General Correspondence:	John Muir Health Physician Network 1450 Treat Boulevard, Suite 350, Walnut Creek, CA 94597
Claims Address	P.O. Box 31255 Salt Lake City, UT 84131
Customer Service:	Phone: **(925) 952-2887; toll free 844-398-5376; TDD/TTY 711**
Physician Relations/ Community Connect support:	Please reach out to your assigned Account Executive: Marcy Vaca: (925) 348-5440, Marcela.vaca@johnmuirhealth.com Athena Sandoval: (925) 268 – 8928 Athena.Sandoval@johnmuirhealth.com, Erica Guerrero: (925) 470-9347 Erica.Guerrero@johnmuirhealth.com
Physician Contracting:	Haydee Acosta Phone: (925) 407-7726 Email: Haydee.Acosta@johnmuirhealth.com
Physician Practice Support Strategies	Michael McCarthy Phone: (702) 280-0815 Email: Michael.McCarthy@johnmuirhealth.com
Credentialing:	Consolidated Credentialing Department Phone: (925) 947-5398 Fax: (925) 941-4033 Email: CCD@johnmuirhealth.com
Specialty/Ancillary Authorizations:	Phone: (925) 952-2887
Inpatient/SNF Authorizations:	Fax line (925) 952-2865; Phone: (925) 952-2887

SECTION 3: HEALTH PLAN/PAYORS

The Health Plan Contracting Department is responsible for negotiating contracts with Health Plans. Health Plan requirements and standards are contained in the Health Plan agreement with John Muir Health Physician Network and passed down to JMHPN contracted providers (Contracted Providers) pursuant to the JMHPN's Network's participation agreement with Contracted Providers (Participation Agreement).

3.1 Health Plan Contracts

A comprehensive list of JMHPN's contracted Health Plans is available on the John Muir Health website which gets updated from time to time.

Top JMPN Plans

Aetna HMO
Anthem HMO,
Blue Shield HMO
Canopy Health (Enrolled with either Health Net or United Healthcare) - HMO
Central Health Plan HMO (formerly Brand-New Day)
CIGNA HMO
Health Net HMO
John Muir Health*y* Employee EPO Plan (self-funded plan)
United Healthcare HMO

For a comprehensive list of all Health Plans accepted by John Muir, please to our website: Health Insurance Plans That Work With John Muir Health

3.2 **John Muir Health*y* Employee EPO Plan**

Effective January 1, 2025, John Muir has returned to a self-insured plan for their employees and their dependents. Employees had an option to choose 1) an EPO plan (similar to an HMO plan) or 2) a PPO plan that utilizes Anthem's PPO (Prudent Buyer) network. Below you will find helpful information for both plans.

Claims for the John Muir Health*y* Employee EPO plan should be submitted to John Muir Physician Network (JMPN) for most Provider services. Services such as DME, chemo-therapy drugs, and certain injections would be billed to Lucent Health, our third-party administrator. Lucent Health's billing address is P.O. Box 6007, Los Angeles, CA 90060-0007 (Payer ID: 47198).

For a complete list of services that should be billed to Lucent Health, please contact JMPN's Customer Service Dept. at (925) 952-2887, or refer to the health plan billing matrix, or you can reach out to Haydee Acosta at Haydee.acosta@johnmuirhealth.com to obtain a copy of the health plan billing matrix.

Authorization requests for the John Muir Health*y* Employee EPO plan can be submitted via Epic or PlanLink or faxed to (615) 461-5354. Lucent Health will review/approve the request. Lucent Health will be using JMPN's prior authorization list

which can be found on the JMH website Resources (johnmuirhealth.com) or in the Appendix.

Eligibility for John Muir Health*y* Employee EPO members can be checked through Epic, PlanLink, or by going to https://jmh.lucenthealth.com under provider resources for EPO.

Should you have questions, please contact JMPN's Customer Service department at (925) 952-2887 or you can contact Lucent Health at (877) 214-2106.

3.3 **John Muir Health*y* Employee PPO Plan**

Effective January 1, 2025, John Muir employees also had a PPO option to choose from. The PPO plan for John Muir Health*y* Employees will utilize the Anthem Prudent Buyer PPO network.

Claims for the John Muir Health*y* Employee PPO plan should be submitted to Anthem Blue Cross, P.O. Box 60007, Los Angeles, CA 90060-0007 (Payer ID:47198). Claims will be paid at the Anthem Prudent Buyer PPO rates that are in your direct agreement with Anthem.

Authorization requests for the John Muir Health*y* Employee PPO plan can be requested by calling Lucent Health/Narus at 1-(877) 499-1774 or by logging onto Lucent's portal to complete an authorization form: Lucent Health Precertification Form.

Eligibility for John Muir Health*y* Employee PPO members can be checked by going to https://jmh.lucenthealth.com under provider resources for PPO, or to Availity.com, or by calling Anthem at 1-(833)-835-2714.

Should you have questions about the John Muir Health*y* Employee PPO plan, please contact Lucent Health at (877) 214-2106.

3.4 Canopy Health Overview

Please go to the Canopy Health website for contracted providers: www.canopyhealth.com. Canopy Health is a single network of alliance partners that expands Enrollee access to specialists, hospitals, and other medical services. Incorporated in March 2015 as an affiliation between UCSF Health and John Muir Health, Canopy Health aims to provide continuum of care across the San Francisco Bay Area through partnerships with primary care providers, community hospitals, medical facilities, and medical groups.

- In addition to its founding members, Canopy Health currently includes five physician groups — John Muir Health Physician Network, Dignity Health Medical Network, Hill Physicians Medical Group, Santa Clara County IPA (SCCIPA) and Providence Medical Network. These groups work together to create a single, integrated Canopy Health referral network. This means that Canopy Health Enrollees have access to in-network services with the entire Canopy Health alliance of nearly 5,500 plus providers and 30 hospitals across nine Bay Area

counties. Additional information about Canopy Health network can be found on the Canopy Health website: www.canopyhealth.com. or in the Appendix.

Canopy Health Alliance Referral Program:

The Alliance Referral Program allows Canopy Health Commercial HMO and Medicare Advantage HMO Enrollees to see any specialist in the Canopy Health Network for medically necessary specialty care as well as access to Ancillary Providers across Canopy Health's Network. A PCP referral and administrative authorization are required for tracking purposes. The one exception is lab services. JMHPN Enrollees must be referred to LabCorp for any lab service.

Alliance Referral Process:

- When clinically appropriate, the requesting physician initiates a written or electronic referral that is entered in the Enrollee's home Medical Group/IPA authorization system.
- Please note, referral requests and Authorizations (orders) for JMHPN Enrollees should continue to be submitted via Epic or PlanLink.
- Canopy Health Enrollees being referred within each Medical Group/IPA listed above, remain governed by the policies and procedures of that Medical Group/IPA.
- Canopy Health Enrollees referred to Canopy Health specialists **outside** their home Medical Group/IPA are governed by the policies and procedures defined by Canopy Health.

Canopy Health Billing Information:

- Professional claims for JMHPN Enrollees should be submitted to John Muir Health Physician Network for payment.
- Certain Canopy Health facility claims are processed by Conifer Value Based Care. Please refer to the Health Plan Billing Matrix for specific details.

Self-Injectables for Canopy Health Enrollees are paid by their health plan partners.

Health Net: For CanopyCare, Blue and Gold and SmartCare Enrollees, please contact Centene Pharmacy Services (800-460-8988 or 800-548-5524, option 3). **Canopy Health Contact Information:**

- Canopy Health Provider Services: (844) 315-4645
- Claims Department: (844) 315-4645 or (818) 461-5055
- Canopy Health website: www.canopyhealth.com

SECTION 4: VERIFYING ELIGIBILITY

All Enrollees are issued an identification card (ID Card). The Enrollee should present the ID card when seeking medical services. ID cards generally provide the following information:

1. Subscriber, spouse, domestic partner or covered dependent name
2. Certificate number
3. Employer group number (for group coverage only)
4. Health Plan code
5. Coverage code
6. Medical group name, address and phone number (if HMO or POS)
7. Subscriber's effective date with the medical group (if HMO or POS)
8. Additional benefits rider (where applicable)
9. Claims mailing address(es) and Customer Service telephone number(s) for the medical program and any supplemental benefits
10. Instructions regarding carrying and using the ID card
11. Guidelines for obtaining services and reporting emergencies (if HMO or POS)
12. Telephone number for pre-authorizations or pre-service review (if PPO); this information is not available on the Medicare Advantage ID card.

Provider should make and retain a copy of the front and back of an Enrollee's ID card at the beginning of Enrollee's first visit each year and the beginning of any subsequent visit during the year if coverage has changed.

Prior to each patient visit or otherwise initiating care, a Provider must utilize PlanLink or the pertinent Health Plan's Customer Service number or web site to confirm the Enrollee's eligibility, benefits, and prior authorization requirements. The Provider should keep documentation that these steps were completed. Failure to have the most up-to-date information could result in non-payment of claims for ineligible patients.

PlanLink:

PlanLink also known as JMHLink is a web-based tool that provides real-time access to Enrollee information. Physician practices using this tool can access Enrollees' clinical and membership data and communicate with other Network providers to enhance the quality of patient care. Physician practices can also use this tool as a more expedient alternative to calling John Muir Health Physician Network's Customer Service Department. Below are some of the functions of this easy-to-use web-based tool:

- Check eligibility status
- Check plan benefits
- Create a new referral
- Request an authorization
- Check authorization status
- Send/receive messages
- Check claim status
- Review provider remittance advice

If you would like to request access to PlanLink, please follow the link Request EPIC Access and complete the information on the webpage.

FOR QUESTIONS, PLEASE CONTACT THE JOHN MUIR HEALTH (JMH) SERVICE DESK AT (925) 941-2003.

SECTION 5: PRIOR AUTHORIZATION REQUIREMENTS

Any out-of-network services require prior authorization. In addition, there are specific high-cost and frequently utilized services that require prior authorization even when performed by in-network Providers. These services are listed in the Appendix to this Manual entitled "Services Requiring Prior Authorization". When required, prior authorizations must be obtained from the JMHPN Utilization Management Department (UM Department). Current, accurate, and complete clinical documentation must be submitted with any prior authorization request. The UM Department staff use nationally recognized clinical review criteria (InterQual or Health Plan guidelines) to determine whether the requested services are medically necessary and delivered at the appropriate level of care.

Authorization and Referrals:

Prior authorization ensures that services are (i) medically necessary, (ii) covered benefits under the Enrollee's Health Plan, and (iii) furnished at the most appropriate level of care (i.e., inpatient, outpatient, office). JMHPN does not reward UM Department personnel for issuing denials of coverage, issuing denials of service, or encouraging underutilization.

Referral of Enrollees to JMHPN Contracted Practitioners

JMHPN-contracted specialists and providers (JMHPN Providers) are listed in the JMHPN Provider Directory. JMHPN-contracted Primary Care Providers (JMHPN PCPs) may refer Enrollee to most JMHPN-Providers without first securing prior authorization. However, prior authorization is required before referring an Enrollee to those specialists explicitly listed on the "Prior Authorization List." When submitting a request for a referral to a provider on the Prior Authorization List, the requesting Provider must submit current, accurate, and complete clinical documentation in support of the request.

Once an Enrollee has been referred to a JMHPN Provider, the time frame during which the specialist can see the Enrollee is not limited. The specialist has a standing referral to see the Enrollee for as long as (i) the JMHPN Specialist determines it is necessary and (ii) the ongoing care is related to the original diagnosis supporting the referral.

Female Enrollees may self-refer to a JMHPN women's health care specialist for any women's health care issues, including routine and preventive services.

Submission of a Referral or a Referral Authorization Request

When submitting a referral or request for a referral, the requesting Provider must submit current, accurate, and complete supporting clinical documentation. The submission may be made through any of the following channels:

- **Community Connect.** Providers on the Epic/Community Connect system should (i) complete the referral within Community Connect, (ii) email or fax the referral to the desired Provider, and (iii) provide a printed copy of the referral to the Enrollee. If the referral is to a practitioner for whom authorization is required, the referral will automatically “pend” for review by the JMHPN Utilization Review staff.
- **PlanLink.** Providers not on the Epic/Community Connect system may use the PlanLink web program for referrals and follow the same process as described above for Community Connect. If you are not on Epic/Community Connect and are not currently utilizing PlanLink, please contact Physician Relations for assistance in applying for access to the program.

When making an in-network referral, a Provider needs to only submit a Referral Authorization Request if the referral is for services listed in JMHPN’s list of “Services Requiring Prior Authorization.” The following is a list of the information required to process your request:

- The Enrollee’s full name, address, and DOB.
- The health plan name and ID number.
- The ICD-10 code field must be completed. Provide all applicable codes and use 4th & 5th digits when appropriate.
- The required CPT codes.
- The name of the servicing provider.
- Include all pertinent clinical information to support the need for the requested service.
- For requests submitted through PlanLink, clinical records from your Electronic Health Record can be attached to the request.
- For practices on Epic/Community Connect, the Utilization Management staff can access the Enrollee’s medical record for clinical documentation.

You will receive notification of the outcome of the review process as soon as the determination is made. Enrollees are sent authorization notification letters via U.S. Mail. If you do not receive notification within the timeframes listed below, please call Customer Service at (925) 952-2887 or the toll-free number (844) 398-5376. Enrollees inquiring about the status of a service request should also be directed to call Customer Service at (925) 952-2887 or the toll-free number (844) 398-5376.

Please do not give Enrollees the phone number of the John Muir Health Physician Network physician reviewer or Utilization Management staff.

Timeframes for Processing Service Authorization Requests

JMHPN is required to comply with the National Committee for Quality Assurance ("NCQA") authorization timeliness guidelines. The required time frames are as follows:

Authorization Turn Around Times

Please note the below Turnaround times based on Product type and Case type

Every effort will be made to turn authorizations around as fast as possible once all necessary clinical data is received.

Payer	Priority	Turn Around Time
Commercial/Medicare Advantage	Inpatient Admission (Acute/SNF)	24 Hours
Commercial	Urgent	72 Hours
Commercial	Routine	5 Business Days
Medicare Advantage	Urgent	72 Hours
Medicare Advantage	Routine	14 Calendar Days
Commercial /Medicare Advantage	Urgent Pharmacy	24 Hours
Commercial/ Medicare Advantage	Routine Pharmacy	72 Hours

Please note: In order to meet "Urgent" criteria, patient health or safety must be at risk if decision is not rendered within the urgent timeframes

STANDARD REQUESTS

Commercial HMO:

- Decisions must be made on requests within 5 business days from the date of receipt of the request
  - For electronic submissions, select "Routine" in the designated field.
  - For faxed requests, check the "Routine Request" box at the top of the form.

Medicare Advantage:

- Decisions must be made on requests within 14 calendar days from the date of receipt of the request
  - For electronic submissions, select "Routine" in the designated field.
  - For faxed requests, check the "Routine Request" box at the top of the form.

MEDICALLY URGENT REQUESTS

Commercial HMO:

- Decisions must be made within 72 hours of receipt of all necessary information needed for the request.
  - For electronic submissions, select "URGENT" in the designated field.
  - For faxed requests, check the "MEDICALLY URGENT" box at the top of the form.
  - Medically urgent requests requiring immediate determination can also be submitted by calling Customer Service at (925) 952-2887, the toll-free number (844) 398-5376.

Medicare Advantage:

- Decisions must be made within 72 hours of receipt of all necessary information needed for the request.

- For electronic submissions, select “URGENT” in the designated field.
- For faxed requests, check the “MEDICALLY URGENT” box at the top of the form.
- Medically urgent requests requiring immediate determination can also be submitted by calling Customer Service at (925) 952-2887, the toll-free number (844) 398-5376.

IMPORTANT INFORMATION REGARDING SUBMISSION OF URGENT REQUESTS

Authorization requests are to be submitted as “Urgent” **ONLY** when the service is medically urgent. The Centers for Medicare and Medicaid Services (CMS) define urgent as ***“A situation where the time frame of the standard decision-making process could seriously jeopardize the life or health of the patient or could jeopardize the patient’s ability to regain maximum function”.***

Please remember the following when submitting requests for medically urgent review:

- An urgent request is one in which the requested service must be provided in less than 5 business days, and the situation meets the CMS definition of urgent care (as described above).
- Patient convenience or demand does not constitute medical urgency.
- Failing to submit an authorization request in a timely manner does not constitute medical urgency.
- Do not schedule or have Enrollees schedule a consultation, office visit or service which requires authorization until you have received notification that the service has been authorized.
- Retrospective requests for services already provided are not medically urgent and will be handled as routine requests.

Please Note: Submitting requests as needing urgent review when the situation is not medically urgent impedes our ability to process those requests that are truly medically urgent.

Criteria Used in the Review Process

JMHPN utilizes the following clinical guidelines in review of service requests:

- Health Plan specific criteria for Commercial HMO Enrollees
- CMS criteria for Medicare Advantage Enrollees.
- InterQual® guidelines (nationally recognized clinical review guidelines), in the absence of Health Plan or CMS guidelines.
- For preventive health care services, in the absence of health plan specific criteria, United States Preventive Services Task Force (“USPSTF”) recommendations are utilized.

Criteria used in the review process can be obtained by calling Customer Service at (925) 952-2887, the toll-free number (844) 398-5376.

Administrative Authorizations

The Administrative Authorization Process will be used by physicians to obtain payment from the patient's health plan for services for which John Muir Physician Network does not require prior authorization. Examples of the types of services where this may be used include in-office injectable medications or in-office infused medications. The health plan authorization code below should be added to the physician's claim form.

HEALTH PLAN	ADMINISTRATIVE AUTHORIZATION CODE
AETNA	AET0020+patient's birth date
ANTHEM BLUE CROSS	BC0010 +patient's birth date
BLUE SHIELD	BS0060 +patient's birth date
CANOPY HEALTH	CH0090 + patient's birth date
CIGNA	CIG0080 +patient's birth date
CENTRAL HEALTH PLAN	CHP30+ patient's birth date
HEALTH NET	HN0050 +patient's birth date
UNITED HEALTH CARE	UHC0070 +patient's birth date

If the health plan rejects or denies the claim and requests a hard copy of the authorization prior to payment, then the physician office staff should contact Barbara Reagan at 925-941-2661 to request an administrative authorization form. The form will be completed and signed by the treating physician.

Service Denials

When service requests are denied, to give the requesting clinician the opportunity to discuss the case with the physician reviewer, the documentation faxed to the requesting clinician includes the name and phone number of the John Muir Health Physician Network physician reviewer if a peer-to-peer request is needed. **Patients should not be given the phone number of the physician reviewer**. The number is provided for physician-to-physician discussion only.

John Muir Health Physician Network is not delegated by the health plans for review/processing of appeals and grievances. Patients receive a denial letter via U.S. Mail, explaining the reason for the denial and the process for appealing the decision. The member can call the Health Plan directly using the phone number on the back of their ID card for any type of grievance. All appeals and grievances are submitted to and processed by the Health Plans. Patients can also go to the Health Plan website to access appeal and grievance forms.

The Medical Services Department monitors, evaluates and manages the quality and appropriateness of healthcare services delivered to all of its Enrollees. The Care Management Program and copies of all policies are available upon request by contacting the Customer Service Department at (925) 952-2887, the toll-free number (844) 398-5376.
Out-of-Network Referrals

Physicians are required to utilize contracted, in-network Providers. A contracted in-network provider means that the provider is contracted with JMHPN and can be found on the JMHPN provider roster. When requested services are unavailable or cannot be provided by contracted Providers, a request may be submitted for authorization of services by a non-contracted provider. Prior authorization is required for such out-of-network referrals, and the request for such prior authorization must be submitted to the John Muir Health Physician Network Utilization Management Department electronically, through Epic/Community Connect or PlanLink.

SECTION 6: BILLING AND PAYMENTS

JMHPN is responsible for processing appropriately submitted Provider fee-for-service claims and capitated Provider encounter data. Fee-for-service claims processed Thursday through the following Wednesday will appear on the Provider Remittance Advice (PRA) the following week and will be adjudicated (either paid, denied, or pended). Capitated payments are made by the end of each month and capitation payments may be subject to adjustment as a result of retroactive additions or deletions, but offsets and adjustments won't exceed ninety (90) calendar days.

A claims editing software CLAIMS EDITING SOFTWARE (CES) application is utilized by JMHPN to automatically check for claim errors, omission and questionable coding relationships by testing the data against an expansive database containing industry rules, regulations and policies governing healthcare claims. It also detects coding errors relating to unbundling, modifier appropriateness, diagnosis and duplicate claims. The medical necessity edits of the application helps detect procedures billed without supporting diagnosis or not medically necessary based on local and national coverage determinations (LCD/NCD). CES helps manage claims edit system updates and maintain payment integrity.

CLAIMS SETTLEMENT AND PROVIDER DISPUTES: As required by Assembly Bill 1455, the California Department of Managed Care (DMHC) sets forth regulations establishing certain claim settlement practices and a process for resolving claims disputes for managed care products regulated by the DMHC. This information notice is intended to inform you of your rights, responsibilities, and procedures for claim payment and provider dispute resolution for Commercial HMO and POS Health Plans where JMHPN is delegated to perform claims payment and provider dispute resolution.

Claim Submission Requirements

Contracted Providers must submit encounter reports/claims for covered services within ninety (90) calendar days after the date of service via electronic means - Electronic Claims Submission (EDI). If clean encounter reports or claims are not submitted electronically, the claim will be returned to Provider to resubmit via electronic means using one of the EDI options listed in this JMHPN Network Practice Operations Manual. If JMHPN is the secondary Health Plan, then Provider must submit the primary Health Plan Explanation of Benefits (EOB) with applicable claims to facilitate coordination of benefits. Provider shall use the current appropriate diagnosis code and the most recent annual update of procedural coding as applicable in accordance with the Medicare and/or Medi-Cal, and HEDIS guidelines applicable at the time the service was rendered.

Non-contracted Providers have one hundred-eighty (180) days after the date of service to submit a claim.

Claims submitted outside of these time frames may be denied as untimely.

JMHPN shall pay any capitated amounts on or before the last day of each month. JMHPN shall pay any non-capitated fee-for-service amounts within forty-five (45) business days of receipt of a complete and uncontested claim.

Unlisted/Non-Valued Codes

Should Provider provide an authorized Covered Service that is considered a Medicare allowable charge but is listed as a non-valued code under Medicare guidelines, JMHPN may conduct a review of Health Plan priced methods or coding review of operative reports and/or medical records to determine whether a similar code with an established rate can be utilized. In the event that there is no comparable code and rate, services shall be priced at thirty-five percent (35%) of Provider's allowable billed charges, less any applicable Copayments, Co-Insurance, and Deductibles. JMHPN will not reimburse Medicare non-allowable charges.

Coding Changes

JMHPN utilizes nationally recognized coding structures for describing the Covered Services provided for which fees are paid hereunder including, but not limited to, Revenue Codes as described by the Uniform Billing Code, AMA Current Procedural Terminology (CPT), CMS Healthcare Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), ICD-10 Diagnosis and Procedure codes, National Drug Codes (NDC) and the American Society of Anesthesiologists (ASA) relative values. As changes are made to these codes, JMHPN will update internal systems to accommodate new codes and /or coding changes. JMHPN shall notify Provider in writing via facsimile transmission or electronic mail of any such material coding changes.

Electronic Claim Submissions

Electronic Data Interchange (EDI) submission of claims reduces paperwork, eliminates printing and mailing expenses, and improves claims payment accuracy. JMHPN offers the following clearinghouse options:

- Change Healthcare – *Payer ID for John Muir is* ***68036 or JMH01***
- Trizetto – Payer *ID for John Muir is* ***JMH01***
- Office Ally - *Payer ID for John Muir is* ***JMH01***
- FinThrive - *Payer ID for John Muir is* ***78036***

Automated Clearinghouse

Providers are required to receive their payments via Automated clearinghouse (ACH) deposit. Some of the benefits of electronic funds transfer (EFT) payments include:

- Replacing the slower and more cumbersome paper-based system of checks.
- Conducting financial transactions in a more secure fashion.

- Eliminating the inconvenience of potential lost checks and the need for replacement checks due to misdirected mail via the U.S. Postal Service.
- Enhancing cash flow to the physician by up to 5 days.

See Appendix for an automated clearing house (ACH) deposit application form.

Corrected Claims Submitted Electronically

A request made by a contracted provider to change a claim, (e.g. changing information on the service line, modifier addition, diagnosis correction, etc.) that was previously processed is considered a corrected claim. Corrected claims can be submitted electronically and should include all lines from the original claim including the correction. If corrected claims are submitted as a new claim, it can potentially deny as a duplicate and for timely filing. Please note, incorrect submissions of a corrected claim can cause overpayments or delay the handling of the claims process. Providers have 365 days from the most recent action date to submit a corrected claim.

Interpreting Your Provider Remittance Advice

JMHPN receives many calls from billing staff regarding how to interpret the JMHPN Provider Remittance Advice (PRA) documents for capitated claims (that is, for pre-paid services, or for services that are not reimbursed by a fee).

The purpose of this section is to provide clarification on how to interpret information provided on the PRA's. Specifically, there are many different claim determinations that will result in a particular service being excluded from capitation credit/payment. Please see below for explanations of disallowed services. Be aware that the 'Valued Amt' assigned to disallowed services will be 0.00. Billers and payment posters need to know that any time the 'Valued Amt' shows 0.00, cap credit/payment will not be made on this service.

Provider billing/posting staff should carefully review the 'Value Amt' column of the PRA's and any 'Adjst Reason' codes that appear with the service line on the PRA's. Descriptions of these codes are listed in the Codes Summary area of the PRA. Some samples of the more common adjustment reasons that will show a 'Value Amt' of 0.00 are listed below:

- THE PRIMARY HEALTH PLANS EXPLANATION OF BENEFITS HAS BEEN REQUESTED
- THIS IS A DUPLICATE OF A PREVIOUSLY SUBMITTED CLAIM
- DOCUMENTATION DOES NOT SUPPORT CODE BILLED
- SERVICE DATE PRIOR TO PATIENT EFF DATE
- SERVICE REQUIRES PRIOR AUTHORIZATION
- SEND CLAIM TO HEALTHPLAN
- THIS PROCEDURE CODE IS NOT VALID
- THIS DIAGNOSIS CODE IS NOT VALID
- PLACE OF SERVICE IS INVALID
- CODE IS EXCLUDED FROM THE PROVIDER'S CONTRACT
- MODIFIER IS MISSING OR INVALID

The adjustment reasons listed above, as well as others, require follow up by the biller to either (i) correct and resubmit the claim, (ii) obtain updated coverage from the Enrollee, or (iii) re-direct the claim to the proper payer. It is important to review the PRAs and take appropriate actions, even if your practice has a capitated payment methodology.

If you have any questions on how your claim was processed, please call JMHPN's Customer Service at (925) 952-2887 or the toll-free number (844) 398-5376.

Refunds and Adjustments

JMHPN may recover payment, or offset recovery against future payments, in the event that JMHPN determines that an individual was not an eligible Enrollee at the time of services or in the event of duplicate payment, overpayment, payment for Non-Covered Services, error in payment uncovered as a result of a coordination of benefits process, or fraud. Provider disputes and/or appeals can be submitted in writing up to 365 days from the date of JMHPN's last action on the claim.

Balance Billing

Enrollees may only be charged for applicable Copayments, Coinsurance and Deductibles as indicated on the Enrollee's identification card and/or as verified with their Health Plan. Providers are legally prohibited from seeking or accepting payment from an Enrollee for services covered under the contracted Health Plan. This prohibition applies even if JMHPN denies payment to the Provider for the service. For example, if JMHPN denies a claim for a covered benefit because the claim was submitted after the submission deadline, the Physician may appeal the denial but may not bill the Enrollee for the services regardless of the outcome.

Health Plan Billing Matrix

JMHPN carves out specific services as Health Plan or Network financial responsibility in its Health Plan contracts for Commercial HMO and/or Medicare Advantage HMO. A general summary of those carve-outs by Health Plan can be found in the Health Plan Billing Matrix and is subject to modification. The matrix serves as a general guide for Providers to submit claims for certain services to the correct Health Plan and address. The matrix is an administrative reference only and the ultimate determination of financial responsibility for the service is dependent on the fully executed agreement between the Physician Network, John Muir Health, and the Health Plan in effect on the date Provider provides a PCP or Specialty Service.

Escalated Health Plan Issues

If a discrepancy in payment occurs with one of the Health Plans, Provider should appeal and exhaust all efforts with the Health Plan before reaching out to JMHPN for assistance. The Health Plans have a strict appeal process and will not research the issue without having the proper information (listed in paragraph below) in place.

When reaching out to JMHPN for assistance, please make sure to contact Customer Service at (925) 952-2887 and include 1.) Documentation of a Health Plan's denied appeal and denial letters 2.) Reference number from Health Plan.

Section 7: Provider Dispute Resolution Process

A Provider Dispute Resolution Request (PDR) is a Provider's **written** notice to a Health Plan that the Provider is (i) appealing or requesting reconsideration of a claim that has been denied, adjusted, or contested, (ii) seeking resolution of a billing determination or other contract dispute, or (iii) is disputing a request for reimbursement of an overpayment of a claim. Appeals are to be submitted in writing as specified by AB1455 using the Claim Appeal Submission Form (see Appendix).

When a PDR is received, an acknowledgement letter or request for additional information, if applicable, will be sent within 15 working days of receipt. A letter is sent to the Provider advising of the final determination on the dispute within 45 working days of receipt of all information reasonably required to adjudicate the claim.

A complete PDR must include the following information:

1. John Muir Health's claim number (located on provider remittance advice)
2. Provider name
3. Provider tax identification number
4. Enrollee name
5. Enrollee's health plan ID number
6. Dates of service
7. Billed and paid amounts (if applicable)
8. Clear and concise explanation of the reason for the dispute
9. For non-claims issues, a clear explanation of the issue and the Provider's position.

Provider disputes must be submitted within 365 calendar days from the date of JMHPN's last action on the claim. A written dispute may be submitted in the form of a letter or on a Provider Dispute form available from any health plan or by calling Customer Service at (925) 952-2887 or the toll-free number (844) 398-5376. Provider Disputes are processed according to state and federal law and regulations. When clinical or coding issues are involved with the appeal, the case is reviewed by a Certified Professional Coder and if necessary, the Medical Director.

Disputes should be mailed to:

John Muir Health Physician Network
P.O. Box 31255
Salt Lake City, UT 84131

Please note that the foregoing process is initiated only by the submission of a written PDR. Telephone communication does not initiate the dispute resolution process.

Section 8: Provider rights and responsibilities

8.1 Provider Obligations

Contracted Providers are obligated to adhere to the terms of their Provider Agreement, including, without limitation, the obligations outlined in this JMHPN Practice Operations Manual.

8.1.1 Required Coverage

Participating Provider responsibilities include, but are not limited to:

- **Provide timely service:** Providers will furnish medically necessary services, in accordance with the Enrollee's benefit plan. Providers will maintain practice policies supporting the provision of medical services to Enrollees, within the specified intervals between an Enrollee's request for service and the date/time that medical services are rendered. If there is a significant interruption in the Provider's ability to maintain these standards, JMHPN must be notified in writing. See section 8.2 for specific requirements.

- **24/7 Coverage:** If a Provider is unable to provide services at any time, then the Provider shall arrange, at Provider's own expense, for the required coverage from another qualified JMHPN Provider.

Enrollees may also use the JMHPN Urgent Care sites for non-emergent conditions after hours.

A Provider is solely responsible for securing the agreement of any locum tenens, on-call or covering physician and for compensating the locum tenens, on-call or covering physician in accordance with the terms of the JMHPN Participating Provider Agreement. Provider shall be responsible for ensuring that any locum tenens, on-call or covering Provider provides services in Provider's absence to Enrollees in accordance with the terms and conditions of the Provider's Agreement with JMHPN including referring patients for non-emergent care to in-network specialists and hospitals.

8.1.2 Verify benefits and eligibility at the time of service. JMHPN encourages the use of its PlanLink/Epic Community Connect tool to verify Enrollee eligibility. Provider must request current health plan ID card at the time of service and verify patient eligibility before furnishing care. If a patient is not eligible for coverage under a JMHPN contract, then approval or payment for a claim or encounter may be denied.

8.1.3 Admitting to Hospitals: Providers agree to admit Enrollees only to the following hospitals staffed with JMHPN Providers: John Muir Medical Center – Walnut Creek, John Muir Medical Center -- Concord and San Ramon Regional Medical Center (collectively JMHPN Contracted Hospitals). Admission to any other hospitals must either be on an emergency basis or authorized in advance by JMHPN based on medical necessity. An Enrollee admitted without prior authorization to a different hospital will be repatriated to one of the JMH Contracted Hospitals as soon as the Enrollee is medically stable for transfer. This will allow medical director and case manager oversight, improved continuity of care, improved electronic health record documentation and smoother transition of care to the JMHPN Care Coordination and Resource Services Department.

8.1.4 Admitting to Outpatient Surgery Centers: Providers shall refer Enrollees only to outpatient surgical centers contracted with the Enrollees health plan.

8.1.5 Referrals to Urgent Care Centers: Providers shall refer Enrollees to JMHPN Urgent Care centers.

8.1.6 Participate in JMHPN's Quality Improvement Program: Providers shall cooperate with the Quality Improvement Program and agree to cooperate with JMHPN's administration of its internal quality-of-care review and grievance resolution procedures. See the Quality Improvement Section of this Practice Operations Manual for more information.

8.1.7 Participate in JMHPN's Utilization Management: Provider shall cooperate with the Utilization Management (UM) program outlined in their Agreement and agree to cooperate with JMHPNs' administration of its internal quality-of-care review.

8.1.8 Generic Drug Utilization: Providers shall use their best efforts to prescribe generic drugs, as appropriate, and drugs contained in the health plan prescription drug formularies.

8.1.9 Access to Medical Records: Provider shall allow JMHPN access to medical records without a separate fee to the extent allowed by federal and state law, including for the purposes of Enrollee chart audits for quality improvement, Risk Adjustment Factor (RAF) and claims auditing purposes.

8.1.10 HIPAA and Confidentiality Responsibilities: Provider shall keep accurate, complete, timely and legible medical records for all Enrollees in such form and containing such information as required by applicable federal and state laws and regulations ("Medical Records") and shall maintain and store all medical records in a safe and secure location to ensure the privacy and confidentiality of such records at all times and in accordance with the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (collectively, "HIPAA") and other applicable state and federal privacy regulations.

8.1.11 Open Communication: Provider shall openly communicate with Enrollees about their treatment, regardless of benefit coverage limitations. JMHPN medical and UM decision-making is based only on appropriateness of care and service, and existence of coverage. There are no financial incentives for JMHPN medical and UM decision-makers to encourage decisions that may result in inappropriate underutilization.

8.1.12 Notice of Termination: Contracted physicians are required to contact JMHPN with a minimum of 90 (ninety) days prior notice if the physician terminates, his or her participation with the network, per the contract under "Termination" provision, in order to allow JMHPN to notify all health plans.

Additionally, a Provider must agree to provide Covered Medical Services (i.e. Medically Necessary health care services, equipment and supplies which a Enrollee is entitled to receive under the Enrollee's Evidence of Coverage) to any and all Enrollees until such time as the Provider closes his/her practice and is no longer accepting new patients from any health plan with whom Provider contracts. Provider shall give JMHPN prompt written notice of such practice closure.

8.1.13 Notification of Open/Close Panels: Provider shall notify JMHPN Credentialing Department in writing within twenty-four (24) hours (or next business day) of opening or closing a practice to new patients.

8.1.14 Other Provider Obligations: Provider agrees to: (a) furnish JMHPN in a timely fashion all information needed to (i) add Provider to existing or new Contracts, (ii) ensure JMHPN and Health Plans can maintain current, accurate provider directories and rosters, (iii) enable JMHPN to timely respond to Health Plan inquiries, (iv) enable JMHPN to ensure Health Plans make appropriate payment to JMHPN and Provider, and (v) meet any other reasonable need related to the services provided by either Party under the JMHPN Agreement.

8.1.15 Compliance Responsibilities: JMHPN is subject to a wide variety of federal, state, and local laws. These include, but not limited to, laws governing confidentiality of medical records, personally identifiable information, Health Plan and insurance regulatory requirements, government contracts, kickbacks, fraud, waste, and abuse, false claims and provider payments. JMHPN has a responsibility to operate our daily activities both ethically and legally. These obligations apply to our relationships with patients, Enrollees, physicians, third-party payers, subcontractors, independent contractors, vendors, consultants and one another. As part of this responsibility, JMHPN requires contracted providers within our network to operate ethically and legally. JMHPN has adopted a Standards of Ethics and Business Conduct policy and encourages providers to adopt similar policies and practices.

8.1.16 Required Medicare Compliance and Fraud, Waste and Abuse Training Requirements: As a first-tier entity to certain Medicare Advantage (MA) health plans, JMHPN has entered in written arrangements with Health Plans to provide certain administrative or health care services. JMHPN's Provider must satisfy CMS' requirements for general compliance training and fraud, waste and abuse training. The training focuses on how to detect, correct, and prevent non-compliance and fraud, waste, and abuse concerning Medicare programs. All of JMHPN's Providers must ensure that all their respective personnel, employees and contracted staff involved in the administration or delivery of Medicare benefits have successfully completed the above-required training. This requirement applies to all personnel, employees and contracted staff upon initial hire, and training must be completed within 90 days of hire/start date and annually thereafter. Evidence of training must be maintained for a minimum of ten (10) years and produced upon request for audit purposes.

Submission of Training Attestation: Upon request, JMHPN's Providers must provide a compliance statement of attestation indicating compliance with these training requirements.

- The **CMS Medicare Part C & D General Compliance Training** (for training materials complete the General Compliance Training available on the CMS Medicare Learning Network at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf
- If enrolled in Medicare Part A or B, the provider is deemed to have met this requirement. (for training materials, they are available on the CMS Medicare Learning Network at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CombMedCandDFWAdownload.pdf

Exclusion Checks - Prior to hiring or contracting employees, Provider must review federal (HHS-OIG and GSA) and state exclusion lists as applicable. This includes the hiring of temporary workers, volunteers or administrators who have involvement in or responsibility for the administration or delivery to a JMHPN MA Health Plan beneficiaries.

What Providers Need to Do:

- Make sure that potential employees are not excluded from participating in federal health care programs as outlined above. For more information or access to the publicly accessible excluded party online databases, please see the following links:
  - Health and Human Services – Offices of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) at oig.hhs.gov
  - General Services Administration (GSA) System for Award Management at SAM.gov
- Review the federal and state exclusion lists on a monthly basis thereafter.
- Maintain a record of exclusion checks for 10 years. Documentation of the exclusion checks may be requested by JMHPN or CMS to verify that checks were completed.

Reporting Compliance Concerns: Although JMHPN's Compliance and Privacy Office do not serve as a Provider's Compliance and Privacy Officers, the Chief Compliance Officer ("CCO") for JMHPN is available to address any suspected concerns or detected noncompliance concerns involving JMHPN contracted activities. The CCO may be contacted at (925) 947-3344. If there is a suspected improper disclosure or access to information or systems related to JMHPN contracted activities, including but not limited to, beneficiary or Enrollees information, this must be reported immediately to the JMHPN Privacy Officer at (925) 941-2688.

8.2 Provider Access Standards

8.2.1 Continuity of Care:

Continuity of Care decisions must be requested by the patient with their Health Plan and the Health Plan will approve/deny the patient's request.

8.3 Provider Regulatory Requirements:

8.3.1 Access Standards: JMHPN promotes uniform access standards for the health care delivery of preventive care appointments, routine primary care appointments, urgent care appointments, emergency care and access to after-hours care, behavioral health care and key elements of telephone service for Enrollees. The Department of Managed Health Care ("DMHC") has set standards related to access to care for HMO Enrollees. The standards are listed below.

Access Type	Standard
Access to non-urgent appointments for primary care – regular, preventative and routine care (with a PCP)	Within 10 business days of request

Access to urgent care services (with a PCP) that do not require prior authorization	Wait time not to exceed 48 hours of request
Access to urgent care (specialist and other) services that require prior authorization*	Within 96 hours of request
Access to non-urgent appointments with a specialist	Within 15 business days of request
Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness or other health condition	Within 15 business days of request
Non-urgent appointments with a non-physician behavioral health care provider	Within 10 business days of request
Triage or screening wait time	Wait time for return calls from practitioners does not exceed 30 minutes.

*For appointments that require prior authorization, obtaining authorization must be completed within the timeframe for that visit or service. For urgent appointments that require prior authorization, the appointment scheduling must be done in concurrence with the prior authorization process.

Emergency Care: Emergency services are services provided in connection with the initial treatment of a medical or psychiatric emergency. If a patient considers a medical condition to be an emergency, he or she should be instructed to call 911 or go to the nearest hospital emergency room immediately. JMHPN covers emergency services that are necessary to screen and stabilize a condition.

No authorization or precertification is needed if the Enrollee reasonably believes that an emergency medical condition exists. An emergency room visit co-payment may apply. Once the condition is stabilized, the Enrollee or family of patients should contact his or her physician for authorization of any additional services. An Enrollee should be directed to call the telephone number on his or her health plan identification card with any questions.

A medical emergency is an unexpected acute illness, injury, or medical or psychiatric condition that could endanger health if not treated immediately.

Examples of medical emergencies include:

Active labor
Chest pains
Severe pain
Heavy bleeding
Difficulty breathing or shortness of breath
Sudden loss of consciousness
Sudden weakness or numbness of the face, arm or leg on one side of the body
Danger to self or others

California law requires health plans to follow the “prudent layperson” standard in providing directions for emergency care and prohibits payers from denying payment for emergency services even if the situation was discovered not to be emergent – if any “prudent layperson” would have considered the situation to be an emergency.

A “prudent layperson” is a person who is without medical training and draws on his or her practical experience when making a decision regarding whether emergency medical treatment is necessary.

Therefore, JMHPN expects all participating physicians to instruct their after-hours answering service staff that, if the caller believes he or she is experiencing an emergency, the caller should be instructed to dial **911** or go directly to the emergency room.

If an emergency service is authorized by the answering service, this authorization is considered binding and cannot be retracted at a later date. Answering machine instructions must also direct the Enrollee to call **911** or go to the emergency room if the caller believes he or she is experiencing a life-threatening emergency.

For a sample after-hours phone message script, please see the Appendix.

8.3.2 Language Assistance Program

State law mandates that California health plans provide services, materials and information to their Commercial HMO Enrollees in a language they speak and understand. Enrollees also maintain the right to a sign language interpreter under the federal Americans with Disabilities Act. HMO Enrollees may receive language assistance by calling the number on the back of their Health Plan ID card when they need to:

- Explain their symptoms or medical history.
- Understand their health problems or treatment choices.
- Choose among treatments or treatment options.
- Understand instructions about medications, medical equipment or follow-up care.

In addition to language assistance, health plans must translate such things as:

- Standard letters and notices of insurance eligibility and membership requirements.
- Notices of any denial, reduction, modification, or termination of services and benefits.
- Notices of the right to file grievances or appeals.

Language assistance services is provided by the Health Plans for specific languages at no cost to Providers or Enrollees. Health Plans may offer assistance for specific languages based on their Enrollee's demographics so eligible languages may vary between health plans. Language assistance and interpreter services (telephonic and in-person interpretation) may be accessed through the major California HMO health plans.
In addition to the above, the California Department of Managed Health care ("DMHC") operates an HMO Help Center to provide language assistance for HMO Enrollees. The **DMHC Help Center** may be reached at **(888) 466-2219** or by TDD at (877) 688-9891, 24 hours/day, 7 days/week. Please remember to document in their medical record, any instance where an Enrollee refuses language assistance or interpretive services.

SECTION 9: CREDENTIALING

The JMH Consolidated Credentialing Department ("CCD") is responsible for the initial credentialing and subsequent re-credentialing process for all JMHPN physicians. All new physicians are subject to a rigorous credentialing process. Providers are required to participate in the required re-credentialing process at least every 24-36 months. All Credentialing Program policies are available upon request. Contact to request copies: ccd@johnmuirhealth.com.

The CCD consolidates basic credentialing application functions for all four entities (John Muir Concord Campus, John Muir Walnut Creek, Behavioral Health and JMHPN) into one location and data system. The following is a description of the process:

1. The CCD forwards the application or reapplication ("application") to the provider at the time of reappointment (between 24 and 36 months of last credentialing cycle).

2. The provider completes and signs the required areas of the application and returns it to the CCD.

3. Upon receipt, the CCD processes the application and performs Primary Source Verification ("PSV") for:

   - Education and training (initial applicants only)
   - Current licensure
   - Current DEA (if applicable)
   - Sanctions
   - Board certification status
   - Malpractice insurance coverage
   - Malpractice Claims History (current and past years)
   - Current affiliations
   - Past Affiliations (initial applicants only or for re-apps if the change was recent)

4. In addition to PSV's, the CCD evaluates the application for completeness and performs additional required verifications:
   - Office of Inspector General (OIG) query
   - Medicare Opt-Out reports
   - EPLS (Excluded Parties List System)

5. Applicants to JMHPN are evaluated and credentialed in accordance with established quality processes based on National Committee for Quality Assurance (NCQA) standards, health plan delegation requirements, and compliance with JMH/JMHPN established re-credentialing criteria. Additional queries or provider input may be required for criteria needing further clarification. After all processes are completed, provider applications are presented to the following entities for review and approval
   - JMHPN Credentialing Committee
   - JMH Credentialing Sub-Committee
   - JMHPN Board of Directors

6. Following approval by all entities, the provider is notified in writing either by email or certified mail.

SECTION 10: CARE COORDINATION & QUALITY IMPROVEMENT

10.1 Care Management: The JMHPN Care Coordination and Resource Services Program provides personalized management by experienced Nurse Care Managers to Enrollees with complex or non-complex medical needs. The care management team is comprised of Nurse Care Managers, Care Coordinators and Social Workers. The team works directly with the Enrollee, the Enrollee's caregiver, and

the Enrollee's family, as well as with the Enrollee's primary care physician and attending specialists to ensure that the Enrollee receives timely, appropriate, and quality medical care in an appropriate setting. In collaboration with the primary care physician Enrollees will receive a comprehensive assessment, an individualized plan of care including interventions and support services, ongoing monitoring and coaching. Recurring monthly calls and ongoing communication between the primary care physician and the care management team are key success factors for this program. This Care Coordination and Resource Services Program is available to all delegated health plan Enrollees. Referrals can be made in Epic "AMB referral to Case Management" or "REF 139", or via phone at 925-988-7505. A member of the Care Coordination and Resource Services team will contact the Enrollee within two business days from the receipt of a referral. Any messages left on the main line will be returned within one business day. For faxed referrals, please refer to the Appendix for the Enrollee referral and enrollment form.

10.2 Post Discharge Transitions Program: This program is designed to empower Enrollees to understand and better manage their illness or disease state. This program is an Enrollee-centered intervention designed to improve quality of care for Enrollees with complex care needs at high risk of re-hospitalization as they transition across settings, such as when discharged from a hospital to home or from a Skilled Nursing Facility (SNF) to home. Care Coordinators reach out multiple times within the first 30 days to ensure primary care physicians follow up, provide health education and care management support with the goal of preventing readmissions.

10.3 Quality Improvement: The JMHPN Quality Improvement Department, (QI) is responsible for assuring quality outcomes through monitoring and implementing the Integrated Healthcare Association (IHA). Align. Measure. Perform (AMP, formerly Value-based Pay for Performance or VBP4P) Measures outlined by the health plan contracts. It aligns the AMP program with Medicare Advantage (MA) Stars quality measures, as outlined by the health plan contracts. Quality actively engages in ensuring performance improvement includes physicians addressing GAP lists – gaps in care that are provided in quality performance dashboards. QI also has several performance improvement initiatives underway and forthcoming in which physicians are encouraged to participate and provide feedback. These initiatives and small pilots create an opportunity for a practice to improve workflow and patient care and JMHPN invites full participation.

10.4 Quality Improvement and Transformation (QI&T) Committee: The Quality Improvement and Care Management Committee (QICM) Committee oversees Quality Improvement. The committee meets bi-monthly.

10.4.1 Quality Assessment and Data Submission Requirements: Physicians are required to accurately document medical services in Epic/Community Connect using standardized fields for discrete data capture, including but not limited to:

- Regularly reviewing quality performance dashboards and addressing GAP lists
- Epic Flow Sheets
- Epic QM Smart Phrases
- Epic Quality Tab
- Epic Health Maintenance

They are also required to regularly review quality performance dashboards and address GAP lists. Tools are available to support documentation in Epic, e.g., Quick Reference Guide and TIP Sheets. Physicians that do not utilize Epic are expected to regularly review their quality performance dashboard gap lists and provide any missing data via fax or email.

10.5 Risk Adjustment Factor (RAF): Risk Adjustment Factor or Medicare RAF identifies the health status of a patient. It is important that you document all the conditions that a patient has because the Centers for Medicare and Medicaid Services (CMS) adjusts the payment to JMHPN based on how sick the patient is. Reimbursement flows from CMS to Medicare Advantage (MA) Health Plans (Central Health Plan) and Covered California Health Plans (Blue Shield, Aetna, Anthem) and on to providers/ provider networks. Outlined below is a Providers role in Risk Adjustment:

- See all Medicare Advantage patients that are assigned to the Provider at least once a year.
- Document patient's current chronic conditions and ongoing treatment plans at least once a year.
- Documentation should demonstrate complete, and concise picture of the patient's condition. Remember "MEAT":
  - Monitor
  - Evaluate
  - Assess or
  - Treat
- Treatment plan should link conditions to medications.
- Document all conditions that co-exist at the time of the visit and how they impact current care/treatment.
- Add all chronic conditions to the problem list.
- Providers must report the ICD-10 diagnosis codes to the highest level of specificity.
- Documentation must support all ICD-10 codes reported on a claim.
- Allow JMHPN and their respective agents' access to medical records without a separate fee.

Accurate diagnosis code reporting and complete clinical documentation increases the accuracy and completeness of a patient's RAF score.

APPENDIX

Services Requiring Prior Authorization – JMHPN <u>All Plans</u>

(Revised January 2025)

All Providers must obtain **prior authorization** from the JMHPN Utilization Management Department for any service listed below.

Requests can be submitted electronically through **Epic** or **PlanLink**. Offices that do not have access can submit via fax to (925) 952-2865. Medically urgent requests may also be called in to (925) 952-2887.

If you have questions regarding the criteria used in the review process, please call Customer Services at (925) 952-2887.

NOTE: All MRI's, CT's, Home Sleep studies with diagnosis of snoring or apnea, Home Health, Hospice and Wound Care Center Services still require a submission of a prior authorization to facilitate provider and member notifications of approval and to facilitate claims payment.

The following services <u>ALWAYS</u> require authorization, regardless of place of service:

- Inpatient—which includes hospital inpatient and observations, SNF, LTAC, Acute Rehab
- Out of network referrals to and services by providers not listed on the John Muir Physician Network Physician Panel
- Bariatric surgery (Gastric Bypass surgery) – all services, including the initial consult, nutrition consult, and psych evaluation
- Acupuncture
- Biofeedback
- Blepharoplasty
- Bone density screening/Dexa Scans in women < age 65 and men < age 70
- Bone density screening or Dexa Scans if done more frequently than every 2 years, regardless of age
- Cardiac Event Monitoring, external & implantable - 93228-93229, 93268, 93270-93272, 33285
- Chiropractic services, including the initial referral to a chiropractor
- Cologuard Testing - 81528 and 0464U
- CT Scans – outpatient- ordered by a non-JMHPN in-network specialist or primary care physician, Low Dose CT scan of the chest for lung cancer screening, Heart/Cardiac CT of the chest for calcium scoring
- Dietary (Nutritional) counseling referrals only for Bariatric Surgery
- Durable medical equipment Orthotics & prosthetics see codes below; all other codes submit an authorization to facilitate payment of claims. The codes below must undergo review for medical necessity including medical information facilitates timely turnaround:

  A4520, A4553, A4554, A4605, A4624, A4628, A5500-A5513, A6550, A7000-A7002, A9276-A9278, A9286 A9900
  B4034-B4036, B4081-B4088, B4100-B4104, B4149-B4162, B4164-B4199, B4216, B4220-B4224, B5000, B5100, B5200, B9002, B9004, B9006, B9998-B9999

E0172, E0181-E0199, E0218, E0245, E0260-E0297, E0371-E0373, E0431-E0446, E0455, E0470-E0471, E0485-E0486, E0555, E0580, E0600- E0601, E0621-E0640, E0650-E0673, E0676, E0705, E0745, E0747-E0748, E0760,
E0776, E0840-E0860, E0950-E0995, **All codes between E1002-E2402**, E2500-E2512, E2599, E2601, E2625
K0001-K0009, K0013, K0015-K0077, K0105, K0108, K0195, K0553, K0554 K0606, K0669, K0733, K0738, K0743K0746, K0800-K0899
L3000-L3020, L5000-L5999, L7367-L7700, L7900, L7902, L8000-L8030, L8400-L8480
T4521-T4545

- Electrophysiologist referrals when requested by other than a cardiologist
- Genetic testing – excludes testing done in conjunction with an amniocentesis and biomarker testing, as well as testing that is associated with a federal FDA-approved therapy for members with advanced or metastatic stage 3 or 4 cancer, including in cases of cancer progression or recurrence.
- GI Procedures – Capsule Endoscopy 91110, 91111
- Hyperbaric Oxygen treatments
- Infertility services (consult does not require prior authorization)
- Injectable medications – excludes vaccines and drugs from office stock – except for Viscosupplementation for Commercial members
- Investigational/experimental procedures or treatments
- Mohs surgeon referrals/consultations & procedures--for sites other than--head, scalp, face and/or chest
- MRI – outpatient--ordered by non-JMHPN in-network specialist or primary care physician, any type of MRI of the breast, MRI of the prostate for screening of prostate cancer
- Neuropsych testing
- Orthopedic surgery procedures with the following CPTs:
  0001T-9999T, 20930-20938, 20985, 20999, 21899, 22100-22865, 22867-22870, 22899, 23929, 24999,
  25999, 26989, 27299, 27412, 27599, 27899, 28899, 29999, 63001-63687, excluding 63661 (63661 does not require Medical Necessity review), 63700-63746, J7330
- All Outpatient Rehabilitation Services
- PET Scans
- Plastic Surgery services, including the initial referral to a plastic surgeon
- Sleep studies - excluding home sleep studies where there is a diagnosis of snoring or sleep apnea
- Spine surgery
- Transportation—medically necessary transport (BLS and CCT)
- Transplant Services (includes all: work-up, transplant and post-transplant follow-up services)
- Urologic procedures with the following CPTs:
  50300-50380, 53854, 54161 (only for Commercial members), 54400-54408, 55400, 55899, 55970-55980
- Vascular procedures in CPT range: 36468 – 36479 and 37700 – 37785

Regulation Notice to Consumers

Effective June 27, 2010, a new regulation, mandated by Business and Professions Code section 138, went into effect requiring physicians in California to inform their patients that they are licensed by the Medical Board of California, and include the board's contact information. The information must read as follows:

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

The purpose of this new requirement (Title 16, California Code of Regulations section 1355.4) is to inform consumers where to go for information or with a complaint about California medical doctors.

Providers may provide this notice by one of three methods:

- Prominently posting a sign in an area of their offices conspicuous to patients, in at least 48-point type in Arial font.
- Including the notice in a written statement, signed and dated by the Enrollee or Enrollee's representative, and kept in that Enrollee's file, stating the Enrollee understands the physician is licensed and regulated by the board.
- Including the notice in a statement on letterhead, discharge instructions, or other document given to an Enrollee or the Enrollee's representative, where the notice is placed immediately above the signature line for the Enrollee in at least 14-point type.

The notice may be printed in sign form from the following link:

https://www.mbc.ca.gov/Download/Documents/notice-to-consumers-regulation-sample-sign.pdf

For more information, please contact the Medical Board's information officer, at (916) 263-2394.

JMHPN Enrollees Rights and Responsibilities:

These Enrollee rights and responsibilities have been developed to ensure that the most medically appropriate care is comprehensively provided by JMHPN Providers and that the care is responsibly received by JMHPN Enrollees.

Scope:

The Enrollee rights and responsibilities policy will be included in the JMHPN Practice Operations Manual and the new membership packets as appropriate. The policy also will be posted in JMHPN provider offices.

Policy:

JMHPN participating providers and Enrollees will abide by the rights and associated responsibilities of Enrollees in the process of health care service delivery.

All JMHPN providers and Enrollees will be provided with a copy of the Patient's Rights and Responsibilities policy. The providers and Enrollees also will be notified of revisions or updates in these documented rights and responsibilities.

Patient information will be well-designed, comprehensible, and written in languages that represent the major population groups served by the JMHPN.

Procedure:

The JMHPN will implement a comprehensive Enrollee rights and responsibility policy, as follows:

1. Member Patient Rights – The JMHPN Enrollee has the right to exercise the following rights without regard to gender, sexual orientation or cultural, economic, educational, physical/mental disability, or religious background.
    a. Be provided with comprehensible information about the JMHPN, its services, providers and the health care service delivery process. This information includes instructions on how to obtain care with various providers and at varied facilities (e.g., primary care, specialty care, behavioral health services, and hospital services.) Additionally, information will be included on how to obtain services outside the John Muir Health Physician Network system or service area.
    b. Be informed of emergent and non-emergent benefit coverage and cost of care, and receive an explanation of the Enrollee’s financial obligations as appropriate, prior to incurring the expense (including co-payments, deductibles, and co-insurance).
    c. Be provided with information on how to obtain care after normal office hours and how to obtain emergency care including when to directly access emergency care or use 911 services.
    d. Examine and receive an explanation of bills generated for services delivered to the Enrollee.
    e. Be provided with information on how to submit a claim for covered services.
    f. Be informed of the name and qualifications of the physician who has primary responsibility for coordinating the Enrollee’s care; and be informed of the names, qualifications, and specialties of other physicians and non-physicians who are involved in the Enrollee’s care.
    g. Have 24-hour access to the Enrollee’s primary care physician (or covering physician).
    h. Receive complete information about the diagnosis, proposed course of treatment or procedure, alternate courses of treatment or non-treatment, the clinical risks involved in each, and prospects for recovery in terms that are understandable to the Enrollee, in order to give informed consent or to refuse that course of treatment.
    i. Candidly discuss appropriate or medically necessary treatment options for the Enrollee’s condition, regardless of cost or benefit coverage.
    j. Actively participate in decisions regarding the Enrollee’s health care and treatment plan. To the extent permitted by law, this includes the right to refuse any procedure or treatment. If the recommended procedure or treatment is refused, an explanation will be given addressing the effect that this will have on the Enrollee’s health.
    k. Be treated with respect and dignity.
    l. Receive considerate and respectful care with full consideration of the Enrollee’s privacy.

m. Receive confidential treatment of all Enrollee information and records used for any purpose.
n. Be informed of applicable rules in the various health care settings regarding Enrollee conduct.
o. Express opinions or concerns about the JMHPN or the care provided and offer recommendations for change in the health care service delivery process by contacting the JMHPN Customer Services Department.
p. Make recommendations regarding the JMHPN's Patient Rights and Responsibilities policy.
q. Be informed of the Enrollee complaint/grievance and appeal process including how to express a complaint or appeal.
r. Be informed of the termination of a primary care provider or practice site and receive assistance in selecting a new primary care provider or site in this situation.
s. Change primary care physicians by contacting the Customer Services Department.
t. Be provided with information on how the JMHPN evaluates with the health plans, new technology for inclusion as a covered benefit.
u. Receive reasonable continuity of care and be given timely and sensible responses to questions and requests made for service, care and payment (including complaints and appeals).
v. Be informed of continuing health care requirements following office visits, treatments, procedures and hospitalizations.
w. Have all Enrollee rights apply to the person who has the legal responsibility to make health care decisions for the Enrollee.

2. Patient Responsibility: The JMHPN Enrollee has the responsibility to:
   a. Be familiar with the benefits and exclusions of the Enrollee's health plan coverage.
   b. Provide the Enrollee's health care provider with complete and accurate information which is necessary for the care of the Enrollee (to the extent possible).
   c. Be on time for all appointments and notify the provider's office as far in advance as possible for appointment cancellation or rescheduling.
   d. Report changes in the Enrollee's condition according to provider instructions.
   e. Inform providers of the Enrollee's inability to understand the information given to him/her.
   f. Carry out the treatment plan which has been developed and agreed upon by the health care provider and the Enrollee.
   g. Contact the Enrollee's primary care physician (or covering physician) for any care which is needed after that physician's normal office hours.
   h. Treat the health care providers and staff with respect.
   i. Obtain an authorized referral from the Enrollee's primary care physician for a visit to a specialist and/or to receive any specialty care.
   j. Be familiar and comply with JMHPN's health care service delivery system regarding access to routine, urgent and emergent care.
   k. Contact the JMHPN Customer Services Department or the Enrollee's health plan Member Services Department regarding questions and assistance.
   l. Respect the rights, property and environment of all physicians and JMHPN providers, staff and other Patients.
   m. Have all of these responsibilities apply to the person who has the legal responsibility to make health care decisions for the Enrollee.

Authorization Agreement for Electronic Payments (ACH Credits)

I (Authorized Agent for Vendor) hereby authorize John Muir Health Physician Network, and the financial institution named below to initiate credit entries (Electronic Payments) to my account (this includes my authorization to you to reverse any entries made in error*). This authority will remain in effect until I give written notice to John Muir Health Physician Network's Finance & Risk Operations Department.

Vendor Information		
Vendor Legal Business Name:	**Federal Tax ID number:**	**Name of Authorized Agent:**
Telephone of Authorized Agent:	**Signature of Authorized Agent:**	**Date Signed:**

Financial Institution:	**Location (Branch):**	**Routing Number:** *(found between these symbols ⑆: _ _ _ _ - _ _ _ _ _ ⑆: on the bottom left of your check or savings deposit slip)*

Account Type (please select one):	**Account Number:**	**Please select one:**
( ) Checking Account ( ) Savings Account		( ) Business Account ( ) Personal Account

If you did not list the routing number above, please provide a voided check or savings deposit slip.

Please send this form plus the voided check or savings deposit slip to the following address:

John Muir Health Physician Network
Finance & Risk Operations Department
1450 Treat Blvd., Suite 350
Walnut Creek, CA 94597

An "error" refers to a payment that has posted to your account in error and does not include overpayments. Notification of a reversal (written or verbal) will be given prior to submitting the request to the bank.

SAMPLE AFTER HOURS MESSAGES

1. AFTER HOURS PHONE MESSAGE with Answering Service Back-Up

   Thank you for calling Dr. ___________at ___________. If this is a life-threatening emergency, please hang up and call 9-1-1 or go to the nearest emergency room. Our office is now closed. Our regular office hours are_________________. If you are experiencing an urgent medical condition that cannot wait for regular office hours, please press zero (0) or wait on the line for our answering service."

   24 Answering Service greeting:
   "Thank you for calling Dr. _____________'s answering service. If this is a life-threatening emergency, please hang up and dial 9-1-1 or go to the nearest emergency room. Please hold, an operator will answer your call momentarily."

2. AFTER HOURS PHONE MESSAGE with On-Call MD Page as Back-Up:

   Thank you for calling Dr. ___________at ___________. If this is a life-threatening emergency, please hang up and call 9-1-1 or go to the nearest emergency room. Our office is now closed. Our regular office hours are_________________. If you are experiencing an urgent medical condition that cannot wait for regular office hours, please press zero (0) to page the on-call physician. A physician will return your call within 30 minutes."

Claim Adjustment/PDR Request Form

☐ Please process as a routine claim adjustment request.
☐ Please process as a Provider Dispute.

	Name of person submitting appeal
	Provider/Practice Name
	Mailing Address
	City, State, Zip

Complete this form and **attach copy of Provider Remittance Advice (PRA)** showing claim to be adjusted and mail to John Muir Health Physician Network, P. O. Box 31255, Salt Lake City, UT 84131.

☐ **Claim denied for non-eligibility**; current eligibility information attached.
☐ **Payment amount incorrect.** (Cap vs. FFS, not contracted rate, etc.)

Describe:

☐ **Disagree with Claim Check coding edits.**

Describe:

☐ **Other**.

Describe:

☐ **Timely filing denial**.

Describe why the claim was not submitted timely. Use extra sheets if needed.

For timely filing appeals, please attach the documentation listed below:
A copy of the remittance advice with the Claim # circled.
A copy of notification from another IPA or health plan specifying that the claim you originally sent to them is the responsibility of the John Muir Health Physician Network or a copy of an EDI clearing house transmission acknowledgement indicating the claim was successfully transmitted.

John Muir Health Physician Network Adjustment Response
☐ Adjustment request denied. Refer to attached documents for additional information.
☐ Adjustment approved. Claim reprocessed and detail will be reflection on remittance advice.
Reviewed by:

Responses to Provider Disputes will be in compliance with AB1455 requirements, including acknowledgement and final resolution letters.

AUTHORIZATION REQUEST/REFERRAL TO IN-NETWORK SPECIALIST FORM

Please note, this form should only be completed if you are currently not using Epic, PlanLink or on Community Connect.

DATE:

Referring MD Name:____________________**NPI:**__________**Phone#:**__________**Fax#:**__________

Patient Name:____________________**DOB**__________**Phone #:**__________

ID#__________**Address:**____________________**City:**__________**ZIP:**__________

☐ Aetna ☐AHMC ☐ Blue Cross ☐Blue Shield ☐Central Health Plan☐ Cigna ☐Health Net ☐ United Healthcare☐John Muir Healthy EPO
☐CanopyCare HMO ☐Doctors Plan EPO ☐ Canopy Health Net Blue & Gold ☐Canopy Health Net SmartCare ☐Canopy United Healthcare

AUTHORIZATION REQUEST

Complete this section when requesting a referral or service that requires authorization and submit the form to the Care Management Dept
Fax: (925) 952-2865 Phone: (925) 952-2887

Routine Request ☐ Determination will be made within 5 working days of receipt of all clinical information
Urgent Request ☐ Determination will be made within 72 hours of receipt of all necessary information for the request

The following is to be checked ONLY when the time frame of the standard decision making process could seriously jeopardize the life or health of the member or could jeopardize the member's ability to regain maximum functionality MEDICALLY Urgent Request ☐

Diagnosis (Narrative):	ICD 10 (list all and include 4th & 5th digit when indicated)
Findings/Treatment to date (please attach all pertinent information)	
NOTE: SUBMISSION OF DETAILED CLINICAL INFORMATION WILL ENABLE REQUESTS TO BE PROCESSED IN A MORE TIMELY MANNER	
Requested Service (If OON or non-contracting provider is being requested, please list reason service cannot be provided in network) **If this is a patient request, please check this box** ☐	CPT (List all)
Requested facility/provider name:	Check Appropriate box: [ ] in-patient [ ] out-patient [ ] Assist. Surgeon [ ] other
Requesting Provider Signature:	Phone #: Fax #:

REFERRAL TO IN-NETWORK SPECIALIST

Complete this section for referral to a John Muir Health Physician Network specialist when prior authorization is NOT required and fax the form to the specialist.

Referral To (name of specialist):____________________**Phone #:**__________ **Fax#:**__________

Diagnosis:____________________ **Reason for Referral:**____________________

 # Times seen by PCP for this problem:_____ **Treatment Rendered/Studies Completed (attach reports):**__________

Check here if for testing only:_____ **Test Requested:**____________________

Comments: ______________________________

Referring MD Signature:____________________

Specialist, Please Note: The time frame in which you can see this patient is NOT limited. You have a standing authorization to see the patient for as long you feel that it is necessary, without having to obtain additional referrals from the patient's PCP.

Notice: This form is not a guarantee of payment. Charges for non-covered services or for services rendered to patients whose coverage is no longer in effect may be the patient's responsibility.

Modified: January 2025

AUTHORIZATION REQUEST – EXACT SCIENCES/COLOGUARD TEST

Please note, this form should only be completed if you are currently not using Epic, PlanLink or on Community Connect.

Submit the form to the Care Management Department
Fax: (925) 952-2865 Phone: (925) 952-2887

DATE:

Referring MD Name:________________________________**NPI:**________________**Phone#:**_________________**Fax#:**________________

Patient Name:_____________________________________**DOB**_____________________**Phone #:**_________________________

ID#__________________**Address:**___________________________________**City:**______________________**ZIP:**_________________

☐ **Aetna** ☐ **Blue Cross** ☐ **Blue Shield** ☐ **Central Health Plan** ☐ **Cigna** ☐ **Health Net Commercial** ☐ **John Muir Healthy EPO**

☐ **United Healthcare Commercial** ☐ **CanopyCare HMO** ☐ **Doctors Plan EPO** ☐ **Canopy Health Net Blue & Gold**
☐ **Canopy Health Net SmartCare** ☐ **Canopy United Healthcare** ☐ **AHMC (Seton Employees)**

Please answer the following questions.

1. **Is the patient 50 years or older? Yes** ☐ **No** ☐
2. **In the last 10 years, did the patient have a Colonoscopy? Yes** ☐ **No** ☐
3. **In the last 3 years, has the patient had a positive Cologuard Test? Yes** ☐ **No** ☐
4. **In the last 3 years, has the patient had a negative Cologuard Test? Yes** ☐ **No** ☐
5. **In the past 12 months, did the patient have a positive FIT or FOBT test? Yes** ☐ **No** ☐
6. **In the past 12 months, did the patient have a negative FIT or FOBT test? Yes** ☐ **No** ☐
7. **Does the patient have a history of Colorectal Cancer or Advanced Adenoma? Yes** ☐ **No** ☐

Notice: This form is not a guarantee of payment. Charges for non-covered services or for services rendered to patients whose coverage is no longer in effect may be the patient's responsibility.

Care Coordination and Resource Services Referral
Ph: 925-988-7505 Fax: 925-952-2726

DATE: ____________

PATIENT DEMOGRAPHICS		
Last Name:	First Name/MI:	□ Male □ Female
Insurance:	MRN:	DOB:
Address: City/Zip:		
Phone Number: Home:	Cell:	
Other:		
Diagnosis:		
Presenting Problem:		
Significant Other/Relationships:		
Preferred Language: □ English □ Spanish □ Other:		

REFERRAL SOURCE	
Referral Source: Name: Ph: Fax:	PCP Name: Ph: Fax: Same as person making the referral

REFERRAL TO RN	
□ Chronic Disease Management	□ Multiple Hospitalizations
□ Medication Issues	□ New Diagnosis
□ Other:	

REFERRAL TO SOCIAL WORKER	
□ Decline in Ability to Care for Self	□ Elder Abuse/Neglect
□ Long Term Planning	□ Inappropriate/Dangerous Living Situation
□ Cognitive Decline	□ Other:

REFERRAL TO NAVIGATOR FOR RESOURCE(S)	
□ Transportation	□ Counseling
□ Need for Caregiver	□ Placement
□ Food Insecurity	□ JMH Navigation
□ Other:	

Rev. 3/2025

Contracted Laboratory/Pathology Vendors

Below is a list of contracted Lab and Pathology vendors that should be utilized for John Muir Health Physician Network (JMHPN) members. Vendors that are not listed below or on the JMHPN Ancillary Roster will require prior authorization from the JMHPN Utilization Department.

LABORATORY SERVICES

- LabCorp

SPECIALTY LABS THROUGH LABCORP

- Acupath Diagnostic Laboratories, Inc. (Sub-specialized anatomic pathology services)
- Dianon Systems, Inc. (Expertise in dermatopathology, gastrointestinal pathology, hematopathology, and uropathology)
- Esoterix Genetic Lab (BRCA testing, Genetic Testing)
- Litholink (24-hour urine tests, Kidney Stone prevention)
- MedTox Lab (Toxicology, drug screening)
- Monogram Biosciences (HIV resistance testing, HCV specialty diagnostic testing, Oncology receptor testing)
- Personal Genome Diagnostics, Inc. (“PGDx) (Genetic Testing)

PATHOLOGY SERVICES

- Contra Costa Pathology Associates
- Yosemite Pathology Medical Group Inc.

CANOPY HEALTH OPERATIONAL GUIDE

Canopy Health Network of Medical Group/IPA's and Hospitals

CANOPY NETWORK		
County	**Medical Group/IPA**	**Hospitals**
Alameda	Hill Physicians	Alameda/Highland/San Leandro/Washington/UC Benioff Oakland
Contra Costa	John Muir Health Physician Network	John Muir Health Medical Centers – Walnut Creek & Concord/ San Ramon Regional Medical Center
San Francisco	Hill Physicians	UCSF Medical Center/ St. Francis / St. Mary's / SF General Hospital (OB only)
San Mateo	Hill Physicians	Sequoia Hospital
Santa Clara	SCCIPA	Regional Medical Ctr of San Jose / Good Samaritan
Santa Cruz	Dignity Health	Dominican Hospital
Sonoma/Napa	Providence Medical Network	Providence Santa Rosa Memorial Hospital, Petaluma Valley Hospital, Providence Queen of the Valley Hospital, and Healdsburg Hospital

CONTACT INFORMATION for Canopy Health Participating Medical Group/IPA's

Medical Group/IPA	Customer Service Number	Website
John Muir Health Physician Network	(925) 952-2887 or toll free (844) 398-5376	www.johnmuirhealth.com
Dignity Health Medical Network	(831) 465-7800 or toll free (866) 875-3373	www.dhmn.org/santacruz
Hill Physicians Medical Group	(800) 445-5747	www.hillphysicians.com
Santa Clara County IPA	(800) 977-7332	www.sccipa.com
Providence Medical Network	(800) 627-8106	www.providence.org

Health Plans that fall under Canopy Health:

- Canopy Health Net CanopyCare HMO
- Canopy Health Net Blue & Gold HMO
- Canopy UnitedHealthcare SignatureValue Harmony HMO
- Canopy Health Net SmartCare Commercial HMO
- Canopy UnitedHealthcare SignatureValue Advantage Commercial HMO
- Doctors Plan EPO - A unique EPO product co-branded by United Healthcare (UHC) and Canopy Health

EPO OVERVIEW

EPO Network:

- Includes many of the Canopy Health Network of providers (check UHC online provider directory to confirm)

EPO Claims:

- Submitted directly to United Healthcare and are processed according to the direct contracts between United Healthcare and providers
- Submitted directly to United Healthcare and are processed according to the direct contracts between United Healthcare and providers
- Fee-for-service payments to providers are based on direct contracts with UHC

Utilization Management:

- Providers will contact John Muir Health Physician Network for most required prior authorization requests or care management needs
- EPO Prior auth list is consistent with HMO prior auth list
- Patients will receive a welcome call and high touch care management engagement for those in higher risk categories or who have received emergent services

Product:

- EPO sold to Fully Insured and Self-Insured employers
- PCP selection is required
- Specialist referrals are NOT required but encouraged

Canopy Health Electronic Claims Submission Information for certain facility/technical services:

Clearinghouse Name	Phone Number	Payer ID
Office Ally	866-575-4120	CAPMN
Emdeon	877-363-3666	95399
MDX	562-256-3800	CAPMN

Canopy Health Contact Information:

- Canopy Health Provider Services: (844) 315-4645
- Claims Department: (844) 315-4645 or (818) 461-5055
- Canopy Health website: www.canopyhealth.com