



scan™

2026

PROVIDER OPERATIONS MANUAL

CALIFORNIA



Summary of 2026 Changes

SCAN updates its Provider Operations Manual (POM) every year. Below is a summary of changes for the California 2026 POM edition.

Chapter 2: Network Management - Language updated to provide new email addresses.

Care Management - Language updated to provide new email address.

Utilization Management - Language added to provide new email address.

Community Supports - Language updated to provide new email address.

Chapter 3: Verifying Member Eligibility - Electronic Eligibility and Benefit Inquiry & Response (EDI 270/271) (table) - Language updated to provide new phone number.

Enrollment Area and Primary Care Physician Selection – Language updated for clarification purposes.

Dates of Coverage - Language updated for clarification purposes.

Chapter 4: Chronic Condition Special Needs Plan (C-SNP) Diagnosis Verification - Language updated and added for clarification purposes and to provide additional guidance.

Additional Medi-Cal and/or Supplemental Benefits - Language updated and added for clarification purposes and to provide additional guidance.

Behavioral and Mental Health Referrals - Language added to provide additional guidance.

Behavioral and Mental Health Referrals – Validated Screening Tools (table) - Language added to provide additional guidance.

Chimeric Antigen Receptor (CAR) T-cell Therapy - Language updated to provide clarification and additional guidance.

Hospice Medication Management – Value Based Insurance Design (VBID) language removed as is no longer applicable.

Chapter 5: Organizational Changes – Language added to provide new guidance.

Credentialing – Direct Credentialing (Facilities) - Language added to provide new guidance.

Credentialing Process and Nondiscrimination - Language added to provide new guidance.

Timeline for Re-Credentialing - Language updated and added to provide new guidance.

Provider Appeals - Language added for clarification purposes and to provide additional guidance.

Provider Change - Termination of Primary Care Physician (PCP) or Behavioral Health Provider (table) - Language updated for clarification purposes.

Provider Change - Termination of Other Specialist Providers (table) - Language updated for clarification purposes.

Provider Change - Termination of Facility (table) - Language added to provide new guidance.

Member Notification (Provider Terminations) - Language updated for clarification purposes.

Provider Directory - Language updated and added for clarification purposes and to provide additional guidance.

Access to Care Standards and Hours of Operation - Language added to provide additional guidance.

Summary of 2026 Changes

SCAN Health Plan 2026 Provider Operations Manual - California

Summary of 2026 Changes

SCAN updates its Provider Operations Manual (POM) every year.
Below is a summary of changes for the California 2026 POM edition.

Access to Care Standards and Hours of Operation – Accessibility Standards (table) - Language updated and added for clarification purposes and to provide additional guidance.

Appeals, Grievances, and Payment Disputes - Language added to provide additional guidance.

Transgender, Gender Diverse or Intersex Cultural Competency Training Program and Provider Directory Requirements - Language added to provide new guidance.

Disruptive Member Issues - Language added to provide additional guidance.

Skilled Nursing Facilities - Language added to provide new guidance.

Chapter 6: Immunotherapies - Language updated to provide clarification and additional guidance.

Peer Review Requests - Language updated to provide clarification and additional guidance.

Timeliness of Pre-Service Organization Determinations (Part C) (table) - Language updated to provide clarification and additional guidance.

Medi-Cal and Supplemental Benefits - Language added to provide new email address.

Notice Requirements – Extension Needed for Additional Information (table) - Language updated to provide clarification and additional guidance.

Chapter 7: SCAN Care Management Programs – Program Description (table) - Language updated to provide clarification and additional guidance.

Chapter 9: Member Appeals and Grievances - Language added to provide additional guidance.

Member Appeals and Grievances – Time Frames (table) - Language updated and added for clarification purposes and to provide additional guidance.

Member Appeals and Grievances – To Render Decision and Notify Member and Provider – Standard (table) - Language updated and added for clarification purposes and to provide additional guidance.

Member Appeals and Grievances – To Render Decision and Notify Member and Provider – Expedited (table) - Language updated and added for clarification purposes and to provide additional guidance.

Part C & D Level 1 Appeal Adjudication Timeframes in accordance with CMS requirements (table) – New language added for clarification purposes and to provide additional guidance.

Requesting Reconsideration/Redetermination on Behalf of a Member - Language updated and added for clarification purposes and to provide additional guidance.

State Fair Hearing Rights – Language updated to provide updated phone number and mailing address information.

Chapter 10: Credentialing Committee - Language added to provide new guidance.

Audit Summaries - Language updated to provide updated email address information.

Credentialing Oversight (Providers delegated for credentialing activities) – Scope of Audit (table) - Language updated and added for clarification purposes and to provide additional guidance.

Summary of 2026 Changes

SCAN updates its Provider Operations Manual (POM) every year.
Below is a summary of changes for the California 2026 POM edition.

DHCS Facility Site Review (FSR) and Medical Record Review (MRR) – Scope of Audit (table) - Language updated and added for clarification purposes and to provide additional guidance.

Chapter 11: Mail Order Pharmacy Program - Language updated to provide updated guidance.

Coverage Determination Process - Language added to provide email address and mailing address information.

Changes to Prescription Drug Benefit - Language updated to provide updated guidance.

Opioids - Language updated for clarification purposes.

Part D Vaccines - Language updated for clarification purposes.

Part D Insulin - Language updated for clarification purposes.

Part B Prescription Drugs - Language added for clarification purposes.

Hospice and End Stage Renal Disease (ESRD) Part D Exclusions - Value Based Insurance Design (VBID) language removed as is no longer applicable.

Hospice Medications - Value Based Insurance Design (VBID) language removed as is no longer applicable.

End Stage Renal Disease (ESRD) Prospective Payment Program – Drug Category (table) - Language updated and added for clarification purposes and to provide additional guidance.

End Stage Renal Disease (ESRD) Prospective Payment Program - Language updated and added for clarification purposes and to provide additional guidance.

Chapter 12: Wire Transfers (Capitated Providers Only) – Statement of Domestic Stock, Articles of Incorporation, or Service Agreement language removed.

Chapter 13: Claims - Language added to provide new guidance.

Guidance for Providers Delegated for Claims Activities - Language added to provide new guidance.

Chapter 14: Submit Complete and Accurate Encounter Data in the Proper Format - Language updated for clarification purposes.

Submit Timely Encounters - Language updated for clarification purposes.

Chapter 15: Improper Payments – Language added to provide new guidance.

Appendix B: Provider Network - Language added to provide new guidance.

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Chapter 1: Welcome and Overview

About SCAN

*Our **mission** is simple: Keeping Seniors Healthy and Independent. That's been our mission since we were founded in 1977.*

It started when a group of senior activists in Long Beach, California got together, determined to improve access to the care and services they needed so they could stay as independent as possible.

They brought together experts in medicine, gerontology, psychology, and social services and formed the Senior Care Action Network, a not-for-profit health plan for people with Medicare.

Now known as SCAN, we are still not-for-profit. And we are still dedicated to helping our Members live how and where they choose, with the assistance they might need as they get older.

To learn more about SCAN, please visit our website:

<https://www.scanhealthplan.com>

Welcome

Congratulations and welcome to a new year with the SCAN Health Plan (SCAN) family! We look forward to working with you to meet high quality of care standards and provide and manage cost-effective health care for our Members.

About this Manual

This manual outlines your responsibilities as a provider participating in the SCAN network of providers. As indicated in your provider contract with SCAN, you are obligated to comply with the terms of this manual.

This manual is updated annually and is available on our website at <https://www.scanhealthplan.com//provider-operations-manuals>

The use of the term “provider” in this manual refers to individuals and entities contracted with SCAN to provide health care or ancillary services to Members. “Provider” shall also mean any subcontractor contracted with a “provider” to provide services to Members. The use of the term “group” or “medical group” or “provider group” in this manual refers to a provider that is a medical group or IPA. All capitalized terms are defined in accordance with Medicare rules unless a different definition is stated in this manual or in your contract with SCAN.

Non-Interference

Nothing contained in this manual is intended or shall be construed to interfere with the professional relationship between a Member and his/her physician(s), including the physician’s ability to discuss treatment options with the Member or advocate for the Member in his/her Grievances relating to services. Providers likewise may not prohibit Members from completing SCAN surveys and/or otherwise expressing their opinion regarding services received from providers.

Medicare Advantage

SCAN is a Medicare Advantage Organization (MA Organization) subject to the requirements of the Medicare Advantage (MA) Program as administered by the Centers for Medicare & Medicaid Services (CMS). As such, neither

SCAN nor its delegates represent Medicare directly. Any reference to or use of the Medicare name, CMS logo, and products or information issued by the Federal Government, including the Medicare card image, is permitted only with authorization from CMS. SCAN benefit plans also include Medicare Part D prescription drug coverage (also referred to as “MA-PD Plans”). All providers are subject to Medicare Advantage plan requirements including Part D requirements. In order to be a SCAN provider, you must be eligible for payment by Medicare. This means that to be in the SCAN network you cannot be excluded from participation in any federal health care program and that you have not opted out of the Medicare program. See [Appendix A: Select CMS Requirements](#) for select requirements.

Medi-Cal

SCAN also contracts with the California Department of Health Care Services (DHCS) to provide health care services to eligible Medi-Cal recipients in designated counties. Services provided to these Members, also referred to as dually enrolled or Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP) Members, are subject to Medi-Cal requirements as administered by the DHCS. (See [Appendix B: Select DHCS Requirements](#) for select program requirements). For more information on Medi-Cal covered benefits see: [DHCS Medi-Cal Provider website](#) or [SCAN Medical Policy](#).

Benefit Plans - Medicare

All SCAN products include the full benefits of Original Medicare (Part A and Part B) and pharmacy drug (Part D) coverage. Products may also include additional benefits beyond Original Medicare. These additional benefits are Supplemental Benefits. Supplemental Benefits include Medicare Mandatory Supplemental Benefits and Optional Supplemental Benefits. Examples are vision and hearing coverage, **as well as additional benefits for the chronically ill**. See [Chapter 4: Physician Responsibilities](#) for section entitled Additional Medi-Cal and/or Supplemental Benefits.

Benefit Plans - Special Needs Plans

SCAN offers Special Needs Plans (SNPs), which are Medicare Advantage coordinated care plans specifically designed to provide targeted care and limit enrollment to special needs individuals. See <https://www.cms.gov/SpecialNeedsPlans/html>.

SCAN offers the following SNP plans:

- Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) serving Members in designated counties, who are at least 65 years of age, dually eligible and dually enrolled with SCAN.
- Chronic Condition Special Needs Plans (C-SNP) serving Members with specific severe or disabling chronic conditions including cardiovascular disorders, chronic heart failure, diabetes mellitus, and end-stage renal disease (requiring any mode of dialysis).
- Institutional Special Needs Plan (I-SNP) serving Members who live in institutions or are institutional equivalent (living in the community, i.e., in Assisted Living) and require

an institutional level of care. Members must meet nursing facility level of care criteria and reside in designated counties.

Each SNP type has a Model of Care (MOC) that outlines the SNP population, care coordination provided, provider network, quality measurement and performance to ensure that each member's unique needs are identified and addressed through the plan's care management practices.

Annual SNP Model of Care (MOC) training is a regulatory requirement for all providers who serve SNP members.

For a summary of SNP MOC requirements visit <https://snpmoc.ncqa.org>. Other references include: Medicare Managed Care Manual Chapter 5 - Quality Assessment and Chapter 16b – Subchapter B - Special Needs Plans at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326> and CMS Model of Care (MOC) at [Model of Care \(MOC\) | CMS](#)

Providers who serve SNP members are required to complete annual training on the SNP Model of Care. See 42 C.F.R. § 422.101(f)(2)(ii). This requirement may be satisfied by completing SCAN's training or another training program that sufficiently covers all required topics. See SCAN website for [Special Needs Plan Model of Care Training](#).

Review the applicable Summary of Benefits, Evidence of Coverage (EOC), and formulary documents available online at <https://www.scanhealthplan.com//plan-materials> for more information.

Participation in Benefit Plans

Providers are deemed participating in **all benefit plans** associated with their participating networks and may not terminate participation in an individual benefit plan. Providers may contact Provider Relations Lead at ProviderRelations@scanhealthplan.com

Refer to [Chapter 4: Physician Responsibilities](#) for further information related to C-SNP diagnosis verification.

Chapter 2: Key Contacts Resource Guide

SCAN Resources for Providers	
SCAN website includes, but is not limited to, the following information/resources Online: https://www.scanhealthplan.com	
<p>Provider Enrollment/Information</p> <ul style="list-style-type: none"> • <i>Access and enroll in the SCAN Provider Portal</i> • <i>Welcome Packet/ Quick Reference Guides</i> • <i>Report Fraud, Waste and Abuse</i> • <i>General Information for Office Staff</i> <ul style="list-style-type: none"> ○ <i>SCAN CMS Approved Letter Templates</i> ○ <i>SCAN Case Management Program Fact Sheets</i> ○ <i>Privacy Policy</i> • <i>Health Education</i> <ul style="list-style-type: none"> ○ <i>Cultural Competency Training Resources</i> ○ <i>Care and Communication Tips</i> ○ <i>Patient Handouts</i> • <i>Provider Directory (search)</i> • <i>Multi Cultural Resources and Interpreter Services</i> • <i>Provider Compliance Resources</i> <ul style="list-style-type: none"> ○ <i>Code of Conduct</i> ○ <i>Report a Compliance Issue</i> • <i>Provider Operations Manuals</i> • <i>Plan Materials</i> <ul style="list-style-type: none"> ○ <i>Evidence of Coverage (EOCs)</i> ○ <i>Benefit Highlights</i> ○ <i>Printable Provider Directories</i> ○ <i>Claims and Reimbursement Request Forms</i> ○ <i>Enrollment Forms</i> 	<p>Quality Improvement Program</p> <p><i>Clinical Guidelines & Practice Tools</i></p> <ul style="list-style-type: none"> • <i>Available SNP resources/training</i> <ul style="list-style-type: none"> ○ <i>SNP Model of Care (MOC)</i> ○ <i>SNP Plan Codes</i> • <i>Available Training resources:</i> <ul style="list-style-type: none"> ○ <i>General Compliance</i> ○ <i>Fraud, Waste, and Abuse (FWA)</i> ○ <i>Onboarding</i> <p>Pharmacy (Find a Pharmacy)</p> <ul style="list-style-type: none"> • <i>Formulary Drug (search)</i> • <i>Pharmacy (Benefits and Information)</i> <p>Eligibility and Benefit Information</p> <ul style="list-style-type: none"> • <i>Eligibility and Benefit Verification</i> • <i>Resources for Caregivers and Family Members (Community Connections)</i> <p>Claims Information</p> <p>(see next section 'SCAN Provider Portal' for more Claims information)</p> <ul style="list-style-type: none"> • <i>Processed Claim Inquiry</i> • <i>Provider Disputes and Appeals information and form (Claims)</i> • <i>Claim Payment and Electronic Remittance Advice (ERA) Information</i> • <i>Claims Overpayment and Recovery information and forms</i> • <i>Claim Submission Information</i> • <i>Provider Claim Talking Points</i> <ul style="list-style-type: none"> ○ <i>Reason Codes on Remittance Advice</i> ○ <i>Carve Out Benefits</i> ○ <i>FAQs</i>

SCAN Resources for Providers

SCAN Provider Portal* includes, but is not limited to, the following information/resources

Online: <https://www.scanhealthplan.com/providers>

(Disclaimer: SCAN Provider Portal available content may vary depending on which Provider Portal accessed (Healthx vs. Availability))

- | | |
|---|---|
| <ul style="list-style-type: none"> • Encounters Module (Encounter Data Portal) • Eligibility Module: <ul style="list-style-type: none"> ○ Verify Member Eligibility and Benefits. Also, print Member eligibility with confirmation date ○ Obtain maximum out of pocket (MOOP) amount and if MOOP has been met ○ Obtain appropriate address to submit claims ○ Member Benefits Services FAQs ○ Eligibility Inquiry Guide • Claims Module: <ul style="list-style-type: none"> ○ Lookup claim status for claims processed directly by SCAN ○ Claim Inquiry Guide • Delegated Entities Reports if applicable: <ul style="list-style-type: none"> ○ 5 Star Risk adjustment and HCC ○ Capitation ○ Eligibility and New Member ○ PCPASAP/IHA ASAP ○ Pharmacy ○ Risk Pool | <ul style="list-style-type: none"> • Resources and Guidelines Module: <ul style="list-style-type: none"> ○ Annual SCAN Benefit Grids ○ Provider Quick Reference Guide <i>(Eligibility/Benefits/Claims information)</i> ○ Processed Claim Inquiry <ul style="list-style-type: none"> ▪ Ask questions about claim processed directly by SCAN ▪ Obtain MOOP Accumulator amount ○ Provider Disputes and Appeals information and form <i>(Claims)</i> <ul style="list-style-type: none"> ▪ Check status of Provider Dispute or Non-Contracted provider appeal ○ Claim Payment and Electronic Remittance Advice (ERA) ○ Claim Overpayment and Recovery information and form ○ Provider Claim Talking Points and FAQs ○ Prior Authorization Requirements ○ Audit and Oversight Provider Resources ○ SCAN Provider Newsletter |
|---|---|

*** SCAN contracted delegated entities, if you are an employee of a SCAN direct-contracted delegated entity, please contact your provider group administrator to grant access or email SCAN Provider Portal Admin to confirm group administrator at ProviderPortal@scanhealthplan.com**

**Delegated entities are required to notify SCAN when there is a change in designated SCAN Provider Portal Administrator for your organization. Please submit request to change Portal Administrator to ProviderPortal@scanhealthplan.com.*

SCAN Resources for Providers	
Network Management	
Email: ProviderRelations@scanhealthplan.com	
<ul style="list-style-type: none"> • For general Provider Relations inquiries • Access/availability questions • Assistance with in-network specialists, Medicare-approved facilities, or other providers • Requests for corporate changes 	
Email: OTOrequest@scanhealthplan.com	
<ul style="list-style-type: none"> • For one time only requests 	
Email: ProviderUpdates@scanhealthplan.com	
<ul style="list-style-type: none"> • Provider roster submissions • Add or terminate providers 	
Email: NetworkManagementAdministration@scanhealthplan.com	
<ul style="list-style-type: none"> • For all other general inquiries 	
Email: ProviderContracting@scanhealthplan.com	
<ul style="list-style-type: none"> • If you are interested in joining SCAN’s network, please complete the <i>Letter of Interest (LOI) form</i>. LOIs will be reviewed and responded to within 60 days. • General contracting inquires 	
Provider Information Line	
Phone: (877) 778-7226	
<ul style="list-style-type: none"> • Verify eligibility and/or benefit information via IVR, automatic voice response and/or faxback* • Submit Alternative Format Selection for Members 	<ul style="list-style-type: none"> • Hospital Authorizations • Interpreter services (24/7) • Virtual Remote Interpretation (VRI) (See <i>Chapter 5: Network Standards</i>)
*For immediate assistance, log into the SCAN Provider Portal (to create an account see the SCAN Provider Portal section in this chapter) and/or use Electronic Data Interchange (EDI).	
Care Management	
Email: SCANCC_CM@scanhealthplan.com	
<ul style="list-style-type: none"> • Case management Questions/Support 	Refer a Member*
* Referrals may be emailed to CMReferral@scanhealthplan.com	

SCAN Resources for Providers	
Utilization Management	
Email: UMCCMDEPARTMENT@scanhealthplan.com Phone: (800) 250-9048 (Option 2) Fax: (800) 411-0671	
<ul style="list-style-type: none"> Organization Determination/Coverage guidance DOFR/Risk clarification Authorizations for services to SCAN contracted entities (Refer to Informational Letter – Carve Out) 	<ul style="list-style-type: none"> Report an admission Hospital Authorizations Report an event (See Chapter 5: Network Standards – Plan Notification (Member Events))
Claims	
<ul style="list-style-type: none"> Verify claims status via SCAN's Provider Portal. Register at www.scanhealthplan.com/providers Request copies of a remittance advice, confirm payments of a check, electronic, or virtual card payment, or set up payment preference, please visit https://www.providerpayments.com or call (888) 984-5025 Submit claims electronically by signing up with SCAN's electronic clearinghouse, Office Ally, directly at (360) 975-7000 (Option 1) or visit https://cms.officeally.com/ For all other claims questions see Chapter 13: Claims 	
Encounter Data Team	
Email: Encounters_Operations@scanhealthplan.com	
<ul style="list-style-type: none"> Submit Alternative Submission Files (ASM) using the Health Industry Collaboration Effort (HICE) format Encounter data portal questions 	<ul style="list-style-type: none"> Audit, data reconciliation and error resolution issues and questions Risk Adjustment Processing System (RAPS) and Encounter Data Processing System (EDPS) Questions
Pharmacy Benefits	
Express Scripts (Pharmacy Benefits Manager (PBM))	
For Coverage Determinations, 24/7:	(844) 424-8886; Fax (877) 251-5896 TTY (800) 716-3231
For mail order prescriptions:	(888) 327-9791 Fax (800) 837-0959 Address: Express Scripts Mail Pharmacy Service, PO Box 66566, St. Louis, MO 63166-6566
To request to add a drug to the SCAN Part D Formulary:	Mail request to: SCAN Health Plan, Attn: Sr. Director, Pharmacy and Formulary Operations, 3800 Kilroy Airport Way, Suite 100, Long Beach, CA 90806

SCAN Resources for Providers	
Enroll in the Mail Order Program	
Online at: www.StartHomeDelivery.com or mail a completed application (available from Member Services) to: Express Scripts, Mail Pharmacy Service at PO Box 66566, St. Louis, MO 63166-6566.	
Report Fraud, Waste, or Abuse	
Email: FraudWaste&AbuseProg@scanhealthplan.com	
Phone: (877) 863-3362 (anonymous)	
Online: https://www.scanhealthplan.com/scan-resources/report-an-issue/fraud-information-and-resources	
Report a HIPAA Breach	
Email (preferred): PrivacyOffice@scanhealthplan.com	
Phone: (877) 863-3362	
Certified mail:	
SCAN Health Plan, Privacy Office, 3800 Kilroy Airport Way, Ste 100 Long Beach, CA 90806	
Initiate an Appeal on Behalf of a Member	
Online (Part D only): File an Appeal	
Phone: (800) 559-3500	

SCAN Resources for Members	
Member Services	
Phone: (800) 559-3500	
<ul style="list-style-type: none"> • Resolve service issues or claims issues • Assistance with the Grievance or Appeal Process • Get a Member ID card • Questions and information • Address and phone number changes • Supplemental Benefit Information • Benefits and co-payments • Pharmacy benefits 	<ul style="list-style-type: none"> • Plan materials and changes • Provider directory • Select a physician or request to transfer physicians • Translation/interpreter services • Virtual Remote Interpretation (VRI) (See Chapter 5: Network Standards) • Caregiver support • Community resource assistance • Information regarding clinical trials
Transportation	
Phone: (844) 714-2218	
SCAN Health Plan's routine transportation service is a supplemental benefit and not covered by Original Medicare. The primary purpose of routine transportation is to provide non-emergency transportation to medically necessary services. All transportation, including wheelchair and gurney/stretchers transports, must meet SCAN criteria. The routine transportation benefit is not available to all SCAN plans. Refer to applicable SCAN Evidence of Coverage (EOC) to determine if routine transportation is covered. Each one-way trip may not exceed 50-75 miles for eligible Medicare passengers. Please refer to your EOC to review the maximum number of miles available to your plan.	

SCAN Resources for Members

Non-Medical Transportation (NMT) is available in taxis, sedans, and ride share vehicles for ambulatory passengers. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated.

Private conveyance using a personal vehicle may be used when no other method of transportation is available.

- This form of transportation is only available to passengers enrolled in SCAN Connections and SCAN Connections at Home and must be authorized in advance.

Non-Emergency Medical Transportation (NEMT) covers transportation provided in wheelchair vans, gurney/stretchers transports, and Basic Life Support (BLS) vehicles.

- NEMT trips exceeding 75 miles (one-way) require prior authorization from SCAN Utilization Management as well as a Physician Certification Statement (PCS) signed by a physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender.
- SCAN will provide authorization for NEMT for the duration of the recurring appointments for SCAN Connections and SCAN Connections at Home Members for the remainder of the calendar year.

To schedule transportation:

To ensure timely access, transportation arrangements must be made no less than twenty-four (24) hours in advance (not including weekends) for a passenger vehicle and no less than forty-eight (48) hours in advance for wheelchair service (not including weekends). Rides requiring door-to-door service or gurney/stretchers vehicles require no less than seventy-two (72) hours in advance (not including weekends).

Members should arrive no later than 15-minutes prior to their scheduled appointment. For this reason, members are requested to arrange scheduled pick-ups at least one-hour prior to the appointment time.

Transportation from an acute care setting, i.e., inpatient hospital, skilled nursing facility, inpatient psychiatric facility, must be provided within a three (3) hour time frame from the time of discharge. Rides must be cancelled in advance if the transportation is no longer needed. If a ride is not cancelled before the driver has been dispatched, the ride will be counted towards the Member's annual ride limit.

For curb-to-curb, door to door, and other available services please refer to Member's Evidence of Coverage (EOC) available online at:

<https://www.scanhealthplan.com//plan-materials> for more information.

“Will Call” Rides: “Will Call” rides are scheduled when a pick-up time is not provided at the time of the reservation. This is usually done for medical appointment return pickups as appointments may run longer than expected. When the Member is ready for pick-up, call **“SCAN Transportation” at 1-844-714-2218** to schedule the pick-up for the ride home. Will call rides may take up to **one (1) hour** for the ride to reach the pick-up location. Successful pick-ups require Members to be waiting **curbside at the front main entrance** of the address unless other directions were provided at the time of reservation.

SCAN Resources for Members

Note: To check on an already scheduled ride or if the driver does not arrive in 10 minutes from the time of your scheduled pick up, please call SCAN Transportation at **1-844-714-2218** to dispatch another driver. A new pick-up time will be provided.

Additional Resources for FIDE-SNP (Medicare/Medi-Cal) Members

Special Needs Plan Team

Phone: (866) 722-6725 (TTY users call: 711)

- Education related to Medicare and Medi-Cal benefits, navigation through the managed care system, and Grievance/Appeal process and state fair hearing process
- Facilitation of the Initial Health Appointment
- Assistance with coordination of transportation, claims/billing issues, address, and phone number changes, Long Term Services and Supports (LTSS) benefits, and PCP/medical group changes

Long Term Services and Supports (LTSS)

Email: ILP_OOD@scanhealthplan.com

Phone: (800) 887-8695

- LTSS – FIDE SNP service questions
- Community Based Adult Services/Adult Day Health Care
- Bathroom DME (non-Medicare covered)
- Home delivered meals

LTSS Supply Line

Phone: (888) 353-7226

- Incontinence supplies/nutritional supplements

Care Management

Email: SCANCC_CM@scanhealthplan.com

- See *Chapter 7: Care Management*

Utilization Management

Email: UMCCMDEPARTMENT@scanhealthplan.com

Phone: (800) 250-9048

Fax: (800) 411-0671

- DME/medical supplies (non-Medicare covered)
- Medi-Cal Only benefits (FIDE-SNP members)
- Transplants
- Inpatient mental health (in a psychiatric facility) in excess of Medicare benefit

Community Supports

Email: CMreferral@scanhealthplan.com

- Housing Transition Navigation Services – assistance with obtaining housing
- Housing Deposits – assistance with one-time funding of housing deposits
- Housing Tenancy and Sustaining Services – assistance with maintaining stable housing
- Short Term Post Hospitalization Housing – provide care in a facility after exiting an inpatient hospital, nursing facility, recuperative care, etc.
- Recuperative Care – short-term care in a medical facility for ongoing health conditions, which would be exacerbated by an unstable living environment, after an inpatient hospitalization

Chapter 3: Enrollment and Eligibility

To enroll in a SCAN product, individuals must meet all eligibility requirements and complete the SCAN application process during a valid enrollment election period.

Medicare Advantage Prescription Drug Plan	Medicare Advantage Prescription Drug and Medi-Cal Fully Integrated Dual Special Needs (FIDE SNP) Plan
Eligibility Requirements	Eligibility Requirements
<i>To enroll, an individual must:</i>	
<ul style="list-style-type: none"> • Have Medicare Parts A & B and continue paying Part B premium,¹ • Live in the benefit plan's service area,² and • Be a United States citizen or otherwise be lawfully present in the United States, See Chapter 1: Welcome and Overview. 	<ul style="list-style-type: none"> • Meet Medicare eligibility requirements, • Be enrolled in Medi-Cal with full benefits, • Be at least sixty-five (65) years of age, • Not be enrolled in a Medi-Cal waiver program,³ • Dual-eligible enrollees agree to allow access to Medicare and Medi-Cal benefits to be managed by SCAN including provision of personal care and related homecare services.
<p>¹ Includes those under age sixty-five (65) and qualified by Social Security as disabled. ² Member must continuously reside within the service area for six (6) months or more. ³ The Medi-Cal waiver programs include but are not limited to: AIDS Syndrome Waiver, Nursing Facility Acute Hospital Waiver, Multipurpose Senior Services Program (MSSP) Waiver, In-Home Operations (IHO) Waiver, The Assisted Living Waiver Pilot Project, In-Home Supportive Services (IHSS) Independence Plus Waiver.</p>	

Open Enrollment, Lock-in, and Disenrollment

CMS requires MA Organizations to have an Annual Enrollment Period, which currently runs from October 15 to December 7 of each year. Usually, this is the only time when MA health plans and prescription drug plans are open and accepting new Members, other than those who are newly eligible or qualify for Open Enrollment Period or special election.

MA Organization Members are "locked-in", meaning Members can only switch MA plans during open enrollment unless they qualify for a special election enrollment or switch to a 5-star health plan. Special election situation examples include, but are not limited to, a Member moving outside the service area of their current plan, turning/recently turned sixty-five (65), moving to a new service area, has Medi-Cal, losing retiree health coverage, being diagnosed with a qualifying disability, etc. Other special election situations may exist, as determined by CMS.

Members also have a Medicare open enrollment period in which they may enroll or voluntarily disenroll, typically between January 1 and March 31, of each calendar year and have the choice to switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage).

SCAN must disenroll a Member when:

- 1) Member does not retain Medicare Coverage Parts A and B,**
- 2) Member is deceased,**

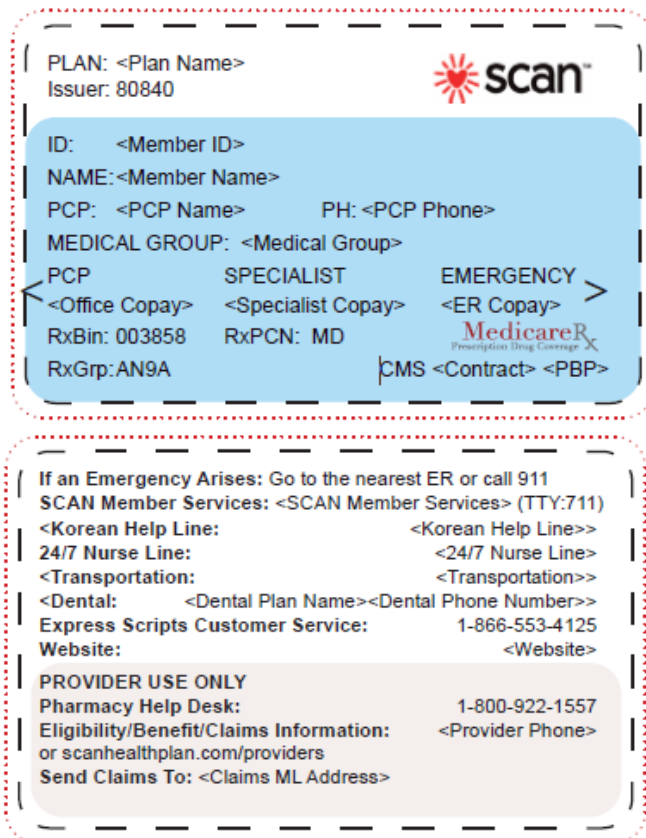
- 3) Member no longer meets SNP status requirements,
- 4) Member permanently moves out of SCAN's service area, or is outside of SCAN's service area for more than six (6) continuous months,
- 5) Member is not lawfully present in the United States, or
- 6) CMS requires SCAN to disenroll a Member

SCAN also must disenroll Members when SCAN's contract with CMS is terminated or SCAN reduces its service area. SCAN may pursue disenrolling a Member if the Member fails to pay applicable monthly plan premiums, or provides fraudulent information or the misuse of their membership identification card. For optional disenrollment, SCAN's discretionary decision shall be final. All covered services must continue to be provided until the disenrollment effective date.

SCAN cannot ask a member to leave the plan for any health-related reason.

Identifying a Patient as a SCAN Member


Member identification cards are intended to identify the Member, the type of plan the Member has, and provide important/relevant information regarding copayments, etc. Cards for various products may have different looks, but the general information displayed on the identification card is similar to the example below:



Applicable Claims address will appear on Member's ID card.

Members are instructed to use a temporary ID card if services are needed prior to the receipt of the permanent identification card, similar to the example below:

Rx Bin: 003858 Rx PCN: MD Rx GRP: AN9A
Issuer 80840



Enrollee Name _____
Date of Birth _____
Medical Group _____
Doctor _____
Dr. Phone # _____
SCAN Representative _____
Proposed Effective Date _____

Verifying Member Eligibility

Each medical group receives a monthly eligibility report that includes all Members assigned to that medical group; however **providers are responsible for verifying eligibility each time a Member receives care**. Inclusion on the eligibility list and/or possession of a Member identification card does not guarantee eligibility.

SCAN offers the following options to verify Eligibility and Benefits.

Electronic Eligibility and Benefit Inquiry & Response (EDI 270/271)
EDI 270/271 is the most efficient option to obtain SCAN Member eligibility and benefits information. To establish connectivity with SCAN, providers should contact their Clearinghouse and Practice Management System (PMS) vendor or Hospital Information System (HIS) vendor to provide SCAN's Payer ID# 10178 .
SCAN's EDI 270/271 clearinghouse vendor is FinThrive (formerly TransUnion). Contact them for testing and connectivity questions by email: TUPrtnrSupt@finthrive.com or call (800) 390-7459 (option 2, then option 2 again)
SCAN's Provider Portal
Providers can self-register at https://www.scanhealthplan.com/providers and gain immediate access to check Member eligibility status, view benefit plan information including PCP information, print eligibility/benefit confirmation and access Plan Evidence of Coverage (EOC).
SCAN's Provider Automated Interactive Voice Response (IVR)
Providers can verify member eligibility/benefits and request a faxback via SCAN's IVR. No registration is required. Call (877) 778-7226, available 24/7.

Member Eligibility

Help us help the Member – Verification is based on the data available at the time of the request. Subsequent changes in eligibility may occur or may not yet be available, therefore, verification of eligibility **is not** a guarantee of coverage or payment.

Enrollment Area and Primary Care Physician Selection

Upon enrollment, Members are asked to select a Primary Care Physician (PCP) and medical group. SCAN encourages, but cannot require, a Member to select a PCP within thirty (30) minutes or thirty (30) miles of their residence. If a Member does not select a PCP and medical group on the enrollment form, SCAN will auto assign a SCAN contracted PCP and medical group within thirty (30) minutes or thirty (30) miles of the Member's residence.

Continuation Area

A Member may elect a SCAN benefit plan if he/she permanently resides in the benefit plan service area. A temporary move into a benefit plan's service area does not enable the Member to elect that benefit plan – therefore, SCAN must deny such election. SCAN, however, may offer a continuation of enrollment option to local benefit plan Members when they no longer reside in the benefit plan service area, but permanently move into a SCAN designated continuation area local plan. (See 42 CFR 422.54(b)).

Member Requests to Change PCP

A Member may change their PCP and/or medical group or Independent Practice Association (IPA) for any reason, at any time. If a Member wishes to change their PCP within their contracted medical group or IPA, this change will be effective on the first day of the following month. If Member wishes to change their PCP to one affiliated with a different contracted medical group or IPA, the Member's request must be received on or before the twentieth (20th) of the month. The change will then be effective the first (1st) of the following month. Change requests received after the twentieth (20th) of the month will be processed and effective for the first (1st) of the second month after the change request.

Dates of Coverage

A Member's effective date is the first day of the month, and a Member's termination date is the last day of the month. Coverage begins at 12:00:01 a.m. (PST) on the effective date and ends at 11:59:59 p.m. (PST) on the termination date. Members typically become effectively enrolled on the first (1st) day of the month after completing an enrollment application. During Open Enrollment: Application is received by the plan between October 15 to December 7 of each year effective date of enrollment will be January 1st of the following year. Outside of Open Enrollment: If an enrollment application is received by the plan between January 1st-January 31st the effective date February 1st. Members may be enrolled for future effective dates (ninety (90) days in advance) when they are approaching the age of sixty-five (65) and become eligible for Medicare Parts A and B in future months. SCAN refers to these "future effectives" as "Age-Ins". Age-Ins If member is new to Medicare Part A and B entitlement date is effective July 1. The member can submit an enrollment application (3) months prior to entitlement date:

Completed enrollment between

April 1 - June 30 for an effective date of July 1

Chapter 4: Physician Responsibilities

Physicians participating in SCAN network have responsibilities based on their role as PCPs and/or specialists. Contracted medical groups/IPAs are responsible for ensuring that their physicians comply with SCAN requirements as set forth in this POM, including the requirements set forth in this Chapter. Directly contracted physicians are responsible for ensuring compliance with the same requirements. This responsibility extends to clinical and non-physician staff responsible for supporting physicians; therefore, all uses of “physician” shall be understood to extend to such staff.

Participation in Benefit Plans

Providers are deemed participating in all benefit plans associated with their participating networks and may not terminate participation in an individual benefit plan. Providers may contact Provider Relations Lead at ProviderRelations@scanhealthplan.com.

PCPs and Specialist Physicians

A PCP is a family physician/family practitioner, general practitioner, internist, or other specialist allowed by the Member’s benefit plan, selected by the Member to be responsible for supervising, coordinating, and providing care to the Member. To ensure quality and continuity of care, the PCP is responsible for coordinating all of the Member’s health care needs (from providing primary care services to coordinating referrals to specialists and providers of ancillary or hospital services). PCPs are also responsible for maintaining the Member’s medical records, including documentation for all services provided to the Member. Members may choose to see a Nurse Practitioner or Physician Assistant who supports the PCP.

A specialist physician is a physician credentialed to provide certain specialty care outside the expertise of the PCP.

Medicare Wellness Visits

Wellness Visits are annual appointments with a healthcare provider that are primarily focused on preventive care and overall wellness rather than specific acute illness treatment. Comprehensive Wellness Visit/Assessment and Health Exams must include but are not limited to the following:

- Complete history and physical (including, but not limited to)
 - Present and past illness(es) with hospitalizations, operations, medications
 - Physical exam including review of all organ systems
 - Height, weight, body mass index (BMI), blood pressure (BP), cholesterol screening
 - Preventive services per the United States Preventive Services Task Force (USPSTF) A and B Guidelines for 65-year-old (including age-appropriate assessments such as tuberculosis screening, clinical breast exam, allergy, colon cancer screening, mammogram, pap smear, etc.)

- Review of the beneficiary's current opioid prescriptions and screening for potential substance use disorders, including a referral for treatment as appropriate.
- Medication Review
- Pain Assessment
- Mental health evaluation/Screening for depression
- Cognitive impairment screening
- Social history
 - Current living situation
 - Marital status
 - Work history
 - Education level
 - Sexual history
 - Use of alcohol, tobacco, and drugs
- Assessment of risk factors and development of behavioral risk health education – to include assessment of:
 - Nutrition
 - Functional status (including activities for daily living/instrumental activities for daily living (ADL/IADLs) Physical Activity
 - Risk of falling (including history of fractures/Osteoporosis)
 - Urinary Incontinence
 - Environmental Safety
 - Dental/Oral Health
- An assessment of need for preventative screens and services
- Diagnoses and plan of care

Initial Health Appointment (IHA)

Previously known as the Initial Health Assessment (IHA), the Initial Health Appointment (IHA) is required for all new Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP) Members enrolled with SCAN within ninety (90) days of the Member's enrollment effective date. In an effort to assist physicians in meeting these requirements, SCAN provides Medical Groups a monthly Report, accessible through the Provider Portal.

Chronic Condition Special Needs Plan (C-SNP) Diagnosis Verification

As a part of our C-SNP enrollment process, we are required to verify that a Member has a qualifying diagnosis within the first 2 months of enrollment. PCPs or other contracted treating providers are required to provide a signature and dated documentation to verify C-SNP eligibility or non-eligibility of a qualifying diagnosis to ensure appropriate care coordination services for those who are eligible. Treating providers include Doctors of Medicine (MD), Doctors of Osteopathic Medicine (DO), Physicians Assistants (PA), and Nurse Practitioners (NP). PCPs and contracted treating providers who refuse to assist in the diagnosis verification process may be restricted from managing C-SNP members.

Please refer to the following for more information:

<https://www.uspreventiveservicestaskforce.org/>

<https://www.medicare.gov/preventive-visit-and-yearly-wellness-exams.html>

Post Emergency Department and/or Hospitalization Visit – Transitions of Care

PCPs are required to follow best practices to ensure a post emergency department and/or hospitalization visit is performed within seven (7) days of discharge. These follow-up visits present an ideal opportunity for the PCP to prepare the Member and family caregiver for self-care activities, make sure the discharge instructions are documented and being followed, medications are reconciled and to head off situations that could lead to readmission. Members may be eligible for additional benefits, such as short-term home delivered meals and personal care services following an inpatient hospital or SNF stay. Please refer to the following section for more information.

Additional Medi-Cal and/or Supplemental Benefits

SCAN Members may be entitled to additional benefits beyond Original Medicare, including Medi-Cal only benefits and/or Supplemental Benefits such as prescription drug, vision and hearing coverage, and short-term home delivered meals and in-home care after a post-acute event, hip or knee replacement, or due to ADL deficits (criteria applies). Members eligible for full Medi-Cal benefits may qualify for Long Term Services and Supports (refer to the Long Term Services and Supports Benefits section below for more details). PCPs should refer Members to the SCAN Member Services Department at (800) 559-3500, to learn about and arrange for Medi-Cal only and Supplemental Benefits.

Homelessness: SCAN also offers Community Supports to eligible FIDE-SNP Members who are experiencing homelessness or who are at risk of losing housing. Subject to DHCS requirements, such Community Supports include Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, Short-Term Post-Hospitalization Housing, and Recuperative Care.

PCPs remain responsible for the coordination of Member care, and for referring FIDE-SNP Members to SCAN for Medi-Cal only benefits.

Special Needs Plan Team for FIDE-SNP Members: Help SCAN Help the Member

SCAN offers a dedicated unit with specially trained employees to respond to questions from FIDE-SNP Members about their Medicare and Medi-Cal benefits. These SCAN employees are able to assist with care coordination, identification, and access to care and services. Providers should encourage Members to reach the Special Needs Plan Team at (866) 722-6725.

Long Term Services and Supports (LTSS) Benefits

FIDE-SNP Members may be eligible for LTSS benefits. LTSS benefits are offered to qualified SCAN Members residing in designated counties, who are assessed and meet nursing facility level of care (NFLOC) criteria and elect to receive services in their home and community.

An eligible Member may qualify for LTSS benefits if they:

- Have a chronic medical condition that limits functionality
- Require the assistance of another person to complete activities of daily living
- Have little or no support from family or friends
- Arrive to appointments with assistance or repeatedly forgets appointments or are reluctant to access care
- Become easily confused or exhibits significant memory loss

LTSS benefits are provided to give Members who might otherwise require nursing home placement the extra support they need to continue living safely and independently in the comfort and security of their own homes. LTSS services may include:

- Personal care such as bathing and grooming
- Homemaker services, such as grocery shopping, light cleaning and laundry
- Caregiver relief
- Home-delivered meals
- Community Based Adult Services/Adult Day Care
- Transportation escorts to and from medical appointments

To refer Members to LTSS, call (800) 887-8695 or send an e-mail referral information to: ILP_OOD@scanhealthplan.com.

Advance Directives

Members are encouraged to complete advance directives. PCPs are required to educate Members on advance directives and document the discussion in the Member's medical record. Completed advance directives must be placed in a prominent place in the Member's medical record (See 42 CFR 422.128(b)(1)(ii)(E)). SCAN supports and recommends the following resource: 'PREPARE for your Care' <https://prepareforyourcare.org/en/prepare/welcome>

For additional information see: <https://www.scanhealthplan.com/caregivers-and-family/advance-care-planning>

Referrals

PCPs and specialist physicians must provide referrals for Members timely and appropriately. Providers are expected to direct Members to in-network health professionals, hospitals, laboratories, and other facilities unless appropriate specialty care is not available within SCAN's network. In circumstances where out-of-network services are needed, authorization is required except in the case of Emergency Services.

In-Network Services and Medicare-Approved Facilities: Help us Help the Member

Providers may contact Provider Relations Lead at ProviderRelations@scanhealthplan.com for assistance determining financial responsibility for services, locating in-network specialists, or a Medicare-approved facility. Providers may also go to <https://www.scanhealthplan.com> to locate participating providers.

Prior authorization shall **not** be required for:

- Routine women’s healthcare, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as received services from a network provider (See 42 CFR 422.100(g)(1));
- Influenza vaccine and pneumococcal vaccine received from a network provider. Co-pays may not be charged (See 42 CFR 422.100(g)(2));
- Emergency Services from network providers or from out-of-network providers;
- Urgently Needed Services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible;
- Kidney dialysis services that the Member gets at a Medicare-certified dialysis facility when the Member is temporarily outside the plan’s service area;
- Any other services specified in the applicable EOC; and
- Mental and Behavioral Health services.

Out of Area Dialysis Services: Help us Help the Member

PCPs should advise Members to contact SCAN Member Services before they leave their benefit plan service area so that SCAN can help arrange for maintenance dialysis while the Member is away.

Behavioral and Mental Health Referrals

PCPs must screen Members for mental and behavioral health needs using validated screening tools at each visit and, when appropriate, initiate a mental health or substance use referral to Member’s assigned medical group. If a FIDE-SNP Member’s mental health needs exceed traditional outpatient services available within the medical group’s network, providers should refer the Member to SCAN for additional care coordination and support by emailing CMreferral@scanhealthplan.com. Refer to the SCAN Evidence of Coverage (EOC) for available Mental and Behavioral Health benefits.

Referrals for Mental and Behavioral Health services must be:

- Made within-network; and/or
- To a vendor who is contracted with the medical group to provide behavioral health or substance use services for the medical group (unless otherwise specified in the agreement between the medical group and SCAN).

Validated screening tools include:

Behavioral Health Disorders	Validated Screening Tools
Depressive Disorders	PHQ2, PHQ9, GDS
Anxiety Disorders	GAD2, GAD7
Bipolar Disorders	MDQ, RMS
Psychosis	PQ-B, SIPS
PTSD	PC-PTSD, SPRINT, TSQ
Substance Use Disorders	CAGE-AID, SBIRT, TAPS

Opioid Treatment Program Services: Medicare Part B Benefit

Section 2005 of the SUPPORT for Patients and Communities Act establishes Opioid Use Disorder treatment services furnished by Opioid Treatment Programs (OTPs) as a **Medicare Part B benefit**, including necessary medications, counseling, therapy, and testing.

Standing Referrals

PCPs may allow standing referrals where a Member requires continuing specialty care over a prolonged period of time (e.g., Member has a life-threatening, degenerative or disabling condition that requires coordination of care by a specialist instead of PCP). PCPs and referred specialists coordinate care and treatment, along with the Member, and develop a treatment plan that addresses the number of approved visits or the period of time during which the visits are authorized and the plan for each visit.

Specialist Physician Referrals

When a PCP refers a Member to a specialist physician, in addition to consultation, the specialist may refer the Member for additional in-network testing and services that are within the guidelines of their specialty. A treatment plan must be agreed upon by the PCP, the specialist physician, and the Member. In addition, a specialist physician may substitute as a PCP for a Member with a life-threatening condition or disease or degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, when authorized by the medical group.

Second and Third Opinions

Second and third opinion consultations are covered even if the service is determined not to be covered. PCPs must provide referrals to another network physician when a second or third opinion is requested and appropriate. Patient-initiated second opinions that relate to the medical need for surgery or for major nonsurgical diagnostic and therapeutic procedures are covered under Medicare. In the event that the recommendation of the first and second physician differs regarding the need for surgery (or other major procedure), a third opinion is also covered. Second and third opinion referrals are for consultation only and do not imply referral for ongoing treatment. (See Medicare Benefit Policy Manual, Chapter 15: Covered Medical and Other Services.)

Chimeric Antigen Receptor (CAR) T-cell Therapy

CAR-T immunotherapy is a covered service when the CMS National Coverage Determination (NCD) criteria are met. See <https://www.cms.gov/medicare-coverage-database>. Inpatient administration is included in Hospitalization responsibility.

CAR-T immunotherapy is covered under Medicare Part B when it meets the criteria outlined in the CMS National Coverage Determination (NCD). Refer to <https://www.cms.gov/medicare-coverage-database> for specific coverage guidelines.

- **Inpatient administration:** Covered under hospitalization services.
- **Outpatient administration and drug:** Covered under outpatient facility services and Medicare Part B drug benefits.

Refer to the Division of Financial Responsibility (DOFR) and Evidence of Coverage (EOC) for additional guidance on responsible payor and member cost-sharing. CAR-T therapy is not considered a transplant service.

Transplants

Transplant evaluation and services **must** be provided in a Medicare-approved transplant center; therefore, Members may only be referred to facilities that meet minimum standards established by Medicare to ensure Member safety.

When SCAN has financial risk for transplant services, per the DOFR, SCAN will render a transplant evaluation authorization which may be performed concurrently with medical management of an inpatient event. Transplant related professional, facility and diagnostic services (including transplant evaluation) must be billed separately from other services. All other services not directly related to transplant services remain the financial responsibility of the entity at risk for inpatient care.

Medical groups are **required** to notify SCAN and review **all** transplant requests for collaboration. Please refer to your DOFR for further information.

Documentation of Referrals

Referring providers are responsible for ensuring that all relevant clinical information is sent to the referred provider. The referral, as well as the determination (denial or acceptance) of the referral needs are to be documented in the Member's medical record by both the referring provider and referred provider. Specialists must provide the referring PCP informative reports on care rendered in a timely manner.

Members on Palliative Care

Palliative Care (Medi-Cal Benefit for Dual – Eligible Members)

Palliative care eases symptoms of serious illnesses and may accompany treatments to cure the illness. SCAN covers medically necessary palliative care services for dual-eligible members diagnosed with a serious and/or life-threatening illness received from a Medi-Cal provider, as determined and documented by the treating health care provider. Medi-Cal covered palliative care services rendered in an inpatient, outpatient or community setting or in the member's home include, but are not limited to:

- Advance care planning
- Palliative care assessment and consultation
- Pain and symptom management
- Plan of care
- Care coordination
- Nursing services
- Psychosocial services
- Discharge planning
- Physical or occupational therapy
- Palliative care team

For additional information, see [*Medi-Cal Provider Manual – Palliative Care \(palli care\) and Medi-Cal Providers*](#).

Members on Hospice

The PCP remains responsible for Members receiving Medicare certified hospice care to ensure appropriate non-hospice care and services are provided. Refer to the Member's EOC at <https://www.scanhealthplan.com//plan-materials> for more information.

Member elects Hospice*			
Type of Services	Member Coverage Choice	Member Cost-Sharing	Payments to Providers
Hospice	Hospice Program	Original Medicare cost-sharing	Original Medicare
Non-Hospice Parts A&B	In Network/Medical Group	SCAN cost-sharing	Original Medicare
Non-Hospice Parts A&B	Out of Network	Original Medicare cost-sharing	Original Medicare
Non-Hospice Part D	SCAN Part D	SCAN cost-sharing	SCAN
Supplemental	SCAN	SCAN cost-sharing	SCAN

*For more information, please refer to *SCAN Medical Policy*.

Hospice Medication Management

Drugs and biological products paid for under the Part A are excluded from coverage under Part D. In general, hospice will provide medications related to the care plan for the terminal diagnosis, and certain drugs that relieve common symptoms during the end of life, regardless of terminal diagnosis. These symptoms include pain, nausea, constipation, and anxiety.

For Members enrolled in Hospice, SCAN has Member-level Prior Authorization requirements on the following four medication categories to determine their coverage under Part A versus Part D benefit: analgesics; antinauseants (antiemetics); laxatives; and antianxiety drugs (anxiolytics) as required by Medicare.

- For these drugs, Hospice-affiliated providers must provide a statement supporting whether the prescribed drug is unrelated to the Member's "terminal illness or related condition" for Part D coverage.

Refer to Hospice and End Stage Renal Disease (ESRD) Part D Exclusions (See *Chapter 11: Pharmacy*).

Out of Area Hospitalizations

Medical Groups are required to notify SCAN within 24 hours of admission. When SCAN is at financial risk per the DOFR, PCP and Medical Group are expected to work collaboratively with SCAN to coordinate care and services in collaboration with the out of area providers, until the Member is discharged or stable and can safely be transferred/repatriated into the contracted network. (See *Chapter 5: Network Standards*)

Out of Country Hospitalizations

SCAN will coordinate care and services in collaboration with the out of country providers until the Member is discharged or stable for transfer and repatriation into the contracted network. PCPs and Medical Groups are expected to work collaboratively

with SCAN to safely transfer the Member into the contracted network and continue coordinating the Member's transition of care.

Continuity of Care

Continuity of care is the continuous coordinated care afforded to all Members by a practitioner involved in their care and treatment. This care is a collaborative effort between providers and SCAN. Physicians are responsible for working with SCAN to ensure continuity of care. (See *Chapter 6: Utilization Management* for further details on Continuity of Care.)

Clinical Trials

SCAN Members may participate in Medicare-approved clinical trials and stay enrolled in SCAN to continue to get care not related to the trial through their assigned Medical Group/PCP.

For Clinical Studies Approved under Coverage with Evidence Development (CED) and Investigational Device Exemption (IDE) Studies, authorization is required. Refer to the Division of Financial Responsibility (DOFR) and Evidence of Coverage (EOC) for additional guidance on responsible payor and member cost-sharing.

For Medicare approved clinical trials other than CEDs and IDEs, clinical trial providers should bill Original Medicare for clinical trial-related services. These services are not carved out to SCAN, though SCAN may offer assistance in identification of Medicare-approved clinical trials. Authorization is not required for participation in Medicare-approved clinical trials.

Experimental and Investigational procedures and items are not covered. For additional information on coverage of clinical trials, CED/IDE, and experimental/investigational procedures and items, refer to:

- Medical Policy: '*BCG0111-Clinical Trials, Experimental Procedures and Items, and Investigational Devices*'
- Member's applicable EOC, which can be found at <https://www.scanhealthplan.coms//plan-materials>

Providers may also refer Members to Medicare at 1-800-MEDICARE (1-800-633-4227) for more information.

Clinical Trials: Help us Help the Member

Members do not need SCAN's permission to participate in a clinical trial. Providers should direct Members to SCAN Member Services for all clinical trial information. See *Chapter 2: Key Contacts Resource Guide* (Member Services).

Access Requirements

*Maintain and monitor a **network of appropriate providers** supported by written agreements and sufficient to provide adequate access to covered services to meet the needs of Members*

*Demonstrate that providers are appropriately **credentialed***

*Ensure plan services are available **24 hours a day, 7 days a week** and are provided in a **culturally competent manner***

*Ensure appropriate **ambulance services, Emergency and Urgently Needed Services, and post-stabilization care services** coverage*

*Establish **written standards for timeliness of access to care** and Member services that meet or exceed established standards, **continuously monitor** these standards, and take **corrective action** as necessary*

*Ensure **continuity of care** and **integration of services***

See 42 CFR 422.111-114; Title 28, Section 1300.67.2.1

Chapter 5: Network Standards

Ensuring access to care is a collaborative effort between SCAN and the SCAN provider network through established standards. All network providers are responsible for abiding by these network standards. Panel closures may be initiated in SCAN's sole discretion, including but not limited to ongoing poor performance or non-compliance with network standards, a governing federal or state regulatory requirement or a contractual or POM requirement. Further actions may be taken if deficiencies are not corrected to SCAN's reasonable satisfaction.

Organizational Changes

Contracted medical groups/IPAs are required to notify SCAN of any material organizational changes that may impact operations. These include, but are not limited to, Management Services Organization (MSO), mergers, acquisitions, terminations, subcontractor relationships, third party vendor supports, banking information, disclosure of ownership, etc. Such notifications must be submitted according to your contract's notice provisions and copy to ProviderRelations@scanhealthplan.com within 90 days of the effective date.

Credentialing

Direct Credentialing

SCAN Health Plan abides by National Committee for Quality Assurance (NCQA), CMS and applicable state requirements. To be eligible to participate in the SCAN network, all providers must demonstrate that they meet SCAN credentialing requirements including, but not limited to, the following:

Professional

- For professionals, in good standing with all state and federal regulatory bodies;
- For professionals, not have been excluded, suspended, and/or disqualified from participating in Medicare, Medicaid, or any other government health related program; and
- For professionals, enrolled in Medicare and Medi-Cal, as applicable

Facilities

- For facilities, in good standing with all state and federal regulatory bodies.

- For facilities, reviewed and approved by an accrediting body or, if not accredited, can provide appropriate evidence of successfully passing a recent state or Medicare site review, or meets other plan criteria;
- For facilities, maintains current general, professional, workers compensation liability insurance, and other insurance types as applicable;
 - SCAN must be listed as the 'additional insured' under the General Liability insurance.

Delegation of Credentialing Functions

SCAN may delegate credentialing functions. Entities that have been delegated to perform credentialing functions on behalf of SCAN must comply with all requirements applicable to SCAN, including the requirements set forth in this section. See also *Chapter 10: Delegation Oversight*.

Credentialing Process and Nondiscrimination

SCAN's Credentialing Committee is responsible for the development and maintenance of a comprehensive credentialing and re-credentialing process, to make credentialing and re-credentialing decisions, monitor quality of care and services, provide guidance for continuous quality improvement to meet NCQA, CMS and applicable state requirements. Credentialing decisions are made on a fair and impartial basis according to predetermined criteria related to professional conduct and competence, not based on an applicant's race, gender, age, ethnic origin, sexual orientation, language or type of patients or procedures in which the provider specializes.

The credentialing process consists of three parts: information gathering, information review, and decision. All providers are expected to provide full, accurate, and timely information. Failure to do so could result in delay or a determination not to credential the provider. If unfavorable information about a provider is discovered during the credentialing process (e.g., professional liability settlements, sanctions, or other adverse information, etc.), SCAN or a delegated entity may deny or terminate provider credentialing. Applications deemed incomplete, where required information is missing, or that do not meet standards for review will not be accepted and are not subject to appeal.

Timeline for Re-Credentialing

All providers and Health Delivery Organizations must complete the credentialing process prior to becoming a SCAN participating provider and must complete the re-credentialing process every thirty-six (36) months. Any new provider will be considered an out-of-network provider until the credentialing process is complete and will not be listed in the SCAN provider directory. Health Delivery Organizations (HDOs) that have fewer than three (3) stars under the CMS 5-Star Quality Rating System may be granted a provisional credential of one (1) year (with an additional two (2) years granted if improvement is shown).

Medical Specialties Board Certification

SCAN requires verification of board certification on all network and contracted physicians from the American Board of Medical Specialties (ABMS), the American Medical Association (AMA), or American Osteopathic Association (AOA). For Non-Board Certified physicians, highest education attained must be primary source verified. ABMS

and AOA Board Certification demonstrates a physician’s exceptional expertise in a particular specialty and/or subspecialty of medical practice and provides a trusted credential that is important to patients and relevant to physician practice. ABMS, and AOA Board Certification is peer-developed, externally validated program that reflects the critical core physician values of compassion, patient-centeredness, and a passion for education. Patients, physicians, health care providers, insurers, and quality organizations look for these markers as the best measure of a physician’s knowledge, experience, and skills to provide quality health care within a given specialty. (See <http://www.abms.org/board-certification/> <https://amacredentialingservices.org/credentialing/physician-profiles> <https://certification.osteopathic.org/validate/>)

Provider Appeals

Providers will be notified in writing of any decision to limit, suspend, or terminate participation in the SCAN network. Notification will include the reasons for the action, the appeals process or options available to the provider, where to submit the appeal request, and time limits for submitting an appeal. All appeals will be reviewed by a panel of peers. When termination or suspension is the result of quality deficiencies, if reportable, it will be reported to the appropriate licensing boards, National Practitioner Data Bank (NPDB), or other appropriate disciplinary bodies within their respective submission timeframes. See 42 CFR 422.202(d)(1)-(4) for applicable requirements.

Provider Changes (Additions, Terminations, Panel Closures)

Providers and provider groups are responsible for timely notifying SCAN of requests for provider additions, provider terminations, address changes and panel changes. Unless otherwise stated in the contract between the provider or provider group and SCAN, and for all products except provider sponsored plans, requests are processed per the following timelines. Notification is to be emailed to ProviderUpdates@scanhealthplan.com.

Provider Change
<i>Termination of Primary Care Physician (PCP) or Behavioral Health Provider</i>
Delegated entity shall deliver notice to SCAN no less than seventy-five (75) calendar days prior to the effective date of termination, or as soon as the delegated entity is notified by the terminating provider, in order for SCAN to appropriately take provider record off of SCAN’s directory display. The delegated entity or SCAN (directly contracted providers) shall notify Members of these changes at least forty-five (45) calendar days prior to the effective date of termination. In the event a PCP is terminated with less than seventy-five (75) calendar days’ notice, then the delegated entity must provide SCAN with written notice within five (5) business days of becoming aware of the termination. Terminations will become effective the 1st of the month following the expiration of the notice period unless SCAN is able to process the request earlier. In the event of a PCP termination, the delegated entity must also provide SCAN with a replacement PCP to whom to transfer the Members. The replacement PCP must be affiliated with SCAN and accepting Members.
<i>Termination of Other Specialist Providers</i>
Delegated entity shall deliver notice to SCAN no less than sixty (60) calendar days prior to the effective date of termination, or as soon as the delegated entity is notified by the terminating provider, in order for SCAN to appropriately take provider record off of SCAN’s directory display. The delegated entity or SCAN (directly contracted providers) shall notify Members of specialist changes at least thirty (30) calendar days prior to the effective date of termination, except behavioral health provider changes, which require notice at least forty-five (45) calendar days prior to the effective date of termination. In the event a specialist is terminated with less than sixty (60) calendar days’ notice, then the delegated entity must provide SCAN with written notice within five (5) business days of becoming aware of the termination.

<i>Termination of Facility</i>
Delegated entity shall deliver notice to SCAN no less than sixty (60) calendar days prior to the effective date of termination, or as soon as the delegated entity is notified by the terminating provider, in order for SCAN to appropriately take provider record off of SCAN's directory display. The delegated entity or SCAN (directly contracted providers) shall notify Members of facility changes at least thirty (30) calendar days prior to the effective date of termination. In the event a facility is terminated with less than sixty (60) calendar days' notice, then the delegated entity must provide SCAN with written notice within five (5) business days of becoming aware of the termination.
<i>Adding New Providers</i>
Requests must include a complete profile for the new provider or a file containing all the required data elements. Incomplete requests will be returned with details regarding deficiencies and/or notice of action needed. SCAN will notify the provider or provider group if the Add request is declined and provide the reason. (Reasons for declining an Add request may include: provider is no longer practicing at locations requested, provider's specialty is one which SCAN does not load, provider has quality management issues and is closed to new site affiliations, requested site affiliation has a corrective action pending, or that contract limitations exist (e.g. provider is located outside of SCAN's market or the delegated entity contracted service area, etc.)). Provider Add requests will become effective on the 1 st of the following month when received before the 16 th of the month. Requests received on or after the 16 th will be effective the 1 st of the next month (e.g. If a provider Add request is submitted on 8/10, the earliest effective date would be 9/1. If submitted 8/20, the effective date would be 10/1).
<i>Panel Closures</i>
Notice to be received by SCAN at least sixty (60) calendar days in advance of any PCP who will no longer be able to accept Members. If the delegated entity is unable to meet this requirement because a PCP has failed to give the delegated entity notice of a closure, the delegated entity shall provide SCAN notice within five (5) business days of first learning of the closure. Unless otherwise stated in the contract between SCAN and the delegated entity, in no event shall a delegated entity ever have more than twenty percent (20%) of its PCP panel closed to Members at the same time.
<i>Notice to SCAN of Adverse Actions</i>
<p>Provider and Provider Groups are required to immediately notify SCAN upon discovery of any contracted providers who have an adverse action against their medical/clinical license, such as an accusation, probation, or other disciplinary action imposed by the Medical Board of California and/or any applicable licensing body. Notification is to be submitted to credentialing@scanhealthplan.com</p> <ul style="list-style-type: none"> • Delegates are required to review healthcare practitioners who have an accusation adverse action against their license declared by the Medical Board of California and/or any applicable licensing body. Review should include, as appropriate, but is not limited to: <ul style="list-style-type: none"> ▪ Discussion of the accusation ▪ Discussion of complaints and Grievances concerning quality of care ▪ Review of prescribing practices (if applicable) ▪ Implementing appropriate interventions if there is concern of poor quality that could affect Member safety (e.g., panel closure, monitoring of practitioner, termination, etc.) • Delegates are also required to monitor healthcare practitioners who have adverse action decisions (e.g., public letter of reprimand, probationary terms, etc.) against their license declared by the Medical Board of California and/or any applicable licensing board. Monitoring should include, as appropriate, but is not limited to: <ul style="list-style-type: none"> ▪ Grievances concerning quality of care ▪ National Practitioner Data Bank (NPDB) queries ▪ Medical Board of California daily e-mail notifications ▪ Other applicable licensing board, as appropriate ▪ Practitioner's registration and/or completion of required courses

Member Notification (Provider Terminations)

The delegated entity or SCAN (directly contracted providers), is required to make a good faith effort to provide written notice and make at least one attempt at telephonic notice of the termination of PCP and Behavioral Health Providers at least forty-five (45)

calendar days before the termination effective date to all Members who are assigned to or currently receiving care from that PCP and to Members who have been patients of that PCP or Behavioral Health Provider within the past three (3) years.

Following state and federal requirements, delegated entity or SCAN (directly contracted providers), is required to make a good faith effort to provide written notice of the termination of a contracted specialist provider at least thirty (30) calendar days before the termination effective date to all Members who are patients seen on a regular basis by that provider (See 42 CFR 422.111(e) and 42 CFR 438.10(f)). The phrase “patients seen on a regular basis” means Members who are assigned to, currently receiving care from, or have received care within the past three (3) months from a specialist provider or facility being terminated.

The delegated entity or SCAN (directly contracted providers) is responsible for identifying and notifying impacted Members who accessed the terminating specialist or facility in the prior three (3) months and/or who accessed the terminating PCP or Behavioral Health Provider within the past three (3) years. The content of provider termination notices must comply with the model communications material and all applicable requirements (See 42 CFR 422.2267(e)(12)).

Plan Notification (Member Events)

In order to ensure prompt and appropriate payment of claims, providers are required to notify SCAN timely of the following Member events when SCAN is financially responsible, failure to comply with the notification requirements may result in the denial of payments.

Event	Notification Timeframe
Admissions (Planned or Unplanned)	
Acute Inpatient (in/out of area)	Within twenty-four (24) hours of admission
Outpatient Observation Stay	Within twenty-four (24) hours of admission
Skilled Nursing Facility	Within twenty-four (24) hours of admission
Long Term Care Facility	Within twenty-four (24) hours of admission
Authorizations	
Acute Rehabilitation Unit/Long Term Acute Care (LTAC)	Prior to admission (at time of request)
Elective inpatient procedures (planned transition)	Within one (1) business day of admission
Transplants	
Solid Organ & Bone Marrow Transplants	Prior to transplant pre-evaluation
Fax notifications to SCAN Utilization Management at (800) 411-0671 or call (800) 250-9048.	

Out of Area/Network Services v. Directed Care/In Area Initiated Care

In general, SCAN only covers services that are delivered by providers that are in the SCAN contracted network and in the plan service area (i.e., that are delivered “in network” and “in area”). Delegated entities are responsible for ensuring that referrals to out of network and/or out of area providers are appropriate per the terms of the Member’s EOC and may retain financial responsibility for those referrals (e.g., referring a Member to an out of network or out of area provider for care that is non-urgent and non-emergent

and/or is available from an in network provider). It is also important that providers understand that not all care that is delivered outside the service area constitutes “out of area” services for purposes of determining financial responsibility. Delegated entities remain responsible for out of network services when a provider, advertently or inadvertently, refers a Member to an out of network provider (“directed care”) or transfers a Member out of network for care that was initiated by an in network provider (“in network initiated care”). This includes situations where a provider directs a Member to an out of area provider based on a standing instruction, no bed availability in network facilities or because care is not available in the service area. In the case of both directed care and in area initiated care, all subsequent services related to that episode of care, including but not limited to diagnostics, admissions to acute or non-acute facilities, and consults are considered in area for purposes of determining financial responsibility.

For Transplant related care/services refer to [Chapter 4: Physician Responsibilities](#).

Providing Information

All providers are expected to cooperate timely with SCAN’s requests for information for SCAN to, among other regulatory requirements, meet disclosure obligations required by CMS and other regulatory agencies, related to all information necessary to: (1) administer and evaluate the program; and (2) establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare services. (See 42 CFR 422.64(a), 422.504(a)(4)). This information includes but is not limited to, SCAN quality and performance indicators for benefits including, disenrollment rates for Medicare enrollees electing to receive benefits through SCAN for the previous two (2) years, information on Medicare enrollee satisfaction, information requested to support organization determinations, and information on health outcomes. See 42 CFR 422.504(f)(2)(iv)(A)-(C). See [Chapter 14: Encounter Data](#) for requirements specific to encounter data.

Access and Availability

CMS has established access to service and related rules to ensure that all covered services, including supplemental services, are available and accessible to Members for the duration of the benefit year (for Members hospitalized on the termination date or, in the event of an insolvency, through discharge) and are provided in a manner consistent with professionally recognized standards of care. See 42 CFR 422.112, 422.504(a)(3)(iii).

SCAN is also required to establish acceptable accessibility standards in accordance with our contract with the DHCS. See below Access to Care Standards and Hours of Operation.

Provider Network

SCAN contracts with a network of providers to ensure that all covered services, including supplemental services, are available and accessible. To accomplish this, SCAN maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are used in the network as PCPs,

specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers. See 42 CFR 422.112(a)(1)(i).

Specialty Care

Delegated Medical Groups are responsible for providing and arranging necessary specialty care. Delegated Medical Groups are also responsible for allowing Members direct access to certain routine and preventive health services, including mental and behavioral health services. The Medical Group arranges for specialty care outside of the provider network when network providers are unavailable or inadequate to meet a Member's medical needs. If needed, SCAN can assist in arranging this care. See 42 CFR 422.112(a)(3).

Behavioral and Mental Health Referrals

PCPs must screen Members for mental and behavioral health needs using validated screening tools at each visit and, when appropriate, initiate a mental health or substance use referral to Member's assigned medical group. Refer to the SCAN Evidence of Coverage (EOC) for available Mental and Behavioral Health benefits.

Referrals for mental and behavioral health services must be:

- Made within-network; and/or
- To a vendor who is contracted with the medical group to provide behavioral health or substance use services for the medical group (unless otherwise specified in the agreement between the medical group and SCAN).

As required by DHCS, Medi-Cal covered Behavioral Health services, including Specialty Mental Health Services (SMHS), Non-Specialty Mental Health Services (NSMHS), and Substance Use Disorders (SUD) must be coordinated. Refer to the SCAN Evidence of Coverage (EOC) for available Mental and Behavioral Health benefits. PCPs should refer Members to the SCAN Member Services Department at (800) 559-3500, to learn about and arrange for Medi-Cal only and Supplemental Benefits.

Medi-Cal only covered services are coordinated by SCAN. When Medically Necessary covered services are not available within SCAN's network, SCAN will coordinate services outside of the network, even if such services are seldom used or are unusual specialty services.

Provider Directory

SCAN is mandated to have accurate provider data displayed on its online and print directories. To ensure compliance with its mandate, SCAN maintains regular auditing/validation processes against its provider data and requires all providers and provider groups to provide current and accurate provider data. SCAN requires any provider updates to be reported immediately, but in no event more than five (5) business days from the time the provider or provider group is aware of changes to provider roster.

SCAN's auditing and validation efforts are performed transactionally as new providers are submitted to the plan via provider rosters, and quarterly against a provider or provider group's full/active roster. These auditing and validation activities may include reaching out to providers and/or comparing external provider data sources using a vendor partner (e.g.,

CAQH, HiLabs, etc.). Outreach to providers may include the use of fax, email, and phone calls. Providers are required to provide timely responses to such communications. Failure to do so may result in suppression of provider data from the plan’s directories and/or automatic termination of provider records based on the findings identified.

To fulfill the plan’s requirements for submitting current and accurate provider data, the plan requires providers and provider groups to utilize the plan’s standardized roster templates and submission process. Within five (5) business days from a change in provider data, providers and provider groups shall generate a change roster and submit to the plan. Provider information expected to be submitted via rosters includes, but is not limited to additions, terminations, changes in ability to accept new patients, street address, phone number, and any other changes that affect availability to Members or displayed information on the plan’s directories as mandated by Medicare or Medicaid regulations as applicable to providers and groups. Submission of changes to provider rosters should be submitted to SCAN’s dedicated mailbox ProviderUpdates@scanhealthplan.com (when credentialing is delegated) or ProviderRelations@scanhealthplan.com (when SCAN performs credentialing).

Finding Providers: Help us Help the Member

Members can access SCAN’s online searchable provider directory at <https://www.scanhealthplan.com> and request a hardcopy provider directory from SCAN’s Member Services department or the SCAN website.

Access to Care Standards and Hours of Operation

CMS requires that SCAN employ written standards for timeliness of access to care and services, make these standards known to all providers, continuously monitor its provider networks’ compliance with these standards, and take corrective action as necessary. These standards must ensure that SCAN’s network hours of operation are: (1) convenient for Members, non-discriminatory, and at least as accessible as those offered to other patients; and (2) available 24/7 to provide Covered Services when Medically Necessary. See 42 CFR 422.112(a)(6)(i) and 42 CFR 422.112(a)(7)(ii) and Medicare Managed Care Manual (MMCM), Chapter 4, Section 110.1.1. Under SCAN’s contract with DHCS, SCAN is also required to establish acceptable accessibility standards in accordance with 28 CCR Section 1300.67.2.1 and *DHCS All Plan Letter (APL) 25-006 'Timely Access Requirements'*. DHCS will review and approve these standards, and SCAN is required to communicate, enforce, and monitor SCAN’s network compliance with these standards.

To ensure network access standards are met and network adequacy in accordance with federal and state requirements, SCAN has established the following accessibility standards for all contracted providers:

Accessibility Standards	
Services	Standard (Measured From Time of Request)
Urgent/Emergent	
Emergency Services*/Urgent Care	Immediately 24/7
Urgent Care Appointment: PCP/Specialist	Forty-eight (48) hours if no prior authorization.

Accessibility Standards	
Services	Standard (Measured From Time of Request)
Urgent/Emergent	
Urgent Care Appointment: PCP/Specialist	Ninety-six (96) hours if prior authorization required.
Non-Physician Mental Health or SUD provider	Forty-eight (48) hours if no prior authorization.
Post stabilization services**	Thirty (30) minutes (DHCS = 30 Minutes) (CMS = 1 hour)Δ
Dental	Seventy-two (72) hours (DHCS)
* 1 or more physicians and 1 nurse on duty at all times	
** Contracted delegated entities must provide 24/7 access to providers for prior authorization of Medically Necessary post-stabilization care and to coordinate the transfer of stabilized Members in an emergency department. Requests from the facility for prior authorization of post-stabilization care must be responded to by the delegated entity within 30 minutes (DHCS = 30 Minutes) (CMS = 1hour) or the service is deemed approved. Upon stabilization, additional medical-necessity assessment should be performed to assess the appropriateness of care and assure that care is rendered in the appropriate venue.	
Non-Urgent/Non-Emergent	
Ancillary services	Fifteen (15) business days (DHCS)
Specialty Care	Fifteen (15) business days (DHCS)
PCP	Ten (10) business days (DHCS) Seven (7) business days (CMS) Δ
Non-Physician Mental Health or SUD provider	Ten (10) business days (DHCS)
Routine and preventive care (PCP)	Thirty (30) business days (CMS)
Dental Non-preventive	Thirty-six (36) business days (DHCS)
24/7 Nurse Triage Line	Response/Call within thirty (30) minutes (DHCS)
Other	
Interpreter services	24/7 (DHCS)
Dental Preventive	Forty (40) business days (DHCS)
Member Services Line	Ten (10) minutes (DHCS)

Δ The stricter of the two standards applies.

Provider organizations are required to monitor their network providers' availability in accordance with the standards set forth above, as well as conduct an Access and Availability Study not less frequently than annually, retain evidence of the studies, and provide to SCAN upon request as proof of compliance. Provider organizations must also maintain procedures for: (1) follow-up on missed appointments to monitor waiting times in physician's offices, telephone calls (to answer and return), and time to obtain appointments; and (2) for triaging Members' calls, providing telephone medical advice (if it is made available), and accessing telephone interpreters.

For list of Telehealth services see <https://www.cms.gov/Medicare/Medicare-general-information/telehealth/telehealth-codes>

Cultural Competency and Interpreter Services

Providers are responsible for ensuring that all services are provided in a culturally competent manner and are accessible to all Members including those with limited English proficiency (LEP), low literacy levels, hearing, sight, or cognitive impairment, or those with diverse cultural and ethnic backgrounds. See 42 CFR 422.112(a)(8), MMCM, Chapter 4, and *DHCS All Plan Letter (APL) 22-002 'Alternative Format Selection for Members with Visual Impairments'*. Please reference *Appendix B: Select DHCS Requirements* for more information.

To this end, providers are expected to ensure that:

- Referrals are made to culturally and linguistically appropriate community services and agencies, when indicated (See [Chapter 2: Key Contacts Resource Guide](#))
- Interpreter services are available 24/7 at no charge to the Member either directly or through SCAN resources
- Members are to use interpretive services instead of using family and friends, especially minors, as interpreters (Section 1557 of the Patient Protection and Affordable Care Act)
- Trained and fluent bilingual staff are used in medical interpreting; *Source: Health Industry Collaboration Effort (HICE) Tips for Communicating Across Language Barriers; <http://www.iceforhealth.org/>
- Visible signage is displayed to assist Members in requesting an interpreter
- The Member's primary spoken language and any request or refusal of interpreter services is recorded in their medical record: and
- Language assistance written and/or alternative format communication must meet the appropriate regulatory requirements.
 - Centers for Medicare & Medicaid Services (CMS) eighth grade level

For additional tools and resources, please see below:

- Multi-Cultural Toolkit - <https://www.scanhealthplan.com/providers/multi-cultural-resources-and-interpreter-services>
- Health Equity Tip Sheet - https://www.scanhealthplan.com/////health-equity-tip-sheet_v5.pdf
- California Department of Public Health, Office of Health Equity <https://www.cdph.ca.gov/Programs/OHE/Pages/OfficeHealthEquity.aspx>
- U.S. Department of Health and Human Services Office of Minority Health. <https://minorityhealth.hhs.gov>
- Office of Disease Prevention and Health Promotion, Healthy People 2030 <https://health.gov/healthypeople>
 - Topics include, but are not limited to:
 - *Older Adults*
 - *Access to Health Services*
 - *Disability and Health*
 - *Lesbian, Gay, Bisexual, and Transgender Health*
 - *Social Determinants of Health*

Interpreter Services: Help us Help the Member

SCAN provides free interpreter services to Members. To access services, call the Provider Information Line, twenty-four (24) hours a day at (877) 778-7226 (TTY User: 711) and select the Interpreter Services option when prompted.

You can also access SCAN Virtual Remote Interpretation (VRI) at <https://scan.cqfluencyvri.com>, enter access code: scan and select language.

VRI requires no prior scheduling, offers professional interpreters in ASL and 170 languages, reduces wait times and provides high quality care in minutes.

Health Education

Providers must implement and maintain an easily accessible Member health education program. (See 42 CFR 422.112(b)(5)). It is the responsibility of each delegated entity to conduct annual review and evaluation for all health education programs, as well as provide annual staff education on the availability of health education programs.

The program must include:

- Policies and procedures describing the health education program;
- Designation of an individual responsible for implementing and overseeing the health education program;
- Health education material must be:
 - Obtained from credible and reliable sources;
 - Meet appropriate levels of readability and suitability for an older adult population;
 - Meet appropriate CMS plain language and written communication requirements not exceeding an 8th grade reading level;
- Available in threshold languages and alternative formats, based on Member population including availability of interpreter services (Interpreters, American Sign Language, and TTY/TDD);
- Inventory of health education program components including, but not limited to: Education interventions (e.g., classes, webinars, telephonic) based on educational strategies appropriate for Members. At least some classes are offered free of charge and are available for the following topics either directly or by referral (e.g., affiliated hospital, contracted agency, community based) – tobacco use and cessation, alcohol and drug use, fall or injury prevention, weight control/nutrition/physical activity, and self-care and management of health conditions including asthma/COPD, diabetes, hypertension, and Congestive Heart Failure (CHF)

Health Education resources are available on the SCAN Health Plan [Provider Health Education Site](#).

Provider Training and Education

SCAN supports provider partners by regularly offering training and education on a variety of topics including, clinical protocols, evidenced-based practice guidelines, claims and billing, and cultural awareness and sensitivity instruction for Members. Provider participation is encouraged. Medical groups are responsible for providing additional training, to ensure best practices are integrated into their organizations.

Additionally, and in compliance with DHCS requirements, SCAN provides a Provider Orientation Packet (POP) to all new providers participating in SCAN's Medi-Cal products in the designated counties. The POP and SCAN's annual SNP Model of Care (MOC) training contain key information and [training materials](#) to assist in the management of Members.

For operational details related to onboarding and needs post-contracting, please consult your respective [Welcome Packet](#). The Welcome Packet contains information on member eligibility and benefits, prior authorizations and referrals, claims, payments, provider rosters and compliance. If you require additional assistance, please contact your Provider Relations Lead or ProviderRelations@scanhealthplan.com.

Appeals, Grievances, and Payment Disputes

SCAN does not delegate Member Appeals and Grievances functions to its contracted providers. See *Chapter: 9 Member Appeals and Grievances* for more information.

In order to meet regulatory requirements, SCAN requires its providers to:

- Instruct Members to contact SCAN to file all Appeals and Grievances;
- Forward all Grievances and/or Appeals to SCAN on the day of receipt;
- Respond timely to requests for information and records from SCAN; and
- Effectuate overturn decisions in a timely manner and provide proof of timely effectuation. (See, e.g., 42 CFR 422.618(b)(2) and (c)).

Member Appeals and Grievances are time-sensitive procedures that require timely collaboration between health plans and their provider organizations. Untimely responses to requests for medical records or other lack of cooperation may result in a favorable Member determination against the provider organization. Failure to timely effectuate overturn decisions may also result in adjustments to reimbursement. Please see “*SCAN HEALTH PLAN APPEALS, GRIEVANCES AND COMPLAINTS EXPECTATIONS*” for additional requirements.

SCAN must inform Members of their rights to an Independent Medical Review (IMR) in accordance with the Knox-Keene Act, including but not limited to H&S sections 1368.03, 1370.4, and 1374.30, and 28 CCR sections 1300.70.4 and 1300.74.30, and include verbatim language required by H&S section 1368.02(b), as well as the most recent IMR form provided by the Department of Managed Health Care (DMHC), application instructions, the DMHC toll-free telephone number, and an envelope addressed to DMHC when the following requirements are met:

1. The denied IOD (Integrated Organization Determination) is for experimental or investigational therapy, or is a denial of urgent care or emergency service; and
2. The denied IOD is not for a Medicare only service or benefit; and
3. The IOD is relating to a denial, in whole or in part, of a Medi-Cal service or benefit, including cases where there is an overlap of Medicare and Medi-Cal.

Marketing and No Steering Rule

SCAN is responsible for any comparative/descriptive material developed and distributed on SCAN's behalf by providers and, as such, SCAN must ensure that providers (and subcontractors) comply with CMS marketing rules. See Medicare Communications and Marketing Guidelines (eff 02/09/2022 and subsequent updates) (MCMG); 42 CFR 422.2260 and 422.2262.

Providers may **not**:

- Offer sales/appointment forms or accept enrollment applications;
- Direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests;
- Mail marketing materials on behalf of SCAN;
- Distribute marketing materials/applications in areas where care is being delivered, except in common areas;

- Offer anything of value to induce SCAN Members to select them as their provider;
- Offer inducements to persuade beneficiaries to enroll in a particular plan;
- Health screen when distributing information to patients;
- Accept compensation directly or indirectly from SCAN for enrollment activities; or
- Steer, or attempt to steer, an undecided potential enrollee toward a plan, or limited number of plans, based on the financial interest of the provider or its subcontractors. Providers should remain neutral parties in assisting plan sponsors with marketing to beneficiaries or assisting with enrollment decisions.

Providers may:

- Provide the names of plans with which they contract and objective information on all benefits based on a particular patient's medications and health care needs;
- Make available or distribute plan marketing materials, display posters for all plan sponsors being offered;
- Refer their patients to other sources of information such as CMS's website or phone number; and
- Use SCAN's logo, or engage in co-branding, with SCAN's prior written consent.

Member Rights and Nondiscrimination

All new and existing Members receive communications regarding rights and responsibilities in their annual EOC. To ensure these rights, providers must:

- Treat the Member with fairness and respect at all times;
- Ensure that the Member gets timely access to covered services and drugs;
- Protect the privacy of the Member's PHI;
- Support the Member's right to make decisions about care;
- Allow the Member the right to make complaints and to request reconsideration of decisions made;
- Advise the Member what to do if the Member believes he/she is being treated unfairly or rights are not being respected; and
- Advise the Member how to get more information about their rights.

Providers may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in an MA plan offered by the organization on the basis of any factor that is related to health status including, but not limited to, the following: medical condition including mental as well as physical illness, claims experience, receipt of health care, medical history, genetic information, evidence of insurability including conditions arising out of acts of domestic violence, potential third-party liability for payment for the service, or disability. (See 42 CFR 422.110(a) and 42 USC 1396a(a)(25)(D)). Providers further may not differentiate or discriminate against any Member as a result of their enrollment in SCAN or another managed care organization, because they are a Medicare or Medicaid beneficiary, because they filed a complaint, grievance, or lawsuit, or because of sex, race, color, creed, religion, ancestry, national origin, ethnic group identification, income level, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, identification with any other persons or groups defined in Penal Code 422.56, or on the basis of any other protected class or characteristic under applicable laws. Providers must also ensure equal access to health care services for limited English proficient (LEP), limited reading skills,

hearing incapacity and speech impaired Members through provision of high quality interpreter and linguistic services.

Transgender, Gender Diverse or Intersex Cultural Competency Training Program and Provider Directory Requirements

DHCS All Plan Letter (APL) 24-017 'Transgender, Gender Diverse or Intersex Cultural Competency Training Program and Provider Directory Requirements' outlines SCAN's contractual obligations, compliance, downstream compliance and guidance regarding the transgender, gender diverse, intersex (TGI) cultural competency training program and Provider Directory changes required by Senate Bill (SB) 923 (Chapter 822, Statutes of 2022) for the purpose of providing trans-inclusive health care to MCP Members.

Safeguard Privacy and Maintain Records Accurately and Timely

For any medical records or other health and enrollment information maintained with respect to Members, providers must establish policies that abide by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. (See 42 CFR 422.118).

Providers must further:

- Safeguard the privacy of any information that identifies a particular Member and have procedures that specify: (1) for what purposes the information will be used within the organization; and (2) to whom and for what purposes it will disclose the information outside the organization;
- Ensure that medical information is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas;
- Maintain the records and information in an accurate and timely manner;
- Ensure Member timely access to records and information that pertain to them; and
- Timely report breaches of PHI (See *Chapter: 16 Privacy and HIPAA*).

Disruptive Member Issues

There are situations in which a Member's behavior can place a strain on the provider and/or the Provider Organization. CMS generally does not permit the involuntary termination of a Member, except in very specific circumstances. SCAN will work with providers to find a way to meet the needs of the Member while addressing the concerns of the affected providers. Under no circumstances should providers refuse to continue to provide and arrange care for a Member. All efforts should first be made to resolve the issue at the practice level.

Disruptive behaviors may include abusive, harassing, or derogatory comments to staff, including yelling or profanity, threats of violence, threats of lawsuits, and inappropriate public behavior.

If a Member is violent or is threatening violence, law enforcement should be notified immediately. In addition, promptly notify SCAN via your assigned Provider Relations Lead or email ProviderRelations@scanhealthplan.com and include any supporting details and documentation.

Providers **may not** end a relationship with a Member because of a Member’s medical condition, the cost and type of care/treatment required, or for the Member’s failure to follow treatment recommendations.

Providers **may not** refuse to continue to coordinate care as long as the Member is assigned to the Provider.

A Member **may not** be involuntarily transferred to a new provider or medical group without the approval of SCAN.

Each provider organization must have a documented Disruptive Member procedure and provide such procedure to SCAN upon SCAN’s request. If all efforts have been exhausted, SCAN will work with Provider to transfer disruptive Members to another provider for repeated, continuous, and unabated disruptive behavior by the Member that prevents the provider from providing services to the Member. Prior to requesting a member transfer, the provider must provide SCAN with contemporaneous documentation of the disruptive behavior and all attempts made to resolve the issue.

Refer to Medicare Managed Care Manual, Chapter 2 – Medicare Advantage Enrollment and Disenrollment, Section 50.3.2 – Disruptive Behavior
<https://www.cms.gov/files/document/cy-2024-cost-plan-enrollment-and-disenrollment-guidance.pdf>.

Providers may contact Provider Relations Lead or ProviderRelations@scanhealthplan.com for more information.

FDR and Compliance Program Requirements

Providers that have contracted with SCAN to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program are considered first tier or downstream entities of SCAN (also referred to as “FDRs” for “first, tier downstream, and related entities”). CMS requires that FDRs fulfill specific Medicare compliance program requirements which are outlined below and further specified in each provider contract. (See also MMCM Chapter 21, Medicare Prescription Drug Benefit Manual (PDBM) Chapter 9, and 42 CFR 422.503, 423.504.)

Compliance Program Requirements	
Written Standards	
<i>FDRs must have written standards, that may be stated in a separate Medicare-specific stand-alone document or be within a corporate Code of Conduct, which describe at a minimum the FDR’s:</i>	
<ul style="list-style-type: none"> • Mission and commitment to compliance with law and to the highest ethical standards; • Procedures to avoid and address conflicts of interest; • Procedures for fraud, waste and abuse prevention, detection and correction; • Policy of non-intimidation and non-retaliation; 	<ul style="list-style-type: none"> • Method and frequency by which provider distributes standards of conduct to employees and downstream entities (required within 90 days of hire, upon update and annually); • System for routine monitoring and identification of compliance risks; and • Compliance officer and high level oversight.

General Compliance Training	
<p><i>FDRs may utilize CMS's standardized training available on the Medicare Learning Network at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo, or equivalent training. FDRs may use CMS's standardized general compliance training, or equivalent training, or incorporate the CMS general compliance training materials or equivalent. Training must include:</i></p>	
<ul style="list-style-type: none"> • Review of compliance policies and procedures, and commitment to business ethics and compliance with all Medicare requirements; • Overview of how to ask compliance questions; training should emphasize confidentiality, anonymity, and non-retaliation; • Requirement for contractor to report to the sponsor actual or suspected Medicare and/or Medicaid program noncompliance or potential Fraud Waste and Abuse (FWA); • Examples of reportable noncompliance; 	<ul style="list-style-type: none"> • Review of the disciplinary guidelines for non-compliant or fraudulent behavior; • Attendance and participation in compliance and FWA training programs annually; • Training must be made part of the orientation for new employees; • Overview of HIPAA, CMS Data Use Agreement (if applicable), and the importance of maintaining the confidentiality of PHI; • Overview of monitoring and auditing process; and • Review of the laws that govern employee conduct in the Medicare program.
Fraud, Waste and Abuse (FWA) Training	
<p><i>FDRs may use CMS's standardized FWA training, or equivalent training, or incorporate the CMS FWA training materials or equivalent. FWA training must include:</i></p>	
<ul style="list-style-type: none"> • Laws and regulations related to MA and Part D FWA; • Obligations of FDRs to have appropriate policies and procedures to address FWA; • Processes for employees to report suspected FWA to the sponsor directly or to their employer who then must report it to the sponsor; • Protections for FDR employees who report suspected FWA; 	<ul style="list-style-type: none"> • Types of FWA that can occur in the settings in which FDR employees work; • Requirement for training to occur within ninety (90) days of hire and annually; and • Effective ways to communicate information from the compliance officer to others including physical postings of information, e-mail distributions, internal websites, and individual/group meetings with compliance officer.
Offshore Subcontracting (CMS issued guidance 08/15/2006 and 07/23/2007; and 2008 Call Letter.)	
<p><i>FDRs that engage in offshore subcontracting (CMS issued guidance, https://www.hhs.gov/guidance/document/offshore-subcontractor-data-module-hpms) must have policies that:</i></p>	
<ul style="list-style-type: none"> • Ensure that PHI and other personal information remains secure; • Appropriately limit subcontractor's access to Medicare data; 	<ul style="list-style-type: none"> • Allow for immediate termination of the subcontractor upon discovery of a significant security breach; and • Include language that requires compliance with applicable laws and regulatory guidance.
Exclusion Screening, Oversight, and Records	
<p><i>FDRs must have policies that:</i></p>	
<ul style="list-style-type: none"> • Ensure that no persons or entities are excluded or become excluded from participation in federal programs. See Social Security Act 1862(e)(1)(B), 42 CFR 422.752(a)(8), 423.752(a)(6), 1001.1901. 	<ul style="list-style-type: none"> • Describe oversight of FDRs and process to monitor and audit FDRs; and • Specify retention of compliance related records for ten (10) years, or longer if required by applicable law.

SCAN providers acknowledge that compensation by SCAN is contingent on full and ongoing compliance with their agreement with SCAN and this manual, including submission of all required attestations to demonstrate compliance. In the event a SCAN provider fails to timely provide SCAN any such attestation, SCAN may impose corrective action, including, but not limited to, financial penalties related to noncompliance.

Disclosure of Ownership and Control Interest and Management Statement

SCAN providers must fully comply with all state and federal requirements for disclosure of ownership and control, interest and management, business transactions, and information for persons convicted of crimes against federal related health care programs, including Medicare and Medicaid programs. See 42 CFR 422.500, 42 CFR 422.222, and 42 CFR 455 (as applicable).

A full and accurate disclosure of: (1) direct or indirect ownership in the disclosing entity and/or (2) ownership interest in an obligation of the disclosing entity, is required and must be reported to SCAN if it equates to an ownership interest of five percent (5%) or more in the disclosing entity or at least five percent (5%) of the value of the property or assets of the disclosing entity, respectively.

Providers may contact Contracting Lead at ProviderContracting@scanhealthplan.com for more information.

Skilled Nursing Facilities

SCAN requires applicable Freestanding Skilled Nursing Facilities (SNF) Level-B and Adult Freestanding Subacute Facilities Level-B, which are eligible to participate in the Medi-Cal Program and which furnish services to SCAN Members, to comply with *DHCS All Plan Letter (APL) 25-002 'Skilled Nursing Facility Workforce Quality Incentive Program'* regarding how payments will be processed, how to file a Provider grievance, and how to determine the responsible payer. Additional information can be found at the DHCS SNF WQIP website. <https://www.dhcs.ca.gov/services/Pages/SNF-WQIP.aspx>

In-home Service Agency Requirements

SCAN requires in-home service agencies, providing Medicaid-funded personal care services (PCS) and in-home visits, to comply with *DHCS All Plan Letter (APL) 22-014 'Electronic Visits Verification Implementation Requirements'* and California's Welfare & Institutions (W&I) Code section §14043.51.

For additional resources, please see below:

- Provider Types and Codes: <https://www.dhcs.ca.gov/provgovpart/Documents/EVV-Provider-Types-and-Codes.pdf>
- DHCS EVV Webpage: <https://www.dhcs.ca.gov/provgovpart/Pages/EVV.aspx>
- DDS EVV Webpage: <https://www.dds.ca.gov/services/evv/>
- CalEVV program general questions: Email EVV@dhcs.ca.gov
- CalEVV technical assistance: Call or email the Customer Support team at 1 (855) 943-6070 or CACustomerCare@sandata.com
- Alternate EVV assistance, Call or email the Alternate EVV Customer Support team at 1 (855) 943-6069 or CAAltEVV@sandata.com

Chapter 6: Utilization Management

The role of utilization management is to ensure the consistent delivery of high-quality health care services to SCAN Members. At SCAN, utilization management is a collaborative and cooperative effort between SCAN and its provider and provider groups. We work together to ensure that Members receive covered services that are medically necessary, appropriate to the Member's condition, rendered in the appropriate setting, and meet professionally recognized standards of care.

SCAN monitors and provides oversight of utilization through the Utilization Management Committee.

Delegation of Utilization Management

SCAN may delegate utilization management functions to its contracted delegated entities for most items and services. The entities delegated to perform utilization management activities on behalf of SCAN must comply with all requirements applicable to SCAN, including those set forth in this Chapter.

Providers should refer to their Delineation of Responsibilities (DOR) Grid for additional information. This only applies if Utilization Management is delegated to the provider. See also *Chapter 10: Delegation Oversight* for more information.

Where items or services are not delegated and remain SCAN's responsibility, providers should send authorization requests to SCAN Utilization Management.

Immunotherapies

New immunotherapies, such as Tumor-infiltrating lymphocyte (TIL) therapy approved by the FDA for certain cancers, are currently in Medicare-approved clinical trials and/or have received FDA approval, but CMS National or Local Coverage Determinations are not yet available. Similar to CAR-T immunotherapy, for reasonable and necessary treatment Inpatient administration is included in Hospitalization responsibility.

CAR-T immunotherapy is covered under Medicare Part B when it meets the criteria outlined in the CMS National Coverage Determination (NCD). Refer to <https://www.cms.gov/medicare-coverage-database> for specific coverage guidelines.

- **Inpatient administration:** Covered under hospitalization services.
- **Outpatient administration and drug:** Covered under outpatient facility services and Medicare Part B drug benefits.

Refer to the Division of Financial Responsibility (DOFR) and Evidence of Coverage (EOC) for additional guidance on responsible payor and member cost-sharing. CAR-T therapy is not considered a transplant service.

Organization Determinations

An Organization Determination is any decision made by an MA Organization, or its delegated entity, regarding receipt of or payment for a managed care item or service, the amount SCAN requires a Member to pay for an item or service, or a limit on the quantity

of items or services. Organization Determinations include, but are not limited to, prior authorizations, concurrent review, retrospective review, and requests for continuity of care. Should SCAN receive a request for an Organization Determination where the responsibility for making the determination has been delegated, SCAN will refer the request to the appropriate delegated entity.

Organization Determinations must be made by health care professionals, who have appropriate clinical expertise in treating the Member's condition or disease, in accordance with currently accepted medical or health care practices. When there is insufficient guidance in the applicable NCD, LCD, or Medicare statutes and regulations, flexibility may be applied in coverage decisions. (Refer to: [Guidance \(scanhealthplan.com\)](https://www.scanhealthplan.com)) Organization Determinations are always based on Member eligibility and appropriateness of care/service. SCAN does not reward providers or other individuals for approving or issuing denials of authorizations.

When an entity delegated to make Organization Determinations does not have all of the information it needs to make a determination, the delegated entity must make reasonable and diligent efforts to obtain all necessary information in accordance with CMS guidelines. See <https://www.cms.gov/ORGDetermin.html>.

Delegated entities are expected to stay apprised of new and/or changing Medicare Part A and Part B coverage policies, including those that result from CMS's NCDs and LCDs.

Members must be provided all the basic benefits covered under original Medicare Part A and Part B. In general, Medicare coverage and payment is contingent upon a determination that:

- A service is in a covered benefit category;
- A service is not specifically excluded from Medicare coverage by Title XVII of the Social Security Act (the "Act"); and
- The item or service is "reasonable and necessary" for the diagnosis or treatment of an illness or injury, to improve functioning of a malformed body member, or is a covered preventive service.

See [MMCM Chapter 4 – Benefits and Beneficiary Protections Section 20.4](#) for Medicare Managed Care Enrollee Grievances, Organization Determinations, and Appeals guidance.

Peer Review Requests

In accordance with CMS Medicare Advantage regulations, the delegated group should offer a peer-to-peer (P2P) discussion before a final adverse determination is issued. The requesting practitioner may contact the delegated group to speak with the reviewing medical director of like or greater specialty; this conversation must be completed within the original decision window. If the denial is upheld, the member—or the treating provider with a valid appointment of representative—may submit a Level 1 reconsideration (appeal) within 65 calendar days of the denial notice. All P2P communications, denial

rationales, and appeal outcomes must be documented in the case file and retained for at least ten years.

Prior Authorization

SCAN may delegate the responsibility for prior authorizations to its delegated entities, depending on the Provider's contract with SCAN. For Medi-Cal only benefits, forward referrals to SCAN Utilization Management and/or refer Members to the SCAN Member Services Department at (800) 559-3500.

Prior authorization is never required for Emergency Services, including behavioral health services necessary to screen and stabilize Members.

Prior authorization is always required for planned out of area services that are not Urgent or Emergent.

Refer to Timelines of Pre-Service Organization Determinations (Part C) discussed below.

All SCAN providers must adhere to the following decision-making hierarchy when considering coverage criteria for medical necessity determinations, which is publicly available at [Medical Policy \(scanhealthplan.com\)](https://www.scanhealthplan.com/medical-policy):

1) Medicare Guidelines including, but not limited to:

- [Medicare National Coverage Determinations \(NCD\)](#)
- [Medicare Local Coverage Decisions \(LCD\)](#)
- [Local Coverage Articles \(LCAs\) \(Active/Retired\)](#)
- [Medicare Manuals \(Internet Only Manuals \(IOM\)\)](#)

2) In the absence of Medicare guidelines, SCAN may create internal coverage criteria based on current evidence in widely used treatment guidelines or clinical literature that is publicly available:

- Nationally recognized evidence-based guidelines/criteria: e.g.,
 - Utilization Management Guidelines such as InterQual® or MCG®, in conjunction with the clinical judgement of a qualified health professional
 - National Comprehensive Cancer Network (NCCN)®
 - American Diabetes Association (ADA)®
 - American Heart Association (AHA)®

and/or

- In coverage situations where there is no NCD, LCD, or guidance on coverage in original Medicare manuals, an MAO may adopt the coverage policies of other MAOs in its service area
 - Reference: [Medicare Managed Care Manual \(MMCM\) Chapter 4, Section 90.5 Creating New Guidance](#)

NOTE:

- When there is insufficient guidance in the applicable NCD, LCD, or Medicare statutes and regulations, flexibility may be applied in coverage decisions when supported by current widely used treatment guidelines or evidence-based literature to allow for circumstances where clinical benefit is highly likely to outweigh any clinical harm.
- For SCAN members who are *dual-eligible*, refer also to [DHCS Medi-Cal Guidelines](#) for specific information on coverage criteria and coordination of benefits. SCAN reviews requests for Medi-Cal only benefits which should be forwarded to SCAN Utilization Management.

SCAN will make MCG criteria publicly accessible. For FDRs that utilize other third-party vendor criteria, it is the responsibility of the FDR to publicly post vendor link on their public page. For other criteria coverage questions, contact SCAN Medical Policy at <https://medicalpolicy.scanhealthplan.com> or (medicalpolicy@scanhealthplan.com).

Timeliness of Pre-Service Organization Determinations (Part C)

This section applies to Part C pre-service Organization Determinations only (i.e., determinations with respect to the provision of medical services/items). Please see [Chapter 11: Pharmacy](#) for Part D Coverage Determinations.

A Member or his/her physician may seek pre-service Organization Determination from SCAN or, where applicable, its delegated entities. The Member or his/her physician may request that an Organization Determination be expedited when he/she believes that waiting for a decision under the standard time frame could place the Member's life, health, or ability to regain maximum function in serious jeopardy. Time frames for Part C pre-service Organization Determinations are:

To Render Decision and Notify* Member and Provider (from Receipt of Request)	
Standard	<ul style="list-style-type: none"> • Seven (7) calendar days and may extend the timeframe up to fourteen (14) calendar days (See 42 C.F.R. § 422.568 (b)(1)(ii) and (b)(2)(i)). • Seventy-two (72) hours after receiving the request for Part B drugs and cannot be extended
Expedited	<ul style="list-style-type: none"> • Seventy-two (72) hours with possible extension, not to exceed fourteen (14) calendar days • Twenty-four (24) hours after receiving the request for Part B drugs and cannot be extended
To Provide Notice* of Denial of Request to Expedite	
Prompt oral notice and subsequent written notice within three (3) calendar days	
*See the Notice Requirements section of this Chapter for details regarding the form of notice required	

See 42 C.F.R. § 422.568(b); <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf>

Medi-Cal and Supplemental Benefits

Members may be entitled to additional benefits beyond Original Medicare by virtue of

eligibility/enrollment in Medi-Cal (e.g., incontinence supplies, safety DME, home health services supplies, hearing aids, etc.). Members may also be entitled to Supplemental Benefits such as prescription drug coverage, vision coverage, and hearing coverage.

SCAN **does not** delegate Organization Determinations for **Medi-Cal only benefits** (e.g., prior authorization). Providers are responsible for referring dually enrolled Members to SCAN for Medi-Cal only benefits (see [Chapter 2: Key Contacts Resource Guide](#)). In addition, for referrals for Medi-Cal only benefits received by the provider, SCAN requires that the provider send notification to the Member advising that Medi-Cal benefits will be administered by SCAN. See [Chapter 4: Physician Responsibilities](#) and Notice Requirements, below in this Chapter, for additional information See [Chapter 2: Key Contacts Resource Guide](#).

Delegated entities may request coverage guidance from SCAN by referring to [Medical Policy](#), sending an email to medicalpolicy@scanhealthplan.com, or contacting SCAN's Utilization Management Department at (800) 250-9048, Option 2 or send email to: UMCCMDEPARTMENT@scanhealthplan.com.

Concurrent and Retrospective Review

SCAN typically delegates the responsibility for concurrent review to its delegated entities. When delegated for concurrent review, Delegated Entity must follow guidelines outlined in [Chapter 10: Delegation Oversight](#) and refer to the Delegated Entities Delegation of Responsibilities (DOR) for more information. When concurrent review is not delegated, SCAN performs inpatient (including continued stay review, discharge planning, and discharge review) and outpatient concurrent reviews. For inpatient stays, SCAN performs concurrent review from the day of admission through discharge to assure the medical necessity of each day, that services are provided at the appropriate level of care, and that necessary discharge and/or transition of care arrangements have been made.

SCAN also typically delegates the responsibility for retrospective review to its delegated entities. When delegated for retrospective review, Delegated Entity must follow guidelines outlined in [Chapter 10: Delegation Oversight](#) and refer to the Delegated Entities DOR for more information. When retrospective review is not delegated, SCAN conducts retrospective medical record review as may be required for health care services that were provided without formal prior authorization and medical necessity screening. Regardless of delegation, a retrospective review can be triggered by claims/encounter data where services are denied for failure to obtain prior authorization or pre-defined focused reviews such as diagnosis related grouping (DRG) validation, short stay, readmission reviews, etc.

Notice Requirements

Delegated entities are responsible for ensuring that all Member notifications are provided in a culturally competent manner. SCAN requires member-facing materials to be written in appropriate levels of readability and suitability for an older adult population, understanding that there may be exceptions.

Language assistance, written, and/or alternative format communication must also meet the applicable regulatory requirements, including:

- CMS - eighth grade level
- DHCS - sixth grade level

Member notices must be complete and accurate, including adequate rationale specific to the decision, written in a manner easily understandable to Members, and not subject to interpretation. Notification of denial must include citation of criteria used, rationale, and recommendations for alternative and/or follow up with physician/provider. Notices must not use acronyms or technical/clinical terms unless an explanation/definition is provided.

Delegated entities performing utilization management functions must use SCAN-approved notices. These templates have been designed to meet CMS notice requirements, translations into SCAN threshold languages and are available at: <https://www.scanhealthplan.com///scan-cms-approved-letter-templates>

SCAN Provider Readability Guidelines are available at: <https://www.scanhealthplan.com/////provider-partner-readability-guidelines>

Delegated Entities must follow guidelines outlined in *Chapter 9: Member Appeals and Grievances*. See also 42 CFR 422.624, 422.626, 489.27, and *Parts C&D Enrollee Grievances, Organization/Coverage Determinations, and Appeal Guidance*.

Notice	When Required
To Member (or Representative) After Request for Prior Authorization	
Notice of Authorization letters (Facility and Services)	Issue when service/item/stay is authorized
Notice of Dismissal of Pre-Service Request	Issue when: <ul style="list-style-type: none"> • Request lacks valid appointment of representative form or written equivalent or valid authorization • Service/item requested already been received
To Member (or Physician) After Denial of Medical Coverage See https://www.cms.gov///MADenialNotices.html	
Notice of Denial of Medical Coverage (NDMC) <i>Not to be used for FIDE-SNP members (see table below)</i>	Issue when denying a request for medical services. <ul style="list-style-type: none"> • Pre-Service Denials – Standard or Expedited • Exhaustion of Skilled Nursing Benefit Denials • Psychiatric Facility Exhaustion of Benefits Denials • Refusal to Transfer <i>Note: Not to be used for Post Service Denial of Payment</i> https://www.cms.gov/medicare/medicare-general-information/bni/downloads/integrated-denial-notice-instructions-cms-10003.pdf
Extension Needed for Additional Information	Issue for the following: <ul style="list-style-type: none"> • The extension is requested by the enrollee; • The extension is justified and in the enrollee’s interest due to the need for additional medical evidence from a non-contract provider that may change an MA plan’s decision to deny an item or service; or • Is in the enrollee’s best interest due to extraordinary, exigent, or other non-routine circumstances, such as a natural disaster.
Services Do Not Meet Expedited Criteria	Issued when the Member has requested an expedited initial decision and the request does not meet Expedited Initial Organization Determination (EIOD) criteria

Notice	When Required
To Facility	
Denial of Coverage for Inpatient Hospitalization	Issue when a reviewing physician denies an inpatient facility stay/extension of an inpatient stay
To Hospital Inpatients See https://www.cms.gov//hospitaldischargeappealnotices.html	
Important Message From Medicare (IM)	Issue to inform of hospital discharge appeal rights <i>Note: Must be delivered in person within two (2) calendar days of admission and not more than two (2) calendar days prior to discharge and the patient must sign that they received and understand</i> https://www.cms.gov/medicare/medicare-general-information/bni/downloads/important-message-english-and-spanish.zip
Detailed Explanation of Non-Coverage (DENC)	Issue when the Member has filed an appeal with the CMS Quality Improvement Organization (QIO) for denied covered skilled nursing services (including home health, comprehensive outpatient rehabilitation and hospice) <i>Note: Must be delivered no later than close of business of the day of the QIO notification</i>
Detailed Notice of Discharge (DND)	Issued by the acute hospital when the Member appeals the hospital discharge (with the QIO). Delegated entities are responsible for the oversight of their contracted facilities. <i>Note: Must be delivered to the inpatient before noon of the day after notification by QIO of the appeal. The hospital must provide all documents/information requested by QIO.</i>
To Hospital Observation Patients See https://www.cms.gov//hospitaldischargeappealnotices.html	
Medicare Outpatient Observation Notice (MOON)	Issued when Member is in an outpatient setting receiving observation services and is not inpatient at a hospital or critical access hospital (CAH). https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/MOON-FAQs.docx
To Member (or Physician) Where Group is Not Responsible for Services	
Informational Letter to Beneficiary And Or Provider Physician (Carve Out)	Issue when the Member has requested services that the group does not have responsibility for providing or authorizing (e.g., Medi-Cal only benefits, acupuncture and chiropractic services, hearing aid services, non-Medicare covered podiatry, non-emergent transportation, non-medical vision, home delivered meals, over the counter items)
To Members Whose HH, SNF, Hospice, or CORF Services Are Ending See https://www.cms.gov//FFS-Expedited-Determination-Notices.html	
Notice of Medicare Non-Coverage (NOMNC)	Issued when there is a termination of: <ul style="list-style-type: none"> • SNF • HH (including psychiatric home health) • CORF • Hospice (delivered by Hospice Provider) <i>Note: Must be delivered two (2) calendar days OR the second to last day of service if care is not being provided daily, prior to termination of services unless exception applies and must be delivered in person. The member must sign and receive a copy.</i>
Optional Form to Document Alternate Delivery	Utilized to document the issuance of the NOMNC when the Member and/or Member's representative is unable or refuses to sign the NOMNC <i>Note: If Member is unable to make decisions for him/herself, contact Member's representative on the day of NOMNC issuance and mail the Optional Form on the day of contact</i>
Detailed Explanation of Non-Coverage (DENC)	Issued when the Member has filed an appeal with the QIO for services denied for SNF, HH, CORF, Hospice <i>Note: Must be delivered no later than close of business of the day of the QIO notification</i>
Reinstatement of Coverage	Issued when skilled level of care is reinstated after receipt of NOMNC <i>Note: The letter advises the Member there will be no lapse in coverage. If Member's condition changes, this letter can be issued prior to QIO decision. New NOMNC must be issued for notification of discharge at least two (2) calendar days prior to last covered day.</i>

Special Considerations for FIDE SNP Members

It is important that delegated entities understand coverage rules for utilization management functions applicable to **FIDE SNP (Medicare and Medi-Cal Enrolled) Members** (See *Chapter 1: Welcome and Overview* for a definition of FIDE SNP Members) when making Coverage Determinations and issuing services denials for these Members use the following notifications:

Notice	When Required
Denial Notice/Coverage Decision letter <i>To be used for FIDE-SNP members</i>	Issue this letter to Members enrolled in a SCAN fully integrated dual special needs plan (FIDE-SNP) when an organization determination is made to reduce, stop, suspend, or deny, in whole or in part, a request for a service/item. <i>Note: This letter must be used in place of the Notice of Denial of Medical Coverage / NDMC</i>

Delegated Entities for Utilization Management: Let us Help You

SCAN is available to answer questions regarding required notices and to provide on-site in-service education. Providers may contact Provider Relations Lead or ProviderRelations@scanhealthplan.com for information.

SCAN CMS approved letter templates are available on the SCAN website <https://www.scanhealthplan.com///scan-cms-approved-letter-templates>

Continuity of Care

SCAN, in collaboration with the assigned delegated entity, will coordinate care and services for Members who are newly enrolled, transitioning to a new PCP and/or medical group, or where there is potential for disruption in services to ensure uninterrupted care and safe transition. Continuity of care may be requested for, but not limited to: outpatient mental health/chemical dependency treatment; current acute or SNF hospitalization; chemotherapy, radiation therapy or nuclear medicine; complex chronic condition requiring continued care and ongoing services; DME (e.g. oxygen, hospital bed); terminal illness requiring continued care and ongoing services; and pending authorized surgery/procedure scheduled within one hundred eighty (180) days.

Continuity of care decisions are made in collaboration with the Member’s new PCP and/or medical group. For timing requirements and financial responsibility with respect to continuity of care, please refer the provider’s contract with SCAN.

The delegated entity is responsible for the continuity of care, including, but not limited to, a provider being terminated from the SCAN network due to a quality of care concern, a provider no longer providing services in SCAN’s service area, or if sanctioned by Medicare and/or the medical board. Delegated entities are also responsible for working with SCAN to transition the member safely to a SCAN in-network provider.

Approved requests for members transitioning to SCAN (e.g., fee for service to plan, plan

to plan, or medical group to medical group) who are undergoing an active course of treatment will be authorized a minimum of a 90-day transition period or for the length of the course of treatment.

Chapter 7: Care Management

Delegation of Care Management

SCAN delegates certain activities to contracted providers, and contracted providers must perform these activities according to the contract and in compliance with all applicable state and federal laws, including, but not limited to, Medicare laws and regulations, and CMS guidelines. SCAN, however, remains ultimately responsible for the performance of all delegated activities. (See 42 CFR 422.504(i); 42 CFR 422.202(b); and 422.504(a)(5)).

Providers should refer to their Delineation of Responsibilities (DOR) Grid for additional information. This only applies if Care Management is delegated to the provider.

SCAN monitors and audits all delegated activities to ensure that they are performed satisfactorily. Refer to [Chapter 4: Physician Responsibilities](#) and [Chapter 10: Delegation Oversight](#) for additional information.

This Chapter focuses on Care Management programs that SCAN has implemented to maintain high quality care.

SCAN Care Management Programs

SCAN integrates the person-centered care approach in developing programs and activities to ensure optimal clinical outcomes for Members. SCAN offers telephonic case management programs for Members at high risk for poor health outcomes identified through predictive modeling and referrals. The goals of SCAN's programs include preventing unnecessary admissions/readmissions, facilitating access to care/services, supporting providers by reinforcing adherence to treatment plans, assisting Members in navigating the health care system, facilitating goals of care discussions and completion of advanced care directives, increasing Member satisfaction, improving self-management skills by educating to evidence-based guidelines, and/or addressing gaps in care and care giver support.

Program Description	Staffing
<i>Complex Care Management (CCM) Program</i>	
Telephonic case management for Members identified as high-risk for poor health outcomes and hospitalizations. Program services focus on the social determinants of health (SDOH) as well as supporting adherence to the treatment plan and preventive health care. <ul style="list-style-type: none">Additional focus on Members transitioning from a care setting to home (hospital or skilled nursing facility to home), Members with advanced illness, and/or behavioral health needs.	Registered Nurses (RNs) Social Workers (MSWs, or LCSWs) Clinical Pharmacists Community Health Workers Care Coordinators All supported by a Board Certified Gerontological Specialist

Program Description	Staffing
<i>Disease Management (DM) Program</i>	
<p>Telephonic disease management for Members diagnosed with:</p> <ul style="list-style-type: none"> • Congestive Heart Failure (CHF), • Chronic Obstructive Pulmonary Disease (COPD) and/or • Diabetes <p>Disease management services include education and coaching following evidence-based guidelines for the management of the condition.</p> <p>Additional focus on social determinants of health, medication management, signs and symptoms of an exacerbation and action planning, preventive care, and adherence to the treatment plan.</p>	<p>Registered Nurses (RNs) Social Workers (MSWs, or LCSWs) Clinical Pharmacists Care Coordinators All supported by a Board-Certified Gerontological Specialist</p>
<i>Medication Therapy Management Program (MTMP)</i>	
<p>Based on the CMS guidelines, Members identified receive Comprehensive Medication Reviews (CMRs) and Targeted Medication Reviews (TMRs). If care management needs are identified, Members are connected to Care Management for follow-up.</p>	<p>Clinical Pharmacists RNs</p>
<i>Medication Advisor Program</i>	
<p>High-touch Member outreach program using motivational interviewing techniques to discover barriers and offer individualized solutions to Member with medication adherence issues.</p>	<p>Care Navigators</p>
<i>Care Coordination</i>	
<p>Primarily focused on the Special Needs Plan (SNP) population to support and/or facilitate the following:</p> <ul style="list-style-type: none"> • Diagnosis verifications (C-SNPs only) • Health Risk Assessments (HRA) • Identifying unmet needs and coordinating access to care, services, and benefits • Care planning and referrals to care management • Troubleshooting Medicaid issues (FIDE-SNP only) 	<p>Non-clinical staff</p>
<i>Long Term Services Supports (LTSS) Program</i>	
<p>Providing Long Term Services and Supports (LTSS) to Connections and Connections at Home Members (Medicare and Medi-Cal enrolled) who are identified as needing assistance due to physical, functional, or cognitive limitations and meet the State of California Nursing Facility Level of Care (NFLOC) criteria.</p>	<p>RN/Care Manager Non-clinical staff</p>

For more information regarding these programs including full eligibility requirements, please refer to [Chapter 2: Key Contacts Resource Guide](#) for contact information.

Chapter 8: SCAN's Quality Improvement (QI) Program

SCAN does not delegate Quality Management (QM), however, SCAN network providers are required to meet quality standards and comply with SCAN's Quality Improvement Program, which includes, but is not limited to, the following requirements:

- Maintaining a Quality Improvement Program;
- Routine reporting of delegate data (i.e., HEDIS, ODAG, ODR);
- Providing access to documents, medical records, data and/or information required as part of quality of care and quality improvement activities; and
- Allowing access to office site(s) and medical record keeping and documentation

SCAN's Quality Improvement (QI) Program is designed to objectively and systematically evaluate and improve the quality of care and/or services in collaboration with the contracted provider network. The program ensures that meaningful and relevant programs based on nationally recognized research, evidence, and best practices are implemented to improve member experience and outcomes.

The QI Program encompasses both clinical and non-clinical care and services for all SCAN Members in all SCAN Health Plan contracts. The program activities apply to:

- All medical and mental health care and services, both clinical and non-clinical, provided to Members through the health plan and contracted providers and vendors;
- All Members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

SCAN has adopted the Aims established by the Institute for Healthcare Improvement (IHI) in connection with SCAN's QI goals. SCAN's quality initiatives are in pursuit of these aims:

- Improve the patient experience of care (including quality and satisfaction);
- Improve the health populations; and
- Reduce the per capita cost of health care.

CMS Requirements

*MA Organizations must have a **Quality Improvement Program** to ensure the necessary infrastructure to coordinate care, and to promote quality, performance, and efficiency on an ongoing basis.*

MA Organizations must:

*Develop and implement a **chronic care improvement program** and **quality improvement projects**;*

*Develop and maintain a **health information system**;*

*Encourage providers to **participate in CMS and HHS QI initiatives**;*

*Implement a program review process for **formal evaluation of the impact and effectiveness of the QI Program** at least annually;*

***Correct all problems** that come to its attention through internal surveillance, complaints, or other mechanisms;*

*Conduct the **Medicare CAHPS® satisfaction survey**;*

***Measure performance** and report using standard CMS measures; and*

***Develop, compile, evaluate, and report** certain measures and other information to CMS, its Members, and the public.*

See 42 CFR 422.152.

In conjunction with the IHI Aims, SCAN has adopted the IHI Health Equity Framework. The framework includes:

- Make health equity a strategic priority;
- Make increasing equity core to our business;
- Develop clinical and operational data and processes to support health equity;
- Deploy specific strategies that have a direct impact on equity;
- Decrease institutional racism within the organization;
- Leverage partnerships with providers and community organizations to support health equity;
- Advocate for public policies that promote health equity for older adults; and
- Develop partnerships with community organizations to improve health and equity.

SCAN believes that members are the architects of their care and vital to the healthcare team. By partnering with members, their families, and providers we build a foundation for successfully achieving quality outcomes. Safety is integrated into all components of member enrollment, health care delivery and oversight. These activities are aimed at improving safety for our members and include the following intended outcomes:

- Reduced sentinel events
- Reduced medication errors
- Reduced use of high-risk medications
- Appropriate levels of utilization
- Increased compliance with standards of care
- Services/Care provided by a quality network of contracted facilities

SCAN is person-centered and adheres to the Institute of Medicine definition of patient-centered care as “care that is respectful of, and responsive to, individual patient preferences, needs, and values” and ensures that the member experience is excellent through programs like the Program for Advanced Illness (PAI) and Customer Experience. SCAN evaluates the appropriate cultural and linguistic services provided through an Annual DHCS Population Needs Assessment (PNA), the Community Advisory Committee and ongoing consumer research and health literacy training for staff (Health Equity Program). SCAN focuses on the following outcomes:

- Improved member experience related to the delivery of culturally and linguistically appropriate services
- Improved member experience related to end-of-life care and adherence to end-of-life care decisions
- Attainment of member-centered goals
- Improved member experience with the health plan

Health Outcomes

Effective Care Coordination matches populations with appropriate care and services to ensure positive health outcomes. Care Management and Care Transitions programs are the primary population-based interventions SCAN uses to ensure effective care coordination. SCAN also conducts specific member quality interventions when there are barriers to effective care coordination. While these interventions are applied to all SCAN

populations, the Special Needs Plans have specific requirements which are articulated in the SCAN Models of Care. These activities result in the following outcomes:

- Reduction in readmission rates year over year
- Reduced admissions for ambulatory care sensitive diagnoses
- Timely access to needed care
- Improved communication among providers
- Improved continuity of services
- Improved coordination between medical and behavioral health

Patient Experience

In order to achieve improved health outcomes, physicians and office staff should:

- Schedule all patients for an annual wellness visit to evaluate and manage chronic conditions and close care gaps
- Ensure timely access to care to address acute symptoms (i.e., same day appointments, telehealth, clinical triage and guidance)
- Manage chronic conditions, including medication management and regular testing, to ensure conditions are well controlled
- Engage with patients after emergency department visits
- Manage care transitions between inpatient and outpatient settings by engaging with patients and reconciling medications post hospitalization
- Assess and provide treatment options for common geriatric conditions like fall risk, urinary incontinence, and maintaining physical activity
- Assess and provide treatment for mental health
- Collaborate with specialists and other clinicians to ensure patients receive timely access to care
- Assist patients to navigate and coordinate their care, such as assisting with appointment scheduling with specialists and engaging patients in their treatment plan
- Reconcile patient medications and ensure patients understand their prescriptions, and reduce barriers to non-adherence

SCAN and providers/provider groups can work together to achieve these outcomes by:

- Sharing data and reports including gaps in care, encounter submissions, and performance data, and taking action as needed
- Collaborating to exchange ideas, successes, failures, and constructive feedback on best practices
- Providing documentation and patient records as requested by SCAN

SCAN provides the 5 Star Guidebook intended for provider groups and physicians looking for guidance on how best to improve their performance against a number of measures that CMS uses to evaluate and reward successful implementation of best practices in healthcare. For additional information related to CMS 5 Star measures, see [Part C and D Performance Data | CMS](#)

Access and Affordability

At SCAN, we focus on improving affordability by monitoring for appropriate utilization, benefit design, working to improve health thereby preventing costly hospitalizations, and

implementing programs to detect and prevent fraud, waste, and abuse. These efforts are balanced by a grievance and appeals process and quality investigation process to ensure access to care. Quality outcomes related to affordability include:

- Utilization metrics within accepted benchmarks
- Maximum out of pocket costs in accordance with Medicare regulations
- Reduced ambulatory care sensitive admissions
- Reduced readmissions
- Medication adherence

QI activities are communicated to network providers through Quality Committees, individual provider performance reporting, provider E-Newsletters, and the SCAN Website. The QI Program is available upon request. For more information, please contact your Network Compliance Auditor.

Chapter 9: Member Appeals and Grievances

CMS and DHCS require SCAN to establish and maintain meaningful procedures for timely resolution of Member Appeals and Grievances on both a standard and expedited basis. The summary below provides general details about SCAN’s Member Appeals and Grievances procedures. Please see “[SCAN HEALTH PLAN APPEALS, GRIEVANCES AND COMPLAINTS EXPECTATIONS](#)” for additional requirements.

SCAN does not delegate Member Appeals and Grievance functions to providers. Members should be directed to contact SCAN Member Services. See [Chapter 2: Key Contacts Resource Guide](#) (Member Services).

Help us Help the Member

Should the provider receive a Member grievance, the provider should report the grievance to SCAN Member Services immediately. See [Chapter 2: Key Contacts Resource Guide](#) (Member Services).

The following table describes the difference between Appeals and Grievances and provides a summary of the relevant timeframes:

Appeal	Grievance
An Appeal is a review of an adverse Organization Determination, including Part D Coverage Determinations. The first step of the Appeals process is a “Request for Reconsideration” (Redetermination for Part D).	Any complaint or dispute (other than an Organization Determination) expressing dissatisfaction with the manner in which a health plan, provider, or delegated entity provides health care services, regardless of whether any remedial action can be taken.
Examples	
<ul style="list-style-type: none"> Reconsideration of pre-service denial Reconsideration of determination of co-payment amount Part D: Redetermination of drug denial based on medically accepted off label use 	<ul style="list-style-type: none"> Problems getting an appointment Disrespectful or rude behavior by doctors, nurses, or other staff Part D: General complaint about a drug being excluded from Part D coverage
Who May File	
Enrollees, their representatives (appointed or authorized), and certain providers (see below)	Enrollees and their representatives (appointed or authorized)
Time Frames (All timeframes are calendar days, unless stated otherwise)	
To Request	
Sixty-five (65) days from receipt of denial (extension may be granted)	Sixty (60) days from date of event
Dually Enrolled (FIDE-SNP) Member: Sixty (60) calendar days from Notice of Action.	Dually Enrolled (FIDE-SNP) Members: For Medi-Cal only benefits, members may file at any time from the date of event
FIDE-SNP Member Extension: Must be in writing and explain why the request was not filed on time.	
To Render Decision and Notify Member and Provider (from receipt of request)	
Standard	
Part C – see below. Payment: For FIDE-SNP thirty (30) days.	Thirty (30) days (fourteen (14) day extension may be allowed)

<i>Expedited</i>	
Payment Requests: Cannot be expedited (except for FIDE-SNP members that can prove financial burden)	Twenty-four (24) hours (where criteria are met)
<i>Further Levels of Review</i>	
Second Level: Independent Review Entity (IRE) Third Level: Administrative law Judge (ALJ) Hearing Fourth Level: Medicare Appeals Council (MAC) Judicial Review: Federal District Court	Enrollee may file a complaint with the Quality Improvement Organization (QIO) in addition to or in lieu of a Grievance

Part C & D Level 1 Appeal Adjudication Timeframes in accordance with CMS requirements:

Type	Part C	Part C with Extension	Part D
Standard Request for Item, Service, or Part D Drug	30 days	44 days	7 days*
Standard Part B Drug	7 days	N/A**	N/A
Expedited Reconsideration or Redetermination	72 hours	17 days**	72 hours*
Payment	60 days	N/A	14 days

*Note: Part D redetermination exception requests cannot be tolled for receipt of the prescribing physician's supporting statement.

**Part B drug timeframes cannot be extended.

(See <https://www.cms.gov/medicare/coverage-determinations-and-appeals-guidance.pdf> section 50.7.1 for CMS guidance.)

The foregoing is a resource only. Different rules may apply depending on whether the Appeal and/or Grievance falls under Part C or Part D. For information regarding Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, please see <https://www.cms.gov/medicare/coverage-determinations-and-appeals-guidance.pdf>

Requesting Reconsideration/Redetermination on Behalf of a Member

Part C: Generally, the right of Appeal for a denial of a pre-service Organization Determination belongs solely to the Member. However, CMS allows a physician who is providing treatment to a Member, upon providing notice to the Member, to request Reconsideration on the Member's behalf. In such a case, the physician is not required to

submit proof that he/she is the Member's representative. For post-service the right belongs solely to the Member or authorized representative.

SCAN can accept a written Appointment of Representative (AOR) or equivalent written notice from a Member that complies with regulatory requirements. See <https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf>, Section 20.2 for CMS guidance.

Part D: The Member's prescribing physician or other prescriber may request Redetermination of a Coverage Determination on behalf of the Member. Notice to the Member may be required depending upon the circumstances. See <https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf> for CMS guidance.

To initiate a Request for Reconsideration/Redetermination on behalf of a Member under Part C or Part D, physicians can contact SCAN Member Services. See [Chapter 2: Key Contacts Resource Guide](#) (Member Services). For Part D, Physicians can also initiate a request for a Reconsideration/Redetermination electronically on SCAN's website at: <https://www.scanhealthplan.com//medicare-part-d-benefits-file-an-appeal>.

Continuing Benefits While An Integrated Reconsideration Is Pending:

The Member, or a Member's representative or provider, may request that the Member continue to receive the previously authorized service or item at the previously authorized level while the integrated reconsideration is pending if:

- The request for continuation and the integrated reconsideration are both filed timely, that is, within ten (10) calendar days after the notice of the Organization Determination;
- The service or item was ordered by an authorized provider;
- The integrated appeal involves the termination, suspension, or reduction of previously authorized services; and
- The period covering the initial authorization has not yet expired.

Please refer to [Chapter 13: Claims](#), for more information regarding provider disputes and appeals.

State Fair Hearing Rights

A FIDE-SNP (dual eligible) Member also has the right to request a state fair hearing before a State of California Administrative Law Judge by calling the California Department of Social Services (DSS) at (800) 743-8525 (TDD: (800) 952-8349) or by writing to:

California Department of Social Services
State Hearings Division
P.O. Box 944243
Mail Station 9-17-433
Sacramento, CA 94244-2430

Requests must include the Member's name, address, and number; reasons for appealing; and supporting evidence, such as medical records, doctors' letters, or other information that explains why the Member needs the item or service.

Members must exhaust SCAN's Appeal process prior to requesting a State Hearing.

Requests for state fair hearings must be submitted within one hundred twenty (120) days from the date of the Notice of Appeal Resolution (NAR) regarding their expedited or standard Appeal. If the Member wishes to have continuation of benefits during the state fair hearing, the request must be submitted within ten (10) days of the notice of adverse benefit determination. Members will receive a written decision within ninety (90) days of their request. The written decision will explain any additional appeal rights. DSS can help Members obtain a Legal Aid lawyer, free of charge, to help with the hearing. See <http://www.dhcs.ca.gov////Medi-CalFairHearing.aspx>.

Members can also call the Special Needs Plan Team at (866) 722-6725 (TTY users call: 711) for assistance.

Chapter 10: Delegation Oversight

SCAN delegates certain activities to contracted providers, and contracted providers must perform these activities in compliance with all applicable state and federal laws, including, but not limited to, NCQA guidelines, Medicare laws and regulations, and CMS guidelines (See 42 CFR 422.504(i) and 42 CFR 438.230, and Medi-Cal regulations and guidelines (See 22 CCR 53867). SCAN, however, remains ultimately responsible for the performance of all delegated activities. To ensure that delegated activities are performed satisfactorily, SCAN monitors and audits all delegated activities.

Delegation Determinations

Prior to delegation, SCAN evaluates and documents the entity's ability to perform the delegated activity in accordance with NCQA, state and federal requirements and SCAN requirements. Upon delegation, each delegated entity is provided with a Delineation of Responsibility (DOR) document that describes in more detail the delegated entity's responsibilities and reporting requirements.

SCAN will send updated DORs when there are changes in delegation requirements or delegation status. Delegated entities should refer to their contract with SCAN and their most recent DOR for information related to delegated activities.

SCAN maintains the sole discretion to allow the delegation of activities to contracted providers or other entities. Delegated entities may not modify the delegated activities or the obligation to perform the delegated activities (e.g., sub-delegation) without prior written consent from SCAN. SCAN approved modifications for delegated activities may require additional reporting and auditing requirements, to ensure SCAN has full access to delegate data to execute or oversee regulatory activities, for example in the event of approved sub-delegation.

Performance of Delegated Activities

Delegated entities are responsible for the performance of all delegated activities, including reporting requirements, in accordance with all applicable laws, their contract with SCAN, this POM, and the DOR. Delegated entities may utilize their own policies and procedures to perform delegated activities, provided to the extent that such policies and procedures are consistent with SCAN's requirements. If the delegated entity's policies and procedures are inconsistent with SCAN requirements, SCAN requirements apply.

Delegated entities remain responsible for the performance of all delegated functions, including functions performed by subcontractors. Delegated entities are required to evaluate subcontractors' performance of delegated activities by monitoring and audits. Please see the provider contract with SCAN for subcontracting requirements.

Delegation Status, Revocation, and Resumption

SCAN may only grant delegation to entities that have demonstrated the ability to perform delegated functions through pre-delegation and ongoing monitoring and audit activities. Delegated entities who fail to meet monitoring and/or auditing standards may be subject to corrective action and more frequent and/or focused audits. Delegation status to the delegated entity is subject to change, dependent on the entity's performance.

Per CMS regulations, SCAN may revoke delegated activities, or specify other remedies, in instances where CMS or SCAN determine that a delegated entity has not performed satisfactorily.

SCAN Oversight Committee Structure

Network Performance Committee

The SCAN Network Performance Committee (NPC) is responsible for: (1) establishing and maintaining a formalized, comprehensive oversight program for monitoring delegated functions and services provided by contracted health care providers including FDRs; (2) overseeing SCAN's network providers' compliance with contractual and regulatory requirements; and (3) overseeing efforts to correct identified deficiencies and/or non-compliance.

Credentialing Committee

The SCAN Credentialing Committee is responsible for establishing and maintaining a comprehensive credentialing and re-credentialing process, making credentialing and re-credentialing decisions, monitoring quality of care and services, and providing guidance for continuous quality improvement to meet NCQA, CMS and applicable state requirements. Credentialing decisions are made on a fair and impartial basis, according to predetermined criteria related to professional conduct and competence, and not based on an applicant's race, gender, age, ethnic origin, sexual orientation, language or type of patients or procedures in which the provider specializes.

Audits

In addition to ongoing monitoring, delegated entities are subject to annual audits, focused audits, ad hoc audits, re-audits, and exigent audits.

- **Annual Audits:** Annual audits are conducted on a routine, scheduled basis depending on delegation status.
- **Focused Audits, Ad-Hoc Audit, or Re-Audits:** A focused audit, ad-hoc audit, or re-audit is usually conducted when some aspect of an annual audit reveals non-compliance or at the discretion of the NPC.
- **Exigent Audits:** An exigent audit is conducted when SCAN determines there is a reasonable need for a non-routine audit (e.g., SCAN becomes aware that a provider delegated for claims payment has experienced an event or series of events that might materially affect its ability to pay claims promptly). Exigent audits may be conducted without notice. However, to allow delegated entities to arrange for the necessary resources and staff, the audit team will notify the delegated entity one (1) hour prior to arriving on site.

Providers are required to submit reports to effectuate audit activities (e.g., quarterly, and annual financial statements in connection with the financial audit/monitoring). SCAN notifies Providers annually of the reporting requirements. Failure to submit required reports may result in increased oversight, corrective action, or other appropriate action.

SCAN's Delegated Oversight Unit (DOU) will work with the delegated entity to schedule an audit unless an exigent or ad hoc audit is required.

With the exception of unscheduled exigent/ad hoc audits, once an audit date is set, the delegated entity will receive an audit confirmation letter that includes information about the audit scope, how to prepare for the audit, and other information as may be necessary to conduct the audit. Failure to comply timely with audit requests may result in corrective action, de-delegation, or sanctions.

Audit Results and Corrective Action

Results of the audit and any requests for corrective action will be returned to the delegated entity within thirty (30) to forty-five (45) calendar days of the date of the audit. Corrective action may be

required in addition to other remedies or sanctions (e.g., placing the delegated entity on financial watch status). See Sanctions section, below in this Chapter. Corrective action required by SCAN is separate and distinct from corrective action that may be required by third parties (e.g., corrective action required by the DMHC related to a deficiency regarding California solvency regulations). SCAN will consider corrective action by third parties as corrective action for noncompliance with a contractual or regulatory requirement, however SCAN is not required to accept such action.

Unless otherwise agreed to in writing, delegated entities have thirty (30) calendar days from the receipt of corrective action request to submit a completed corrective action plan (CAP) to SCAN. CAPs must include:

- A root cause analysis that describes the underlying causes that resulted in noncompliance and steps to prevent future noncompliance.
- The expected corrective actions entity will take to remediate and to prevent future noncompliance.
- The date(s) the corrective action is expected to be completed and timeframes for specific achievements.
- The ramifications for failure to implement the corrective action successfully.
- The staff responsible for implementation of the corrective action.

The following are examples of deficiencies that may warrant corrective action:

- Provider is unable or unwilling to provide information needed to conduct the audit, or otherwise fails to cooperate with audit activities.
- Provider is unable or unwilling to take action to comply with legal or contractual requirements (e.g., pay claims in accordance with CMS requirements or reserve funds for Incurred but Not Reported (IBNR) claims).
- Provider lacks written policies and procedures sufficient to meet legal or contractual obligations (e.g., policy requiring that provider report potential fraud, waste, and abuse to SCAN).
- Provider fails to maintain documentation sufficient to meet legal or contractual obligations (e.g., incomplete documentation for CMS required training and/or screening).

Failure to cooperate with a SCAN request for corrective action may result in further corrective action, de-delegation, or sanctions.

Sanctions

If a delegated entity fails to cooperate with audit/monitoring efforts or fails to complete a CAP, SCAN may institute sanctions which may include the following, unless expressly stated otherwise in provider's contract with SCAN:

- Termination of the provider contract with SCAN.
- Require a letter of credit and/or other proof that the organization has access to sufficient funds for the payment of claims for healthcare expenses.
- Exclude the provider from the SCAN network.

Depending on the nature of the deficiencies, SCAN may apply sanctions without first requiring a CAP.

Audit Summaries

The following table provides an overview of delegation oversight activities. For further information,

email delegatedcompliance@scanhealthplan.com.

<p>Credentialing Oversight (Providers delegated for credentialing activities)</p> <ul style="list-style-type: none"> Delegated entities must meet all CMS and applicable DHCS requirements regarding credentialing. (See <i>Chapter 5: Network Standards</i>) SCAN uses the current HICE Audit Tool 	
<p><i>Frequency of Audit (excluding focused audits, ad-hoc audits, re-audits, and exigent audits)</i></p> <ul style="list-style-type: none"> Annual audit or based on risk assessment 	
<p><i>Scope of Audit</i></p>	
<ul style="list-style-type: none"> Initial credentialing file review Recredentialing file review Credentialing policies and procedures Review of committee minutes Adverse actions monitoring & reporting Quality Improvement Reports Quarterly credentialing/recredentialing reports⁺ Ongoing monitoring Delegation of credentialing functions 	<ul style="list-style-type: none"> Notification to authorities and practitioner appeal rights Assessment of organizational providers Identification of HIV/AIDS Specialists Credentialing Information Integrity (fka: credentialing system control) (including but not limited to annual oversight reports, information integrity training, audit and analysis, etc.) CA Assembly bill 2581 and CA Senate bill 487 Data validation policies and procedures ensuring data validation of network roster Additional information may be required
<p>FDR Compliance Oversight (all delegated entities)</p> <ul style="list-style-type: none"> Delegated entities must meet all CMS downstream requirements for first tier, downstream, and related entities (FDRs). See provider contract with SCAN for specific downstream requirements; See also the MMCM, Chapter 21 and the PDBM, Chapter 9. Corrective action is required for audits that result in a score of less than 100%. 	
<p><i>Frequency of Audit (excluding focused audits, ad-hoc audits re-audits, and exigent audits)</i></p> <ul style="list-style-type: none"> Sub-set selected for annual audit based on internal risk assessment Annual compliance attestation component⁺ 	
<p><i>Scope of Audit</i></p>	
<ul style="list-style-type: none"> Compliance policies and procedures, including detecting fraud, waste, and abuse (FWA) Standards of Conduct (aka Code of Conduct) General compliance and FWA training Compliance Issue – Resolution and Reporting 	<ul style="list-style-type: none"> Exclusion screening Monitoring and auditing of FDRs Offshore subcontracting Record retention policy Downstream provider contracts Additional information may be required
<p>Financial Audit (Providers delegated for claims processing activities)</p> <ul style="list-style-type: none"> For more information, see DMHC regulations at https://www.dmhc.ca.gov/AbouttheDMHC/LawsRegulations.aspx Information obtained by SCAN as part of its financial audit will remain confidential and will be used solely to comply with California Health and Safety Code Section 1375.1. 	
<p><i>Frequency of Audit (excluding focused audits, ad-hoc audits, re-audits, and exigent audits)</i></p> <ul style="list-style-type: none"> Quarterly financial review Audit performed based upon failure to meet financial solvency requirements 	

Scope of Audit	
<ul style="list-style-type: none"> Financial Audit Questionnaire Financial statement review IBNR claims review 	<ul style="list-style-type: none"> Stop loss insurance Claims Payable Report Additional information may be required
Financial Review-Quarterly Statements and Annual Financial Reports	
<p>On a quarterly basis, SCAN will send a reminder via email for documents for quarterly review, including unaudited financial statements[†]. Please remit the documents to the email sender's address. Documents are due to SCAN on May 15th (for January 1 – March 31), August 15th (for April 1 – June 30), November 15th (for July 1 – September 30), and February 15th (for October 1 – December 31).</p>	
<p>DMHC regulations require that any organization in a risk sharing arrangement with SCAN must maintain these ratios throughout each quarter:</p> <ul style="list-style-type: none"> Positive Tangible Net Equity Cash to Claims ratio of at least 75% Positive Working Capital 	<p>SCAN will also review the following ratios to evaluate an organization's financial status:</p> <ul style="list-style-type: none"> Debt to Equity Days of Cash on Hand Medical Loss Acid Test
<p>* Alternatively, if a delegated entity is required by California law to submit quarterly and annual financial statements to DMHC, and maintains compliance with all required ratios, SCAN will accept DMHC's published results in lieu of collecting and testing financial statements from delegated entities. However, delegated entities must still promptly submit financial statements to SCAN upon request. See https://www.dmhc.ca.gov/ (licensing and reporting).</p> <p>** Provider Organizations are required to comply with all applicable DMHC Knox-Keene Licensing requirements and to submit proof of compliance to SCAN upon request.</p>	
Monthly Review	
<p>If an organization is placed on financial watch, a monthly review of the financial status of the organization will be required. This monthly review may include monthly unaudited financial statements, an updated Provider Financial Questionnaire, Claims Payable Report, and other financial documents.</p>	
Claims Audit (Providers delegated for claims processing activities)	
<ul style="list-style-type: none"> Delegated entities must meet all CMS requirements regarding claims. (See Chapter 13: Claims, for more information regarding these requirements). 	
Frequency of Audit (excluding focused audits, ad-hoc audits, re-audits, and exigent audits)	
<ul style="list-style-type: none"> Annual audit with monthly reporting component or semi-annual, if indicated based on annual risk assessment 	
Scope of Audit	
<ul style="list-style-type: none"> Inventory management reports Reports of pended claims Medicare Advantage claims processing policies and procedures Training materials Organizational structure Information systems (IS) HICE Operational Review Questionnaire Claim and claim supporting areas Testing of contracted provider status Attestations and supporting copies Excluded providers Additional information as may be required 	<ul style="list-style-type: none"> Claim adjudication review, which may include: <ul style="list-style-type: none"> Non-contracted provider paid claims Unclean non-contracted provider paid claims Contracted provider paid claims Unaffiliated provider denials Denied claims with Member liability* 1st level provider dispute resolution claims Reopened claims

	<ul style="list-style-type: none"> ◦ Direct Member Reimbursement Claims ◦ Misdirected claims
<p>* If the provider is placed in retrospective review status for claim denials, 100% of denials must be submitted weekly for review.</p> <p>** In the event of contract termination, Provider Organization is required to promptly provide all claims data to SCAN upon request.</p>	
Monthly Reporting of Claims Processing Timeliness[†]	
<p>All delegated entities must report claims processing timeliness on a monthly basis, using the current version of the HICE Monthly Medicare Advantage Claim Timeliness Report. The report is available at: http://www.iceforhealth.org/. This report should be e-mailed or uploaded to MFT site: to SCAN/Claims Audit ONLY in time to be received by the 15th of the month following the month being reported.</p>	
Quarterly Reporting of Misdirected Claims[†]	
<p>All delegated entities must report claims that were received but determined to be payable by another entity (e.g., SCAN, another medical group, a capitated provider, etc.). The Misdirected Claims Log template (based on HICE template) will be provided by SCAN to each delegated entity and must be submitted to SCAN via email or MFT site: to SCAN/Claims Audit ONLY by 15th calendar day following the end of each calendar quarter: January, April, July, and October.</p>	
Quarterly Reporting of Provider Dispute Resolution (PDR)	
<p>Pursuant to CMS reporting requirements regarding CMS Provider Payment Dispute Resolution for Non-Contracted Providers, all delegated entities must incorporate certain changes in their quarterly Provider Dispute Resolution Reports to their contracted health plans. The PDR Log template (based on HICE template) will be provided by SCAN to each delegated entity and must be submitted to SCAN via email or MFT site: to SCAN/Claims Audit Only by the 30th calendar day following the end of each calendar quarter: January, April, July, and October.</p>	
Utilization Management Audit (Providers delegated for utilization management activities)	
<p>Delegated entities must meet all CMS requirements regarding utilization management. (See Chapter 6: Utilization Management for more information).</p>	
Frequency of Audit (excluding focused audits, ad-hoc audits, re-audits, and exigent audits)	
<ul style="list-style-type: none"> • Annual audit • Annual SNP component for providers delegated for SNP • Monthly, quarterly, semi-annual, and annual reporting components[†] 	
Scope of Audit	
<ul style="list-style-type: none"> • Utilization management written program description • Senior level Physician involvement • Behavioral health practitioner involvement • Annual evaluation • Clinical criteria for UM decisions • Consistency in applying criteria • Communication services • Appropriate professionals • Use of Board-certified consultants • Timeliness of Decisions and Notifications • Appeals Policies and Procedures • UM Denial System Controls • Delegation of UM 	<ul style="list-style-type: none"> • Specialist Termination Notification • Use of Clinical Practice Guidelines • Continuity and Coordination of Care • SNP MOC Training • Alzheimer’s Disease and Related Dementias Training Development • Second Opinions • Quality Management and Improvement Program Requirements • Out of Network Services • Mail Authorization Process • Health Education

<ul style="list-style-type: none"> • Necessary Specialty Care Provided • Services Provided with Cultural Competence • Advanced Directives • No Member Discrimination in Delivery of Health Care • No Prohibition on Health Care Professional Advice to Patients • Adherence to Medicare Marketing Guidelines • Provider Access during Federal Disaster or Public Health Emergency Declarations • Initial Health Appointment 	<ul style="list-style-type: none"> • Notice to Member (or Physician) Where Group is Not Responsible for Services (Carve-Out) • Population Health Management • Care Transition Policy and Procedures • Affirmative statement about incentives • Adequate and appropriate access to care • Arrangements for Specialty Care • Legislative requirements • U.S. Preventive Services Task Force • Additional information may be required
Scope of UM Service Denial Audit	
<ul style="list-style-type: none"> • Timely Organization Determinations • Timely notification to Members • Correct letter template • Appropriate criteria for denial • Relevant clinical information for decisions • Appeal rights provided • Accuracy of notifications 	<ul style="list-style-type: none"> • Alternate treatment options provided to Members • Language (8th grade level definition of medical terminology, defined acronyms when used) • Additional information may be required
Scope of SNP Audit (Providers delegated for SNP only)	
<ul style="list-style-type: none"> • Care Management Program description • Care Management Assessment process • Individualized Care Plan (ICP) • Interdisciplinary Care Team (ICT) • Ongoing care management 	<ul style="list-style-type: none"> • SNP MOC training requirement • SNP Trigger Report • SNP Transition of Care (TOC) • Additional information may be required
Organization Determinations, Appeals, and Grievances (ODAG) and Organization Determinations and Reconsiderations (ODR) (all delegated entities)	
<ul style="list-style-type: none"> • <i>Delegated entities must submit timely, complete, and accurate ODAG and ODR data for CMS submission. Corrective action required for audits that result in score of less than 100%.</i> 	
Frequency of Audit (excluding focused audits, ad-hoc audits, re-audits, and exigent audits)	
<ul style="list-style-type: none"> • ODAG audits are conducted quarterly, or based upon annual risk assessment[†] • ODR audits are conducted annually[†] • Expedited Organization Determinations (EOD) and Standard Organization Determinations (SOD) audits are conducted quarterly 	
Scope of Audit	
<ul style="list-style-type: none"> • Accurate and complete universe data 	
DHCS Facility Site Review (FSR) and Medical Record Review (MRR)	
<p>California law requires SCAN to maintain adequate facilities and service site locations to meet contractual obligations for delivering primary care within designated service areas. To ensure ongoing compliance, SCAN must conduct initial and periodic Primary Care Provider (PCP) site reviews, which include a Facility Site Review (FSR) and a Medical Record Review (MRR), in accordance with the most current Department of Health Care Services (DHCS) FSR and MRR tools, standards, and all applicable All Plan Letters (APL). See DHCS All Plan</p>	

Letter (APL) 22-017 'Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review' for DHCS requirements.

Frequency of Audit

- SCAN is required to conduct subsequent site reviews, consisting of an FSR and MRR, at least every three years, beginning no later than three years after the initial FSR, and at least every three years thereafter.
- SCAN may conduct site reviews more frequently based on county collaborative decisions, auditor determination, when warranted by ongoing monitoring, evaluation findings, or follow-up on Corrective Action Plans (CAPs).

Scope of Audit

- | | |
|---|---|
| <ul style="list-style-type: none"> • FSRs are conducted to ensure that all contracted PCP sites have sufficient capacity to provide appropriate primary health care services and can maintain patient safety standards and practices. • The FSR tool is composed of both critical and non-critical elements. • Critical elements (CE) have the largest potential for adverse effects on patient health or safety. • Non-critical (non-CE) review elements do not have a large adverse effect but are key components for primary health care services and can maintain patient safety standards and practices. In addition to promoting sites to operate in compliance with all applicable local, state, and federal laws and regulations. | <ul style="list-style-type: none"> • MRRs are conducted to assess compliance with documentation format standards, legal and regulatory requirements, and to evaluate the presence of thorough, timely, and accurate documentation of preventive care, coordination of care, and continuity of care services for the patient population. As part of the county collaborative agreement, SCAN performs these audits on behalf of collaborative health plans to ensure consistent quality and adherence across shared provider networks. • The MRR score is based on a standard review of ten or more randomly selected member medical records which can consist of pediatric, adult, or obstetric medical records, according to the member population served. • The MRR score is determined through a standardized review of ten or more randomly selected medical records, or a number within defined parameters. The selection reflects the member population served and may include pediatric, adult, or obstetric records, as appropriate. |
|---|---|

† Please see **SCAN Annual Reporting and Attestation Due Dates and Notification** for detailed instructions.

SCAN's P&T Committee

SCAN's Part D Formulary is reviewed and approved by SCAN's Pharmacy and Therapeutics (P&T) Committee that meets specific requirements with respect to membership, conflict of interest, P&T member disclosure to CMS, meeting administration, formulary management, formulary exceptions, and P&T committee role.

The SCAN P&T Committee is comprised of physicians and pharmacists that come from various clinical specialties and evaluate new drug therapies for placement on the SCAN Part D Formulary, drug utilization criteria, pharmaceutical management policies and procedures, as well as select treatment guidelines for major medical conditions.

The SCAN P&T Committee meets at least quarterly and its decisions regarding the placement of new medications on SCAN's Part D Formulary are distributed to contracted providers.

See www.scanhealthplan.com for more information.

Chapter 11: Pharmacy

SCAN contracts with CMS to provide Medicare Part D prescription drug coverage for SCAN Members and must comply with CMS's rules and regulations.

SCAN also contracts with DHCS to provide coverage of select drugs excluded under Medicare Part D consistent with the Medicaid Program's guidance to the dual eligible Members who have enrolled both their Medicare and Medi-Cal benefits with SCAN in Los Angeles, Riverside, San Bernardino, and San Diego counties.

Pharmacy Benefits

Providers may contact [Network Management Administration Specialist](#) to request a current SCAN benefits grid. Benefits grids are also available on the SCAN Provider Portal at:

<https://www.scanhealthplan.com/providers>.

Part D Formulary

SCAN's Part D Formulary is a list of covered Part D drugs reviewed and approved by the SCAN Pharmacy and Therapeutics (P&T) Committee and CMS. SCAN's Part D Formulary and the updates to the Part D Formulary are available at:

[Formulary Documents | SCAN Health Plan](#).

Providers shall use SCAN's Part D Formulary and non-Formulary medications subject to the exercise of the prescribing provider's clinical judgement. In cases non-Formulary medications are warranted, Provider will work with SCAN by requesting non-Formulary drugs using the SCAN formulary exception process described in the Coverage Determination section below.

Providers shall prescribe medications listed in the SCAN Part D Formulary for Part D covered indications only consistent with section 1927(d)(2) of the Social Security Act, for example, formulary medications when used for weight loss even for a non-cosmetic purpose (i.e., obesity) are excluded from Part D coverage by CMS and are not covered by SCAN.

Select Members, who are dual eligible Members, may have additional drug coverage, mostly over-the-counter medications, consistent with DHCS requirements. These drugs are listed in an “Additional Drug Listing for Medicare and Medi-Cal Members” at: <https://www.scanhealthplan.com///documents-relevant-to-formulary>.

Requests to Add Drugs to the Part D Formulary

Providers may request that drugs be added to SCAN’s Part D Formulary. Providers may submit written requests to: SCAN Health Plan, Attn: Sr. Director, Pharmacy and Formulary Operations, 3800 Kilroy Airport Way, Suite 100, Long Beach, CA 90806.

Finding a Network Pharmacy

SCAN’s pharmacy network includes over sixty-six thousand (66,000) pharmacies, many of which have preferred cost-sharing. Providers can locate a network pharmacy, including a pharmacy with preferred cost-sharing, by using the pharmacy search tool on SCAN’s website at: <https://www.scanhealthplan.com//pharmacy-search>. To find a pharmacy in a specific area, search options must be entered, which include selection of the following options: a specific zip code; pharmacies within a certain mile radius. Once results are returned, the “Services” section will advise if the pharmacy has preferred cost-sharing, open 24 hours, or dispenses a 100-day supply.

Specialty Pharmacies and Specialty Medications

SCAN provides clinical support, therapy management, counseling, and social services for Part D specialty medications through its contracted Specialty Pharmacy, Accredo. Members may also choose to use other network specialty and retail pharmacies to obtain Part D specialty medications. Coverage determinations for specialty medications follow the procedure described below under “Coverage Determination Process”.

Mail Order Pharmacy Program

Members are encouraged to use SCAN’s mail order pharmacy program, administered by Express Scripts, which allows Members to receive a three (3) month supply (e.g., 90-100 day) for chronic medications delivered at home. Express Scripts Pharmacysm is our preferred mail order pharmacy. While Members can choose any mail order network pharmacies to fill their prescription medications, they may pay less at the preferred mail order pharmacy. Providers can fill mail order prescriptions at Express Scripts Pharmacy as set forth below:

- By phone: (888) 327-9791
- By fax: (800) 837-0959
- Electronically: software required, please contact Express Scripts

To avoid delays, all prescriptions must have three (3) forms of identification (e.g., Member name, ID number, date of birth, etc.). If the three (3) forms of identification are not listed, the processing of prescriptions will be delayed. When sending prescriptions for controlled substances, a handwritten signature must be on the prescription. For more information, visit: <https://www.scanhealthplan.com///order-prescriptions-for-home-delivery>

Coverage Determination Process

SCAN delegates Part D Coverage Determinations to Express Scripts. Providers may request Coverage Determinations from Express Scripts 24/7 as set forth below:

- Electronically (Preferred): By an electronic prior authorization process (e.g., CoverMyMeds, ExpressPath, Surescripts, etc.) (see <http://lab.express-scripts.com//physicians> for more information)
- By phone: (844) 424-8886 (If complete information provided, decision will be given on the call)
- By fax: (877) 251-5896 (Completed forms only) Forms available at <https://www.scanhealthplan.com/scan-resources/pharmacy/prior-authorization-and-step-therapy-forms>
- By email: medicarepartdparequests@express-scripts.com
- By mail:
Express Scripts, Inc.
Attn: Medicare Reviews
P.O. Box 66571
St. Louis, MO 63166-6571

Incomplete forms or insufficient information may result in delay or denial. Providers must respond timely to requests for information from Express Scripts. See <https://www.scanhealthplan.com/SCAN-Members/SCAN-Resources/Formulary-and-Part-D-Information/Part-D-Coverage-Determination-Process> for more information and additional ways to request Coverage Determinations.

Part D v. Part B: Let Us Help You

For assistance determining whether a drug falls under Part D or Part B, call the Provider Information Line at (877) 778-7226. A SCAN Clinical Pharmacist will provide a response, usually within twenty-four (24) hours. Please note, this service is for informational purposes only and is not a Coverage Determination. Coverage Determinations are made by Express Scripts as described above.

Injectables, including intravenous and intramuscular drugs, that are typically not self-administered and furnished “incident to” a physician’s or other practitioner’s service are covered under Part B consistent with section 1861(s)(2)(A) or (B) of the Social Security Act. **Per the “incident to” guidelines, providers are not allowed to instruct patients to purchase a drug themselves and bring it to the provider’s office for administration.**

Transition Policy

A new or continuing Member may be taking drugs that are not on SCAN’s Part D Formulary or that are on SCAN’s Part D Formulary but require prior authorization, step therapy, and/or quantity limits. In these circumstances, SCAN may cover a temporary 30-day transition supply during the first ninety (90) days of coverage. Members should talk to their prescribers to decide if they should switch to an appropriate drug that SCAN covers or request a formulary exception.

If a Member is a resident of a long-term care facility, SCAN may cover a temporary 31-day transition supply during the first ninety (90) days of coverage. After the first ninety (90) days, SCAN may provide a 31-day emergency supply unless the Member has a

prescription written for fewer days.

If a Member has a level of care change, SCAN may cover a temporary 31-day transition supply for those Members who are moving from home or a hospital stay to a long-term care facility. SCAN may cover a temporary 30-day transition supply for those Members who are moving from a long-term care facility, or a hospital stay to home. See <https://www.scanhealthplan.com//transition-policy-documents>.

Medication Therapy Management (MTM) Program

CMS requires all Part D sponsors to implement a medication therapy management (MTM) program for Members who have multiple chronic diseases, are taking multiple medications, and are likely to incur annual costs for covered Part D drugs at a specified threshold and for Members who are at-risk beneficiaries (ARBs) under a Drug Management Program (DMP). The purpose of the MTM program is to optimize therapeutic outcomes through improved medication use by providing comprehensive medication reviews (CMRs) and targeted medication reviews (TMRs) to physicians. Members in the MTM program receive a CMR from a Clinical Pharmacist or other qualified provider and receive a Recommended To-Do List and Personal Medication List upon completing the CMR. Recommendations of drug therapy changes, if any, are sent to the Member's prescriber(s). All eligible members of the MTM program will receive information about: safe disposal of prescription drugs that are controlled substances; drug take back programs; in-home disposal; and cost-effective means to safely dispose of medications. For more information about MTM program, see:

<https://www.scanhealthplan.com/SCAN-Members/Pharmacy/Clinical-Pharmacy-Information/2026-Medication-Therapy-Management-MTM-Program>

Village Health:

<https://www.villagehealthca.com/village-health/medication-therapy-management-program-2026>

Changes to Prescription Drug Benefit

SCAN members won't pay more than \$2,100 out-of-pocket for Part D prescription drugs in 2026 and will continue to have the payment option, called Medicare Prescription Payment Plan (M3P), which allows SCAN members to spread out their' payments in monthly amounts through the year. This payment option is designed for members with high out-of-pocket prescription drug cost (e.g., \$600 or more per single prescription). M3P doesn't lower enrollees' prescription drug costs. "Extra Help" from Medicare and help from State Pharmaceutical Assistance Program (SPAP) and AIDS Drug Assistance Program (ADAP), for those who qualify, are more advantageous than participation in the M3P. All Medicare members are eligible to participate in this payment option, regardless of income level, but only those with high out-of-pocket prescription drug cost are likely to benefit from this program.

Opioids

The CMS finalized opioid policies for Medicare drug plans effective January 1, 2019. Providers are in the best position to identify and manage potential opioid overutilization in the Medicare Part D population. The policies include improved opioid safety alerts

(pharmacy claim edits) when opioid prescriptions are dispensed at the pharmacy and drug management programs for Members determined to be at-risk for misuse or abuse of opioids or other frequently abused drugs. As of January 1, 2022, all part D sponsors are required to have a drug management program for Members who are at-risk due to obtaining opioids from multiple prescribers and/or pharmacies or obtaining opioids with history of opioid related overdose. Providers shall cooperate with SCAN and provide necessary information concerning the use of opioids by a Member or Members as part of SCAN's drug management program. Residents of long-term care facilities, those in hospice care, Members receiving palliative or end-of-life care, Members with sickle cell disease (SCD), and Members being treated for cancer-related pain are exempt from these interventions. These policies do not impact access to medication-assisted treatment, such as buprenorphine. For more information on opioid safety alerts, drug management program, and medication-assisted treatment, see:

<https://www.scanhealthplan.com/scan-resources/pharmacy/programs-to-help-member-manage-medication-safety/drug-utilization-management>.

Part D Vaccines

SCAN encourages Members to obtain Part D-covered vaccines through a retail pharmacy if the vaccine is recommended by their PCP. Pharmacies will dispense and administer the vaccine under protocol. In such a case, the pharmacy submits the vaccine claim to Express Scripts with the drug cost and administration fee. Pursuant to the Inflation Reduction Act of 2022, Section 11401 (Coverage of Adult Vaccines Recommended by the Advisory Committee on Immunization Practices Under Medicare Part D), SCAN Members will have access to Part D-covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) at no cost to them even if they have not paid a deductible, if any. The effective date of the \$0 copay for a new adult vaccine recommended by the ACIP will align with the date on which the CDC Director adopts the respective recommendation, as published on the CDC website, or the date after the last day of the ACIP meeting at which the recommendation was approved, if no date is published on the CDC website. Some covered Part D-covered vaccines include, but are not limited to, Shingrix (shingles), M-M-R II (measles), and T-DAP (whooping cough) vaccines. Providers can find a complete list of the Part D-covered vaccines SCAN covers in SCAN's Part D Formulary. For more information, see <https://www.scanhealthplan.com///part-d-vaccines>.

Part D Insulin

\$0 insulin is available in select SCAN plans. Consistent with §§ 423.100 and 423.120(h), SCAN members won't pay more than \$35 for a one-month supply of each insulin product covered by SCAN on our Drug List (Formulary), regardless of cost-sharing tier, or 25% of the insulin cost if that amount is lower. This includes insulin products covered through coverage determination, appeal, or transition. The deductible, if any, does not apply to covered insulin products. Providers can find a complete list of the insulin products SCAN covers in SCAN's Part D Formulary.

Continuous Glucose Monitors

SCAN Members are able to get Continuous Glucose Monitors (i.e., Dexcom and Freestyle Libre) at the pharmacies with a prescription under Part B benefit. Prior Authorization and other limits may apply. All Continuous Glucose Monitors will continue to be available through the Durable Medical Equipment (DME) providers. Prior Authorization may apply.

Part B Prescription Drugs

Pursuant to the Inflation Reduction Act of 2022, Section 11101, beginning April 1, 2023, SCAN Member coinsurance for Part B drugs will be reduced if the drug's price has increased at a rate faster than the rate of inflation. CMS publishes the adjusted beneficiary coinsurance for each Part B drug in the quarterly pricing files posted on the CMS website. SCAN members pay \$0 - 20% of the Medicare-approved amount for Medicare Part B prescription drugs. Prior Authorization rules may apply.

Consistent with the Inflation Reduction Act of 2022, Section 11407, beginning July 1, 2023, SCAN members pay no more than \$35 for a one-month supply of a Part B insulin furnished through an item of durable medical equipment, such as a medically necessary insulin pump.

Beginning on January 1, 2026, select Medicare Part B drugs may have Step Therapy requirements applicable to new starts only. For example, SCAN members who are currently receiving a non-preferred Part B drug and have a paid claim for it within the past year will not be subject to Step Therapy. The following link takes you to a list of Medicare Part B drugs that may be subject to Step Therapy requirements: www.scanhealthplan.com/part-b-step-therapy-preferred-drug-list.

Hospice and End Stage Renal Disease (ESRD) Part D Exclusions

Medicare specifies that a drug prescribed to a Part D eligible Member cannot be considered a covered Part D drug if payment for such drug is available (or would be available) under Part A or B for that Member. Two examples of drugs covered under Part A or B are: (1) drugs and biological products related to the terminal illness or related conditions for Members who have elected the Medicare hospice benefit - these drugs should be covered under the Part A; and (2) drugs used for ESRD beneficiaries receiving renal dialysis services - these drugs are included in the Part B bundled payment to an ESRD dialysis facility. It is important Providers understand these requirements.

Hospice Medications

PCPs remain responsible for Members receiving Medicare certified hospice care to ensure non-hospice care and services are provided.

- Drugs and biological products paid for under the Part A are excluded from coverage under Part D. In general, hospice will provide medications related to the care plan for the terminal diagnosis and four categories of drugs that relieve common symptoms during the end of life, regardless of their terminal diagnosis. These symptoms include pain, nausea, constipation, and anxiety.
- For Members enrolled in Hospice, SCAN has Member-level Prior Authorization requirements on the following four categories to determine their coverage under Part A versus Part D

benefit: analgesics; antinauseants (antiemetics); laxatives; and antianxiety drugs (anxiolytics) as required by Medicare.

- For these drugs, hospice-affiliated providers must provide a supporting statement of whether the prescribed drug is unrelated to the Member’s terminal illness or related condition for Part D coverage.

PCPs should:

- Understand CMS guidelines for the management of Members in hospice
- Demonstrate use of SCAN guidelines
- Implement intervention to manage hospice Members including:
 - Monitoring patient status
 - Ensuring care transition support
 - Ensuring non hospice care needs are met
 - Managing medications (Hospice vs. Medical Group coordination)
- Explain care responsibilities for Members that transition into and out of hospice

End Stage Renal Disease (ESRD) Prospective Payment Program

CMS applies a bundled prospective payment system (PPS) for renal dialysis services provided by an ESRD dialysis facility that includes drugs used in the treatment of ESRD. CMS provides a single payment to ESRD facilities that covers all of the resources used in furnishing an outpatient dialysis treatment including supplies and equipment used to administer dialysis, drugs, biological, laboratory testing, training, and support services. As a result, drugs used for ESRD Members receiving renal dialysis services are excluded from Medicare Part D as these drugs are included in the Medicare Part B bundled payment to an ESRD dialysis facility. CMS has identified four (4) categories of drugs that will always be considered renal dialysis drugs when furnished to an ESRD Member and used as specified in the table below:

Intended Use	Drug Category
Access Management	Drugs and biological products used to ensure access by removing clots from grafts, reverse anticoagulation if too much medication is given, and provide anesthetic for access placement.
Anemia Management	Drugs and biological products used to stimulate red blood cell production and/or treat or prevent anemia. Examples of drugs and biological products in this category include Erythropoiesis-Stimulating Agents (ESAs) and iron.
Bone and Mineral Metabolism	Drugs and biological products used to prevent or treat bone disease secondary to dialysis. Examples of drugs/biological products in this category include phosphate binders and calcimimetics.
Cellular Management	Drugs and biological products used for deficiencies of naturally occurring substances needed for cellular management. This category includes levocarnitine.

Part B vs. Part D edits may apply at Point of Service (POS) for ESRD Members for drugs that are considered to be “always” ESRD-drugs.

Sensipar® (cinacalcet) is included in the ESRD PPS and is not payable under the Part D benefit when used for the provision of renal dialysis services (Part B vs. Part D edit will apply to cinacalcet at Point of Service (POS) for ESRD Members).

Oral phosphate binders (e.g., calcium acetate, ferric citrate, lanthanum carbonate,

sevelamer carbonate, sevelamer HCL, sucroferric oxyhydroxide, tenapanor HCL, etc.) will be dispensed by dialysis organizations and included in the ESRD bundled PPS for patients with ESRD undergoing dialysis treatment.

Chapter 12: Provider Payment

This section provides general information regarding provider reimbursement. Non-contracted providers and contracted providers paid on a fee-for-service basis should also refer to [Chapter 13: Claims](#) and/or their contract with SCAN for more information. Contracted capitated providers should refer to their contract with SCAN for capitation rates and other specific details, including the Division of Financial Responsibility (DOFR). Capitation is paid on or about the fifteenth (15th) day of each month. Capitation reports are available in the SCAN Provider Portal. Exceptions may be considered for individual providers directly contracted with SCAN. Providers may contact Provider Relations Lead or ProviderRelations@scanhealthplan.com for more information.

Corporate Information Changes

Providers must notify SCAN of any corporate information changes to ensure that payments are made correctly. Corporate information includes organization name, dba, organization ownership, tax identification number (TIN), and payee name and address. To notify SCAN of corporate information changes, please email the following documentation to ProviderRelations@scanhealthplan.com:

- A letter on provider letterhead signed by an officer;
- Evidence of Provider's State of California Statement of Domestic Stock Corporation document, Articles of Incorporation, or Service Agreement;
- A Fictitious Name Permit if the request is to a "dba"; and
- A W-9 if the request includes a TIN change.

Wire Transfers (Capitated Providers Only)

To request that payments be made via wire transfer, please email the following documentation to Provider Relations Lead or ProviderRelations@scanhealthplan.com:

- A letter on provider letterhead signed by an officer that includes a written statement approving the wire transfer of capitation funds and the following information:

✓ Account Number	✓ Bank Contact Person	✓ Destination Address
✓ Routing Number	✓ Bank Phone Number	✓ Beneficiary Names
✓ Bank Name	✓ Bank Fax Number	✓ TIN
- An electronic funds transfer Form (EFT Form, available upon request) signed by an officer;
- A W-9

Automated Clearing House (ACH) Bank Transfer

To request that payments be made via ACH transfer, please email the following documentation to Provider Relations Lead or ProviderRelations@scanhealthplan.com:

- A W-9; and
- A Supplier Information form (available upon request).

Physician Incentive Plans: Requirements and Limitations

CMS does not allow specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit Medically Necessary services. Indirect payments may include, but are not limited to, offerings of monetary value (e.g., stock options, waivers of debt) measured in the present or future. Additionally, if a physician incentive plan places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself, SCAN must

ensure that all physicians and provider groups at substantial financial risk have either aggregate or per-patient stop-loss and conduct periodic surveys. SCAN is required to provide all information requested by CMS (See 42 CFR 422.208). SCAN designs its own physician incentive programs to comply with all state and federal regulations, including 42 CFR § 422.208. Our programs are structured to reward quality and positive health outcomes, and not to act as an inducement to reduce or limit medically necessary services.

Chapter 13: Claims

SCAN processes claims for reimbursement for services rendered in accordance with all applicable regulatory requirements, including CMS requirements. These claims are for services provided to SCAN members by both contracted and non-contracted providers. SCAN will only process, and if appropriate, pay, claims for which SCAN is financially responsible, dependent on any delegated risk arrangement. Delegates with claim payment responsibilities on behalf of SCAN must also comply with requirements applicable to SCAN including the requirements set forth in this Chapter.

If applicable, for Covered Services to dually eligible Medi-Cal beneficiaries, SCAN shall pay or deny Clean Claims covered under Medi-Cal within thirty (30) calendar days following receipt of a Clean Claim. Provider agrees that SCAN shall have the right to determine the accuracy, appropriateness and reasonableness of all Clean Claims submitted to it, including but not limited to verification of all elements of the submitted claim that affect the liability of SCAN. This pre-payment review could include the use of claims editing software programs to assist in determining proper coding of submitted claims. If applicable, for agreements where Medi-Cal Covered Services beyond Original Medicare are provided by Provider's downstream subcontractor, Provider shall ensure its downstream agreements provide for payment of Clean Claims within thirty (30) calendar days as required by DHCS. Reference: [DHCS All Plan Letter \(APL\) 23-020 'Requirements for Timely Payment of Claims'](#).

SCAN may review and audit claims on a pre and post payment basis for appropriateness and accuracy in accordance with prevailing Correct Coding Initiatives (CCI) Edits, regulatory requirements, and proper billing validation. SCAN may conduct these audits internally or through a third-party vendor. Providers are required to cooperate with SCAN's audits of claims and payments by providing access to requested claims information, all supporting documentation, including but not limited to itemized bills, medical records, and other related data. See [Chapter 10: Delegation Oversight](#).

CMS Requirements

*MA Organizations and their delegated entities, must make **correct claim determinations**, which include developing the claim for additional information when necessary for:*

- *Services obtained from a non-contracted provider;*
- *Ambulance services dispatched through 911;*
- *Emergency services;*
- *Urgently needed services;*
- *Post-stabilization care services; and*
- *Renal dialysis services.*

MA Organizations, and their delegated entities, must also provide reasonable reimbursement for the foregoing services as well as services for which coverage has been denied but found to be services the Member was entitled to upon appeal.

See 42 C.F.R. 422.100(a) and (b)(1); 422.132; 422.504(g)(1); Manual Ch. 4 – Section 10.2.

Definition of Clean Claim

Unless defined otherwise in a provider's contract with SCAN, a "clean" claim means a claim that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare. (See 42 U.S.C. 1395u). SCAN reviews claims for correct coding including National Correct Coding Initiative (NCCI) edits, National Coverage Determination (NCD) edits and Local Coverage Determination (LCD) edits. Claims which do not meet the coding requirements may be rejected (e.g., SCAN follows all CMS and DHCS regulatory processing requirements.) For questions, please refer to: CMS - *Internet-Only Manuals (IOMs) | CMS*
DHCS - *Providers & Partners (ca.gov)*

Claims Submission

SCAN prefers receiving claims in an EDI format through SCAN's clearing house, Office Ally. Electronic claims submission is at no cost to the provider. EDI claims submission improves timely disposition of claims in accordance with CMS requirements.

Electronic claims must be submitted via a clearinghouse using the HIPAA Compliant 837 Version 5010 transaction set format. Providers can use their preferred clearinghouse, but only if the clearinghouse can complete transactions with Office Ally. If providers do not have a clearinghouse or have been unsuccessful in submitting claims to a provider's clearinghouse, please contact your clearinghouse or Office Ally directly at (360) 975-7000.

Providers can also contact Office Ally directly to establish electronic claims submissions connectivity with SCAN. To contact Office Ally, call (360) 975-7000 Option 1 or visit <https://cms.officeally.com/>.

SCAN accepts paper claims where electronic submission is not feasible. Claims must be submitted on current CMS standard forms: UB-04 (CMS-1450), or CMS HCFA 1500 (red form only).

Paper claims may be submitted to:

SCAN Health Plan
Claims Department
P.O. Box 21543
Eagan, MN 55121

All claims must conform to CMS clean claim requirements and claim submission guidelines, including those set forth in the Medicare Claims Processing Manual, which can be found on the CMS website, and in accordance with prevailing Correct Coding Initiatives (CCI) Edits, LCDs, and NCDs.

Claims submitted without all required information will be rejected through the clearing house or returned with a cover letter indicating the claim is incomplete. To have a claim

reconsidered for payment, provider will have to resubmit the claim with the correct and complete claim information.

SCAN may request additional information to facilitate claims processing, such as medical records, invoices (e.g., for organ procurement), or an itemized bill. Providers should submit requested documentation within forty-five (45) days for reconsideration of the claim. Information received after forty-five (45) days will be considered based on regulatory requirements.

Providers must submit claims for services rendered within one (1) year of the date of service or discharge, unless otherwise stated in a Provider's contract. SCAN encourages providers to submit all claims as soon as possible. Claims received after one (1) year from the date of service/discharge will be denied as untimely. Untimely claims are not eligible for dispute or appeal except in rare circumstances where the delay was caused through no fault of the provider.

SCAN will provide payment or denial determinations for clean claims in accordance with CMS regulations. Providers can find claim determination periods in their contract. For non-contracted providers, claim determinations will comply with CMS regulations. SCAN utilizes *Claim Adjustment Reason Codes* (CARCs) and *Remittance Advice Remark Codes* (RARCs) to indicate claim determinations. Provider will receive a Remittance Advice (RA) or Explanation of Payment (EOP) indicating payment amount, member out of pocket, or reason(s) a claim was denied.

Claim Payments

Provider payments are produced by SCAN's vendor partner, Change Healthcare, and their partner ECHO Health. Providers are encouraged to register with Change Healthcare/ECHO Health as soon as practicable.

Following registration, providers will be able to review payments and remittance advice documents, to request copies of a remittance advice, confirm payments of a check, electronic, or virtual card payment, check tracer options, or to set up payment preference.

Electronic payment options:

1. **EFT (Electronic Funds Transfer) / ACH (Automated Clearing House)** – Automatic Direct Deposit
2. **Virtual Card (vCard)** – Virtual Visa Debit Transaction (This is the default option. Providers must call ECHO to make a change)
3. **Paper Check**
4. **Medical Payment Exchange (MPX)** – Deluxe Corporation's digital portal solution that allows Providers instant access to both payment and EOP/EOB simultaneously.

To enroll please visit [ECHO New User Registration for Provider Payments Portal](#) and provide SCAN's ePayment Enrollment ID: 72261

- For all enrollment, technical and payment questions, please contact ECHO at www.providerpayments.com or call (888) 984-5025.

Overpayment and Recovery

Providers are required to report any payments made to them by SCAN to which they are not entitled and to return any overpayment to SCAN no later than sixty (60) days after the date on which the overpayment was identified and to notify SCAN in writing of the reason for the overpayment.

If SCAN determines that it has made an overpayment to a provider, it will make a claim for such overpayment by sending written notification to the provider that has received the overpayment. Providers have sixty (60) days from the date of the notice of the overpayment to contest or reimburse the overpayment.

Under existing regulation, 42 CFR § 405.374, providers and other suppliers will have fifteen (15) days from the date of the notification/revised demand letter to submit a statement of rebuttal, including all information and evidence stating why recoupment should not be initiated. The rebuttal is not an appeal of the overpayment determination, and it will not delay recoupment before a rebuttal response has been rendered; however, the outcome of the rebuttal process could change how or if payment is recouped.

Providers can request immediate recoupment instead of waiting for the recoupment process to begin. Submission of the immediate recoupment form in the provider portal is required. If immediate recoupment is not requested, and provider does not submit repayment within thirty (30) days of the date of the overpayment notice, deductions from future payments will begin at day forty-one (41).

Whether the provider is notified of an overpayment by SCAN or discovers such overpayment independently, the provider must mail the refund check along with a copy of the notification or other supporting documentation to the following address:

SCAN Health Plan
Claims Department
P.O. Box 21543
Eagan, MN 55121

Coordination of Benefits

Coordination of Benefits is the process used to determine health care payments for a Member with one or more insurers providing coverage. SCAN, and delegated entities for claims payment, must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits. (See 42 CFR 422.108 and MMCM, Chapter 4, Section 130).

Providers must identify other payers who have primary responsibility for payment and bill that payer prior to billing SCAN (or its delegate). If a balance is due after receipt of payment from the primary payer, a claim may be submitted to SCAN (or its delegated entity) for payment consideration.

The claim must include information verifying the payment amount received from the primary payer as well as a copy of the primary payer's explanation of payment statement. Upon receipt of the claim, SCAN (or its delegate) will review its liability using the coordination of benefits rules and/or the Medicare/Medicaid "crossover" rules—whichever is applicable.

Where a member has a dual plan (Medicare and Medicaid), the Medicaid plan may cover any remaining balance, out of pocket or authorized services not covered under Medicare. Medicaid is always the payer of last resort; therefore, all other insurance coverage must be processed before the Medicaid benefits are applied.

SCAN will process both Medicare and Medicaid payments for Members who elect and qualify for a SCAN dual eligible special needs plan. Providers will not need to take any further action. Providers will, however, need to submit a claim to a Medicaid payer when a Member has Medicare with SCAN and Medicaid with a different payer.

Third-Party Liability

Members who experience injury or loss due to another person or entity will have all claims processed by the third-party liability (TPL) vendor. Claims paid on behalf of a Member by SCAN or a SCAN delegated entity will be submitted to the respective payer's TPL insurer for reimbursement. Most TPL claims are initiated by a member through an insurer or attorney, who will notify SCAN of the claim. SCAN will refer TPL claims to the SCAN TPL vendor for claims paid by SCAN. SCAN will refer any TPL claims to a SCAN delegated entity where the delegated entity paid the Member's claims.

Maximum Out of Pocket (MOOP) Limit

CMS requires MA Organizations to have a MOOP limit, which refers to the limit on how much a Medicare Advantage Member pays out-of-pocket each year for medical services covered under Medicare Part A and Part B. Co-payments, co-insurance, and deductibles comprise Member expenses for purposes of MOOP. MOOP is in addition to the Member's Medicare Part B Premium. The MOOP limit is accumulated based upon claims paid by SCAN and encounters reported to SCAN by delegated providers who process claims on SCAN's behalf.

Members who meet their annual MOOP limit will not have to pay any additional out-of-pocket costs for covered Medicare Part A and Part B services. When the Member reaches this level, SCAN will no longer deduct any applicable Member out-of-pocket costs from the provider's reimbursement.

Members' MOOP amounts are calculated on an annual basis, beginning on the new calendar year (or when a member joins the plan), and ending at the end of that calendar year. The MOOP is reset at the beginning of the year and MOOP limits do not cross calendar years. A member who does not meet MOOP in the calendar year, and is in treatment, will start the MOOP accumulation period beginning with the new year.

Members are notified in writing of their MOOP accumulation twice each month. Providers can access Member MOOP information through the provider portal to verify if a Member has/has not met the annual limit.

The MOOP can vary by benefit plan and may change from year to year. Please see the applicable EOC available at <https://www.scanhealthplan.com//plan-materials> for more information.

No Balance Billing

Member balance billing (MBB) is strictly prohibited. SCAN's payments to providers are considered payment in full, less any copays, coinsurance, or deductibles – which are the financial responsibility of the Member (up to the MOOP limit). Providers are prohibited from seeking additional payment from Members for any other unpaid balances.

Providers that engage in balance billing may be subject to sanctions by SCAN, CMS, and other regulatory agencies.

Please note that providers may seek payment from a Member for a covered service that is NOT Medically Necessary or for a non-covered service ONLY IF provider obtains written informed consent stating financial responsibility for the specific services prior to services being rendered.

If a copayment, coinsurance, and/or deductible amount collected from a Member at the time of service exceeds the Member cost share, the provider is required to refund the overpaid amount within **fifteen (15)** calendar days. Providers shall not apply overpayments to outstanding balances.

Delegated providers who process claims on SCAN's behalf must have established systems and processes in place which tracks and accurately applies Member cost share. Delegated providers must also ensure timely billing practices for provider and downstream providers/subcontractors to prevent MBB. This process must include, but is not limited to, designated personnel that serves as a primary contact for MBB issues and provider notification to downstream providers regarding MBB requirements. Delegated Provider's process must comply with all requirements set forth by SCAN and federal/state regulators.

To ensure compliance with MBB restrictions, SCAN requires providers to investigate and resolve MBB cases within fifteen (15) calendar days of a request, whether from SCAN, a Member, or another party. Providers and Delegates are also required to cooperate with SCAN to resolve any MBB issues that arise.

Delegates who fail to respond timely to SCAN's inquiries may have their capitation deducted to satisfy the balance.

Claims Adjudication

Rejected v. Denied Claims

SCAN may reject claims that do not meet the definition of a "clean" claim due to missing or invalid required information. Rejected claims do not have Appeal rights. See

<http://www.cms.gov/////clm104c01.pdf>. The provider must correct and resubmit the claim timely for further adjudication. If the provider resubmits the claim after one (1) year from the date of service or date of discharge, the claim will be considered untimely and will be denied.

SCAN will deny a claim if SCAN determines that all or some portion of the claim is not payable and, in such a case, no payment is applied to the denied claim item(s). Denied claims cannot be resubmitted for payment but may be appealed (see below).

SCAN may reject or deny claims which are received by SCAN for which a delegated entity is responsible for claims processing. A provider may see the denial on the remittance advice; however, SCAN has forwarded the claim to the appropriate delegate for processing. Providers can find the correct billing address on the back of the Member's SCAN member ID card or by accessing the Member's eligibility information on the SCAN Provider Portal.

Providers are required to comply with all National Correct Coding Initiative standards, National Coverage Determinations, and Local Coverage Determinations when submitting claims. Claims not meeting these standards will be rejected with the appropriate Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs).

Payment

SCAN processes clean claims according to provider's contract, Medicare regulation and guidance, and in compliance with all federal and state regulatory requirements.

Special Rules for Non-Contracted Provider Claims

95% of "clean" claims from non-contracted providers must be paid or denied within thirty (30) days of receipt. (See 42 CFR 422.500; 422.520(a)(1); Manual Ch. 11 – Section 100.2 & Ch. 13 – Section 40.1). Non-contracted claims that do not meet the definition of "clean claim" must be denied within sixty (60) days of receipt. (See 42 CFR 422.520(a)(3); Manual Ch. 11 – Section 100.2 & Ch. 13 – Section 40.1). If clean claims from non-contracted providers are not paid or denied within thirty (30) days, interest must be paid in accordance with 1816 (c)(2)(B) and 1842(c)(2)(B). (See 42 CFR 422.520(a)(2); Manual Ch. 11 – Section 100.2).

Checking Claims Status

Claims status can be checked on-line via SCAN's Provider Portal. To register, please go to <https://www.scanhealthplan.com/providers> and follow the registration process. See [Chapter 2: Key Contacts Resource Guide](#) (Claims) for more information. Providers should check the claim status in the Provider Portal before submitting a request for additional information.

Providers who need a check reissued for claims paid by SCAN, can make the request through the provider inquiry form in the SCAN provider portal. Providers whose claims were processed by a SCAN delegate should contact the delegate directly.

Providers can submit inquiries on claims, disputes, or payments, through the claims inquiry form in SCAN's Provider Portal. Providers inquiring on the status of claims

processed by a SCAN delegate should contact the delegate directly, either through the delegate’s provider portal or call center.

Provider Claims Disputes and Appeals

Payment disputes and appeals processes for contracted providers are governed by the terms of the contract between the provider and SCAN and the information below. Where the contract is silent as to disputes and appeals, providers should follow the non-contracted dispute resolution process discussed below. Providers also can find information on to how to file disputes and appeals on the SCAN Provider Portal.

For disputes related to claims determinations made by SCAN, providers must submit the following process before invoking any other dispute resolution and arbitration procedures. First, the provider must submit a provider dispute of a decision to SCAN within sixty (60) calendar days of the last written determination. Provider claims disputes should be submitted to SCAN by fax to 562-997-1835 (preferred method).

Provider’s claims dispute should, at a minimum, identify in writing why provider contends the determination was in error, identify the evidence in the claim record that it contends supports its position, and provide any other applicable documentation necessary for SCAN to evaluate provider’s dispute. SCAN will respond in writing to provider’s dispute filed pursuant to this paragraph within sixty (60) calendar days of receipt of the dispute unless otherwise indicated in the Provider’s contract with SCAN. If Provider fully complies with SCAN’s process and disagrees with SCAN’s redetermination of Provider’s claims, Provider may then proceed to the dispute process described further in the contract between Provider and SCAN.

Special Rules for Non-Contracted Providers

SCAN has established a Provider Payment Dispute Resolution (PDR) process for non-contracted providers to dispute the amount paid for a covered service (e.g., the amount is less than the provider’s expected amount that would have been paid under Original Medicare). The PDR process for non-contracted providers cannot be used to challenge payment denials that result in zero payment being made to the non-contracted provider. These matters must be processed as Appeals. The Appeals and PDR processes are summarized below.

Appeals (Denied Claims Only) – Non Contracted Providers
<i>Provider may request an Appeal within sixty (60) calendar days of receipt of RA</i>
The request must include: <ul style="list-style-type: none">• A signed Waiver of Liability (WOL) form holding the Member harmless regardless of the outcome of the appeal and supporting documentation such as a copy of the original claim and any clinical records; and• Other documentation that supports the provider’s request.
NOTE: A copy of the WOL is available at: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms . If the WOL is not received timely, the request for an appeal will be sent to MAXIMUS for dismissal and the provider will receive written notification of the dismissal directly from MAXIMUS.

<ul style="list-style-type: none"> • SCAN has sixty (60) calendar days to reconsider the denial. • Upheld denials are automatically submitted to MAXIMUS for the next level of review. • Provider will be advised regarding further appeal rights .
1st Level PDR (Payment Dispute Resolution)
<i>Within one hundred twenty (120) calendar days of receipt of RA to appropriate payer</i>
<ul style="list-style-type: none"> • 1st level PDR is delegated to medical groups where the medical group is delegated for claims. • SCAN, or the delegated medical group, has thirty (30) calendar days to reconsider the claims payment.
2nd Level PDR Process (Payment Dispute Resolution)
<i>May be submitted to SCAN within one hundred eighty (180) calendar days of receipt of upheld 1st level PDR via</i>
<ul style="list-style-type: none"> • Preferred by fax: (562-997-1835) • By mail: SCAN Health Plan, Attention: Claims-2nd Level Appeal, P.O. Box 21543, Eagan, MN 55121
<ul style="list-style-type: none"> • 2nd level PDR is not delegated to medical groups. • SCAN has sixty (60) calendar days to render a decision.

See [Chapter 5: Network Standards](#) for provider responsibilities with respect to Appeals, Grievances, and Payment Disputes.

Guidance for Providers Delegated for Claims Activities

This section provides additional guidance for providers delegated for claims activities to ensure that claims paid on SCAN’s behalf are paid in accordance with CMS requirements, DHCS requirements, and SCAN policies.

Guidance for Providers Delegated for Claims
<i>Check Handling Delays</i>
The number of days allowed to mail checks after they are printed should be documented in policies and procedures. The date the claim payment check is placed in USPS mail or equivalent for delivery must be used to define the end of the measurement time when measuring timeliness.
An intentional delay before mailing checks, and beyond the routine number of days it takes to audit or sign them, is a non-compliant process unless provider’s reporting and timeliness compliance measurement has been adjusted to allow for the delay.
<i>Claim Date Deficiencies</i>
Each claim should be date-stamped with the date the claim is received.
Wrong Dates: If it is necessary to change a date stamp because a wrong date was stamped it should be done in accordance with the industry best practice. The industry best practice recommends that a line be drawn through the incorrect stamp, that the employee making the correction initials the correction, and that the correction is dated. The claim should then be stamped with the correct date received. Except for a situation where a date was accidentally stamped incorrectly, claims employees should not alter or change date stamps.
Double Dates: Claims submitted to SCAN or to the delegated entity, where the other party is responsible for claim payment, is deemed a “double date” claim. Claims will reflect the date the entities received the claim either by the submitter (first submission) or the entity (claim forwarded). While deemed “double date” claims, this process may occur more than twice. Once a claim is sent to the plan from the delegated entity and where the DOFR indicates the delegated entity is responsible for the claim, SCAN shall send the delegated entity a notice indicating their payment responsibility.
In the event of double dated claims, the earliest date stamp must be used to measure the timeliness of the claim payment or denial (also see Misdirected Claims below). All date stamps are relevant date stamp(s) unless they can be shown to be impressed on a claim proof of loss by an entity that is not part of the delegated network.

Electronic Clearinghouses: Electronic claims which are transmitted directly to a clearinghouse by 5:00p.m. (or by its closing time if it routinely closes between 4:00 p.m. and 5:00 p.m.) (according to the clearinghouse’s time zone), must be considered as received on that day even if the delegated entity does not upload or process the data until a later date.	
Misdirected Claims Deficiencies	
Delegated entities must have a process for forwarding misdirected claims.	
Triage and sorting processes must be established so that misdirected claims can be identified and forwarded within ten (10) calendar days of receipt to ensure that the payer has the necessary time required to adjudicate and pay the claim.	
Delegated entities should instruct their physicians and downstream contracted providers on where to submit claims for services that are the delegate’s risk. Correct billing address can be found on the Member’s SCAN ID card or by accessing the Member’s eligibility information on the SCAN Provider Portal.	
Calculation of Federal Interest	
Delegated entities must pay interest on clean claims that have not been paid within thirty (30) calendar days of the earliest relevant received date stamp. Interest must be paid at the current rate beginning the 31 st day from the receipt of the claim up until the date that the payment is placed in the USPS mail or equivalent.	
To calculate the daily federal interest rate for senior claims, divide the current approved interest rate by three hundred sixty-five (365) calendar days (three hundred sixty-six (366) calendar days for leap years). The daily interest rate is then multiplied by the total days beyond the 30 th and the total amount of the claim payment that is due. Always ensure the correct interest rate when paying prompt payment interest. The rate changes semi-annually, on January 1 and July 1, and is available at https://fiscal.treasury.gov/prompt-payment/rates.html .	
Example 1: The payment due on a clean claim for a non-contracted provider is \$1,200. It is being processed 53 calendar days after receipt and will take an additional 3 calendar days to verify, sign, and mail the check. The interest payment, which would be calculated based on 26 calendar delayed days (23+3 for check issuance, processing, and mailing), is 26 x \$1,200 x (the current annual interest rate)/365 days.	Example 2: The amount to be paid for a non-contracted provider is \$220. Today is the 32 nd day after the receipt of the claim. The checks will not be printed, signed, and mailed 6 calendar days from today. Based on the delay of 8 calendar days (2 + 6 for check processing), the interest payment is 8 x \$220 x (the current annual interest rate)/365 days.
CMS Approved Current Procedural Terminology (CPT) Codes with No Medicare Value	
Delegates must have a process for pricing CMS approved CPT codes with no Medicare value.	
If a new code appears, delegated entities must make every effort to determine whether the procedure, drug, or supply has a pricing history and profile. If there is a pricing history, map the new code to previous customary and prevailing charges, or fee schedule amounts, to ensure continuity of pricing. If there is no pricing history or coding implosion and explosion, delegated entities must make an individual consideration determination for pricing and payment of a covered service.	
MOOP/Encounter Data	
Delegates must have processes that ensure accurate data, including encounter data, used to accumulate the MOOP limit. (See Chapter 14: Encounter Data)	
Providers are expected to have systems and processes in place to track MOOP amounts and to apply benefit limitations. Providers are also required to submit encounter data to the plan that includes MOOP amounts taken on claims. This information is required to avoid overcharging Member MOOP when SCAN pays claims that are the plan’s responsibility under the DOFR.	
1st Level PDR Process	
Request for a 1st Level PDR may be made via phone or in writing but must be submitted to the delegated provider within one hundred twenty (120) calendar days from the notice of initial determination (i.e., Explanation of Benefits (EOBs), RA’s, Letters). Provider must follow and include: <ul style="list-style-type: none"> • EOB or RA used to transmit initial determination to a non-contracted provider; • Completed Payment Dispute Decision (PDD) form; • Appointment of Representative (AOR) form, if applicable; and 	

- Claims Supporting documentation.

2nd Level PDR Process

Delegated providers must notify non-contracted providers that they may seek 2nd level review directly from SCAN within one hundred eighty (180) calendar days from 1st level PDR decision notice by sending their request via:

- Preferred by fax: (562) 997-1835.
- By Mail: SCAN Health Plan, Attention: Claims 2nd Level Appeal, P.O. Box 21543, Eagan, MN 55121.

Non-Contracted Provider Appeals

EOB or RA used to transmit a denial to a non-contracted provider must include the following information:

- Non-contracted providers have the right to request a reconsideration of the denial within sixty (60) calendar days from the remittance notification date;
- Non-contracted providers must include a signed WOL form holding the Member harmless regardless of the outcome of the Appeal;
- Non-contracted providers should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's Appeal; and
- Non-contracted providers can mail requests for reconsideration to: SCAN Non-Contracted Provider Appeal, P.O. Box 22644, Long Beach, CA 90801-9826.

All non-contracted provider Appeals must be sent to this address for reconsideration as soon as possible along with the original claim; a copy of the denial letter with Member liability if applicable; a copy of the RA or EOB and the reason for the denial, including any supporting documents

Delegated Claims Denial

CMS has strict requirements for the use, format, content, and delivery of the notice of a denial with Member liability (e.g., claim denial that results in a Member having liability for a medical service that would otherwise be the responsibility of the plan or the provider). Correspondence to Members regarding claims denials must meet CMS formal notice requirements including that they are sent in an envelope that states, on the outside, in a pre-printed format: "Important Plan Information About Your Enrollment".

- If SCAN overturns a denial, SCAN will pay the claim and deduct the amount from capitation payment to the delegate.

CMS Requirements

MA Organizations must:

*Submit full and complete data that **conforms to CMS' requirements** for MAPD data equivalent to Medicare fee-for-service data, as well as other relevant national standards.*

*Submit encounter data **electronically to the appropriate CMS contractor**. Data must come from the provider, supplier, physician, or other practitioner that furnished the item or service. See 42 CFR 422.310(d).*

*Submit **medical records for the validation of encounter data**, as required by CMS. There may be penalties for submission of false data. See 42 CFR 422.310(e).*

***Certify** (based on best knowledge, information, and belief) the **accuracy, completeness, and truthfulness** of all data submitted. 42 CFR 422.504(l)(3).*

Chapter 14: Encounter Data

Submission of timely, accurate, and complete encounter data is a collaborative effort and is crucial to appropriate care and reimbursement. MA Organizations are required to collect and submit encounter data to CMS that conforms to Medicare fee-for-service standards for all Medicare covered services and supplemental services that MA Organization providers perform. (See 422.310(d)(3)-(4), 422.504(d)-(e), (i)(3)-(4), (l)(3)).

Provider Responsibilities

To meet CMS and other regulatory requirements, SCAN requires providers to:

Submit Complete and Accurate Encounter Data in the Proper Format

- Submit all encounters using the HIPAA Compliant 837 version 5010 transaction set format in conformance with SCAN Encounter Data Requirements:
- Medicare Providers must screen their encounter data for the presence of Provider Preventable Conditions (PPC) on a monthly basis and report any PPC occurrences via DHCS' secure online reporting portal at <https://apps.dhcs.ca.gov/PPC/SecurityCode.aspx> and at Encounters_Operations@scanhealthplan.com.
- Submit encounters directly to SCAN (If authorized), or through a SCAN contracted clearinghouse.
- Submit all claim detail for adjudicated claims only, including all applicable billed amount, paid amount, MOOP amount, adjusted claims, and denied claims information.
- Include all information necessary for SCAN to submit data to CMS in accordance with applicable CMS requirements.
- Encounter data should reflect all procedures and applicable diagnoses that accurately reflect evaluation and treatment during the course of a single health care encounter.
- Document the Member's conditions as specifically as possible (e.g., diabetic with secondary ophthalmologic and renal complications, should not be coded as "diabetes without complications" – complications should be clearly identified in documentation).
- All supplemental data, including chart review data and added or deleted diagnosis codes, submitted via the Alternative Submission Methodology (ASM) must be submitted in the SCAN ASM format and linked to an original 837 encounter. Unlinked supplemental data may not be

accepted by CMS for EDPS submission. (See ‘Submission of Supplemental Encounter Data’ below). Providers must submit ASM files using the encounter module in the SCAN Provider Portal or via MFT.

- Encounter data should accurately reflect the medical record stored at the provider office.

Companion Guides: <https://www.csscooperations.com/internet/csscw3.nsf/DID/C1QB31Y8ZY>

Submit Timely Encounters

- Unless a longer period is expressly allowed in provider’s contract with SCAN, all encounter data should be submitted to SCAN within three (3) months of date of service (DOS). Timeliness is critical to enable SCAN to comply with regulatory requirements, accurately capture data for medical programs, and to impact medical and financial performance. Failure to timely submit data may result in corrective action and/or penalties.
- Submit all encounter data for CMS sweep periods at least four (4) weeks prior to CMS deadlines. SCAN reserves the right to audit encounters for appropriateness of quantity and quality and take corrective actions as appropriate.
- Remediate any issue impacting CMS acceptance of the encounter data within one hundred eighty (180) days of notice, including, but not limited to, 5010 errors, SCAN edits, CMS rejections, etc. Additionally, all rejections must be corrected at least four (4) weeks prior to the final sweeps submission deadline for the visit’s DOS. All deadlines are subject to change at any time should CMS rules change.
- Refrain from resubmitting duplicate encounter data for CMS sweep periods. Only updated, corrected, or new encounter data will be accepted by CMS.
- Providers may reconcile encounter submissions at any time to ensure successful submission to SCAN and CMS (See “Reconciliation Process” below).
- Monthly rejection and reconciliation reports are available on the SCAN Provider Portal in the “HCC and Encounters” tab or via MFT.

Cooperate with CMS and SCAN Audits

- Cooperation with all federal, state, and SCAN audits is mandatory (e.g., Risk Adjustment Data Validation (RADV) audits, Recovery Audit Contractor (RAC) audits, data validation audits, etc.), to ensure accuracy, timeliness, and completeness of submitted results. Providers must additionally provide requested data within specified timeframes. Failure to provide requested support for encounter data submitted to CMS and DHCS may result in corrective action and/or other impacts and penalties from state and federal regulators.
- Providers must also cooperate with corrective action(s) requested by SCAN to resolve encounter data issues or errors.

Recommended Monthly Activities

- Perform monthly (but not less than quarterly) reconciliations using the production reports available on the SCAN Portal. A few of the most important reports include:
 - Hierarchical Condition Category (HCC) Monthly: contains all HCCs associated with the diagnosis codes for both EDPS & RAPS received during a given DOS.
 - MAO-004 Monthly: contains a list of all diagnosis codes received during a given DOS.
 - All Patient Control Number (PCN) Monthly: contains a list of all PCNs received during a given DOS.
- Perform monthly corrections for all errors in SCAN Rejection Reports:
 - Rendering Entity (RPX): the national provider identifier (NPI) for the entity was incorrectly provided; correct by providing the NPI for the “individual” provider.

- Provider Name Mismatch (PNM): the rendering NPI on the encounter is incorrect and/or does not match with SCAN provider name.
- Full Encounter Data Reports (EDS): contains CMS rejection for EDS “Full Encounter” Data (See SCAN Resolution Guide for instructions on how to fix full encounter data rejections located on the Provider portal).
- Invalid DX: diagnosis code is invalid during the DOS, or the diagnosis code does not have the required level of specificity per CMS.
- Place of Service (POS) 21-31: professional encounter has invalid POS or is missing the corresponding Inpatient (21) or Skilled Nursing Facility (31) encounter. Either submit missing Inpatient or SNF encounters in the 837 format or correct professional encounter POS.
- ICE Pend: supplemental diagnosis codes submitted via ICE file (Alternative Submission Method (ASM)) are not rolling up to an existing 837 parent encounter or the *Member ID, From/Thru DOS, NPI, and Visit Type* on the ICE submission does not match the parent 837 encounter. Correct by submitting the parent 837 or ensure the ICE encounter matches with the five key data elements on the parent 837 encounter.
- Inconsistent Condition Data Validation (ICDV): medical conditions which are unlikely to be addressed outside of an acute setting. Correct by submitting subsequent hospital visit or medical record supporting the condition. If the code is truly invalid and should not be submitted to CMS, submit corrected 837 using the same claim ID as initial submission via your clearinghouse with the invalid code removed (do not submit an ICE file to delete the bad code).

Recommended Annual Activities

- Perform annual reconciliations using the production reports available on the SCAN Portal. A few of the most important reports include:
 - New Member Encounter Recon: SCAN provides the member list by February of each year. Submit historical ICE files for prior year’s encounter by July of the existing year.

Because providers are required to submit complete and accurate data to SCAN to meet SCAN’s compliance obligation with CMS, any data in error or not reflected in SCAN reporting must be resubmitted prior to CMS and SCAN deadlines.

Encounter Data System (EDS) Edits Resources	
Reject Type	Resource
277 Edits	https://www.csscooperations.com/internet/csscw3.nsf/DID/I9IQVMOVZR
CMS Companion Guide	https://www.csscooperations.com/internet/csscw3_files.nsf/F/CSSCAppendix_3A_MA_Companion_Guide10162020.pdf/\$FILE/Appendix_3A_MA_Companion_Guide10162020.pdf
SCAN Resolution Guide	See monthly EDS notification emails that include a SCAN Resolution Guide attachment

Reconciliation Process

Reconciliation of encounter data occurs between providers and SCAN and between providers and clearinghouses. Where provider organizations are working with clearinghouses for submission, each clearinghouse will supply reporting details directly to the providers on the total number of encounters received, accepted, and rejected. Encounters that are rejected at the clearinghouse are not sent to SCAN. For providers

that submit encounters directly to SCAN, SCAN will supply the providers with similar reporting. Providers are responsible to review and remediate any rejections identified by the clearinghouse or SCAN error reporting.

Once the encounter has been accepted by the clearinghouse and sent to SCAN for processing, the results of the encounters will become viewable on the SCAN Encounter Data Portal (EDP), accessible at <https://secure-portal.scanhealthplan.com>. The EDP will display the total number of encounters received, accepted, rejected, and sent to CMS, as well as show the results received from CMS (accepted and rejected). The EDP can also be used to modify or correct encounter data. Please note, error resolution completed on the EDP will be reflected within forty-eight (48) hours.

SCAN does not currently supply 999 or 277 reports to providers. All accepted and rejected encounter detail must be reviewed on the EDP or via the provider’s clearinghouse portal.

Reconciliation reports are available monthly on the EDP, under the HCCs and Encounters modules, or by emailing the SCAN Encounter Data Team at Encounters_Operations@scanhealthplan.com.

Submission of Supplemental Encounter Data

All Providers that have submitted encounter data may send supplemental data through either the clearinghouse or directly to SCAN as outlined below.

Clearinghouse Submissions	
Diagnosis codes in excess of twelve (12) per professional encounter and twenty-five (25) per institutional encounter may be submitted to the clearinghouse by:	
<i>Submission of multiple v5010 encounters (duplicate of the entire encounter with the exception of the DX Codes). The following data is required to be identical to the original encounter to ensure “roll-up” of all diagnosis data into the appropriate visit:</i>	
<ul style="list-style-type: none"> Member ID Start and End DOS 	<ul style="list-style-type: none"> Rendering Provider NPI Procedure Code
<i>Submission of multiple iterations of the 2300 Loop (includes service loop) within one encounter. Same requirements as above, plus:</i>	
<ul style="list-style-type: none"> Use same PCN (CLM01 segment, 2300 Loop) 2nd Iteration of the 2300 Loop should differ only in diagnosis codes 	<ul style="list-style-type: none"> Keep service line (2400 Loop) in order between the 1st and 2nd iterations of the encounter the same
ASM Alternative Submission	
Supplemental diagnosis data can also be sent using the SCAN modified ASM alternative submission format. The ASM alternative submission format is intended only to communicate adds or deletes of diagnosis codes for previously submitted encounter data through the clearinghouse to SCAN. Original encounter data should not be sent via the ASM alternative submission because CMS requires full encounter data format (CMS 5010). All supplemental data, including chart review data and added or deleted diagnosis codes, submitted via the ASM must be submitted in the ASM format and linked to an original 837 encounter. Unlinked supplemental data may not be accepted by CMS for EDPS submission.	
<i>Enrolling for ASM Alternative Submission and Testing</i>	
Email the SCAN Encounter Data Team at: Encounters_Operations@scanhealthplan.com . ASM files will not be accepted by SCAN until ASM file submission enrollment and testing is complete.	

ICE Alternative Submission File Specifications			
SCAN utilizes a modified version of the ASM standard format for alternative submission. All requirements for both professional and institutional ASM formats, including the file naming convention, must be strictly adhered to in order for files to successfully process.			
Submitting ASM Production Files via the Encounter Data Portal			
ASM alternative submission files should be uploaded through the File Transmission module on the EDP. These are 'fixed' file templates and if the specifications are not followed, files may be DENIED in the upload and will require a re-check to provider's file to confirm that it meets the specifications required. Note: ASM alternative submission "test" files should be submitted directly to provider's encounter data contact rather than through the EDP, which is for production file(s) only.			
ICE Alternative Submission Hints, Tips and Notes			
Ensure diagnosis codes and procedure code fields are formatted as text. If MS Excel is used as a working draft for correcting errors, then the cell containing a diagnosis and procedure code must be formatted as text. Otherwise, the leading zero may be deleted. Decimal points must be eliminated from diagnosis codes prior to submission in order to mirror CMS standard formatting.			
At least one procedure code is always required on a professional encounter. On institutional encounters, either a procedure code and/or revenue code is required along with the bill type.			
Be careful of any 'date' field. MBR_DOB, DOS_From, and DOS_Thru fields must include the leading zero and be in the format mm/dd/yyyy. Date field errors most often occur with /txt-direct submission files and CMS error files that are resubmitted for correction.			
Examples:	20240103	needs to be	01/03/2024
	1032024	needs to be	01/03/2024
	1324	needs to be	01/03/2024
	1/3/24(DOS)	needs to be	01/03/2024
	1/3/24(DOB)	needs to be	01/03/2024
	1/03/2024	needs to be	01/03/2024
The Provider NPI is required. If the provider does not have an NPI or it is unknown, then the Tax ID and License number are required. If only the Tax ID is provided, it may not be enough to accurately identify the provider or institutional encounters; Tax ID may be entered into the MPN_NBR field. In order to link to the original 837 encounter, the Member ID, from date, thru date, and provider NPI from the ASM submission must be consistent with the original encounter.			

For more information, please contact the SCAN Encounter Data Team at:
Encounters_Operations@scanhealthplan.com.

Chapter 15: Fraud, Waste, and Abuse

Providers must abide by all applicable fraud, waste, and abuse laws and regulations including, but not limited to, applicable provisions of state and federal criminal law, the federal and state False Claims Act (FCA) (31 USC §§ 3729 et. seq.; Cal. Gov. Code §§ 12650 et seq.), the Anti-Kickback Statute (section 1128B(b)) of the Social Security Act; 42 USC § 1320a-7b(b)), and the Physician Self-Referral Law (Stark Law) (42 USC § 1395nn). (See 42 CFR § 422.504(h)(1)).

In addition to federal and state statutes, SCAN and its providers may be subject to other legal requirements concerning the reporting of credible fraud, waste, or abuse allegations. This Chapter outlines SCAN's and its contracted providers' obligations with respect to identifying and mitigating fraud, waste, and abuse.

Examples of fraud, waste, and abuse include, but are not limited to:

- Billing for procedures not performed.
- Physician kickbacks for referrals.
- Authorizing and/or billing for services not medically necessary (i.e., acute inpatient instead of observation, advance life support ambulance services instead of basic life support ambulance services, etc.).
- Certifying terminal illness when criteria is not met.
- Obtaining benefits without medical necessity (i.e., glucose test strips, incontinence supplies, etc.).
- Billing for services that do not meet procedure code/revenue code descriptions.
- Falsifying information in a medical record/claim.
- Improper bundling/coding of charges/procedure codes.
- Misrepresentation by a member/provider to seek benefits.
- Unsupported risk adjustment data (including encounter data) submitted to CMS.
- Inaccurate Prescription Drug Event (PDE) and Direct/Indirect Remuneration (DIR).
- Improper opioid prescribing/dispensing.
- Incorrect enrollment into MA plans, Part D plans, and other government programs.

Special Investigations Unit (SIU)

The SCAN Special Investigations Unit (SIU) is responsible for investigating potential fraud, waste, and abuse. See 42 C.F.R. §§ 422.503(b)(4)(vi)(F), 423.504(b)(4)(vi)(F). SCAN has the right to conduct a review or audit of billed items and services to ensure appropriate coding and billing, medical record accuracy, medical necessity, compliance with accepted medical standards, and adherence to SCAN policies and contracts.

Investigation Process

SCAN utilizes data analytics, record reviews and other techniques, including member and provider reports, to identify fraud, waste, and abuse on a prospective and retrospective basis.

SCAN may request medical records, itemized bills, invoices, and other substantiative documentation when conducting prospective or retrospective claim reviews as required

or allowed by applicable law. Providers are expected to comply with the response timeframe identified in the record request letter. Failure to provide the requested documentation may result in claim denial(s) until the information necessary to adjudicate the claim(s) is received.

Member and Provider Interviews

SCAN may conduct member interviews to verify that items and services were rendered and appropriately billed.

Provider interviews may be conducted to discuss billing details and/or provide education. With the consent of both parties, interviews may be recorded to ensure the communication is accurately captured.

Site Inspections

Site inspections may be performed when fraud, waste, and/or abuse are suspected. Advance notification of a site inspection may not be provided in certain circumstances, including if there is a concern of fraud or member harm.

Medical records and other substantiative documentation may be requested. SCAN staff will observe the documentation being produced to ensure a complete record is provided.

With the consent of both parties, interviews conducted during the site inspection will be recorded to ensure the communication is accurately captured.

Improper Payments

Hospital emergency room claims may be subject to pre-payment or post-payment reviews. Billed charges are non-reimbursable if inadequate documentation is submitted to validate that the items or services were provided. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for covered services, resulting in a claim denial. For more information see: Medicare Program Integrity Manual, 3.3.2.1.1 - Progress Notes and Templates (*Medicare Program Integrity Manual*) and *Palmetto GBA - Medical Record Cloning*.

Investigation and Audit Outcomes

If fraud, waste, or abuse is identified, SCAN will take appropriate action to remediate the issue(s). Potential corrective actions include:

- Reporting allegations and investigative findings to appropriate regulatory and law enforcement agencies
- Providing education
- Reprocessing claim(s)
- Recovering overpayments*
- Issuing corrective action plans (CAPs)
- Requiring periodic self-audits to ensure ongoing compliance
- Terminating the provider from SCAN network

**Chapter 13: Claims* describes the overpayment recovery process for fee-for-service claims. In the case of capitated agreements, SCAN may also adjust capitation payments as necessary to recover an overpayment in accordance with 42 CFR 401.301-305 and 42 CFR 438.608(d).

Provider Responsibilities

In order to meet regulatory requirements, providers are required to:

Be Diligent and Immediately Report Suspected Fraud, Waste, and Abuse

- Watch for suspicious activity and red flags; and
- **Immediately** report suspected fraud, waste, and abuse that affects SCAN or SCAN members:

By Web: <https://www.scanhealthplan.com/scan-resources/report-an-issue/fraud-information-and-resources>

By E-Mail: FraudWaste&AbuseProg@scanhealthplan.com

By Phone: (877) 863-3362 (may be made anonymously)

All reports will be kept confidential to the extent possible and in accordance with applicable law. Providers may also report directly to the Department of Health and Human Services Office of Inspector General (HHS OIG):

By Phone: (800) HHS-TIPS ((800) 447-8477)

By E-Mail: HHSTips@oig.hhs.gov

By Mail: Office of the Inspector General HHS TIPS Hotline, P.O. Box 23489, Washington, DC 20026

Cooperate with SCAN Investigations, Resolve Issues, and Protect Your Employees from Retaliation

- Cooperate with SCAN's investigation of potential fraud, waste and abuse by responding timely to requests for medical records and other information;
- Comply with any corrective action requested by SCAN to resolve potential fraud, waste, and abuse (including return of overpayments);
- Cooperate with referrals to law enforcement and/or regulatory agencies; and
- Do not retaliate against employees who act lawfully in furtherance of an action under the FCA, including investigation for, initiation of, testimony for, or assistance in an action filed, or to be filed under the FCA. Retaliation includes, but is not limited to, discharge, demotion, suspension, threats, harassment, or any other manner of discrimination against the employee in the terms and conditions of employment.

Training and Education

- Provide fraud, waste, and abuse, general compliance, and specialized training as required by CMS (See *Chapter 10: Delegation Oversight*);
- Require completion of training as a condition of employment or contracting;
- Participate in other fraud, waste, and abuse and compliance training opportunities; and
- Educate other providers, members, and vendors when opportunities arise.

Compliant Policies, Procedures, and Practices

- Establish and maintain appropriate policies, procedures, and practices – that are updated regularly to address trends in fraud, waste, and abuse (e.g., prescription drug abuse and hospice enrollment fraud);
- Strive for accuracy and excellence in rendering care, coding, and billing;
- Document member medical records properly and accurately (e.g., do not up-code, bill for services not rendered or not medically necessary, unbundle services, submit duplicate billing, etc.);
- Safeguard privacy; and
- Maintain records accurately and timely.

Monitoring and Oversight

All providers delegated to perform functions on behalf of SCAN are audited on a routine basis to determine compliance with CMS and other requirements related to eliminating fraud, waste, and abuse. (See *Chapter 10: Delegation Oversight* for specific information).

Fraud, Waste and Abuse Resource Sheet
<i>Applicable Laws</i>
Civil False Claims Act (FCA) (31 USC 3729 et seq.)
Allows a civil action to be brought against any person or entity who, among other things: (a) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to any federal employee; (b) Knowingly makes, uses or causes to be made or used a false record or statement to get a false or fraudulent claim paid; or (c) Conspires to defraud the government by getting a false or fraudulent claim allowed or paid.
California False Claims Act (California Government Code Section 12650-12656)
Makes it illegal, among other things, for any individual to knowingly present or cause to be presented to a state employee a false claim for payment or approval, knowingly make, use, or cause to be made or used a false record or statement to get a false claim paid or approved by the state or by any political subdivision, or to conspire to defraud the state or any political subdivision by getting a false claim allowed or paid by the state or by any political subdivision. It is a crime if a person knowingly submits, causes to be submitted, is the beneficiary or does not report a claim for payment to which the person is not entitled.
Program Fraud Civil Remedies Act of 1986 (38 USC 3801 et seq.)
This statute amended the FCA, among other things, to extend liability to any person or entity that knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.
Fraud Enforcement and Recovery Act of 2009 (FERA) (31 USC 3729)
This statute amended the FCA, among other things, to provide that FCA liability may attach whether or not there is intent to defraud the government (it is sufficient that the false statement is material to a false claim). Therefore, many types of innocuous overpayments could now potentially lead to FCA liability.
Patient Protection and Affordable Care Act and Health Care & Education Reconciliation Act of 2010 (PPACA) (42 USC. 18001 et seq)
PPACA, among other things, requires that: overpayments be reported and returned sixty (60) days after they are identified; items/services be prescribed by a Medicare-enrolled physician or other eligible professional; physicians have a face-to-face encounter with a patient before prescribing; and maintain and provide upon request documentation for certifications for DME or home health services. The PPACA increases civil monetary penalties (CMPs) for making false statements to federal health care programs or for delaying inspections, suspends payment during fraud investigations, and expands the RAC program to include Part C & D.
The Deficit Reduction Act of 2010 (DRA) (42 USC 1396h(a))
The DRA, among other things, requires that any entity that receives or makes payments under the state Medicaid/Medi-Cal plan of at least five million (\$5,000,000) per year provide certain information to its

employees, contractors and agents concerning federal and state false claims act provisions, penalties, and protections.
Anti-Kickback Statute (42 USC 1320a-7b(b))
It is a felony to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referral of items or services paid in whole or in part by a federal health care program. Remuneration includes transfer of anything of value, directly or indirectly, overtly, or covertly, in cash or in kind.
Physician Self-Referral Prohibition Statute (42 USC 1395nn)
The “Stark Law” prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment, interest or with which he or she has a compensation arrangement, unless an exception applies.
Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018 (H.R.2028 Section 195, H.R.6, Section 6063)
Effective in 2022, the SUPPORT Act requires that plans implement drug management programs for at-risk beneficiaries (H.R. 2028 Section 195).

Penalties	
Penalties for violating fraud, waste, and abuse laws include:	
Employee subject to unlawful retaliation entitled to all relief necessary to make the employee whole including reinstatement with the same seniority status, 2x back pay and interest, special damages, litigation costs and reasonable attorneys’ fees, and, where appropriate, punitive damages.	<ul style="list-style-type: none"> • Violation of the FCA or the California FCA is punishable by a civil penalty of not less than five thousand five hundred dollars (\$5,500) and not more than eleven thousand dollars (\$11,000) per claim*, plus 3x the damages the Government sustains • Suspension of payment • Potential criminal liability
* Each separate bill, voucher, or other false payment demand constitutes a separate claim.	
Penalties for violating Anti-Kickback Statute:	Penalties for violating Stark Law:
<ul style="list-style-type: none"> • Criminal: fines up to twenty-five thousand dollars (\$25,000) per violation and up to a five (5) year prison term per violation • Civil/Administrative: FCA liability, program exclusion, potential fifty thousand dollars (\$50,000) CMP per violation, and civil assessment up to 3x amount claimed 	<ul style="list-style-type: none"> • Overpayment/refund obligation • FCA liability • CMPs and program exclusion • Potential fifteen thousand dollars (\$15,000) CMP for each service • Civil assessment of up to 3x amount claimed

HIPAA Requirements

Acquisition, access, use, or disclosure of PHI in a manner not permitted under HIPAA is presumed to be a breach unless there is a low probability that PHI has been compromised, based on a multi-factored **risk assessment** that includes: (i) the nature and extent of the PHI involved, including types of identifiers and likelihood of re-identification; (ii) the unauthorized person who used the PHI or to whom the disclosure was made; (iii) whether the PHI was actually acquired or viewed; and (iv) the extent to which the risk has been mitigated.

For **breaches of PHI, notification** of the breach must be provided to **affected individuals, the HHS Secretary, and, in certain circumstances, to other state agencies and the media.**

Generally, **notification** must be provided **without unreasonable delay and in no case later than sixty (60) days** following the discovery of a breach.

Pub. L. No. 104-191, 110 Stat. 1936 (1996); 45 CFR Parts 160, 162, and 164. For more guidance, see <http://www.hhs.gov/hipaa/for-professionals/breach-notification/>.

Chapter 16: Privacy and Health Insurance Portability and Accountability Act of 1996 (HIPAA)

SCAN delegates various SCAN activities to certain providers that involve the use and disclosure of protected health information (PHI), making these delegated providers business associates of SCAN under HIPAA. Further, SCAN recognizes that providers, for the provision of medical services, are also covered entities and therefore have their own legal obligations related to HIPAA.

SCAN requires that providers respect the privacy of SCAN Members (including SCAN Members who are not patients of the Provider) and comply with all applicable laws and regulations regarding the privacy of patient and Member PHI. Privacy and Security of Member and patient PHI should only be used or disclosed as permitted or required by applicable law.

Inadvertent Disclosures of PHI: SCAN may, on occasion, inadvertently misdirect or disclose PHI pertaining to SCAN Member(s) who are not the patients of the provider. In such cases, the provider shall return or securely destroy the PHI of the affected SCAN Members in order to protect their privacy. The provider must not further use or disclose such PHI and will provide an attestation of return, destruction, and non-disclosure of any such misdirected PHI upon the reasonable request of SCAN.

HIPAA provides a floor for patient privacy. Where state law is more stringent than HIPAA, state law should be followed.

In addition to HIPAA, SCAN and SCAN providers may be subject to other legal requirements concerning the privacy of Member information. For example, SCAN must notify DHCS *immediately* of suspected security incidents and within twenty-four (24) hours of breaches involving a Medicare/Medi-Cal beneficiary. Furthermore, SCAN is required to notify OCR of HIPAA breaches involving 500 or more Members, without

unreasonable delay. By meeting the obligations in this Chapter, SCAN and its providers ensure that all HIPAA obligations are met.

The business associate agreement (BAA) between SCAN and a delegated provider details the business associate's responsibilities with respect to Member PHI, including reporting PHI breaches to SCAN. While timeframes are set forth in each BAA, SCAN requests that providers notify SCAN of Member PHI breaches **immediately or as soon as possible** in order to meet strict regulatory incident notice expectations.

In order for SCAN to meet regulatory incident reporting expectations, prompt reporting, cooperation, and follow up from its business associates is critical. Therefore, in the event of a Member PHI breach, providers must do the following:

- Notify SCAN **immediately or as soon as possible** after the discovery of any breach, but no later than the time frame set forth in the provider's BAA. Notice should be addressed to the SCAN Privacy Office via email (preferred) or certified mail to:

Email: PrivacyOffice@scanhealthplan.com
Certified Mail: SCAN Health Plan
Attention: Privacy Office
3800 Kilroy Airport Way, Ste 100
Long Beach, CA 90806

- Promptly investigate all breaches and draft an initial incident report that includes, at a minimum:
 - An initial description of the nature and circumstances of the breach;
 - A description of the number of individuals involved;
 - A description of the types of PHI involved;
 - The date of the incident which caused the breach;
 - The date of discovery of the potential breach;
 - A list of affected Members involved in the breach, including their SCAN ID numbers;
 - Any efforts taken to mitigate harm to the individuals/Members; and
 - Sufficient information, including the investigative report, to allow SCAN to ensure that SCAN's obligations under HIPAA and other regulatory and contractual requirements are met.
- Cooperate with any SCAN investigation; including providing timely responses to SCAN inquiries regarding the breach;
- Collaborate with SCAN to determine which entity will provide any required notices;
- Work with SCAN to draft any required notices or obtain SCAN's approval for any notice sent on behalf of SCAN prior to distribution; and
- Ensure providers do not include SCAN's name in any notice to Members without SCAN's prior written approval.

For any questions about breach events, please contact SCAN's Privacy Office via email PrivacyOffice@scanhealthplan.com.

Appendix A: Select CMS Requirements

MMCM, Chapter 11 requires that MA Organizations include certain contract provisions in their downstream provider contracts. Additionally, MA Organizations must include certain MA-related provisions in the policies and procedures that apply to providers and suppliers that constitute the MA organizations' health services delivery network. The following table summarizes some of these provisions and where they can be found in this POM:

CONTRACT REQUIREMENTS SET FORTH THROUGH POLICIES, STANDARDS, & MANUALS		
	Title 42 CFR §	POM CHAPTER
Safeguard privacy and maintain records accurately and timely	422.118	Chapter 5, Network Standards
Permanent "out of area" members to receive benefits in continuation area	422.54(b)	Chapter 3, Enrollment and Eligibility
Prohibition against discrimination based on health status	422.110(a)	Chapter 5, Network Standards
Pay for Emergency and Urgently Needed Services	422.100(b)(1)(ii)	Chapter 4, Physician Responsibilities Chapter 5, Network Standards
Pay for renal dialysis for those temporarily out of a service area	422.100(b)(1)(iv)	Chapter 13, Claims
Direct access to mammography and influenza vaccinations	422.100(g)(1)	Chapter 4, Physician Responsibilities
No copay for influenza and pneumococcal vaccines	422.100(g)(2)	Chapter 4, Physician Responsibilities
Agreements with providers to demonstrate "adequate" access	422.112(a)(1)(i)	Chapter 5, Network Standards
Direct access to women's specialists for routine and preventive services	422.112(a)(3)	Chapter 5, Network Standards
Services available 24 hrs./day, 7 days/week	422.112(a)(7)(ii)	Chapter 5, Network Standards
Adhere to CMS marketing provisions	422.2260, <i>et seq.</i>	Chapter 5, Network Standards
Ensure services are provided in a culturally competent manner	422.112(a)(8)	Chapter 5, Network Standards
Maintain procedures to inform Members of follow-up care or provide training in self-care as necessary	422.112(b)(5)	Chapter 5, Network Standards
Document in a prominent place in medical record if individual has executed advance directive	422.128(b)(1)(ii)(E)	Chapter 4, Physician Responsibilities
Provide services in a manner consistent with professionally recognized standards of care	422.504(a)(3)(iii)	Chapter 5, Network Standards
Continuation of benefits provisions (may be met in several ways, including contract provision)	422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)	Chapter 5, Network Standards
Payment and incentive arrangements specified	422.208	Chapter 12, Provider Payment
Responsibility over first tier, downstream and related entities	422.504(i)	Chapter 7, Care Management Chapter 10, Delegation Oversight

Disclose to CMS all information necessary to (1) Administer & evaluate the program (2) Establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services	422.64(a); 422.504(a)(4) 422.504(f)(2)(iv)(A)-(C)	Chapter 5, Network Standards
Must make good faith effort to notify all affected Members of the termination of a specialist provider contract 30 days before the termination by plan or provider and termination of a PCP or Behavioral Health provider at least 45 days before termination by the plan or provider	422.111(e)	Chapter 5, Network Standards
Written termination notice to Members regarding PCP, Behavioral Health or specialist providers must include required communication content and process in accordance with applicable requirements.	422.2267(e)(12)	Chapter 5, Network Standards
Submission of data, medical records and certify completeness and truthfulness	422.310(d)(3)-(4), 422.310(e), 422.504(d)-(e), 422.504(i)(3)-(4), 422.504(l)(3)	Chapter 14, Encounter Data
Comply with medical policy, QI, and MM	422.202(b); 422.504(a)(5)	Chapter 7, Care Management
Disclose to CMS quality & performance indicators for plan benefits re: disenrollment rates for beneficiaries enrolled in the plan for the previous two years	422.504(f)(2)(iv)(A)	Chapter 5, Network Standards
Disclose to CMS quality & performance indicators for the benefits under the plan regarding enrollee satisfaction	422.504(f)(2)(iv)(B)	Chapter 5, Network Standards
Disclose to CMS quality & performance indicators for the benefits under the plan regarding health outcomes	422.504(f)(2)(iv)(C)	Chapter 5, Network Standards
Notify providers in writing for reason for denial, suspension & termination	422.202(d)(1)-(4)	Chapter 5, Network Standards
Provide 60 days' notice (terminating contract without cause)	422.202(d)(1)-(4)	Chapter 5, Network Standards
Comply with federal laws and regulations to include, but not limited to: federal criminal law, the False Claims Act (31 U.S.C. 3729 et. Seq.) and the anti-kickback statute (section 1128B(b) of the Act)	422.504(h)(1)	Chapter 15, Fraud, Waste, and Abuse
Prohibition of use of excluded practitioners	422.752(a)(8)	Chapter 1, Overview Chapter 5, Network Standards Chapter 10, Delegation Oversight
Adhere to appeals/grievance procedures	422.562(a)	Chapter 9, Member Appeals and Grievances

Appendix B: Select DHCS Requirements

DHCS requires SCAN to include certain contract provisions in SCAN's downstream provider contracts that provide health care services to eligible Medi-Cal beneficiaries, SCAN's FIDE-SNP Members. The following table summarizes some of these provisions and where they can be found in this POM:

PROVISION	REQUIREMENT	POM
Quality Improvement System	<ul style="list-style-type: none"> Providers will participate in Quality Improvement System activities as required or delegated and follow requirements if responsibilities are delegated All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified, or registered All providers must have good standing in the Medicare and Medicaid/Medi-Cal programs and a valid National Provider Identifier (NPI) number Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in SCAN's provider network Ensure all contracted laboratory testing sites have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number SCAN may delegate credentialing and re-credentialing activities and require that regulations are followed for these delegated duties Must maintain appropriate/accessible Medical Records for Members and have them secure at the provider site and adhere to Title 28, CCR, Section 1300.80(b)(4), Title 28, CCR, Section 1300.67.1(c), and 42 USC Section 1396a(w). 	<p>Chapter 8, SCAN's Quality Improvement (QI) Program</p> <p>Chapter 5, Network Standards</p> <p>Chapter 10, Delegation Oversight</p>
Provider Network	<ul style="list-style-type: none"> Ensure that networks satisfy the following full-time equivalent provider to Member ratios: <ol style="list-style-type: none"> Primary Care Physicians 1:2,000 Total Physicians 1:1,200 Non-Physician Medical Practitioner shall not exceed a full-time equivalent provider/patient caseload of one provider per 1,000 patients Ensure compliance with Title 22, CCR, Section 51241 in regards to Physician Supervisor to Non-Physician Medical Practitioner Ratios Shall have a designated emergency service facility providing care 24 hours per day, 7 days per week with one or more Physicians & one Nurse on duty at all times Will establish and operate a system to assure a Member's continuity of care through referrals, monitoring, documentation, and follow-ups Shall maintain adequate numbers & types of specialists within their network to accommodate the need for specialty care in accordance with Title 22, CCR, Section 53242 	<p>Chapter 5, Network Standards</p>

PROVISION	REQUIREMENT	POM
	<ul style="list-style-type: none"> • Will offer second opinions by Specialists to any Member upon request • Shall maintain a network of Primary Care Physicians which are located within 30 minutes or 10 miles of a Member's residence • Shall have a plan Physician available 24 hours per day, seven days per week to coordinate the transfer of care of a Member whose emergency condition is stabilized, to authorize medically necessary post-stabilization services, and for general communication with emergency room personnel • Shall ensure that network providers offer hours of operation to Members that are no less than the hours of operation offered to other patients • Shall ensure that the composition of provider network meets the ethnic, cultural, and linguistic needs of Members on a continuous basis • Shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of practice of his or her license or certification under applicable State law, solely on the basis of that license or certification • All Network Providers must be screened and enrolled in accordance with Title 42 CFR 438.602(b), and <i>DHCS All Plan Letter (APL) 22-013 'Provider Credentialing / Re-Credentialing and Screening / Enrollment'</i>. Contractor must screen and enroll Provider types that are not currently enrolled in Medi-Cal FFS if those Provider types are necessary to maintain an adequate Network. Contractor shall implement and maintain requirements for the screening and enrollment of both Medicare and Medi-Cal Network Providers, and shall submit them to DHCS for review and approval. 	
Provider Relations	<ul style="list-style-type: none"> • Shall receive a Provider Manual and updates to the providers of Medi-Cal services. The manual and updates shall serve as a source of information, as an extension of the Contract, to providers regarding Medi-Cal services, policies and procedures, statutes, regulations, telephone access and special requirements, and the Member grievance, appeal, and State Fair Hearing process. • Shall ensure that all providers receive training or information regarding the Medi-Cal Managed Care program in order to operate in full compliance with the contract and all applicable Federal and State statutes and regulations • Shall conduct training or provide information for all providers within 10 (ten) working days after a new contracted provider is brought on active status • Shall ensure that ongoing training is conducted, or information is provided when deemed necessary 	<p>All Chapters</p> <p>Chapter 5, Network Standards</p> <p>Chapter 9, Member Appeals and Grievances</p>

DHCS CONTRACT SECTION	REQUIREMENT	POM CHAPTER
Access and Availability	<ul style="list-style-type: none"> • Ensure each Member has a Primary Care Provider and Specialists available & physically present at the service site to ensure access to Medically Necessary Covered Services in accordance with Title 22, CCR, Section 58853(a) and consistent with: • Ensure that no traditional provider, upon entry into Contractor's network, suffers any disruption of existing patient-physician relationships, to the maximum extent possible • Access Requirements comply with appointment, waiting times, telephone procedures, after hour calls, unusual specialty service access requirements in accordance with Title 28, CCR, Section 1300.67.2.1 • Access Standards comply with appropriate clinical timeframes and access standards in accordance with Title 28 CCR Section 1300.67.2.2 • Arrange for the timely referral and coordination of covered services to which provider has religious or ethical objections to perform or otherwise support • Shall provide for standing referrals to specialist in accordance with Health and Safety Code Section 1374.16 • Shall ensure that a Member with an Emergency Condition will be seen on an emergency basis and that Emergency Services will be available and accessible within the Service Area 24-hours-a-day • Shall ensure adequate follow-up care for those Members who have been screened in the Emergency Room and require non-emergency care • Shall ensure that a plan physician is available 24 hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized members in an emergency department, if necessary • Provide access to services with the following special arrangements: Sexually Transmitted Diseases, HIV Testing and Counseling, Immunizations, and Indian Health Services • Provide Notification sixty (60) calendar days prior to making any substantial change in the availability or location of services • Provide access for disabled member as required of Title III of the Americans with Disabilities Act of 1990 • Ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, 45 C.F.R. Part 80) that prohibits recipients of federal financial assistance from discriminating against persons based on race, color, religion, or national origin 	Chapter 5, Network Standards

DHCS CONTRACT SECTION	REQUIREMENT	POM CHAPTER
	<ul style="list-style-type: none"> • Ensure equal access to health care services for limited English proficient Members through provision of high-quality interpreter and linguistic services • Shall have a Cultural and Linguistic Services Program that incorporates the requirements of Title 22, CCR, Section 53876 • Shall assess, identify, and track the linguistic capability of interpreters or bilingual employees and contracted staff (clinical and nonclinical) • Shall provide cultural competency, sensitivity, or diversity training for staff, providers, and subcontractors at key points of contact • Shall comply with Title 22, CCR, Section 53853(c) and ensure that all monolingual, non-English-speaking, or limited English proficient Medi-Cal beneficiaries receive 24-hour oral interpreter services at all key points of contact either through interpreters or telephone language services • Key points of contact include: <ol style="list-style-type: none"> 1) Medical care settings: telephone, advice, and urgent care transactions, and outpatient encounters with health care providers including pharmacists. 2) Non-medical care setting Member services, orientations and appointment scheduling 	
Cost Sharing Protections	<p>Pursuant to the Social Security Act, section 1932(b)(6), and (42 USC. section 1396u-2 (b)(6)), SCAN and all of its subcontractors, including Providers of Supplemental Benefits, must not hold a Member liable for:</p> <ul style="list-style-type: none"> • Payments to provider that furnish Covered Services under a contract or other arrangement with SCAN that are in excess of the amount that normally would be paid by the Member if the service had been received directly from SCAN • Network providers and subcontractors and Providers of Supplemental Benefits must not bill a Member for any services provided under this contract. SCAN must assure that all network provider contracts include requirements whereby the Member must be held harmless for charges for any Medi-Cal covered service • Network Providers are prohibited from imposing on Members cost-sharing requirements. Members are not responsible for any copayments for either Medicare or Medi-Cal Covered Services. SCAN's Provider agreements shall specify that a contracted Provider agrees to accept SCAN's reimbursement as payment in full for services rendered to Members. 	Chapter 13, Claims (No Balance Billing)
Regulatory Notices	Will be responsible for all Regulatory Notices (All Plan Letters, Policy Letters, All County Letters, etc.) deemed applicable to SCAN providers	All Chapters