scan™

2025

PROVIDER ORIENTATION PACKET

Contents

Provider Orientation Packet (POP) Overview

As a participating Provider with a SCAN contracted medical group you are deemed as participating in all SCAN benefit plans and may be assigned to care for our member that are dual-eligible (Medicare/Medi-Cal) and/or dually enrolled (Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP) members and are subject to adhering to both CMS and California DHCS requirements and regulations.

As a DHCS requirement, this information is being provided to you by SCAN to outline key information needed to serve this dual-eligible population. For additional information, refer to the *SCAN Provider Operations Manual*.

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 of the *SCAN Provider Operations Manual* 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 of the *SCAN Provider Operations Manual* 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 of the *SCAN Provider Operations Manual*.

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*

See SCAN website for complimentary *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.

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.

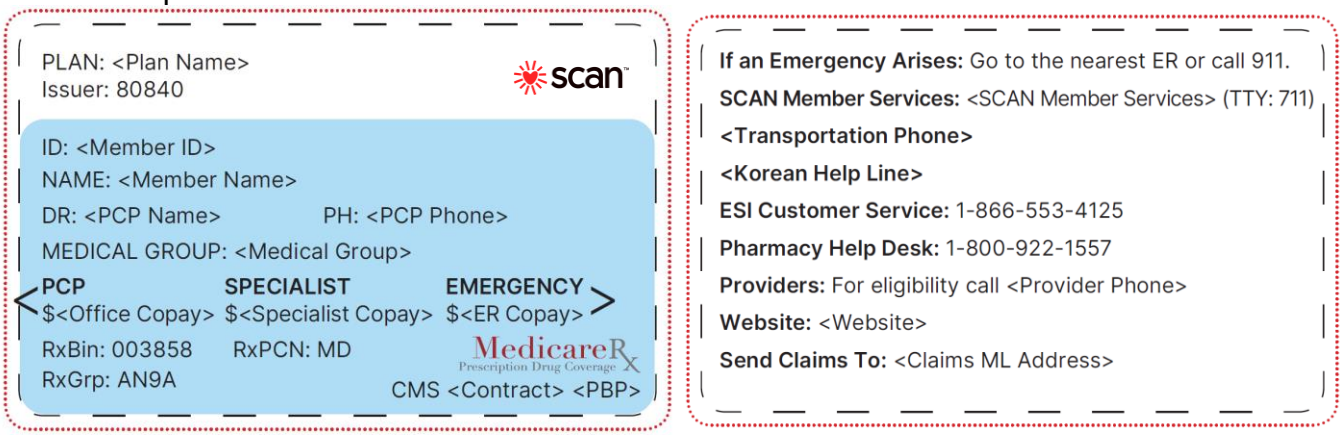
Medicare Advantage Prescription Drug Plan **Eligibility Requirements**	**Medicare Advantage Prescription Drug and Medi-Cal Fully Integrated Dual Special Needs (FIDE SNP) Plan** **Eligibility Requirements**
To enroll, an individual must:	
• Have Medicare Parts A & B and continue paying Part B premium,[1]	• Meet Medicare eligibility requirements, • Be enrolled in Medi-Cal with full benefits,

• 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 of the *SCAN Provider Operations Manual*.	• 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.

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.

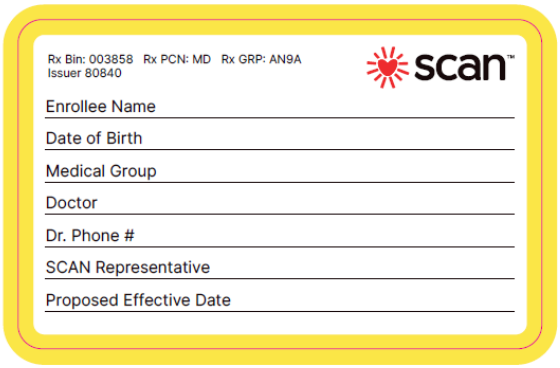
Identifying a Patient as a SCAN Member

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:



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 at email: *TUPrtnrSupt@finthrive.com* or call (877) 732-6853
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.

Providers **employed** with a SCAN contracted medical group are to contact their organization portal administrator to request a Username and Password for SCAN Provider Portal access. All other providers can access the *SCAN Provider Portal* and self-register for an account.

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.

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's 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
    - Preventative services per the United States Preventative 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

Health Risk Assessment (HRA) and Individual Care Plan (ICP)

SCAN conducts required Health Risk Assessments (HRAs) and creates initial individual Care Plans (ICP) for all SNP members. IHA annual training is mandatory for all providers who serve SCAN FIDE-SNP members.

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 personal care after an inpatient hospital or SNF stay. 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 in Los Angeles County 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.

Personal Assistance Line (PAL) Unit 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 PAL Unit at (866) 722-6725.

Long Term Services and Supports Benefits (LTSS)

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*.

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 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. 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.

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/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.

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 the hours of operation of SCAN's network are: (1) convenient to, and do not discriminate against Members and are no less available than hours 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. 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	Forty-eight (48) hours if no prior authorization required for PCP
Urgent Care Appointment: Specialist	Ninety-six (96) hours if prior authorization is required
Post stabilization services**	30 minutes (DHCS = 30 Minutes) (CMS =1 hour)
Dental	Seventy-two (72) hours
* 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 = 1 hour) 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
Specialty Care	Fifteen (15) business days
PCP	Seven (7) business days
Behavioral Health Services appointment (non-physician)	Ten (10) business days
Routine and preventive care (PCP)	Thirty (30) business days
Preventive Care (Dental)	Forty (40) business days
Telephone Triage or Screening	Thirty (30) minutes
Other	
Interpreter services	24/7
Dental (non-preventative)	Thirty-six (36) business days

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 APL 22-022 Alternative Format Selection for Members with Visual Impairments. Please reference Appendix B: Select DHCS Requirements of the *SCAN Provider Operations Manual* 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 of the *SCAN Provider Operations Manual*)
- 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.

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

APL 24-017 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. To view all requirements described in this APL please *click here*.

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.

SCAN does not delegate Member Appeals and Grievance functions to providers. Members should be directed to contact SCAN Member Services at (800) 559-3500. For more information, please refer to Ch. 9: Member Appeals and Grievances of the *SCAN Provider Operations Manual*.

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 section.

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) 24-009 and (APL) 24-010*.

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, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim. (See 42 U.S.C. 1395u).

Claim Submissions for which SCAN is financially responsible:

SCAN strongly encourages providers to timely submit claims electronically. Electronic claims submission is no cost to the provider and helps effectuate the timely disposition of claims in accordance with CMS requirements.

Providers can 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/*.

Paper claims must be submitted on current CMS standard forms: UB-04 (CMS-1450), or CMS HCFA 1500 (red from only). Paper claims may be submitted to: SCAN Health Plan Claims Department, P. O. Box 21543, Eagan, MN 55121.

Claims submitted without all required information will be returned (paper submission) or rejected (electronic submission). Providers should promptly respond to requests for additional information and/or records to facilitate prompt payment and resolution of claims. Providers must submit claims for services rendered within one (1) year of the date of service, unless otherwise stated in a Provider's contract. SCAN encourages providers to submit all claims as soon as possible. For more claims information, please refer to Ch 13 Claims of the *SCAN Provider Operations Manual*.

For more information on Payment, Checking Claim Status, Claims Disputes and more please refer to Ch 13, Claims, of the *SCAN Provider Operations Manual*.

For Claims In Which SCAN is not Responsible:

Log into SCAN's Provider Portal at *https://secure-pportal.scanhealthplan.com/,* for member eligibility & benefits information, in a downloadable 834 or flat file, including but not limited to:

- Member eligibility confirmation
- Member's ID#, status, coverage dates
- Medical group name and ID#
- PCP name and ID# and address to submit claims is available under the Eligibility Tab

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.

Provider Training

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. For more information, please refer to Ch 5 Network Standards of the *SCAN Provider Operations Manual*.

SCAN Provider Directory

SCAN is mandated to have accurate provider data. To that end SCAN relies on all providers and provider groups to provide real-time provider roster information. SCAN is required to audit and validate provider network data and provider directories on a routine basis. 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.

In addition, SCAN conducts a quarterly roster verification process which ensures that each provider network is accurately recorded in SCAN's provider data system. SCAN's validation efforts may include reaching out to providers using a vendor partner (CAQH and HiLabs). Outreach to providers may include the use of fax, email, and phone calls. Providers are required to provide timely responses to such communications.

DHCS Site Audits and Monitoring

For Provider offices in Los Angeles, Riverside, San Bernardino, and San Diego counties, DHCS requires that SCAN conduct an audit every three years for every PCP site in which SCAN members are treated. SCAN will notify physicians in advance of the site audit.

SCAN also reserves the right to conduct audits and monitoring as needed.

SCAN Contact and Resource Information

For SCAN contact or additional resource information for Members and Providers, please refer to the *SCAN Provider Operations Manual* or visit *SCAN website*.