Contracted Provider
Reference Guide

June 2021
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Welcome

Participating Contracted Provider
Welcome Participating Contracted Provider

L.A. Care’s first directly contracted provider network aims to:

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

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

Member ID Card Example:

![Medi-Cal Program ID Card Example](lacare.org)
Covered Medi-Cal Benefits
All covered benefits are free to the Member:

- Doctor visits
- Dental and Mental health services* 
- Vision Care
- Hospital care and emergency room care
- Prescription drugs, shots (immunizations), and more

* Dental services and specialty mental health services are carved out from L.A. Care required benefits.

To learn more about covered Medi-Cal benefits visit [http://www.lacare.org/health-plans/medi-cal/benefits-guide](http://www.lacare.org/health-plans/medi-cal/benefits-guide)

**Community Based Adult Services (CBAS)**

**Core Services:**

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

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

**Long Term Care (LTC)**

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

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

- PCP needs to complete a written order.
- Fax the completed CBAS or Long Term Care authorization request form WITH the physician order to the appropriate number.
- All Authorization Forms are available at LACare.org.
- CBAS and LTC Authorizations are managed by L.A. Care’s Utilization Management department.

In Home Supportive Services (IHSS)

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

The MLTSS Department assists Members with IHSS by:

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

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

Members who need IHSS can be referred directly to the DPSS IHSS Application Line (888.944.4477) or to the MLTSS Department for assistance.

- L.A. Care is financially responsible and oversees this program.
Multipurpose Senior Services Program (MSSP)

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

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

The MLTSS Dept. assists Members with MSSP by:

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

Members who need MSSP can be referred to L.A. Care's MLTSS Department. L.A. Care is financially responsible and oversees this program.
Managed Long Term Services and Supports (MLTSS) Contact Information

- The MLTSS Referral form is available in L.A. Care website at https://www.lacare.org/sites/default/files/la2562_mltss_referral_form_202005.pdf
- Fax the completed MLTSS Referral form to the MLTSS department, Secure Fax: 1.213.438.4866

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

- **Phone:** 1.855.427.1223
- **Email**: MLTSS@lacare.org

**Note:** Emails containing Member PHI must be securely encrypted
**Behavioral Health Services**

Non Specialty (Members with mild to moderate needs)

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

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

For Non-Specialty service, please contact: **Beacon Health Strategies at 1.877.344.2858**

**Specialty (Members with complex or inpatient needs)**

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

L.A. Care has partnered with Los Angeles County to link our Members: [https://dmh.lacounty.gov/](https://dmh.lacounty.gov/)

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

**Department of Public Health/Substance Abuse Prevention & Control (DPH)**

For referral to substance abuse services please call **1.800.564.6600.**

**L.A. Care’s Behavioral Health Department**

For more information on the behavioral system of care, please call **1.844.858.9940.**

**Pharmacy Benefits Manager (PBM) – Navitus Health Solutions**


- Formulary status (updated monthly)
- **Prior authorization requirements**
- Step-therapy
- Quality limits
- Exceptions for drugs
Transportation

Non-Emergency Medical Transportation:

NEMT is covered when a member requires medically necessary Medicare and/or Medi-Cal service, when prescribed life sustaining treatment, and when the member’s medical and physical condition does not allow travel by public or private conveyance (DHCS APL 17-010, DHCS DPL 18-001).

- Air Ambulance – Only if ground transportation is not feasible.
- Ambulance – facility transfers, acute care hospital, oxygen.
- Litter Van – prone or supine position, added safety.
- Wheelchair Van – Incapable of being in passenger car or public transportation during transport, disabling physical or mental limitation, safety.

Non-Medical Transportation

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

- Passenger car, rideshare, taxicab, bus, train, or any other form of public or private conveyance.
- Does not include invalid, infirm, convalescent or incapacitated.

<table>
<thead>
<tr>
<th>Product Line</th>
<th>Transportation Type</th>
<th>Benefit</th>
<th>Authorization Responsibility</th>
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<tbody>
<tr>
<td>Medi-Cal (MCLA)</td>
<td>Emergency Medical</td>
<td>Unlimited</td>
<td>Authorization not required</td>
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<tr>
<td></td>
<td>*NEMT:</td>
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<tr>
<td></td>
<td>Advance Life Support</td>
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<td>(ALS)/Basic Life</td>
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<td></td>
<td>Support (BLS)</td>
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<td></td>
<td>Critical Care</td>
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<td></td>
<td>Transport (CCT),</td>
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<tr>
<td></td>
<td>Gurney/Litter Van</td>
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<td></td>
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<tr>
<td></td>
<td>and Wheelchair Van</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unlimited</td>
<td></td>
<td>*L.A. Care provides authorization</td>
</tr>
<tr>
<td></td>
<td>NMT</td>
<td>Unlimited</td>
<td>Authorization not required to eligible location</td>
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In accordance with the All Plan Letter (APL) 17-010: Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) Services, L.A. Care Health Plan will require a PCS form for all services before NEMT is arranged effective February 1, 2020.

- Dialysis
- Chemotherapy
- Surgery Follow-Up
- Mammogram
- Radiation

However, in efforts to avoid unnecessary delays, discharges and transfers will remain as an automatic approval where a PCS form can be submitted within 24 hours after transportation has been rendered.

In other words: If there is no PCS form on file, transportation cannot be scheduled.

As a reminder, the PCS form is not required for NMT.

Health Plan must approve request before transportation is coordinated—review turn-around time is five (5) business days.

How to complete the PCS Form for NEMT Click here for Form and Instructions

- Who Can Prescribe NEMT?
  - Physicians
  - Physician Assistants
  - Nurse Practitioners
  - Certified Nurse Midwives
  - Physical Therapists
  - Speech Therapists
  - Occupational Therapists
  - Mental health or substance use disorder providers

Utilization Management (U.M.) Review

- Reviews Prior Authorization Request
- Approval duration for 30 days, six months, or one year
- Notifies Member, Provider, Transportation Broker/Manager

https://www.lacare.org/providers/provider-resources/forms-manuals
Referrals and Prior Authorizations
**Health Care Services:** *(never require prior authorization)*

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

**Note:** Direct Referrals shall follow the recommended guidelines, with the exception of OB/GYN services which are defined in policy Direct Referral OB/GYN policy). To see which services require Prior Authorization, please use our Online [Prior Authorization Tool](#).
When does a direct referral apply:

General Office Visits to in-network specialists are to follow the Referral Process outlined on the Prior Authorization Form. Procedures performed during office visits may require prior authorization. Please use the online Prior Authorization Tool to verify if prior authorization is required. Reminder: Out-of-network services always require Prior Authorization, with a few exceptions outlined in the benefits section.

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<th>Procedure Code</th>
<th>External Description</th>
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<tr>
<td>99202</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient (20 minutes)</td>
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<td>99203</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient (30 minutes)</td>
</tr>
<tr>
<td>99204</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient (45 minutes)</td>
</tr>
<tr>
<td>99205</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient (60 minutes)</td>
</tr>
<tr>
<td>99211</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician (5 min)</td>
</tr>
<tr>
<td>99212</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem-focused history, a problem-focused examination, and straightforward medical decision-making (10 min)</td>
</tr>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem-focused history, an expanded problem-focused examination, and medical decision-making of low complexity (15 min)</td>
</tr>
<tr>
<td>99214</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history, a detailed examination, and medical decision-making of low complexity (40 min)</td>
</tr>
<tr>
<td>99215</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history, a comprehensive examination, and medical decision-making of high complexity (80 min)</td>
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L.A. Care Direct Network Prior Authorization (PA) Rules

OUTPATIENT CARE:

- PA required for contracted providers for outpatient hospital-based, ambulatory surgery center and office-based procedures unless for sensitive services, preventative care or a procedure specifically outlined below
- PA required for non-contracted providers for outpatient hospital-based, ambulatory surgery center and office-based procedures unless only related to sensitive services
- PA required for all contracted and non-contracted hospice services
- PA required for all contracted and non-contracted DME (i.e supplies, equipment, orthotics, prosthetics)
- PA required for all contracted and non-contracted home health services (i.e RN, PT, OT, SLP)
- PA required for all contracted and non-contracted ancillary services (i.e chiropractic care, acupuncture and OP rehab services (speech therapy, occupational therapy, physical therapy, cardiac rehab, pulmonary rehab, etc)
- PA required for all contracted and non-contracted CBAS services
- PA required for all contracted and non-contracted services classified as experimental, investigational or unknown (EIU)
- PA required for all contracted providers for complex laboratory or complex radiology regardless of place of service (see below for specific codes)
- PA required for all non-contracted providers for ALL laboratory and radiology regardless of place of service
- PA required for some contracted providers for infusions/injections/PAD drugs (see below for specific codes)
- No PA required for contracted providers for basic laboratory or basic radiology services regardless of place of service (see detailed listing attached for specific codes)
- No PA required for all contracted and non-contracted Sensitive Services with correct ICD-10 and CPT/HCPCS combinations
- No PA required for all contracted preventative health services (i.e vaccines, colonoscopies) if billed with screening code and/or modifier 33
- No PA required for contracted community providers for speciality office visits (POS 11 + CPT 99201-99205, 99211-99215, 99241-99245)

INPATIENT CARE:

- PA required for contracted and non-contracted providers for all elective and emergency room inpatient admissions/surgeries except routine labor and delivery, both vaginal and c-section, if billed with ICD-10 O60.1-O60.23X9 or Z37-Z38.8
- PA required for contracted and non-contracted providers for admissions to Skilled Nursing Facilities (SNF)/Long Term Care (LTC), Rehabilitation, Long-Term Acute Care (LTAC) Facilities, Congregate Living (CLHF) and Recuperative Care.
- PA required for contracted and non-contracted Tertiary-Quaternary referrals (see Tertiary-Quaternary referral policy)
- No PA required for contracted and non-contracted providers required for professional services when performed within POS 21, 31,32,33,51, 54, 56 and 61
EMERGENCY ROOM & URGENT CARE:
- No PA Required for contracted and non-contracted providers for both facility and professional services for Emergency or Urgent Care services
- No PA required for contracted and non-contracted providers for all emergency room admissions to observation level of care (if REV CODE 450 on the claim)
- No PA required for Professional services for contracted or non-contracted Providers when performed within POS 19, 20, 22, 23, 24

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

NON-PAR PROVIDERS AND SERVICES:
- PA required for ALL non-contracted services unless specifically mentioned above

You will need to submit an Authorization for:
- Acupuncture
- Audiology
- Behavioral Health Therapy for children with Autism; (all others handled through Beacon)
- Chiropractic services
- DME
- Hearing Aid
- Home Health
- Home Infusion
- Hospice
- NMT Transportation (PCS form only once per year)
- Occupational and Physicial Therapy
- Out of network services (except emergency care)
- Prosthetics / Orthotics,
- Sleep Study
- Some specialty office test and procedures
  - Please use Prior Authorization Tool at lacare.org under the Provider Forms tab to see a codified list
- Surgeries (Inpatient and Outpatient)
Services that \textit{DO NOT} Require Prior Auth

\textbf{Note:} This is not an all-inclusive list. Other restrictions may apply.

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

:: Specialty Visits
   o Referral to any in-network medical specialist / provider for consults or follow up visits

:: Routine Care
   o Routine radiology tests such as x-rays, ultrasounds, echocardiograms, EKGs, etc.
   o Routine lab services, preparations and tests: CBC, metabolic panels
   o Non-Medical Transportation (NEMT requires a PCS form to be submitted once per year)
   o Urgent Care visits

:: Well Woman / OB Care / Family Planning
   o Well woman care (including annual cervical cancer screening, pelvic exams and mammography screening at intervals specified in the US Preventative Services Task Force Guidelines)
   o Basic prenatal care including in-network Obstetric (OB) referrals and consults
   o Family Planning services (including tubal ligation, vasectomies and outpatient abortion)
   o Lab tests as a part of the decision-making process for choice of contraceptive methods
   o Health education and counseling necessary to understand contraceptive methods and make informed choices
   o Follow-up care for complications associated with contraceptive methods
   o Certain sensitive and confidential services including HIV testing, STD diagnosis and treatment and sexual assault services

:: Inpatient Services
   o Emergency medical screening and stabilization services
   o Admission for Observation level of care
   o Admission for routine (uncomplicated) vaginal or routine (uncomplicated) C-section deliveries

:: Mental Health
   o Initial behavioral assessments
   o Physical exam for admission for inpatient mental health/behavioral health treatment

:: Preventative Health Services and Education
   o Preventative health services including immunizations, influenza and pneumococcal vaccinations
   o Health educations services provided by L.A. Care’s Health Education team

:: Dialysis, both in network and out of area
Pre-Service Authorizations

Inpatient Request vs. Outpatient Request

- **Inpatient Request**
  - All Non-Emergent Hospital Stays
  - Skilled Nursing Facilities
  - Essentially anything that may require the member to stay overnight

- **Outpatient Request**
  - Durable Medical Equipment
  - Home Health
  - Ambulatory surgery
  - Medical Supplies

Concurrent Review

Providers will not be submitting Concurrent Review in iExchange Portal

- Must be done via fax or phone
  - Please submit fax sheet and all supporting clinical documentation via fax. 213.438.5680
  - A UM nurse will contact the facility if necessary

Retrospective Authorizations

- Must be done via fax or phone
- Outpatient requests can be submitted in iExchange portal if it does not exceed 30 calendar days from the date of service.
- If timeframe exceeded for iExchange portal submission, retro authorizations need to be sent via fax.
  - Must include clinical records justifying need for service or supplies requested.

Standard Authorization Timeframes

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

- **Pre-Service Expedited / Urgent**
  - 72 hours from the receipt of the request for service
  - An expedited authorization in which the Provider indicated/determines that the standard timeframe could jeopardize the Member’s life or health or ability to attain, maintain or regain maximum function.

- **Retrospective / Post Authorization Review**
  - Within 30 calendar days of the request
  - Service occurred without prior authorization
How to get set up on iExchange

- Use the Medecision iExchange to submit requests electronically at:
  - [https://nexaligniexchange.medecision.com/IEApp/login/providerLogin.faces](https://nexaligniexchange.medecision.com/IEApp/login/providerLogin.faces)
  - Set up your office account with your preferred specialists, facilities and vendors
  - Configure your most used Procedure and Diagnosis Codes
  - Check Auth status on-line at your convenience
  - Technical support available 7 x 24

How to submit an authorization in iExchange

- iExchange link:
  - [https://nexaligniexchange.medecision.com/IEApp/login/providerLogin.faces](https://nexaligniexchange.medecision.com/IEApp/login/providerLogin.faces)
  - Set up your office account with your preferred specialists, facilities and vendors
  - Configure most used Procedures and Diagnosis Codes
  - Check status on-line at your convenience
  - Technical support available 7 x 24
  - Medi-Cal members in LA Care’s Direct Network DO NOT require an authorization for specialist consults and office visits, so they may be referred directly to the specialist.
  - Use the “Find a Doctor” online provider directory at [Online Provider Directory (OLPD)](http://www.lacare.org/sites/default/files/pl0840_prior_auth_request_form_202007.pdf) to find a participating provider in the member’s network.

How to Submit an Auth Request via Fax

- Use the Direct [Network Authorization form](http://www.lacare.org/sites/default/files/pl0840_prior_auth_request_form_202007.pdf) under the For Providers tab:
  - Confirm service(s) require Prior Authorization using our [Prior Auth Online Tool](http://www.lacare.org/sites/default/files/pl0838_iexchange_training_202007.pdf).
  - Mark Routine or Urgent
  - Complete the Member demographic information section
  - Complete the Specialist information section
  - Complete clinical and diagnosis sections
  - Attach any applicable clinical data
  - Use the matrix at the top of the form to determine where to fax the form

iExchange Portal:
- [https://nexaligniexchange.medecision.com/IEApp/login/providerLogin.faces](https://nexaligniexchange.medecision.com/IEApp/login/providerLogin.faces)

Direct Network Fax Form:

Direct Network FAQs:

Direct Network Customer Service: 1.844.917.7272
Direct Network Prior Authorization Process

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- iExchange Portal Overview
- iExchange Registration/Administration
- Pre Service Authorization
- Inpatient Authorization
- Outpatient Authorization
- Discussion / Disputing a Decision
- iExchange Demo
- Faxing Authorizations
- Resources

Purpose and Objectives

L.A. Care Health Plan is pleased to announce an alternative way for you to submit your authorization requests. Use of the iExchange Portal for submitting authorizations applies to members in the L. A. Care Direct Network.

After this training Providers will understand:

- How to gain access and login details to the Authorization Portal
- How to verify member eligibility and complete an authorization request via portal
- How to access near real time tracking (submission confirmation, status) – no phone call needed.
- Learn the updated fax process for non-portal users

With the fast pace in which we operate, it is our goal to continually offer process improvement opportunities. The new ability to offer an electronic way for submitting authorizations is our latest value added service to our providers.

We will share how quickly Providers can submit, review and track authorizations.
Who can use the iExchange Portal?

Audience

Audience includes Direct Network PCP’s, Specialists and Ancillary Service Providers. All Contracted Direct Network Providers.

Click here to access Direct Network Training Document

Provider Training UR

- Autism/Behavioral Health Therapy
- Behavioral Health
- CBAS
- Hospice
- Palliative Care
- Transgender Services
- Transportation

iExchange Portal

What is iExchange?

iExchange is a web-based, bi-directional communication platform.

- Allows providers to perform healthcare transactions with health plans and payers.
- Provides efficient, expedited workflows to reduce time expense associated with paper, phone and fax processes.

Why use the portal?

- Provides efficient, expedited workflows to reduce time and expense associated with paper, phone and fax processes.

Who should have access?

- Those who are responsible for submitting and monitoring authorization requests.

How do you receive access?

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

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Getting Started

Registering a New User

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

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

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

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

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

The activation link is valid for 72 hours.

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

A. Log on to the Provider Portal and select “Member Eligibility Verification.”

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

Figure 2
Claim(s) Search

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

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

Figure 3 - If you have the claim number available
Figure 4 - If you do not have a claim number available
Forms

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

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

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

Figure 5
Incentive Programs

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

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

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

Figure 6
Reporting

L.A. Care offers a number of reports for providers to view and download through the Provider Portal. Figures 7, and 8 are examples of what reports are available for Providers to view. If you have questions about a particular report or need more information about reporting please contact DNProviders@lacare.org for further assistance.

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

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

Figure 7
C. From the list of reports displayed, select the report you would like to view. See Figure 8 below.

Figure 8
Claims & Reimbursement
Urgent Claim Reminder to ALL Contracted Providers

In accordance with the mandatory language in the Direct Network Contract and/or Addendum, **ALL SERVICES provided** (including services covered under PCP Capitation) **must be submitted** to L.A Care Health Plan for processing. Claims submitted by PCPs will satisfy the mandatory requirement and will be processed according to contract specifications. ALL capitated and non-capitated services performed by any PCP or Specialist must be submitted. All claims should be submitted within 30 days of rendered service date.

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

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

Additionally, EDI can help reduce your administration costs by eliminating manual labor associated with preparing and mailing of a paper claim. EDI also gives you access to real-time verification of your claim submissions, allowing you to have visibility to errors and rejections so that you can correct for resubmission in real-time. Additional benefits include:

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

How to Enroll to Submit Your Claims Electronically

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

- Contact your Billing Service/Software Vendor to add L.A. Care to your practice management system to allow real-time electronic transmissions to Change Healthcare. Please reference L.A. Care’s Payer Id “LACAR”.
- If you do not have access to Real Time transactions via a software vendor or a billing service, please contact Change Healthcare Customer Support at: **877.363.3666** or visit their website at “https://support.changehealthcare.com/customer-support-portal” for more information on other options that may be available for direct submission to Change Healthcare.
Electronic Eligibility Verification

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

- Have the ability to create a 270 Eligibility Request and Receive a 271 Eligibility Response. The EDI 270/271 are common transactions in healthcare data exchange and are available through your practice management system and/or billing service. If you do not have access to create a 270/271 transaction, please contact your software vendor/billing service for additional information.

- Have the ability to electronically submit a 270 Eligibility Request to Change Healthcare. L.A. Care contracts with Change Healthcare Clearinghouse to receive and respond to all electronic eligibility requests on our behalf. If you do not have the ability to submit an EDI transaction to Change Healthcare, please contact your software vendor and/or billing service to add L.A. Care to your practice management system for submission to Change Healthcare.

- If you do not have the ability to submit using your current practice management system, please contact the Change Healthcare customer support line at 877.363.3666 for alternative options that may be available to your practice.

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

Electronic Funds Transfer (EFT) & Electronic Remittance 835

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

- Improved cash flow because you receive your reimbursement faster.
- Secure transaction
- Reduced administrative fees by eliminating the need to go to the bank
- No more lost checks
- Capitation and incentive payments can be directly deposited too!
How to enroll with Electronic Funds Transfer (EFT)

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

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

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

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

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

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

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

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

1. Login into your existing account at PaySpan
2. Request a new registration code
3. PaySpan Health will send you an automated email with your new registration code
4. Once you receive your registration code, go to www.payspanhealth.com
5. Select “Your Payments”
   a. Enter the Registration Code
   b. Provider Identification Number
   c. Tax Identification Number
   d. National Provider Identifier
7. Begin Registration

If you need additional assistance, contact a PaySpan Health Provider Service Specialist by phone 1.877.431.2273 or email.
Additional Information You Need To Know

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

Hard Copy (Paper) Claim Submissions by Mail

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

L.A. Care Heath Plan  
Attention: Claims Department  
P.O. Box 811580  
Los Angeles, CA 90081
Provider Dispute Resolution (PDR)
Provider Manual: Chapter Claims
A Provider has a right to file a dispute in writing to L.A Care within 365 days from the date of service or most recent action date if there are multiple actions. A Provider dispute is a written notice to L.A Care challenging, appealing or requesting reconsideration of a claim such as the following:

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

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

1. Provider Name, TAX ID under which services were billed and contract information
2. If the payment dispute concern a claim or a request for reimbursement or overpayment of a claim – a clear identification of the disputed item using LA Care's original claim number, the date of service, and a clear explanation of the basis upon which the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is disputed.
3. If the payment dispute is not about a claim, a clear explanation of the issue and the Provider’s position on the issue.
4. If the payment dispute involves a Member or a group of members, the name(s), and Member ID(s) (CIN) need to be documented along with rationale.
5. Second Level Disputes must state “Second Level Dispute” and include a copy of the first level dispute filing and determination.
Provider Disputes and Cap Deduct Disputes can be submitted via mail or fax.

- Mailed disputes are acknowledged within 15 days of received date. Faxed disputes are acknowledged within 2 days of received date.
  
  L.A. Care Health Plan  
  Attn: Provider Disputes  
  P.O. Box 811610  
  Los Angeles, CA 90081  
  Fax: 213.438.5057

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

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

✓ Claims and PDR

- Claims Customer Service: 1.866.522.2736

✓ Claims only

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

✓ Contact Account Manager

- Claims Customer Service: 1.866.522.2736
Resources at a Glance
With this reference guide, L.A. Care is confident that you will be equipped with the information you need to provide our members with care. Listed below are some additional resources that you may find helpful.

<table>
<thead>
<tr>
<th>RESOURCE</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Information</td>
<td>Phone: 1.866.522.2736</td>
</tr>
<tr>
<td>Member Services Line</td>
<td>Phone: 1.888.839.9909</td>
</tr>
<tr>
<td>Online Prior Authorization Tool</td>
<td>Prior Authorization Tool</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>Provider Referral Form: <a href="https://www.lacare.org/sites/default/files/care-management-referral-form-0916.pdf">https://www.lacare.org/sites/default/files/care-management-referral-form-0916.pdf</a> Email: <a href="mailto:cmreferral@lacare.org">cmreferral@lacare.org</a> Fax: 213.438.5077</td>
</tr>
<tr>
<td>Specialty Services</td>
<td>Call The Car English: 1.626.817.9211 Spanish: 1.866.529.2142 Vision Service Plan (VSP) Phone: 1.800.852.7600 TTY/TDD: 1.800.428.4833 Navitus Pharmacy Phone: 1.844.268.9786 Managed Long Term Services &amp; Supports E-mail: <a href="mailto:MLTSS@lacare.org">MLTSS@lacare.org</a> Phone: 1.855.427.1223 Fax: 213.438.4877 Nurse Advice Line (24/7) Phone: 1.800.249-3619 TTY: 711 Medi-Cal Dental Services Phone: 1.800.322.6384 TTY: 1.800.735.2922</td>
</tr>
<tr>
<td>Case Management</td>
<td>Specialist Mental Health Services Department of Mental Health Phone: 1.855.854.7771 Specialty Substance Use Disorder Department of Public Health Phone: 1.844.804.7500</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Non-Specialty Services Beacon Health Options Phone: 1.877.344.2858 L.A. Care Behavioral Health Services Phone: 1.844.858.9940 Email: <a href="mailto:behavioralhealth@lacare.org">behavioralhealth@lacare.org</a></td>
</tr>
<tr>
<td>Member Programs</td>
<td>Disease Management Asthma: 1.888.200.3094 Diabetes: 1.877.796.5878 Heart: 1.855.707.7852 Health Education Phone: 1.888.839.9909 Interpreting Services In-Person: 1.888.839.9909 Telephonic: 1.888.930.3031 California Relay Svcs: 711</td>
</tr>
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</table>
| Claims Department | Claims Forms: https://www.lacare.org/providers/claims-edi/submitting-claim  
  - Fee-For-Service PCP and Specialists – CMS 1500 Form Required  
  - CHDP Services – PM160 Form Required  
  - Provider Disputes Resolution (PDR) Electronic Claims Submission: http://www.lacare.org/sites/default/files/universal/office_ally_pm160.pdf Electronic Payment: https://www.payspanhealth.com/providerportal/registration Claims Submission Mailing Address: L.A. Care Claims Department PO Box 811580 Los Angeles, CA 90081 Provider Disputes Resolution Mailing Address: L.A. Care Claims Department Attn: Appeals and PDR Unit PO Box 811610 Los Angeles, CA 90081 Fax: 213.438.5793 |
# Direct Network Provider Tools & Resources

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

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

## Resource Name | Resource Description | Link
--- | --- | ---
Physician Pay for Performance | The Physician P4P program offers performance-based incentives to qualified high-volume physicians and higher-volume Community Clinics that provide high-quality preventive and chronic care to L.A. Care members. | https://www.lacare.org/providers/provider-central/quality-care-initiatives/p4p-program

Elevating the Safety Net | Launched in July 2018, Elevating the Safety Net is a $31 million initiative to address the physician shortage in Los Angeles County. Programs under the initiative include the Provider Recruitment Program, Provider Loan Repayment Program, Medical School Scholarship Program, Residency Support Program, and IHSS + Home Care Training Program, among others. | https://www.lacare.org/providers/provider-central/elevating-safety-net

Provider Recruitment Program | This program provides grant funds that will allow contracted entities within L.A. Care’s Medi-Cal network to better compete with practices outside of the safety net. Applicants may request up to $125,000 per provider. Funds can be used for salary and benefits subsidies, sign-on bonuses, and/or relocation costs. The five eligible provider types include Family Medicine, Internal Medicine, OB-Gyn, Pediatrician and Psychiatrist. | https://www.lacare.org/providers/provider-central/elevating-safety-net/provider-recruitment-program

Provider Loan Repayment Program | This program provides loan repayments of up to $5,000 per month for 36 months, with an opportunity to extend for an additional two years. Eligible primary care specialties include Family Medicine, Internal Medicine, Pediatrics, Obstetrics/Gynecology, and Psychiatry. | https://www.lacare.org/providers/provider-central/elevating-safety-net/provider-loan-repayment-program

Cozeva | Cozeva is a reporting and analytics platform that allows providers to better monitor and take action on performance gaps for quality and risk measures. Providers can sign up for free. Email lacare@cozeva.com for more information. | N/A

Prop 56 Funds | California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increased the excise tax rate on cigarettes and electronic cigarettes. The revenue was allocated to 6 health programs: Physician Services Supplemental Payments, Family Planning Supplemental Payments, Hyde Reimbursements (Medical Pregnancy Termination), Value-Based Payment Program, Developmental Screening Services and Adverse Childhood Experiences Screening Services. | https://www.dhcs.ca.gov/services/pages/dp-proposition56.aspx
<table>
<thead>
<tr>
<th>Resource Name</th>
<th>Resource Description</th>
<th>Link</th>
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<tbody>
<tr>
<td>Quality Improvement Webinar Training Series</td>
<td>An ongoing series of webinars which cover a wide range of quality improvement topics, ranging from diabetes care to data submission. Some sessions offer the opportunity to earn CME or CE credits.</td>
<td><a href="https://www.lacare.org/providers/provider-central/provider-programs/classes-seminars/">https://www.lacare.org/providers/provider-central/provider-programs/classes-seminars/</a></td>
</tr>
<tr>
<td>Provider Continuing Education Program</td>
<td>L.A. Care Provider Continuing Education (PCE) program is an accredited educational program that consists of Continuing Medical Education (CME) activities for Physicians (MDs, DOs, PAs) and Continuing Education (CE) activities for NPs, RNs, LCSWs, LMFTs, LPCCs and LEPs, and other healthcare professionals.</td>
<td><a href="https://www.lacare.org/providers/provider-central/provider-programs/classes-seminars/">https://www.lacare.org/providers/provider-central/provider-programs/classes-seminars/</a></td>
</tr>
<tr>
<td>Cultural and Linguistic Training</td>
<td>The Cultural and Linguistic Unit offers no-cost workshops available online for network providers. Available workshops include Cultural Competency, Disability Sensitivity and Unconscious Bias.</td>
<td><a href="https://www.lacare.org/providers/provider-central/provider-programs/classes-seminars/">https://www.lacare.org/providers/provider-central/provider-programs/classes-seminars/</a></td>
</tr>
<tr>
<td>Health Education Materials</td>
<td>L.A. Care offers several types of health education resources: order free health education and C &amp; L resources, free health education classes and seminars and health education information on many topics all in a printer friendly format. Providers can also refer patients to free Health Education services via the online referral form.</td>
<td><a href="https://www.lacare.org/providers/provider-resources/tools-toolkits/health-education-tools">https://www.lacare.org/providers/provider-resources/tools-toolkits/health-education-tools</a></td>
</tr>
<tr>
<td>HEDIS Resources</td>
<td>Free HEDIS reference guides for all HEDIS measures that L.A. Care reports. These are designed to help practices provide the best quality care and how to properly submit data.</td>
<td><a href="https://www.lacare.org/providers/provider-resources/tools-toolkits/hedis-resources">https://www.lacare.org/providers/provider-resources/tools-toolkits/hedis-resources</a></td>
</tr>
<tr>
<td>Clinical Practice Guidelines</td>
<td>Clinical Practice Guidelines are available for providers to use for evidence based practice for various medical and behavioral conditions.</td>
<td><a href="https://www.lacare.org/providers/provider-resources/tools-toolkits/clinical-practice-guidelines">https://www.lacare.org/providers/provider-resources/tools-toolkits/clinical-practice-guidelines</a></td>
</tr>
<tr>
<td>Preventive Health Guideline Brochures</td>
<td>Preventive health guideline brochures available for free for providers and their offices. Brochures are for Child/Adolescent, Adult and Older Adult.</td>
<td><a href="https://www.lacare.org/providers/provider-resources/tools-toolkits/clinical-practice-guidelines">https://www.lacare.org/providers/provider-resources/tools-toolkits/clinical-practice-guidelines</a></td>
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<tr>
<td>Resource Name</td>
<td>Resource Description</td>
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<tr>
<td>L.A. Care Community Link</td>
<td>L.A. CARE Community Link is a site where you can search for help with free or low-cost food, bills, job training, legal aid, and more. It's fast, free, and easy to use. Just enter the zip code in the search box and select the type of help that is needed.</td>
<td><a href="https://communitylink.lacare.org/">https://communitylink.lacare.org/</a></td>
</tr>
<tr>
<td>Provider Toolkits</td>
<td>Over a dozen free toolkits for providers on topics ranging from medical and mental health toolkits to serving diverse populations.</td>
<td><a href="https://www.lacare.org/providers/provider-resources/tools-toolkits/toolkits">https://www.lacare.org/providers/provider-resources/tools-toolkits/toolkits</a></td>
</tr>
<tr>
<td>Patient Satisfaction Tips</td>
<td>Tips available to L.A. Care providers to help them increase patient satisfaction and maximize financial payout.</td>
<td><a href="https://www.lacare.org/providers/provider-resources/tools-toolkits/quality-improvement-program/tips">https://www.lacare.org/providers/provider-resources/tools-toolkits/quality-improvement-program/tips</a></td>
</tr>
<tr>
<td>Online Provider Portal</td>
<td>L.A. Care offers two provider portals: one for Contracted/Participating Providers and one for Non-Contracted/Non-Participating Providers. The Non-Par Provider portal only has eligibility and claims status lookup. Eligibility is only for same day queries. No historical eligibility data is available. Additionally, no forms are available for download, no reports, no eligibility coverage history, and no other tools available.</td>
<td><a href="https://www.lacare.org/providers/provider-central/la-care-provider-central">https://www.lacare.org/providers/provider-central/la-care-provider-central</a></td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>L.A. Care’s Pharmacy Services offers several resources and guidelines to assist you with prescribing medications to our members. There is a list of covered drugs, outlined steps to improve medication adherence and prescription drug prior authorizations.</td>
<td><a href="https://www.lacare.org/providers/provider-resources/pharmacy-services">https://www.lacare.org/providers/provider-resources/pharmacy-services</a></td>
</tr>
<tr>
<td>Provider News and Advisories</td>
<td>Stay up-to-date with the latest information about policy and regulatory changes, education and training opportunities, as well as updates on clinical best practices in a bi-monthly email newsletter and quarterly print newsletter.</td>
<td><a href="https://www.lacare.org/providers/provider-central/news">https://www.lacare.org/providers/provider-central/news</a></td>
</tr>
<tr>
<td>Forms and Manuals</td>
<td>One-stop shop for L.A. Care provider manuals and commonly used forms.</td>
<td><a href="https://www.lacare.org/providers/provider-resources/forms-manuals">https://www.lacare.org/providers/provider-resources/forms-manuals</a></td>
</tr>
<tr>
<td>Quality</td>
<td>Email inbox managed by the L.A. Care Quality Improvement Clinical Initiatives team. Providers can reach out with questions.</td>
<td><a href="mailto:Quality@lacare.org">Quality@lacare.org</a></td>
</tr>
</tbody>
</table>
How to Contact an Account Manager

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

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

Please contact the L.A. Care Direct Network Help Line at 213.694.1250 ext. 4297 or e-mail DNProviders@lacare.org. You may also contact your L.A. Care Direct Network Account Manager.